Federal Democratic Republic of Ethiopia

Ministry of Health

Review of the Implementation Status of HSDP III

(A Synthesis Report)

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ACRONYMS

AHOTP	Accelerated Health Officer Training Programme
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
BEOC	Basic Emergency Obstetric Care
BPR	Business Process Re-engineering
CBHI	Community-Based Health Insurance
CDC	Center for Disease Control (USA)
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	Demographic Health Survey
DOTS	Directly Observed Treatment – Short course
DPs	Development partners
DPT	Diphtheria, Pertussis, and Tetanus vaccine
EFY	Ethiopian Fiscal Year
EHNRI	Ethiopian Health and Nutrition Research Institute
EHR	Electronic health record
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
GAVI	Global Alliance for Vaccines and Immunization

GFTAM	Global Fund against AIDS, Tuberculosis and Malaria
GIS	Geographic Information System
JFA	Joint Financing Arrangement
JRM	Joint Review Mission
HCF	Health Care Financing
HCT	HIV counseling and testing
HEP	Health Extension Program
HEW	Health Extension Worker
HHM	HSDP Harmonization Manual
HIT	Health Information Technicians
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
IHP	International Health Partnership
IMNCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
LMP	Logistic Master Plan
LMIS	Logistics Management Information System
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MOFED	Ministry of Finance and Economic Development

MOI	Ministry of Information
MTR	Mid-Term Review
NCD	Non-communicable disease
NCPB	National Committee for the Prevention of Blindness
NGO	Non-Governmental Organization
OPD	Outpatient Department
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund and Supply Agency
PHARMID	Pharmaceutical and Medical Supplies Import and Distribution
PHEM	Public Health Emergency Management
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Maternal to Child Transmission of HIV
PNC	Postnatal Care
PPP	Private-public partnership
RDF	Revolving Drug Fund
RDT	Rapid Diagnostic Test
RH	Reproductive health
RHB	Regional Health Bureau
SCMS	Supply Chain Management System
SHI	Social health insurance
SNNPR	Southern Nations, Nationalities and Peoples Region
SPM	Strategic Plan Management
TB	Tuberculosis
TOT	Training of Trainers
TVET	Technical and Vocational Education and Training Center
USD	United States Dollar
VCT	Voluntary Counseling and Testing

EXECUTIVE SUMMARY

HSDP III, which was launched in EFY 1998, is in its final year of implementation. The programme has been designed in the context of the National Health Policy (1993), Health Sector Strategy (1995), Plan for Accelerated and Sustainable Development to End Poverty (PASDEP) 2005/06-2009/10, the UN Millennium Development Goals (MDGs) and other government policies and strategies. Attempt has been made to harmonize its goals, objectives and targets with the goals, objectives and targets of these policies and strategies.

This report is therefore designed to provide an overview of the performance of HSDP III with emphasis to the achievement of the specific objectives and targets, the challenges encountered, lessons learned and the opportunities that prevailed during the last four years of programme implementation and the strategic issues to be addressed in the design of HSDP IV.

A review of the HSDP III document show that the programme comprises of three goals that include reduction of child morbidity, improvement of maternal health, and combating HIV/AIDS, malaria, TB and other diseases. It has also eight broad objectives and 87 specific targets spreading across eight programme components.

Regarding to the implementation status of the broad objectives of the programme, the objective of covering all rural kebeles with HEP to achieve universal PHC coverage by 2008 has been fully achieved by training and deploying 103% HEWs and constructing 83% of the health posts required to achieve the specified target and in one kebele office until a health post is constructed and equipped. Similarly, various reports illustrate the objective of reducing maternal mortality to 600/100,000 and under-five mortality to 85/1000 life births have been achieved.

Although there are no recent data on fertility, the proxy indicators of contraceptive acceptance rate (CPR)and population growth rate suggest a markedly decline in mortality rate. CPR has increased from 38% (EFY 1998) to 56% (EFY 2001) and population growth rate has declined to 2.1% from the 2005 level of about 2.7%. These imply a reduction of fertility rate.

According to the Single Point Estimate done in 2007, the incidence of HIV has been reduced to 0.68% to 0.27% and the prevalence has declined from 3.5% to 2.1%. In the same vain, morbidity and mortality from malaria have shown significant decreases as 48% and 55% reduction in malaria morbidity and mortality have been observed respectively and the case fatality from TB now stands at 5%.

With regard to maternal health, DHS 2005 illustrated that family planning service coverage in terms of knowledge and use of family planning methods has increased. About 88% married women and 93% married men knew at least one method of contraception. A baseline study in the big regions (Amhara, Oromia, SNNPR and Tigray) showed that half of the married women have ever used family planning methods. In addition to this, as discussed above, contraceptive acceptance rate has reached 56% in EFY 2001and expected to reach the target by 2002.

The HSDP III target of 32% delivery by skilled attendants has not been yet achieved as it now stands at 23%. According to 2009 EmONC Baseline assessment, 51% of hospitals and 14% of health censers provide full comprehensive EmONC while the targets are 87% for hospitals and 20% for health centers.

The targets for child immunization have been behind targets as DPT_3 coverage have reached to 82% against the 85% target and 65.5% for full immunization against the 80% coverage target.

Targets for the major communicable disease have been set in HSDP III. But achievements will be here presented for HIV/AIDS, malaria and TB. As illustrated in ARM of EFY 2001, the target of providing VCT services in 100% hospitals and health centers and PMCTC in 100% hospitals and 70% have been achieved. Both VCT and PMTCT are integrated with existing ANC services. The number of PLWHA receiving ART has now reached 154,378. The 263,000 target is expected to be achieved by end of EFY 2002.

Remarkable achievements are observed in malaria control. A baseline survey undertaken in Amhra, Oromia, SNNP and Tigray regions in 2009 illustrates that two-third of households in these regions have at least one bed net. This is expected to significantly rise in EFY 2002 since over 22.2 million bed nets have been procured and are under distribution in EFY 2001 and 2002. In fact, Ethiopia is now known as a country in Sub-Sharan Africa, after Togo and Sierra Leone, with the highest net coverage. Nevertheless, the same survey, showed a low two net utilization rate. Households that use two bed nets in those four regions constitute 27% while those in Amhara constituted 40%, 23% in Oromia, 31% in SNNPR and 25% in Tigray.

With regard to TB control, the target of 85% treatment success rate is almost achieved in EFY 2001 as it now stands at 84%. The disappointment feature is that the case detection rate of 70% has not been achieved as it now stands at 34%.

According to the MTR, the trachoma treatment success rate achieved has been found to be encouraging. But the overall control activities require improvement and additional effort in the detection rate of the disease. The number of Woredas implementing the WHO recommended Surgery Antibiotics, Facial Cleanliness and Environmental Improvement (SAFE) Strategy has reached 124 in EFY 2001. A total of 37,000 ctaract surgeries were performed in EFY 2001 alone. There has been no specific data found to assess the status of the target. Little is known on the control of onchocerciasis and dranculosis since the involvement of government is limited and some work is being done only by WHO.

In order to establish public health emergency management (PHEM) teams at FMOH and RHBs, 13 epidemic intelligence service officers are being trained at Masters Degree level in Addis Ababa University. Eighteen diseases have been selected for surveillance and detection.

With regard to hygiene and environmental health, latrine coverage stands between 37% and 86%. The national average coverage is 56%. The status on communal solid waste disposal of villages is not known. It is said that the WASH Inventory and the 2010 DHS could provide the necessary information about it. Waste management system is institutionalized in 60% of hospitals. According

to the informant from FMOH, status of drinking water quality monitoring and monitoring of food safety in food processing industries is unknown since monitoring of both establishments has not been included as an activity in last rounds of plan.

Current, consistent and full data on the different types of curative services particularly on the statuses of emergency surgery service and on mainstreaming of mental health are absent. However, the pilot community-based survey conducted in Jimma Zone in 2007 illustrates that out of the 304 individuals studied, 83.5% had got some kind of health care at different levels of health facilities and 19 (5.2%) got inpatient health care. The OPD per capita attendance rate has shown a dwindling trend and wide variation from region to region since the last five years. It ranged from 0.18 in Somali to 0.72 in Tigray with a national per capita attendance rate of 0.30 in EFY 2001. The HSDP III target in this respect was to push it up to 0.66.

Significant progress has been made on the construction and renovation of health and health related facilities, the supply and utilization of inputs to health facilities, maintenance of medical equipment and computers and the expansion of health information technology. The available data show that the targets on increasing the potential health post and health center coverage, and increasing the general potential health coverage, equipping and furnishing of 80% health facilities and the upgrading of 30% of health centers to provide emergency obstetric services will be achieved in EFY 2002 by completing the construction and equipping of the health facilities that have been started in EFY 2001.

Although it has been difficult to find complete and consistent information on the different categories of health workers, the available data from HR Directorate of FMOH show that remarkable progress has been made on the training and deployment of HEWs (103%), health officers and to some extent midwives. The accelerated health officers training programme (AHOTP) and the innovative physician training programme are on schedule. Consultation has been undertaken with relevant national institutions on scaling up the midwifery training programme by enrolling 300 students per year.

Remarkable progress has been also observed in the area of providing efficient pharmaceutical services to public health facilities. The procurement of health commodities has been stepped up by establishing PFSA, constructing storage and warehousing facilities and by shortening the lead time for commodity procurement. PFSA has reached to a level of procuring essential drugs and medical equipment worth of ETB 600.0 million and will procure and distribute ETB 2.8 billion worth of medical commodities in EFY 2002. Nevertheless, since assessments have not been carried out, it has not been possible to know the status of the six targets that fall under the mandates of PFSA and DACA.

There were many activities undertaken in IEC/BCC promotion. Guidelines and materials have been developed and distributed. However, although the guidelines and materials have been developed and distributed, their effectiveness in ensuring behavioral change in preventing and controlling disease of public health importance and the sustainability of their distribution and use has not been evaluated. The target of ensuring 100% popularization, adaptation and implementation of National

IEC/BCC Strategy at all levels of the health system has not been achieved. But a plan has been developed and a task force has been established to undertake popularization, adaptation and implementation of the National IEC/BCC Strategy at all levels. With regard to the target of providing appropriate health communication materials to 100% the HEWs and equipping 100% of kebeles implementing HEP with portable IEC equipment, HEP centered radio spots, audio and video messages numbering 516 and 69 respectively, leaflets/pamphlets, newsletters and posters on HIV/AIDS, malaria, TB, acute watery diarrhea, personal hygiene and environmental health, reproductive health and other health issues have been prepared and distributed to HEWs. About 1,565 tape recorders, 1,488 megaphones, 6,167 video teaching aids and 69 audiocassettes, 69 video cassettes, 62,500 battery cells, 200 amplifiers and 200 horn speakers were procured and distributed.

According to the interview with the concerned case team member from FMOH, apart from DHS 2005, data on current status on are not available on the target of increasing the KAP of the population on HIV/AIDS, malaria and TB by 50% of its 2005 status. Regarding the targets on increasing adolescent awareness and knowledge on HIV/AIDS and STDs from 77% and 30% to 95% and 80% and increase adolescent awareness and knowledge on contraception from 80% to 95%, attempt has been made to increase adolescent awareness and knowledge on HIV/AIDS and STDs. The targets have not been achieved due to lack of sustained planning and implementation on adolescent awareness creation and knowledge on HIV/AIDS and STDs. It is said that focus is now made on care and support than on prevention. This has been reported as worrying as this will reverse the gains that have been achieved.

The Health Management, Management Information System and M&E component seems to be fairly on progress. The CSR has been successfully carried out, staff with appropriate professional knowledge and skills have been deployed at regional and Woreda levels, health management boards are established in many hospitals, a comprehensive national and standardized HMIS has been developed, a process has been started to review and strengthen the existing HMIS at regional and Woreda levels, and evidence-based planning has taken place in 810 Woredas. Achievements in the area of M&E have been also satisfactory. A comprehensive and integrated M&E guideline has been developed, ARMs and JRMs have been regularly undertaken at federal and regional levels, and the harmonization and alignment of donor-government reporting cycle has shown progress.

Major undertakings have taken place in health care financing particularly in the areas of resource mobilization, development of a health insurance system, retention and use of revenue, and increasing the per capita health expenditure. The number of development partners has increased and the amount of resource mobilized and committed by external sources has reached USD 414.7 million at EFY 2001. The necessary legal frameworks have been developed and submitted to the Council of Ministers for the establishment of a social health insurance (SHI) scheme in the country, preparatory activities have been completed for piloting the community-based health insurance (CBHI) system. HIV/AIDS fund has been set up in 5,312 (47%) public sector institutions. Per capita health expenditure is increased from ETB 16.00 in EFY 1998 to ETB 27.00 in 2001. Actual Government expenditure has also increased from ETB 1.2 billion in EFY 1998 to ETB 3.9 billion in

2002. Nevertheless, due to lack of complete data, the expansion of public pharmacies in hospitals and health centers which is one of the targets is not known.

Similar progress has been made in the crosscutting areas of HSDP III, mainly in gender mainstreaming, nutrition, harmonization and alignment. Reports illustrate that gender has been mainstreamed and preparation are under way to launch a programme on physical violence and abuse. Institutional strengthening and activities related to combating malnutrition and deficiency of micronutrients are undertaken in the nutrition area. Nevertheless, according to the informant from FMOH, although assessments have not been carried out on the impacts of the various interventions, there seems to be much progress in improving the nutritional status of children and mothers.

Finally, many challenges have been encountered; there were many opportunities and many best practices and lessons that have been learned during the implementation of HSDP III. They are outlined in sections V, VI and VIII of the report Recommendations and major program issue especially that would be inputs to the development of HSDP IV are found in sections IX and X.

Review of the Implementation Status of HSDP III

(A Synthesis Report)

I. Introduction

HSDP III, which was launched in 2005/06, is in its final year of implementation. The major goals of HSDP III is to improve the health status of the Ethiopian peoples through the provision of adequate and optimum quality of promotive, preventive, basic curative and rehabilitative health services to all segments of the population. The general goals of HSDP III that Contribute to the achievement of the ultimate goals are improving maternal health, reducing child mortality and combating HIV/AIDS, malaria, TB and other diseases. The programme also aims at achieving the health Millennium Development Goals (MDGs) through the principle of stakeholder partnership and harmonization approach.

The Programme has been formulated in the context of the following National Policies and strategies. Attempt has been made to harmonize its goals, objectives and targets with the goals, objectives and targets of these strategies.

- The National Health Policy
- Health Sector Strategy
- The Sustainable Development and Poverty Reduction Programme (PASDEP)
- Health Service Extension Programme (HSEP)
- Accelerated Expansion of Primary Health Care Coverage
- The Health Care Financing Strategy
- The National Strategy for Child Survival
- Policy and Strategy for the Prevention and Control of HIV/AIDS
- Health Human Resource Development Plan
- The National Drug Policy
- The National Population Policy
- The National Policy on Women
- Policy and Strategy on Democracy, Good Governance and Decentralization
- The Capacity Building Strategy and Programme
- The Rural Development Policy and Strategy

Since Ethiopia is not alien to Global Policies and Initiatives and has adopted them so as to benefit from and contribute to them, HSDP III has been also designed taking into account the following Global Policies and Initiatives:

- The Global Fund to Fight HIV/AIDS , Tuberculosis and Malaria (GFATM)
- The President's Emergency Plan for AIDS Relief (PEPFAR)

- Global Alliance for Vaccine Initiative (GAVI)
- Roll Back Malaria Initiative (RBM)
- UN Millennium Development Goals (MDGs)

The last Initiative; the Millennium Development Goals Initiative is one of the most important guiding planning framework for the formulation and implementation of the Programme.

HSDP III was implemented through the preparation of a series of detailed, Woreda and evidence-based annual plans. It followed top-down and bottom-up and participatory approaches its objectives and targets aligned with PASDEP priorities and targets, and MDG targets. Mapping of resources, costing of plans and analysis of gaps were also parts of the process of implementation.

Its implementation has been continuously monitored through Annual Review Meetings (ARMs), a Mid-Term Review, and Joint Review Missions (JRM). The necessary mechanisms and instruments have been designed and appropriately used to assess the progress and identify the challenges and obstacles encountered during the implementation of the programme and to overcome those challenges and obstacles. All of the above monitoring mechanisms were mutually supportive shading lights on the implementation status of the programme. The ARMs, the Mid-Term Review and JRM brought together various partners and stakeholders at Federal, regional, Woredas and community levels. They included Federal and Regional Government agencies, Woreda Health Offices, Health Extension Workers, Health, Population and Nutrition (HPN) Donor Groups, International Organizations, NGOs, Professional Associations, Institutions of Higher Learning and the private sector.

The third ARM of HSDP III was conducted in Dire Dawa from October 7-9, 2009. Like previous ARMs, the objectives of the review meeting were to take stock of the progress made and problems encountered in the implementation of the EFY 2001 Plan, review and endorse the health sector draft Core Plan for EFY 2002, introduce new policy and programme initiatives and strengthen partnership between Government, donors and other stakeholders.

II. Aim of the synthesis report

The aim of the review report is to provide an overview of the performance of the HSDP III with emphasis to the issues, strengths achieved, synthesis of the strategic issues to be focused in the coming five years, and hence, provide information to the design and framework of HSDPIV.

Based on this, the situation analysis saw how well Ethiopia's health system has been performing during the past four years with regard to the specific HSDP III major objectives and specific targets. It has outlined the major challenges and constraints and the lessons learnt during HDP III that can inform the formulation of HSDP IV.

III. Methodology

The main methodology for the review was a desk review and interview of key informants in FMOH which includes the following:

1. Collection of data and information from existing documents and key informants;
2. Review of HSDP III major objectives and specific targets in relation to their performance status;
3. Review of current coverage of interventions and compare it to targets;
4. Review of status of indicators related to availability, access, demand, and quality of health services and knowledge of families in line with the philosophy of the HEP;
5. Review of major activities in the previous five years implementation and assess how well they were implemented;
6. Synthesizing the information and generating ideas on what is needed to reach national and international health targets.

The situation analysis was made against eight measurable and specific programme objectives and 87 targets falling under the eight components of HSDP III[1]. The number of targets under each component of the programme is as follows:

S. No.	Component	No. of Targets
1	Health Service Delivery and Quality of Care	33
2	Health facility Construction , Expansion and Transport	6
3	Human Resource Development	10
4	Pharmaceutical Services	6
5	Information, Education and Communication	6
6	Health management, Management Information System and M&E	12
7	Health Care Financing	6
8	Crosscutting Issues	8
	TOTAL	**87**

[1] FMOH, HSDP III, Health Sector Strategic Plan , 2005/06-2009/10, 2005

All were identified from the programme document and listed in a format prepared for this purpose. Attempt is made to assess and register the status at EFY 2001. The targets set for EFY 2002 were taken into account in some instances to have an overall picture of the situation at end of EFY 2002 which is the end of HSDP III. Trend analysis has been made wherever possible and shown by line graphs. The status of some targets have been assessed by proxy quantitative and qualitative input, process, output and outcome indicators such as access to interventions and coverage i.e. the number of target populations that received intended services.

Challenges, constraints and obstacles encountered during the implementation of each component of the programme and the programme as a whole and the various strategic and component-specific recommendations identified from the various ARMs, the MTR of 2008, JRM of 2009, Baseline National EmONC, Baseline Household Health Survey, and other assessments are also synthesized and presented. Recommendations that help the preparation of HSDP IV have been identified and included in the synthesis report. Over 42 documents were reviewed to find relevant and latest data. The documents in which data have been used are cited at relevant pages and in the reference list.

There are a number of sections in the report. The main sections are the introduction which elucidates the genesis and background of HSDP III. The second section is the major one in which the outcome of the review is reported by programme component using figures and graphs. This includes the implementation status of each specific target of HSDP III and an outline of the major challenges and constraints encountered.

The other sections narrate the opportunities that helped the planning and implementation of HSDP III, the role and contribution of HSDP in the socioeconomic development of the country, the successful elements and lessons learned from HSDP III the recommendations and major issues that have to be addressed in HSDP IV and conclusion of the review as a final section of the report. Last not least, there is an annex that shows a synthesis of the 94 detailed programmatic indicators and targets of HSDP III (refer to annex 3 of the main programme document) with their respective achievements.

Implementation Status of the Major Objectives of HSDP III

HSDP III is Phase III of the long term Health Sector Strategy adopted by the Transitional Government of Ethiopia in April 1995. The main objective of the health service as stipulated in the Health Sector Strategy Document is to give a comprehensive and integrated primary health care in health institutions at the community level. The approach is to emphasize on the preventive end promotive aspects of health care without neglecting essential curative services. The focus is control of communicable diseases, common nutritional disorders and on environmental health and hygiene with special attention to maternal and child health care, immunization, reproductive health, treatment and control of basic infectious diseases like upper respiratory tract infections and tuberculosis, control of epidemics such as malaria, the control of sexually transmitted infections particularly AIDS.

HSDP III constitutes eight major strategic objectives that fall under the different components of the programme. The implementation status of each of the major objectives is as follows.

Major Objectives of HSDP III	**Implementation Status**
1. To cover all rural kebeles with the HEP to achieve universal PHC coverage by 2008	83% of the health posts are constructed until end of EFY 2001. Remaining health posts are expected to be constructed before the end of HSDP III. The training and deployment of HEW in rural kebeles has been achieved by 103% in EFY 2001[2]. HEWs are hosted in kebele offices where health posts are not constructed. HEWs that compensate attrition have been also taken into account. However, their service could be constrained by the delay in the construction of health posts and distribution of medical kits and lack of supportive supervision as the required number of supervisors have not been trained and deployed by RHBs.
2. To reduce maternal mortality ratio from 871 to 600 / 100,000 live births	Since DHS 2005, no recent figures are available, but some studies suggest that this objective of 600/100,000 has been achieved in 2005.Further reduction is anticipated due to the mass intervention by HEWs.
3. To reduce the under-five mortality rate from 123 to 85 per 1000 live births and infant mortality rate from 77 to 45 per 100 live births.	No recent figures available since the DHS 2005 IMR of 77/1000 and <5MR of 123/1000. But reductions are due to as a result of the contribution of the HEWs and voluntary Community Health Workers (vCHWs) in communality mobilization and promotion for EPI and nutrition interventions and child health practices.
4. To reduce the total fertility rate from 5.4 to 4	No recent figures are available. But EDHS shows that between 2000 and 2005, total fertility rate (TFR) among women age 15-49 in urban areas declined from 3.0 to 2.4 where as it remained constant in rural areas as 6 children per women. The national TFR changed very little between 2000 and 2005, declining from 5.5 to 5.4.

[2] FMOH, ARM EFY 2001

	Nevertheless, the proxy indicators of contraceptive acceptance rate and population growth rate suggest a decline in fertility rate as they stand now at 56% [3]and 2.1%[4] in EFY 2001 respectively.
5. To reduce the adult incidence of HIV from 0.68% to 0.65% and maintain the prevalence of HIV at 3.5%	Adult incidence rate in EFY 2000 was 0.27% and prevalence rate is 2.1%[5].
6. To reduce morbidity and mortality attributed to malaria from 22% to 10%.	Morbidity due to malaria declined by 48%, hospital admissions by 54% and mortality by 55% in EFY1999[6].
7. To reduce the case fatality rate of malaria in age groups 5years and above from 4.5% to 2% and case fatality rate in under 5 children from 5% to 2%.	In-patient case fatality for > 5 years old is 3.3% and for the < 5 years is 4.5%[7].The case fatality of the <5 seems to have improved.
8. To reduce mortality attributed to Tuberculosis from 7% to 4% of all treated cases.	TB case fatality is reported at 5%.TB case detection rate is 34%[8]. Both are low rates of performance (FMOH, TB Prevention and Control

Strategic Challenges

- Weak performance of the various programmes such as IMCI, Comprehensive and Basic Emergency Obstetric Care (C-BEmOC), immunization, nutritional interventions, improvement in TB programme,
- Limited number of hospitals and health centers and their distance from their potential beneficiaries
- Shortage of human resources such as physicians, health officers, midwives and other category of health workers
- Financial barriers affecting demand for services
- Poor integration of services such as ANC, PMTCT, STI, TB services
- Delayed in the construction and equipping of basic health facilities, particularly health posts and health centers
- Weak monitoring, support supervisions and HMIS at regional and Woreda levels
- Delay by Development Partners (DPs) in joining the Joint Funding Arrangement (JFA) as only eight DPs signed the IHP Compact.
- Low disbursement of committed fund by DPs as it was 55.4% in EFY 2001

[3] FMOH, ARM EFY 2001
[4] CSA, 2007 National Housing and Population Census Report
[5] HAPCO, Single Pont Estimate, 2007
[6] FMOH, Ethiopia Makes Striking Strides in Malaria Control Efforts, 12 August 2008
[7] Ibid
[8] FMOH, TB Prevention and Control Programme, Annual Bulletin, 2009

Component 1: Health Service Delivery and Quality of Care

1.1 Family Health Services

1.1.1 Maternal and Neonatal Health

Ethiopia is one of the countries with the highest maternal mortality rate in the world, which in 2005 was 671/100,000 live births. MMR in 1990 was 1,040/100,000. The major causes of maternal death are abortion, eclampsia, ruptured uterus, hemorrhage, infection, hepatitis, HIV and malaria[9]. It had also the highest under 5 child mortality which was 204/1000 live births and has been reduced to 123/1000 by 2005. It is planned to reduce it to 67 by 2015. Nevertheless, the 2008 MTR gives a grim picture of the future and at least those targets are unlikely to be achieved with the given programme status.

The Federal Ministry of Health formulated and implemented a number of policies and strategies that provide an effective framework for improving maternal and neonatal health. The policies and strategies that are currently being implemented include Making Pregnancy Safer (2000), Child Survival Strategy (2005), Reproductive Health Strategy (2006), Adolescent and Youth Reproductive Health Strategy (2006) Nutrition Strategy (2008) and the Revised Abortion Law (2005). But achievements in maternal and child health have been generally lower than their targets set although satisfactory performance on immunization has been observed and most regions tend to meet Penta and measles coverage. The success has been attributed to the effort of HEWs and voluntary Community Health Workers (vCHWs) in community mobilization and promotion of household child health care practices. Studies show that 87% of kebeles, have at least one vCHW. But the success has been reduced by shortage of vaccines and supplies as a result of pooling of resources[10].

Expansion of the services is expected to occur through health facility expansion and implementation of the various initiatives in which the initiatives are Accelerated HO training programme (AHOTP) and task shifting, one nurse with midwifery skills in every health center, the training of 300 midwives per year, and training of health officers on emergency obstetric care and surgery in three universities. With this approach, MMR is expected to be brought down to 267 by 20015. Implementations of the specific HSDP III targets are as follows:

[9] Transitional Government of Ethiopia, Health Sector Strategy, April 1995
[1010] FMOH, JRM Report, 2009

Specific HSDP III Targets	Implantation Status
1. Increase family planning service coverage from 25% to 60%	EDHS 2005 shows that knowledge on family planning is high. 88% of married women and 93% of married men know at least one method of contraception. 87% of married women know about the modern method and 17% the traditional method. The pills (84%) are the most known method followed by injectable (83%). The baseline studies fielded in Amhara, Oromia, SNNP and Tigray regions from December 2008-January 2009 demonstrated that half of the married women have ever used family planning methods. Implants, IUDs and female condoms have been observed to be available in 55%, 24% and 7% of all health facilities respectively[11]. Family planning acceptors coverage as measured in terms of contraceptive acceptance rate seems to be on track. It has reached 56.2% in EFY 2001 and is expected to go beyond the target of 64.5% by end of HSDP III. It is planned to push it to 70% in 2002 provided much more effort is exerted in same year as CAR has been increased by about only 2% in EFY 2001 from the 2000 level of 54%.
2. Increase deliveries attended by skilled attendants from 12% to 32%	Currently 90% of the births occur at home/community level. Institutional delivery accounts only 7%with variations among regions (2%-63%). 57% of the institutional deliveries are at hospitals. Between July 2007 and June 2008(EFY1999-2000), 7% of the 174,561 deliveries were attended in 751 health facilities with maternity services. Only 3% of all births took place in fully functioning EmONC facilities. Although not significant, there have been increases in the percentage of deliveries assisted by skilled health personnel during last four years of HSDP III. But the HSDP target of 32% has not been achieved and remains behind this target as it now stands at 24.9%. Poor providers' attitude (harassment, lack of attention to women's complaints, and lack of

[11] JSI, Baseline Household Health Survey, August 2009

	follow up in labor) were reported to be determents to the use of institutional delivery services[12].
3. Provide CEOC in 87% of the hospitals and 20% of the HCs	Caesarean section rate at national level is 0.6% with a range from 0.4% to 49% among regions. The total number of hospitals providing comprehensive and basic obstetric and neonatal services is 111. Out of this, 51 provide comprehensive, 16 basic and 38 partial services. Similarly, the total number of health centers that provide comprehensive and basic obstetric and neonatal services is 684. Out of this, only one health center provide comprehensive, nine basic and 674 partial EMONC services. This is a target that is far behind the plan. The total number of health centers planned to provide BEmONC are 1,656 (69%). According the 2009 EmONC Baseline Assessment 51% of the hospitals provides comprehensive and 14% of the hospitals basic services, while 34% of the hospitals partially function. With regard to health centers, it is only 1% of health centers that provide comprehensive service and almost all (99%) which partially function.
4. Provide BEOC in 100% of HCs	The national coverage for basic and comprehensive EmONC facilities is only 11% of the standard set in the UN process indicator of 5 facilities per 500,000 populations. It is 2% to 10% among regions. With regard to the achievement of the indicated target and although difficult to get accurate and sufficient information on past performances, it seems that achieving the target is remote since the number of health centers planned to provide BEmONC are 1,656 (69%).
5. Reduce the prevalence of teenage pregnancy and unsafe abortion from 20% and 50% to 5% and 10% respectively	Although specific data related to the targets are not available, EDHS 2005 report shows that 17% of teenage girls 15-19 (married and unmarried) are already mothers or pregnant with their first child. Nearly three times as many teenage girls in rural areas as in urban areas have begun child bearing. Almost 30% of teenage girls with no education

[12] FMOH, JRM Report, 2009

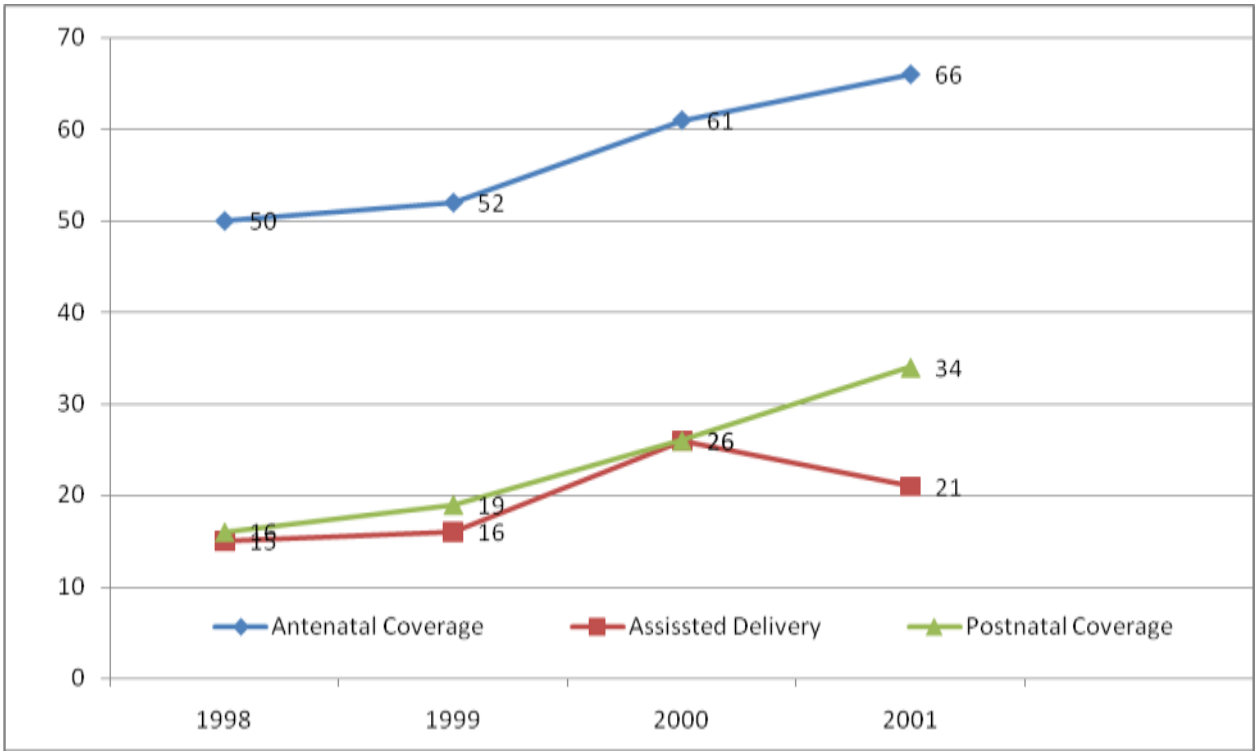
	have begun childbearing. In Ethiopia, 40% of young women have their first child by 19 years of age and 54% of pregnancies of girls under the age of 15 years are unwanted which consequently result in unsafe abortion. Although there have been no performance reports for EFY 1998,1999 and 2000, services on teenage pregnancy and unsafe abortion have been provided to 63,492 teenagers in EFY 2001 and 120,603 teenagers are targeted to receive the services in EFY 2002.
6. Increase DPT_3 coverage from 70% to 85% and increase the proportion of fully immunized children from 45% to 80%	DPT_3 coverage stands at 82% in EFY 2001. It is expected that the 85% coverage will be achieved during the remaining year of HSDP III[13]. Performance on full immunization is far behind the 80% target as it stands at 65.5% in EFY 2001.
7. Increase the proportion of neonatal resuscitation and Ampicilline /Gentamycine for neonatal sepsis from 6% to 32%	The EmONC Assessment Report illustrates that almost half of the facilities did not provide newborn resuscitation; which in 66% of the cases is due to unavailability of bags and masks. The proportion of health facilities that provided parenteral antibiotics is 80%. Lack of equipment and skilled workers constitute as major obstacle /constraint to obstetrics and newborn emergencies. EmONC Assessment shows that out of 111 hospitals 75% and out of 638 health centers 15% and out of a total of 749 health facilities 24% provided newborn services such as parentral antibiotics to newborns in the maternity/labor ward in 2008. 70% hospitals and 16% health centers (total 24%) provided extra care to premature or low birth weight babies.
8. Expand IMNCI implementation from 36% to 90% of HFs, IMNCI implementation from 12% to 80% of the districts and pre-service IMCI training from 65% to 95% of health professionals teaching institutions	Out of 1,767 health centers 930 (52.6%) health centers and out of 131 hospitals 81 (61.8%) hospitals provide IMNCI in EFY 2001. Community IMNCI interventions are undertaken in 215 Woredas in ten regions. Training of trainers and volunteers were trained for 45 Woredas and training was given for 271 health workers, 338 HEWs and 4,355 volunteers. In EFY 1997, the

[13] FMOH, ARM EFY 2001 Report

	number of health centers providing IMNC was 303 (50.5%) while in 2000 the number increased to 548 (74.9%)[14]. The cumulative number of HCs providing IMNCI service will be 2,039 in 2002 and this will constitute 85% of the HCs.

Figures 1 and 2 below show the trend in maternal and child health service delivery in terms of antenatal, delivery by skilled birth attendants, postnatal coverage and contraceptive prevalence rate[15].

Figure 1: Tend in Maternal Health Service Coverage, EFY 1998-2002



[14] FMOH, ARM EFY 2001, Report
[15] FMOH, ARM EFY 2001 Report and Core Plan 2002

Figure 2: Trend in Contraceptive Acceptance Rate, EFY 1998-2002

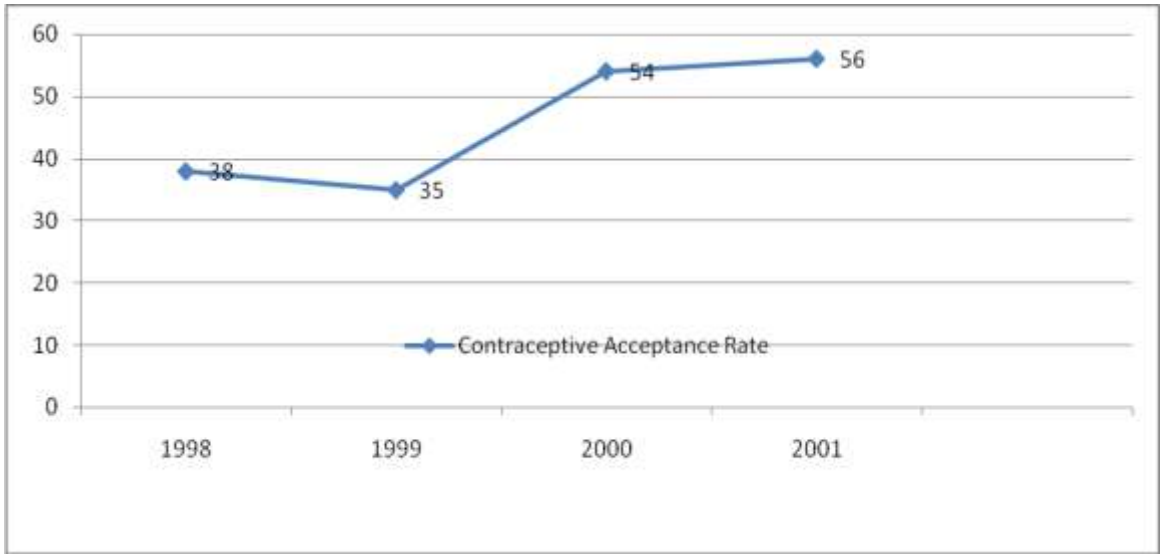
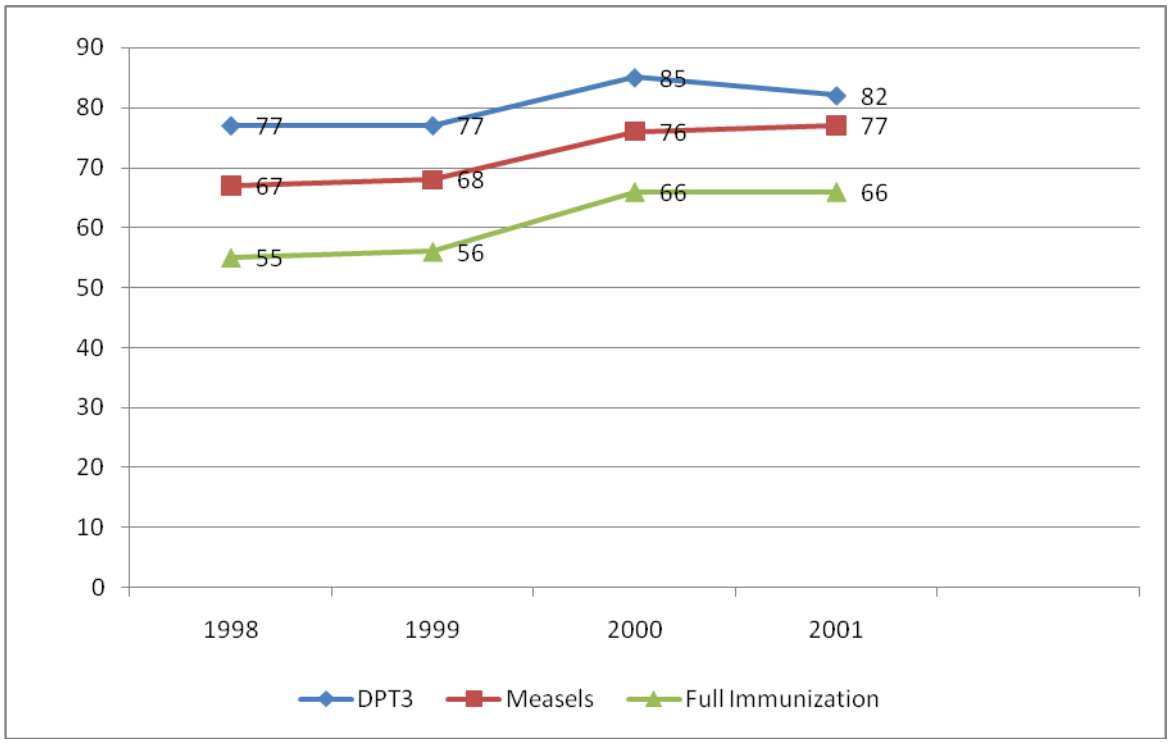


Figure 3: Trend in Immunization Coverage, EFY 1998-2002



Challenges and obstacles

The challenges and obstacles identified by the JRM and various ARMs were demand and supply-related and was the following:

- Traditional beliefs and emotional support provided in the family encouraged mothers to deliver at home
- Poor delivery room environment, poor attitude of the health workers,
- Absence of 24 hours a day and 7 days a week services in most health facilities especially in centers.
- Poor quality and inadequate numbers of midwives to provide skilled birth attendance.
- Long distance of health facilities and lack of transport facility to travel to health facilities
- Shortage of drugs, supplies and equipment that forced mothers to buy gloves, drugs and IV fluids
- Inadequate number and poor training of delivery attendants
- Weak referral system
- Turnover of trained health staff

Neonatal and child health

Despite high National Neonatal Mortality rate, 39/1000LB (EDHS-2005) and the neonatal problems contribute to about 30% of the under-five mortality, the constraints to neonatal and child health services are many. They include the following:

- There is lack of focus and capacity for newborn health at all levels

- There is no mechanism to track progress towards reducing neonatal mortality rate and the national effort made towards addressing the three major killers of newborn babies: neonatal infection, birth asphyxia and prematurity and low birth weight

- Most of the regional and zonal hospitals do not have any kind of neonatal unit where sick newborns can be admitted separately in a special unit

- In most of the hospitals and health centres including referral hospitals, delivery and maternity rooms lack a separate newborn corner inside the labour room with thermo-neutral environment. With the current trend of low newborn health care coverage at both national and regional level, it will be difficult to achieve MDG 4.

Recommendations

As part of the overall government drive for universal coverage, HSDP IV preparation should consider the following for creating universal access to safe motherhood and neonatal and child health services:

Maternal health services related:

a) Provide 24 hours a day and seven days a week delivery services in health centres nation-wide with detailed analysis of the required inputs and mobilising resources especially for under-served regions and areas within regions;
b) Provide comprehensive Emergency Obstetric Care (CEOC) at all hospitals and selected health centres by putting up functional maternities, nurseries, maternity theatres and laboratory services;
c) Scale up the competency training for HEW to bring clean delivery closer to the community;
d) Continue effort to ensure availability of family planning commodity in health facilities (commodity security and distribution);
e) Develop and implement a functional Referral Strategy;
f) Continue demand creation for health services through HEP;
g) Introduce free of charge deliveries in all health facilities
h) Develop a strategy and strengthening program to enhance the health sector's capacity to maintain its health infrastructure at all levels of the system; this is especially important in view of the unprecedented expansion of primary health services that is being carried out in the country.

Neonatal and child health services related:

a) Provide special focus and target for neonatal health and new born care. Consider including separate targets in the fourth HSDP and consider also separate indicators when the HMIS is revised in the future.
b) Establishing newborn unit in all regional and zonal referral hospitals and making sure health workers with appropriate skill are assigned and have the necessary supplies to provide essential newborn care;
c) Establishing newborn health corner in all delivery rooms and maternity wards of all health facilities in order to provide essential new born care including neonatal resuscitation.
d) Scaling up skill based training of HEWs in clean and safe delivery including training on essential newborn care.
e) Increasing the coverage of home based postnatal care using the available community based health cadres(the HEWs); and

f) Harmonizing community maternal, neonatal and child health activities by different partners to synergize the ongoing efforts and avoid duplication of activities.

1.2 Communicable Diseases Prevention and Control

In Ethiopia, about 75% of the endemic diseases are communicable and potentially preventable. Respiratory infections, diarrheal diseases, sexually transmitted infections particularly HIV/AIDS, malaria and tuberculosis are the major ones. The prevalence of blindness is estimated to be about 1.5%. Trachoma, cataract, glaucoma, measles and vitamin A deficiency are the major contributors the problem of blindness[16].

1.2.1 HIV/AIDS Prevention and Control

HIV/AIDS

HIV/AIDS continues to be a major public health challenge for Ethiopia although there has been much done in the last five years to reverse the situation. According to the Single Point Estimate, the adult HIV prevalence was estimated at 2.1% in 2007/08. Urban and rural prevalence rates were estimated at 7.7% and 0.9% respectively. Gender wise, the prevalence rates were 1.7% for males and 2.6% for females[17].

There were around 1,030,000 people living with HIV/ADIS and of these 289,732 needed ART. The total number of HIV positive pregnant women and annual HIV positive births were 75,000 and 14,000 respectively. Ethiopia updated its planning framework and also launched a Millennium AIDS Campaign in 2007 for scaling up key prevention and treatment programmes to achieve MDG6. The HIV Strategic Plan for Multisectoral Response (SPM) was a lead document in organizing and implementing the national response to the disease prior to the adoption of these approaches.

A total of 1,596 health facilities provide HCT, 843 health facilities provide PMTCT and 511 health facilities ART services. A remarkable achievement is achieved between EFY 1998 and 2001 as the number of health facilities providing HCT increased from 801 to 1,596, PMTCT from 93 to 843 and ART from 168 to 511[18].

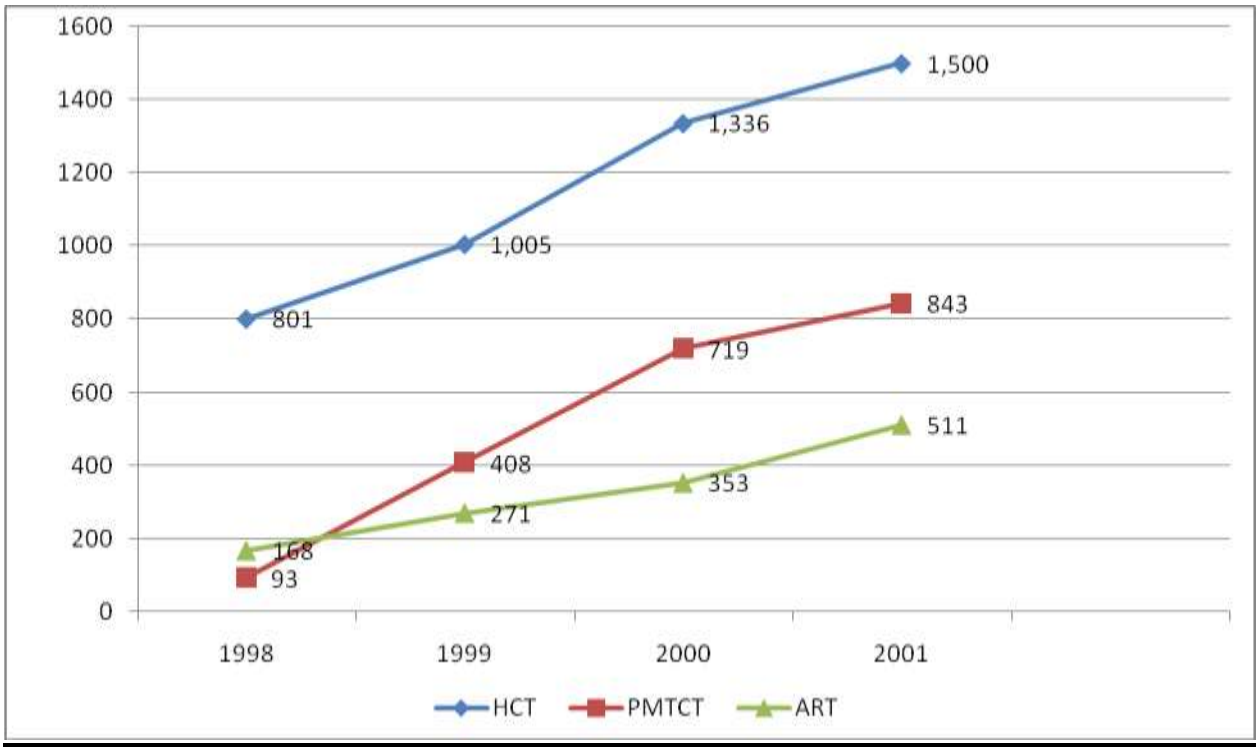
Concerning service delivery, reports from HAPCO illustrates that over 7.4 million people know their status (approximately 10% of Ethiopia's huge total population, or over 45% of Ethiopia's adult population over 15 years of age). Over 67% of ANC clients are provided with pre-test counseling for HIV and over 36% of pregnant women are accessing HIV/AIDS services and ART.

[16] Transitional Government of Ethiopia, Health Sector Strategy, April 2005
[17] HAPCO, Single Point Estimate, 2007
[18] Ibid

Specific HSDP III Targets	Implementation Status
1. Achieve provision of VCT services in 100% hospitals and HCs and PMTCT services in 100% of hospitals and 70% of HCs	VCT and PMTCT are fully integrated in all hospitals. PMTCT is integrated in 100% hospitals and 70% health centers. The service is integrated with the existing antenatal services in the health facilities. PMTCT testing coverage in 2001 was 15.7% while it is planned to push it to 53% in EFY 2002. As a result of integration, 5,853,472 people (88.8% of the target) received HCT services in EFY 2001. This is out of 6,588,497 people targeted for the year. 39,869 mothers received PMTCT prophylaxis treatment. 6,466 (8.2% of the eligible mothers) received ARV. 35% of infected infants received PMTCT prophylaxis in EFY 2001.
2. Increase the number of PLWHA on ART from 13,000 to 263,000	376,722 PLHWA were enrolled, 208,784 ever started and 152,472 are on ART in EFY 2001. The number of PLWHA becomes about 210,000 when those from the Ministry of Defense are included. The following figure shows the number of PLWHA who enrolled for ART, ever started and are currently on ART.

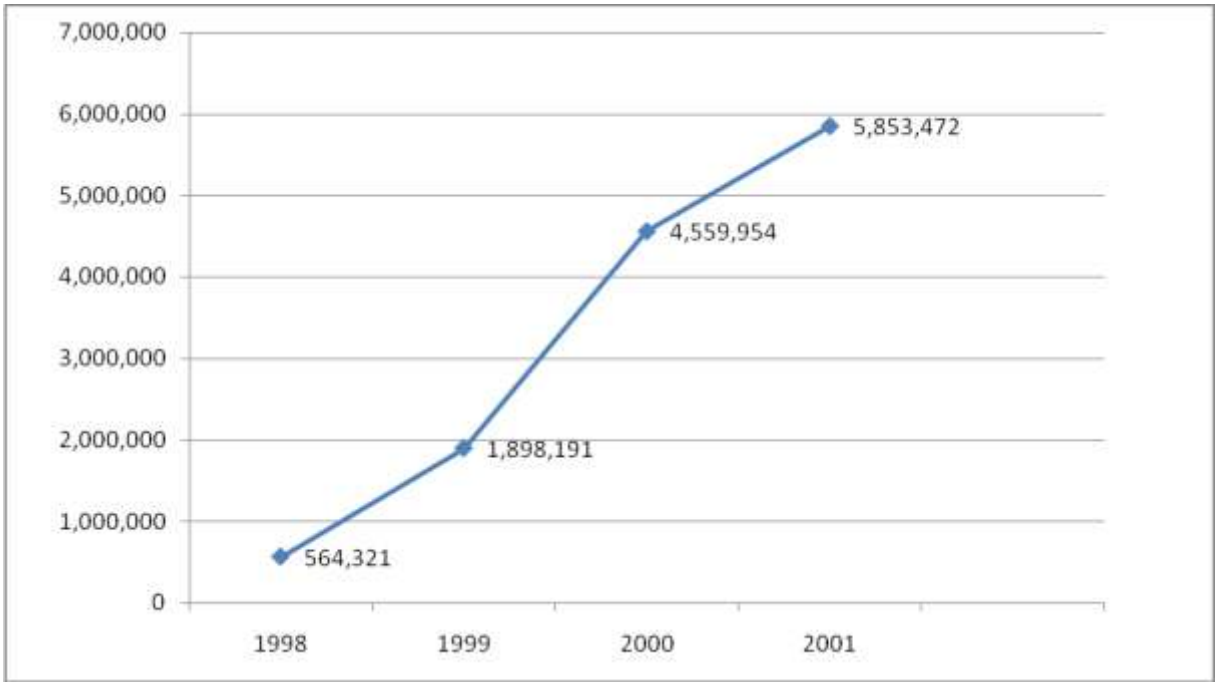
Figures 4 and 5 below show the trend in the number of HFs providing HCT, PMTCT, and ART, 1998-2002, the number of people that received HCT, 1998-2002 and the actual number of PLWHA that accessed care, 1998-2002.

Figure 4: Trend in the Number of HFs Providing HCT, PMTCT, and ART, 1998-2002[19]



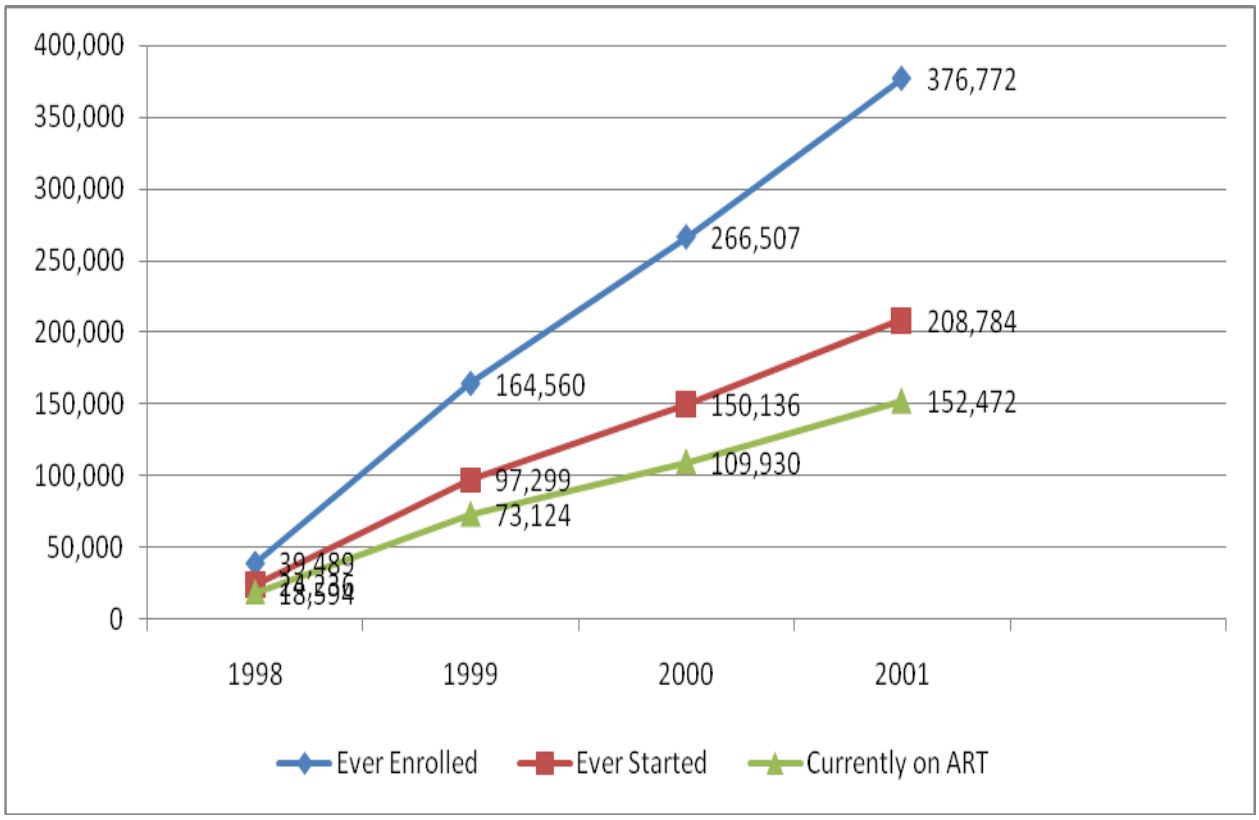
[19] FMOH, ARM EFY 2001 Report

Figure 5: Trend in Actual Number of People that Received HCT, 1998-2002[20]



16 FMOH, ARM EFY 2001 Report

Figure 6: Trend in the Actual Number of PLWHA that Accessed Care, 1998-2002[21]



Challenges

- Shortage of commodities such as test kits
- Inadequate management support to PMTCT at regional, zonal and Woreda levels
- Low performance of PMTCT/MNCH /SRH services in urban and semi urban health posts

1.2.2 Malaria Control

The National Five-Year Strategic Plan for Malaria Prevention and Control (2006-2010) is part of HSDP III. The Strategic Plan aims at 100% household coverage with two ITNs per household in all malarious areas, cover more than 85% of the population living in epidemic prone areas with indoor residual spraying and > 80% of the population to have access to prompt and effective treatment with artemisin-based combination therapy (ACT). Significant progress has been made in indoor residual insecticide spraying and distribution of ITNs. As a result of these significant reductions in

[21] FMOH, ARM EFY 2001 Report

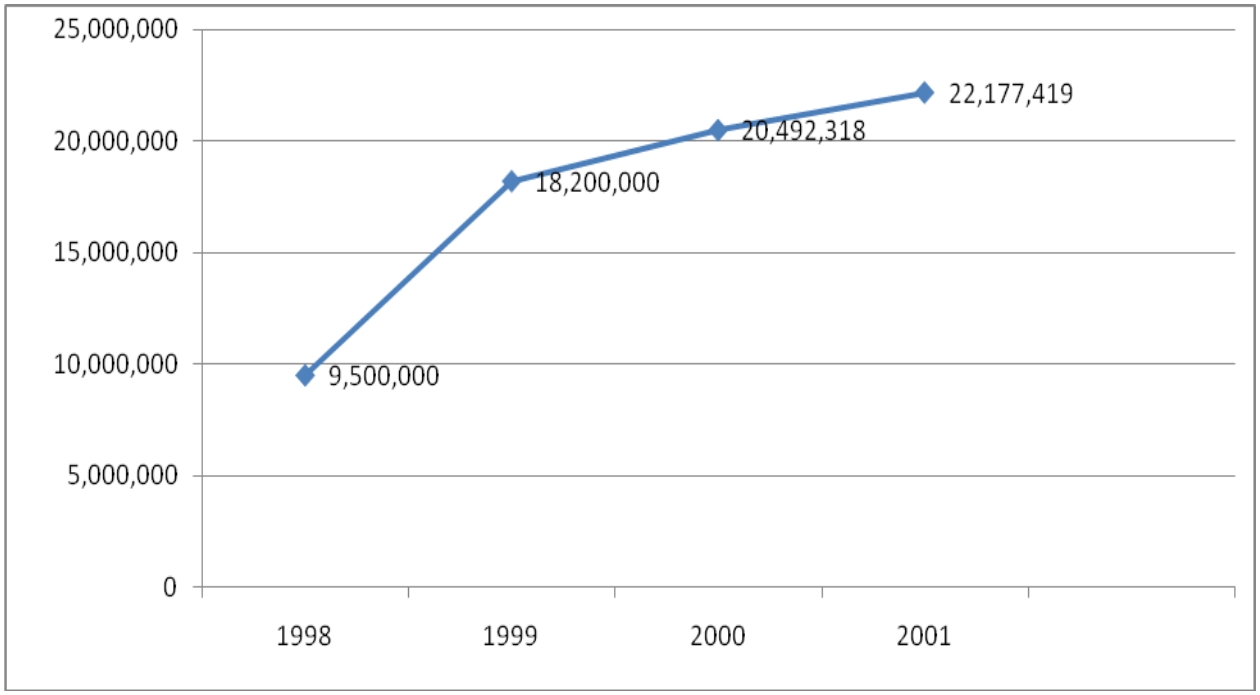
malaria related deaths have been reported by health facilities, as well as a reduction in the number of epidemic affected villages.

Facility-based data illustrate that the LLINs and ACT scale up has markedly reduced in malaria cases and deaths in all ages between 2001 and 2004 and 2007. It was 53% and 55% respectively, while non-malaria cases increased by 14% and non-malaria deaths declined by only 8%[22]. Morbidity due to malaria declined by 48%, hospital admissions by 54% and mortality by 55%. Inpatient case fatality rate in age group older than 5 fell from 4.5% to 3.3%; case fatality rate age group younger than 5 has fallen from 5% to 4.5% in EFY1999[23]. The implementation status with regard to ITN distribution and use, which one of the specific HSDP target is as follows:

Specific HSDP III Target	Implementation Status
Increase the proportion of HHs with 2 bed nets , properly utilized from 2% to 100%	Households that own at least one ITN areas below 2,000m are 65.6% and at least one LLIN were 65.3% in 2007[24]. Nationally, 55.7% of the households own at least one ITN of any kind, 53.8% own at least one ITN and 53.1% own at least one LLIN. The number of ITNs distributed has reached to 22,177,419[25]. Ethiopia has now the highest bed net coverage in Sub-Saharan Africa after Togo and Sierra Leone. The Baseline HH Health Survey (2009) showed that two-third of households in Amhara, Oromia, SNNP and Tigray regions have at least one bed net[26]. With regard to the utilization of ITNs, the same survey showed that 60% of households in Amhara, Oromia, SNNP and Tigray regions use ITNs in EFY 2001. Households that use two bed nets in those four regions constitute 27% while those in Amhara constitute 40%, Oromia 23%, SNNPR, 31% and Tigray 25%.

[22] CCM/E, Round 8 Malaria Proposal to the Global Fund
[23] Ethiopia Makes Striking Strides in Malaria Control Efforts, 12 August 2008, Addis Ababa
[24] FMOH, Malaria Indicator Survey 2007 and CCM/E, Round 8 Malaria Proposal to the Global Fund
[25] FMOH, ARM EFY 2001 Report
[26] JSI, Research and Training Institute Inc., Baseline Household Health Survey, Amhara, Oromia, SNNP and Tigray Regions, August 2009

Figure 7: Trend in the Distribution of LLINs, EFY1998-2002



Challenges

- Low IRS coverage, weak environmental management for vector control, mosquitoes' resistance to DDT,
- Low usage of ITNs by households in some areas

1.2.3 Tuberculosis Control

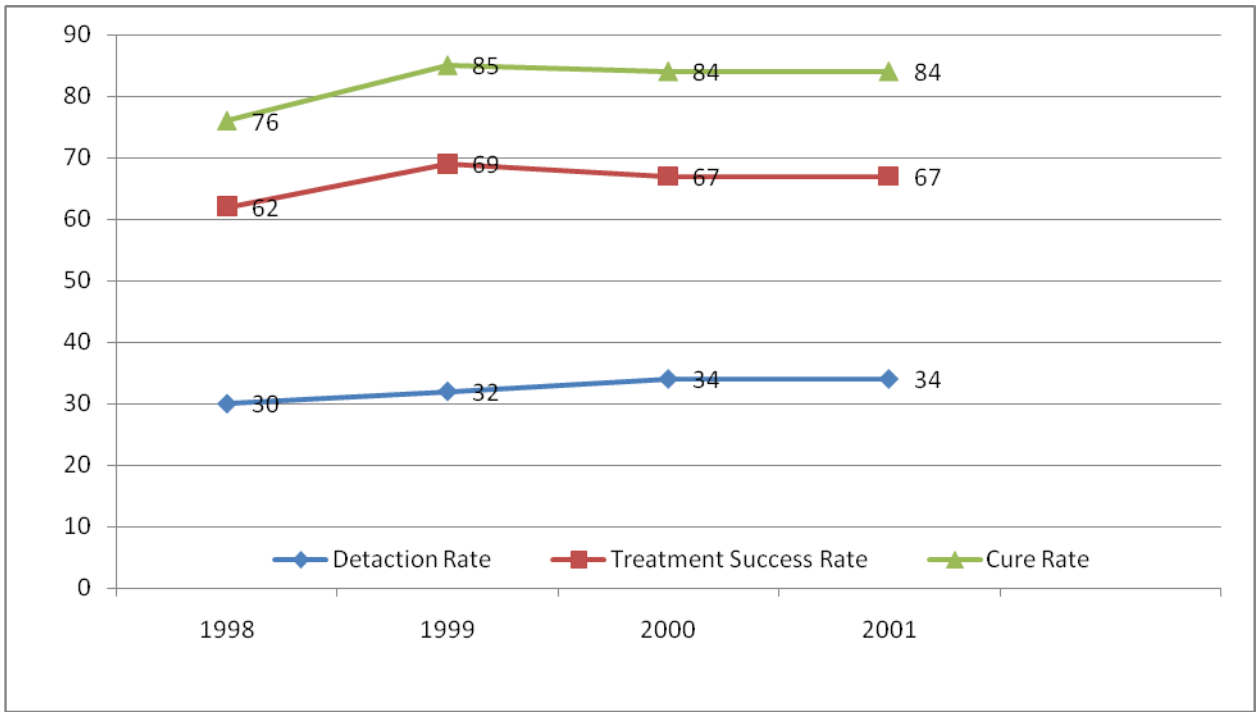
According to the 2008 WHO estimate, Ethiopia stands 7th in the list of High Burden countries for TB[27]. The main strategy for the disease is to enhance the detection rate and completion of regularly provided treatment. The findings of the MTR is that while improvement in the detection rate of the disease still require more efforts, the treatment success being achieved so far is encouraging. The baseline data collected by TB and Leprosy Control Team (TLCT) from July 2008-February 2009

[27] FMOH, Tuberculosis, Prevention and Control Program, Annual Bulletin, Vol.1, No. 1, March 24,2009

illustrate that out of the 9,512 functional health facilities (hospitals, health centers, clinics. Nucleus health centers and health posts, 3,368 (35.4%) health facilities were providing TB-DOTs service and 667 (7%) health facilities implementing TB/HIV collaborative activities[28]. Figure 1.2.3.1 below shows the trend in TB detection, treatment and cure rate from EFY 1998-2000.

Specific HSDP III Target	Implementation Status
1. Increase TB treatment success/cure rate from smear positive cases from 76% to 85%	The target of 85% treatment success rate is almost achieved in EFY 2001. It has reached 84%[29]
2. Achieve and maintain detection rate of at least 70% of new sputum +ve TB cases	Despite the tremendous effort and health service expansion, TB case detection rate still remains low (34%). The prevalence of all forms of TB is now 579,100,000. The target for 2015 is 156 per 100,000. Mortality is 92 while plan is to reduce it to 20 per 100,000[30]. These are far away to achieve the MDGs targets set by 2015

Figure 8: Trend in TB Detection, Treatment and Cure Rate, EFY 1998-2002 [31]



[28] Ibid
[29] Ibid.
[30] ibid.
[31] ARM EFY 2001 and EFY 2002 Core Plan

Challenges

- Low community awareness about TB as reflected in low demand for service
- Weak coordinating mechanisms for Stop TB partnership
- Weak planning and implementation capacity at regional level
- Weak diagnostic laboratory services

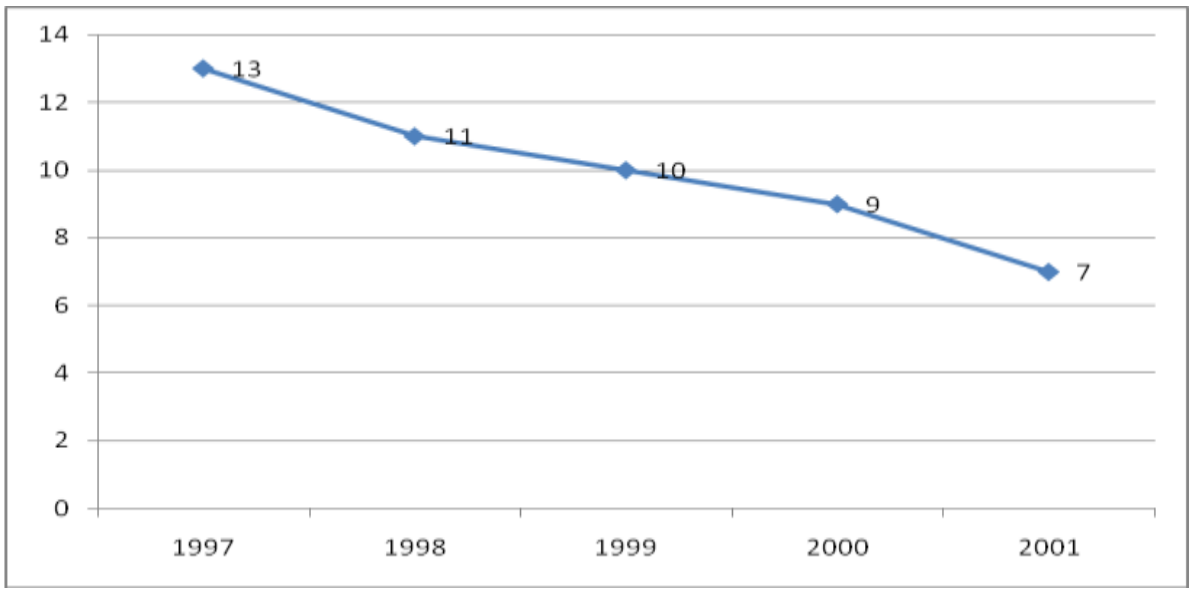
1.2.4 Leprosy Control

Like TB, leprosy control is based on enhancing the detection rate and completion of regularly provided treatment. There seems to be improvement in the detection rate and treatment of this disease although more effort is required to reduce the prevalence of grade 2 disability. The trend in the proportion of disability grade 2 is shown in the Figure below.

Specific HSDP III Targets	Implementation Status[32]
1. Reduce the prevalence of leprosy grade 2 disability from 12% to less than 10%	According to figures from WHO-Ethiopia Country Office, the prevalence of leprosy as estimated at 6 per 100,000 in EFY 1998. It is gradually decreasing since more than 90% of the expected leprosy patients are being identified and put on treatment. It is estimated that 4000-5000 cases are detected every year. Number of all leprosy cases in 1997 was 5, 277 while the new cases detected were 4,698. The number of all cases of leprosy in EFY 2000 was 4,414. They were 3,878 new cases detected in EFY 2001 and the plan for EFY 2002 is to detect 3,807 new cases. Due to incomplete and inconsistent reporting, the status with regard to the disease is reported using the available data.
2.Reduce the proportion of grade 2 disabilities among new leprosy cases to ate least 5%	The proportion of grade 2 disabilities among new leprosy cases was 9% in EFY 2000 while in 2001 it showed a slight decreased and went down to 7%. Currently there the number of leprosy cases with grade 1 was 933 while with grade 2 was 468. Those with unknown grades were 115.
3. Achieve and maintain a treatment completion rate of leprosy to at least 90%	In EFY 1997, out of a total of 5,362 PB and MB registered cases 81.5% completed treatment. In EFY 2000, out of a total 4,160 registered cases, 3,958 (95.1%) cases completed treatment. This shows that the target is well achieved before the end of HSDP III. The evaluation-based data show a treatment completion rate of 86.7% at the same year.

[32] FMOH, Tuberculosis, Prevention and Control Program, Annual Bulletin, Vol.1, No. 1, March 24,2009

Figure 9: Trend in the proportion of Grade II Disability (%), EFY 1997-2000[33]



1.2.5 Trachoma Control

The prevalence of trachoma in Ethiopia is 1.6%. There are 1.2 million people with blindness of all causes and 2.8 million people with low vision. Cataract and trachoma constitute more than 60% of all blindness. The main strategy in place for trachoma control is "SAFE", i.e. Surgery, Antibiotics, Facial cleanliness and Environmental Sanitation, including preventive measures. Accordingly there are trachoma control programmes run in highly affected districts, mainly through community distribution of antibiotics, but with limited attention given to static trachoma detection and care at OPDs, and health posts.

Specific HSDP III Target	Implementation Status
Reduce active trachoma in targeted 80 Woredas by 80% and increase the current Cataract Surgical Rate (CSR) from 350 to 600/million /year	The number of Woredas implementing the WHO recommended Surgery, Antibiotics, Facial Cleanliness and Environmental Improvement (SAFE) Strategy for trachoma has reached 124. 15,439,275 people have been treated with Azithromycin and tetracycline eye ointment and about 37,000 cataract surgeries were performed in EFY 2001.

[33] [33] FMOH, Tuberculosis, Prevention and Control Program, Annual Bulletin, Vol.1, No. 1, March 24,2009

Challenges:

Lack of adequate resources that include shortage of trained personnel, budget, infrastructure and equipment.

1.2.6 Onchocerciasis Control

This is a disease occurring in some parts of the country particularly in the western and north-western/border areas of the country.

Specific HSDP III Target	Implementation Status
Ensure the therapeutic coverage of Onchocerciasis control above 65% in all CDTI areas and ensure its sustainability	Due to lack of information it has not been possible to report the status.

1.2.8 Dranculosis Control

As mentioned in the 2001 ARM in Dire Dawa, this is also one of the neglected tropical diseases (NTDs) where only development partners are involved.

Specific HSDP III Target	Implementation Status
Interrupt indigenous transmission of dranculosis in endemic areas of Ethiopia.	Little is known on the control of dranculosis since the involvement of government is limited and some work is being done by WHO.

1.2.9. Public Health Emergency Management (PHEM)

Public health emergency management preparedness and response is one of the core processes in BPR. It is area that has to be addressed well by all levels (at federal, regional, Woreda and community levels) by (i) strengthening coordination at the RHB level; (ii) allocation of annual budget (iii) drafting contingency plans; and (iv) building the capacity at the level of the RHBs as well as other levels in order to respond effectively and efficiently to any form of emergency outbreak that may occur.

Specific HSDP III Target	Implementation Status
Establish permanent health emergency management team in FMOH and ad hoc teams in 100% of RHBs and 80% of Woreda Health Offices	The BPR on Public Health Emergency Management has been completed and implementation has been started. In order to establish PHEM teams at FMOH, and RHBs, 13 epidemic intelligence service officers are being trained at Masters Degree level in Addis Ababa University. Eighteen diseases have been selected for surveillance and detection. The study on the new PHEM core process to detect and respond to public emergencies on time has been completed and implementation has been started. A new Forecasting, Early Warning, Response and Record System have been designed.

Challenges

- Inadequate capacity of preparedness to efficiently respond to threats of epidemics

1.3 Hygiene and Environmental Health[34]

More than 250,000 children every year die from sanitation and hygiene related diseases. About 60% of the overall disease burden is related to poor sanitation and hygiene. Despite this, low number of households has access to improved sanitation. In order to improve the water and sanitation situation the following activities have been undertaken.

- A National Hygiene and Sanitation Strategy which emphasizes a no subsidy approach to household hardware have been developed in 2004.
- A National Protocol for Hygiene and On Site Sanitation which defines a step by step minimum intervention package to be followed by all stakeholders has been developed in 2006.
- CLTSH implementation , training and verification manuals preparation is underway
- Need assessment to achieve the universal access by 2012 has been developed in 2006
- A National Millennium Hygiene and Sanitation Movement have been started and a mass mobilization and communication strategy has been developed.
- Four regional towns have been selected for the Healthy Cities Programme
- Urban Health Service Package with five manuals for urban health service have been developed

[34] Source: Discussions with staff and PowerPoint presentation from the concerned Case Team of FMOH

- Qualitative Assessment of WASH Status in Primary Schools (2007) and a School WASH Guideline in 2007 and a school WASH design and construction manual for primary schools is being completed in 2009.

The specific WASH targets and their implementation status are shown below.

Specific HSDP III Target	Implementation Status
1.Increase latrine coverage from 20% to 80% and ensure that 100% of the facilities are properly handled sustained and utilized	Coverage stands at between 37% and 86% (national 56% is achieved. Relatively higher coverage are observed in Addis Ababa (76%), SNNPR (75%) and Tigray (71%) The handling and utilization status of existing latrines is not known. The WASH Inventory that is underway in 2009 and 2010 will provide the information on latrine handling and utilization of latrines. The next DHS will also provide the same information.
2.Promote communal solid waste disposal of villages and ensure 100% utilization rate	Achievement is not known. The WASH Inventory and the 2010 DHS could provide the necessary information
3.Improve medical and other waste management system in 100% of public and private health institutions	Waste management system is institutionalized in 60% of hospitals. Guideline has been prepared on institutionalization of medical and other waste management in public and private health facilities. Infection prevention committees are established in these hospitals. Training to 8-10 senior management staffs of hospitals. Activities in private health institutions have not been started. A qualitative WASH survey in primary schools has been carried out in 2006/07. School WASH Guideline prepared in 2008. Waste management coverage in primary schools is 76%. School WASH design and Construction Manual for primary schools is being completed in 2009.
4. Increase drinking water quality monitoring from 44% to 90%	National drinking water coverage in EFY 2000 was 59.5%. (86.2% urban and 53.9% rural. Status o drinking water quality monitoring is not known. Drinking water quality monitoring has not been included in last rounds of plan and the indicator has not been included as a monitoring tool.
5.Achieve 100% monitoring of food safety in food processing industries	The status is the same as above.

Challenges

- Harmonization/alignment of partners and government
- Speeding up the Diffusion of CLTS and Whole System in A Room approach
- Improving the quality of promotional effort of HEWs
- Enhancing the capacity of public and private sectors on WASH

1.4 Curative Services

Current data on the different types of curative services are not available. It is only on hospital curative services that are available. Assessment did in 13 selected hospitals show that the average performance in the period EFY 1998-2000 was 65.9% bed occupancy rate (BOR), 28.8% in patients per bed per year as bed turn-over rate (BTR) and 8.4 days of average length of stay (ALOS). This performance has been found to be above the national average of BOR 35%, but below the international standard. Health facilities are designed to operate most efficiently at a level of about 80-90% of occupancy. It is only two hospitals out of 13 that showed such level of performance.[35]

Regards to utilization of health facilities, an USAID/ESHE funded survey conducted in Amhara, Oromia and SNNP regions in 2008 showed that in 2008, 56% of mothers of sick children reported they had taken their children to health Facilities for treatment 48% mothers did the same in 2003/204[36]. The coverage in the three regions is shown in Figure 8 below.

Specific HSDP III Target	Implementation Status
1.Increase the proportion of people seeking care in case of illness or injury from 41% to 55%	The Pilot community-based survey conducted in Jimma Zone in 2007 illustrates that the prevalence rate of injury was 8.9% per year. Out of the 304 individuals studied, 83.5% had got some kind of health care at different levels of health facilities and 19 (5.2%) got inpatient health care[37].
2.Increase the ratio of emergency surgery service to population to 1/100,000	No data vailable.
3.Increase per capita health service utilization rate from 0.30 to 0.66	The OPD per capita attendance rate has shown a dwindling trend and wide variation from region to region since the last five years. It ranged from 0.18 in Somali to 0.72 in Tigray with a national per capita attendance rate of 0.30 in EFY 2001.
4.Achieve 80% mainstreaming of detection and management of mental health problems in the health system	There has been limited work on mainstreaming the detection and management of mental health problems in the health system.

[35] Nejmudin Kedir et al, Assessing the Performance in Selected Hospitals, A Comparative Analysis, pp 29
[36] USAID/ESHE, Household End-line Survey Synthesis Report, September 2008
[37] WHO Ethiopia Country Office and Jimma University, Community-based Survey of Injuries in ---, 2007

Figure 10: Trend in Health Service Utilization/OPD Attendance, EFY 1998-2002[38]

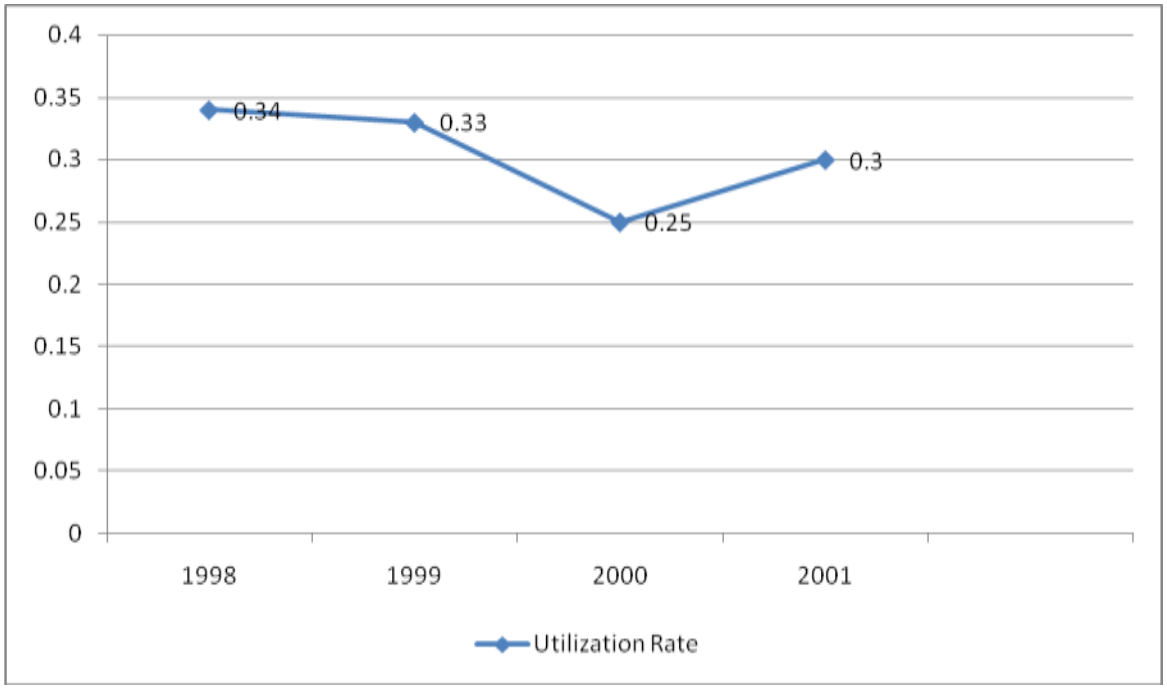
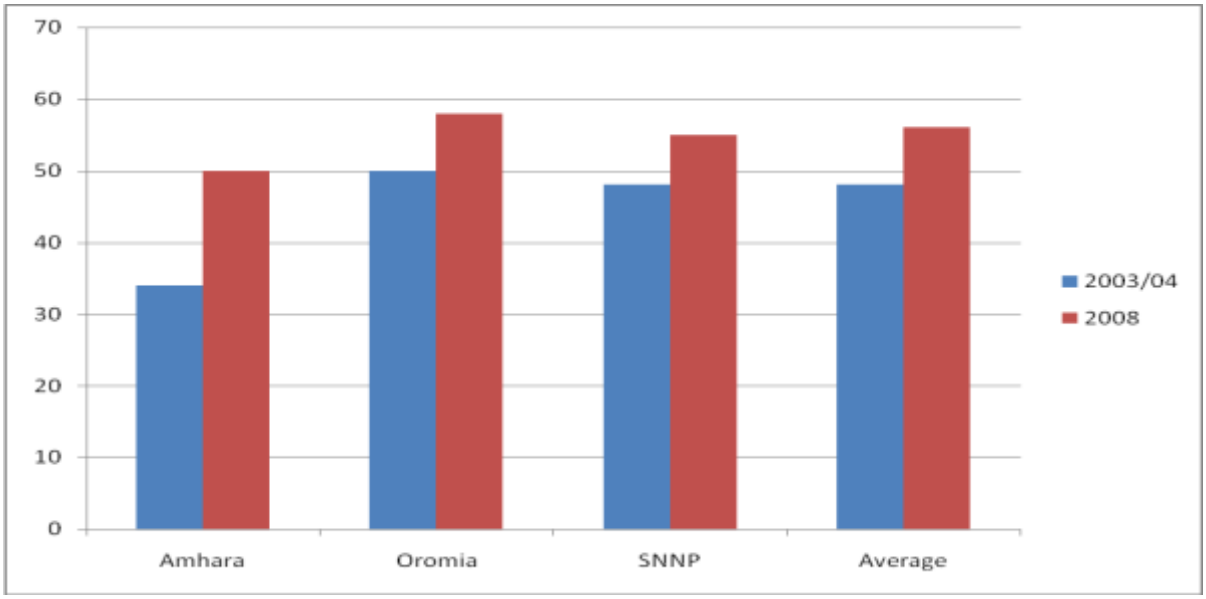


Figure 11: Trend in Use of Health Facilities by Mothers



Factors for the low attendance are distance from health facility which is related time to travel, cost of travel, availability of transport, cultural barriers (health care seeking behavior), poor quality of care and others.

[38] FMOH, ARM EFY 2001Report

Demand creation through awareness creation, and making the health system more friendly, easily accessible and affordable becomes a sin qua non.

Component 2: Health Facility Construction, Expansion and Transport

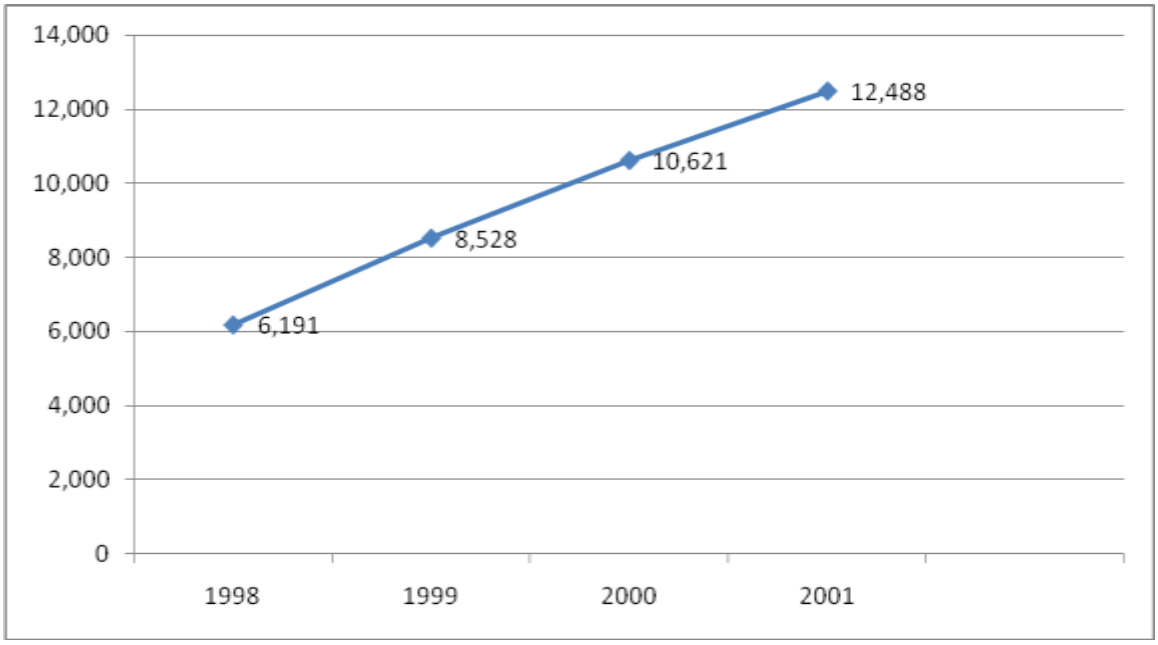
This is one of the core processes of the BPR which the aim of the core process is the construction and renovation of health and health related facilities, the supply and utilization of inputs to health facilities, maintenance of medical equipment and computers and the expansion of health information technology. The physical implementation in the construction and expansion of health facilities is as follows:

2.1 Construction and Equipping of Health Posts

The cumulative number of health posts constructed up to end of EFY is 12,488. This constitutes 83.1% of the requirement at national level. It is planned to construct 3,825 health posts in EFY 2002 and meet target of 100% coverage. The figure below shows the trend in this regard.

Regarding equipping health posts, in the last four years, only 10,797 health posts have been equipped up to end EFY 2001. This comprises of 66.2% of the cumulative target of equipping 16,313 health posts.

Figure 12: Trend in the construction of health posts, EFY 1998-2002[39]



[39] FMOH, ARM EFY 2001 Report and Core Plan 2002

2.2 Construction and Renovation of Health Centers

The HSDP III target is to have potential health coverage of 100% by the end of the programme by constructing and equipping 253 new HCs and upgrading 1,457 HSs to HC level. As illustrated in the table below, the number of HCs reached 1,338 in EFY 2001. This accounts to 41.8% of the target of having 3,200 HCs by the end of EFY 2002. When the 617 HCs completed in EFY 2001 and the 1,247 HCs under construction in EFY 2001 are added with the 1,338 HCs that were available in EFY 2001, there will be 3202 HCs by end of EFY 2002, which implies the achievement of 100% potential coverage at the end of HSDP III.

A study on the functions of health centers and the preparation of a master plan for the renovation of health centers has been completed. The renovation of 41 health centers has been completed according to the master plan.

In order to meet the demand of eclectic power supply for 50 health centers, site selection for installation of solar power has been completed. Solar panel generating electricity has been installed for 10 health centers. Installation work for the remaining 40 health centers has been started and will be completed in EFY 2002.

2.3 Construction, Expansion and Management of Hospitals

The construction and expansion of hospitals was also one of the major programme areas of HSDP IIII. Accordingly, the construction of 29 hospitals in 8 regions is underway the construction of 23 new hospitals, the rehabilitation of 14 hospitals, the expansion of 6 hospitals and the upgrading of 10 hospitals have been and in EFY 2001. In addition to this, a Hospital Management Blue Print has been developed.

With regard to hospital management, A "Blue Print" Standard Guideline for Hospital Management has been prepared and adopted. Accordingly, 42 hospitals in Addis Ababa, Amhara, Tigray, SNNPR, Oromia, Dire Dawa and Harari are implementing the Blue Print Standard Guideline. A total of 17 hospitals from Amhara, 21 hospitals from Oromia, 12 hospitals from Tigray and five hospitals from Addis Ababa are now implementing the BPR.

A total of 25 Hospital Chief Executive Officers (CEOs) are being trained in Hospital Administration at Masters Degree level in Jimma University. They are expected to complete their training in 2002. The training another batch of 30 CEOs is expected to start in EFY 2002.

2.4 Construction of Blood Banks

The construction of 16 blood banks in six regions is underway. The work will be completed in EFY 2002 as 95% of the work has been completed in EFY 2001.

2.5 National Laboratory System Strengthening

The preparation of a National Laboratory Master Plan has been completed. According to the Master Plan, 57 equipments have been procured and distributed to nine regional laboratories to be used for training programmes at regional level. Over 235 technicians have participated in different HIV/AIDS related training programmes[40]. The HSDP III targets and their implementation status are as follows:

HSDP Target	Implementation Status
1.Increase the potential HP coverage from 20% to 100% by constructing, equipping and furnishing 10,736 HPs	12,488 HPs have been constructed by EFY 2001. This is 83.1%. There is variation in achievement from 68% in Tigray to 98% in Benishangul Gumuz. 100% coverage is expected to be achieved at end of HSDP IIII in EFY 2002 by constructing the remaining 4,211 HPs.
2. Increase the potential HC coverage from 18% to 100% by constructing, equipping and furnishing 253 HCs, upgrading 1,457 HSs into HCs and constructing 5 new district hospitals and renovating 37.	The cumulative number of HCs available at the beginning of EFY 2001 was 721. Similarly, the cumulative number of HCs available at the end of EFY 2001 was 1,338. The number of new HCs completed during EFY 2001 was 617 and the number of HCs under construction at end of EFY 2001 was 1,247. . The construction of new HCs is completed and 1,247 HCs are under construction and are expected to be completed in EFY2002. Another 615 new HCs are expected to be completed in 2001. This gives us that by EFY 2002, there will be 3923 HCs and that 100% coverage will be achieved by end of HSDP III. In addition to the above, 49 HCs were available or under construction in Addis Ababa at end of EFY 2001. Commitment of regions to allocate the necessary budget and to undertake close monitoring to the completion of the remaining HC and achievement of the set target is critical.
3.Increase the general potential health service coverage from 72% to 100%	The general potential health coverage will be definitely achieved by the completion of the construction of the planned HPs and HCs.
4.Equip and furnish 80% of HFs as per standard	PFSA has procured equipment for 2,299 HCs at a cost of 506.3 million ETB and procurement for 300 HC was underway in EFY 2001. With this, a total of 2,599 HCs will be equipped in EFY 2002.
5.Upgrade 30% HC s to enable them provide EOC services	According the 2009 EmONC Baseline Assessment 51% of the hospitals and 1% provides C-EmONC. The cumulative number of HCs providing B-EmONC services will be 1,656 in 2002 and this will in 69% of the HCs.
6.Ensure allocation of one car/ambulance per HC	All functional HCs have at least one car or ambulance.

[4040] FMOH, ARM EFY 2001 Report

Challenges

Concerning health center construction and expansion:

- Shortage of qualified contractors willing to take contracts in remote sites
- Serious shortage and high prices of construction materials

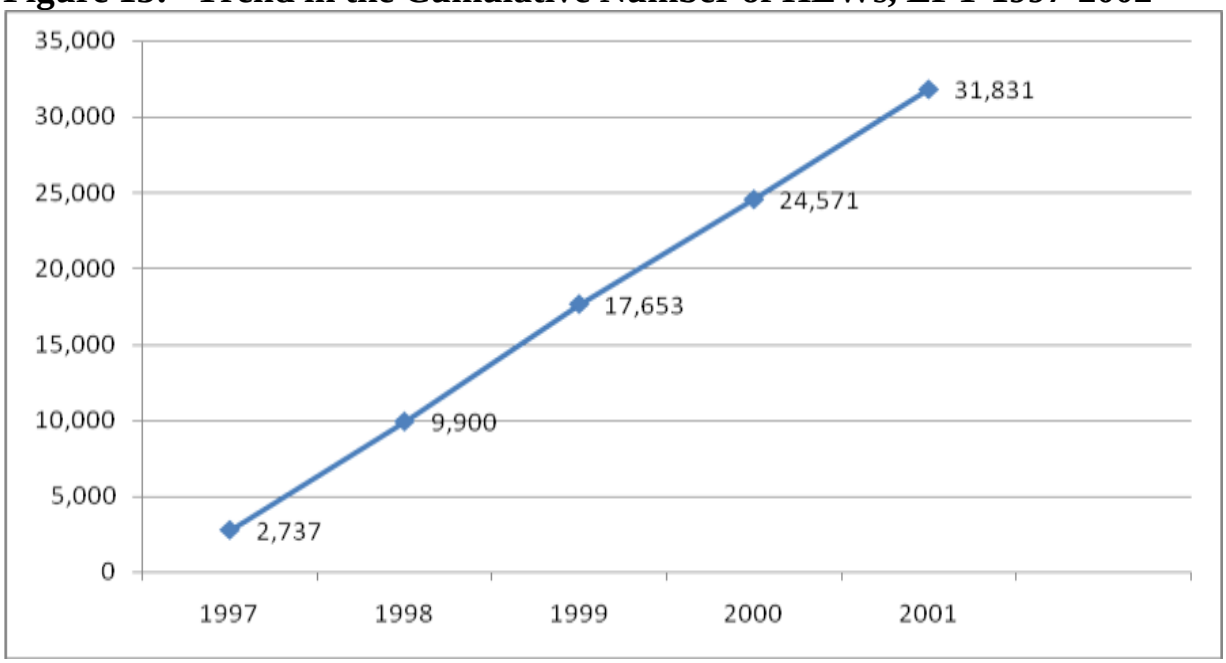
Component 3: Human Resource Development

3.1. Health Extension Workers (HEWs) Training and Deployment

3.1.1 Rural HEWs

To start the implementation of HEP, 35 Technical, Vocational, Educational and Training Centers (TVETs) were identified and provided with the necessary teaching aids and materials to train 30,000 HEWs. HEP Implementation Guideline has been developed and more than 30,000 copies were distributed to regions, health facilities, HEWs and NGOs. The following figure shows the trained in the training and deployment of HEWs in rural kebeles.

Figure 13: Trend in the Cumulative Number of HEWs, EFY 1997-2002[41]



[41] FMOH, ARM EFY 2001 Report and Core Plan 2002

3.1.2 Health Extension Program in Pastoral and Semi Pastoral Areas

The preparation of an HEP Implementation Manual customized to the life style and culture of the pastoral population has been completed. Printing and distribution of the manual in sufficient copies has been also completed.

Three teaching and learning schools (Dupti, Arbaminch and Jijiga) have been selected as centers for the training of HEWs. Technical, financial and material support ha been given to these schools. It is expected that the training and deployment of HEWs will be completed and 100% coverage will be achieved in 2002.

3.1.3 Health Extension Program for the Urban Areas

Expansion of the HEP in the urban areas of the country is a new phenomenon for EFY 2001. It is planned to be implemented in seven regions. Therefore, in order to effectively implement the program the following activities have been undertaken.

Preparatory activities have completed to train and deploy HEWs that provide the packages on the basis of the life style and settlement pattern of the urban population.

The experiences of other regions and countries have been acquired and the experience has been used to develop an appropriate implementation manual for the urban areas based on the experiences. The Implementation Manual has been finalized and the 24 HEP packages have been prepared and distributed to the concerned urban administrations for implementation.

Since the programme requires intersectoral collaboration, sensitization and awareness creation conferences have been conducted in the selected regions. In 2001, over 200 representatives of government entities, heads of sectoral bureaus and offices, professional associations and NGOs have participated in the conferences. The training and deployment of urban HEWs have been undertaken in Addis Ababa and Dire Dawa City Administrations. Out of the total 4,797 urban HEWs required, 4,110 (86%) will be trained in EFY 2002.

3.1.4 Deployment of Model Families

The purpose of the training and deploying model families is to diffuse/communicate step by step innovations through certain appropriate channels over time among members of the social system in different communities.

The selection of female and male household heads has been started in EFY 2001. Basic training on the 16 packages of the programme has been given for 96 hours. As in the previous years, the household heads were selected and trained by the respective HEWs.

In EFY 2001, it was planned to select and train 6,717,228 model families. The actual number of model families trained is 2,603,368. This is only 38.6% of the target for the year which is very low.

It is planned to train 9,872,824 households in 2002 and push the coverage to 61% before the end of HSDP III.

3.1.5 Training and Deployment of HEP Supervisors

In EFY 2001, out of 615 HEP supervisors, 452 (73.5%) have been trained and deployed. The training of HEP supervisors could not be continued because of delayed decisions related to salary and other benefits which have to be decided by RHBs.

3.1.6 Refresher Training

Integrated refresher training to HEWs has been started in EFY 1999 and TOT was given to 546 trainers. A guideline that facilitates the professional career development of HEWs has been prepared and adopted by FMOH and RHBs.

3.2 Health Officers Training and Deployment

The target HSDP III is to train and deploy 5000 health officers in five years. Out of the 5000 planned to be trained, 3000 will be generic and 2000post basic. This is to be accomplished through the FMOH initiated Accelerated Health Officers Training Programme (AHOTP) launched in November 2005. The training will be undertaken in the four health officers training universities namely; Jimma, Haromya, Hawassa, , Mekelle and Gondar Universities. Twenty one hospitals in seven regions (6 in Oromia, 5 in SNNPR, 4 in Amhara, 3 in Tigray one each in Harari, Somali and Dire Dawa have been selected to run the training programme being affiliated with nearby universities.

The AHOTP is going well and on schedule. The first batch of 1,476 health officers has graduated in 2001. This brings the total number of health graduates to 2,518 or 50% of the target. The remaining number of health officers which in the second and third batches will graduate before the end of HSDP III.

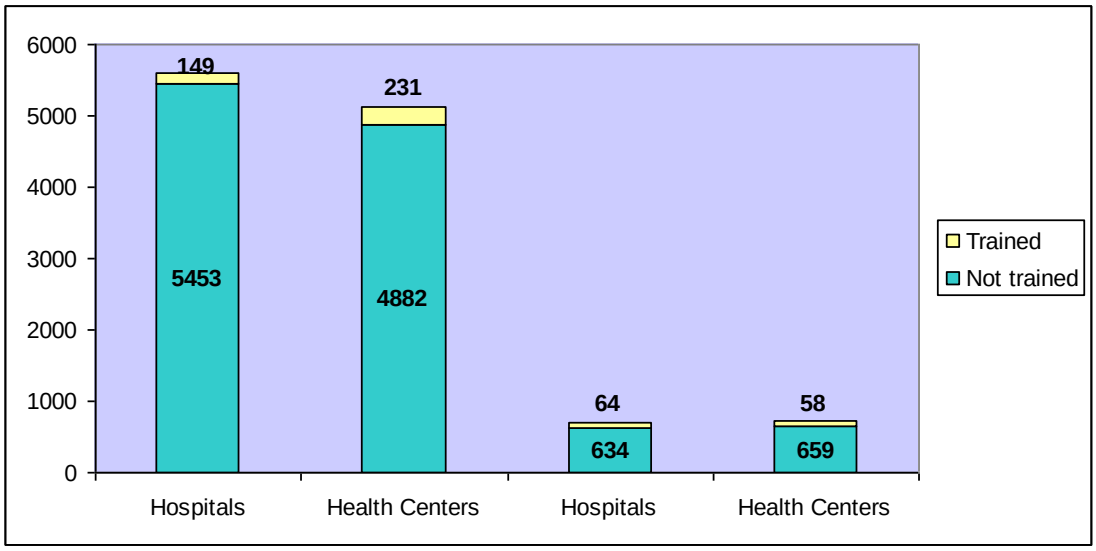
3.3 Innovative Physicians Training Programme

This is also an FMOH initiated programme undertaken by Addis Ababa, Mekelle, Haromaya, and Jimma Universities. In order to implement the programme, 80% of the curriculum development has been completed and actual training is expected to commence after the finalization of the curriculum.

3.4 Training of Health Officers in Emergency Obstetric Care

This is a two years Masters programme that has been recommended by the MTR of HSDP III. The programme has been started in Mekele, Jimma, and Hawassa Universities. Gonada and Haromaya Universities are expected to join the other universities after assessing their capacities. Ninety health officers are now under training. The figure below shows personnel trained in EmONC and not yet trained by health facility.

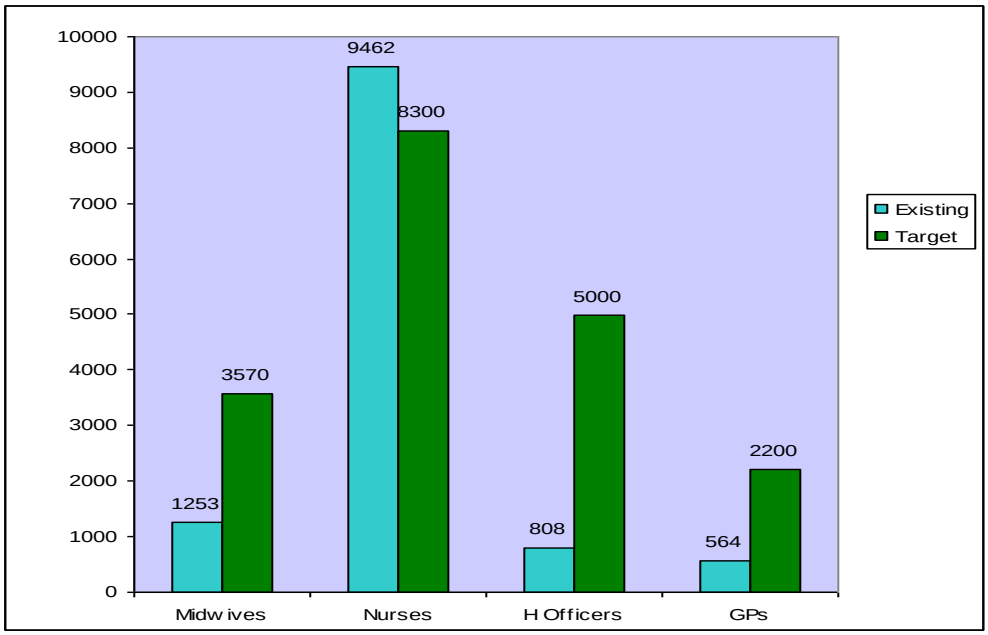
Figure 14: Personnel trained in EmONC and not yet trained by type of facility[42]



3.5 Midwifery Training

As shown in the figure below, the number of trained general practitioners, health officers, nurses and midwives in hospitals and health centers is low. Consultation has been carried out with relevant national institutions to scale up this programme by enrolling 300 midwife students.

Figure 15: HSDP-III human resource targets and availability in facilities[43]



[42] National EmONC Baseline Assessment, 2009
[43] National EmONC Baseline Assessment, 2009

3.6 Deployment of Other Health Workers

The plan to deploy 3,000 health workers has been implemented by deploying 112 general practitioners, and 2,486 other categories of health workers.

HSDP III Human Resource Targets and Achievements

Specific HSDP Target	Implementation Status
1. Increase HEWs to population ratio to 1:2,500	In EFY 2001, taking the population from the 2007 census, the ratio has been 1:2,054. It is expected to be 1:2,062 in 2002.Calculation is based on an annual population growth rate of 2.6%.
2. Increase the ratio of midwives to women of reproductive age group from 1:13,388 to 1:6,759	It has not been possible to know the actual cumulative number of midwives in the country and calculate the ratio.
3. Staff all health facilities according to the standard and RHBs and Woreda Health Offices as per their respective organizational structure	According to the draft HRH Strategic Plan assessment (2009-2020), low density and insufficient mix among health workers, poor distribution with significant density in rural areas, , poor HRH management at all levels that is inadequate to address the concern of health workers in terms of motivation and performance evaluation. Migration of health workers to Western Europe and America and internal migration from the public to the private sector is a major challenge. In 2002, 17% of nurses and 30% of doctors left the country. About 72% of medical students and 62% of nursing students indicated their intention to migrate (Serra 2008).
4. Establish implementation of transparent and accountable human resource management at all levels	This has been done through the Civil Service Reform Programme (CSRP) and BPR
5. Train 7,500 HEWS in 2006,2007 and 2008; compensate attritions	This has been addressed by the training 103% of HEWs.
6. Deploy a total of 30,000 HEWs with reasonable number of community promoters/volunteers	31,831 HEW have been so far trained. This is 103% of the target of 30,786. This takes account of compensating the anticipated attrition. Out of 615 HEP supervisors, 452 (73.5%) have been trained and deployed.
7. Conduct annual two weeks refresher training to HEWs on relevant health programmes	Not done. But TOT for the conduct of refresher training has been undertaken.
8. Conduct in service training to Woreda Health	Data not available

Office managers for supervision of HEWs	
9. Make available a total of 43,200 different categories of health workers, upgrade 6,480 health workers and provide on the job skills upgrading training to 33,357 health workers and administrative staffs.	At EFY 1997 there were 2,453 physicians, 776 health officers, 18,809 nurses, 6,363 health assistants, 1,312 environmental workers, 6,259 para-medicals and 2,737 HEWs (total = 38,709). In EFY 2000, the number of physicians was 2,085, health officers 1,242, nurses 16, 765, health assistants 2,140, para-medicals 7,731and HEWs 24,571 (total=54,534). In 2001, 133 physician, 185 health officers, 440 nurses, 1,232 para-medicals and 7,260 HEWs (total=9,250) graduated and joined the sector. This implies that there was total 54,534+9,250=63,784 health in EFY 2001. According to EFY 2002 Core Plan 386 physicians, 605 health officers, 909 nurses, 2,647 para-medicals and 1,942 HEWs (total =6,424) will graduate and deployed. This also implies that 70,208 health workers will be available at end of HSDP III (2002). All do not take into account attritions due to various reasons. Sources: Health and Health Related Indicators, ARM 2001 Report, 2002 Core Plan, HR Directorate of FMOH.

Challenges/constraints

- Inadequate budget for salary to employ some health professionals

Component 4: Pharmaceutical Services

Ensuring the availability of effective, safe and affordable essential drugs, medical supplies and equipment throughout the country is crucial to the delivery of health services. The objective of the pharmaceutical services component of HSDP III is, therefore, to ensure a regular and adequate supply of the same in the public and private sector and ensuring their rational use. Six targets have been set achieve the above objectives. Out of the six targets, three fall under the responsibility of the Pharmaceutical Fund and Supply Agency (PFSA) and the other three on Drug Administration and Control Agency (DACA). The following have been implemented by the respective agencies.

4.1 Institutional Restructuring

In order to make the procurement system more efficient and undertake additional tasks capitalization, PHARMID has been replaced by the new institution called Pharmaceutical Fund and Supply Agency (PFSA). The agencies capacity is being now strengthening in different ways. Procurement officers, engineers, information specialists and druggists have been recruited and

deployed. Technical assistance has been given to the agency by SCMS and UNFPA. TOR has been developed to recruit procurement specialists and their employment will be effected in EFY 2002. PFSA will also be supported with Logistical Management Information System (LMIS). This will be establishing LMIS within PFSA. The aim of establishing LMIS is to link health facilities to regional hubs and then to PFSA HQs.

4.2 Procurement of Health Commodities

Government through PFSA and international competitive bidding has reached to a capacity to procure and distribute health commodities worth of 550 million ETB at EFY 2001. The procurement of health center equipment, health post kits and HIV/AIDS and TB testing kits and drugs.

According to the study made on health commodity procurement, 369 days were required to procure health commodities. With the standard target set by the BPR, It has been now possible to procure health commodities within 120 days. It has been also possible to procure anti-TB and HIV/AIDS testing kits within 90 days under normal government procedure.

4.3 Storage and Warehousing

In order to increase the capacity of health commodity procurement and distribution, a cold room has been built. This has increased the national capacity of procurement by five fold. Eighteen sites have been selected, the design has been completed and the financial resource required or the construction of warehouses in different regions has been secured. As reported, USD 5.3 million from PEPFAR, USD 4.7 million from GAVI and USD 1.6 million from GFTAM have been secured.

4.4 Transportation and Distribution

PFSA has now 92 trucks to efficiently distribute health commodities to regions and health facilities. It will soon receive another 28 trucks. PFSA feels that this capacity is not adequate to deliver drugs and equipment especially HIV/AIDS, test kits, drugs and reagents directly to health facilities on time. Health facility mapping is carried out since it is intended to use this distribution channel to deliver other drugs and commodities especially medical equipment to health centers and health posts.

4.5 Provision of Essential Drugs and Medical Equipment

Government has now reached to a capacity to procure and distribute to health facilities essential drugs worth of hundreds of million of ETB. In EFY 2001 alone, PFSA procured and distributed essential drugs worth of 600 million ETB. It is expected to reach 2.8 billion ETB by EFY 2003.

4.5 Drug Administration and Control

- Institutional building at federal and regional levels and expansion of the drug administration and control system has been undertaken. Five branch offices have been established and delegation on drug administration and control has been given to RHBs. The system has been expanded address the public and private sectors.
- Familiarization on the developed drug administration and control system has been carried out among all stakeholders and the society at large.
- A guideline and different standards have been developed to ensure sustained drug availability in the country has been prepared and familiarized.
- Drug quality and rational use has been ensured through the process of reviewing drug documents, physical and laboratory quality assurance checks.
- Prevention and control has been undertaken on the use of narcotic drugs and tobacco on the basis of the international legal instruments. Collaboration has been established with youth organization, anti-drug clubs have been established and capacity building activities have been conducted for the same purpose.
- An instrument for the disposal of expired drugs has been bought, installed and used.
- In order to control the distribution and use of elicit drugs, trainings have been given to those working in the legal system, police, customs and others.
- Institutional building at federal and regional levels and expansion of the drug administration and control system has been undertaken. Five branch offices have been established and delegation on drug administration and control has been given to RHBs. The system has been expanded address the public and private sectors.
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- An instrument for the disposal of expired drugs has been bought, installed and used.
- In order to control the distribution and use of elicit drugs, trainings have been given to those working in the legal system, police, customs and others.

Implementation status of the six specific targets of HSDP III with regard to availability, administration and control of effective, safe and affordable essential drugs and medical equipment and their rational use at public health facility level is as follows:

Specific HSDP III targets	Implementation Status
Increase availability of essential drugs from 75% to 100% in each public HF	The statuses of the all of the targets mentioned below were supposed to be known by field based assessments/surveys. But has not been done and therefore assessments/surveys in sample regions and facilities are suggested by both PFSA and DACA.
Ensure 80% availability of standard medical supplies and equipment in all public HFs	
Scale up the percentage of imported and locally produced drugs with safety ,efficacy and quality investigated from 40% to 100%	
Reduce the percentage of expired drugs from 8% to 1% in public HFs	
Increase the proportion of health institutions that practice rational use of drugs from 25% to 100%	
Increase the inspection coverage of drug trading facilities from 20% to 100%	

Component 5: Information, Education and Communication

There were many activities undertaken until 2001. But it is reported that that IEC/BCC activities are now weakened due to shift of responsibility from FMOH to FMOI and RHBs. Sometimes, it is not clear who is responsible for IEC/BCC for health behavioral change. Nevertheless, the implementation statuses of the HSPD III targets under this component are the following:

Specific HSDP III Targets	Implementation Status
1.Develop and implement IEC/BCC that ensures effective social mobilization to tackle diseases of public health importance	IEC/BCC guidelines and materials have been developed and distributed. Although the guidelines and materials have been developed and distributed, their effective in ensuring behavioral change in preventing and controlling disease of public health importance and the sustainability of their distribution and use has not been evaluated.
2.Ensure 100% popularization, adaptation and implementation of National IEC/BCC Strategy at all levels of the health system	100% of the target has not been achieved. But a plan has been developed and a task force has been established to undertake and popularize, adapt and implement the National IEC/BCC Strategy at all levels.
3. Provide appropriate health communication materials to 100% the HEWs and equip 100% of kebeles implementing HEP with portable IEC equipment	HEP centered radio spots, audio and video messages numbering 516 and 69 respectively , leaflets/pamphlets, newsletters and posters on HIV/AIDS, malaria, TB, acute watery diarrhea, personal hygiene and environmental health, reproductive health and other

	health issues have been prepared and distributed to HEWs. 1,565 tape recorders, 1,488 megaphones, 6,167 video teaching aids and 69 audiocassettes, 69 video cassettes, 62,500 battery cells, 200 amplifiers and 200 horn speakers were procured and distributed.
4. Increase the KAP of the population on HIV/AIDS, malaria and TB by 50% of its 2005 status.	Apart from DHS 2005, data on current status on are not available. DHS 2005) A harmonized message manual on malaria is under preparation
5.Increase adolescent awareness and knowledge on HIV/AIDS and STDs from 77% and 30% to 95% and 80%	Attempt has been made to increase adolescent awareness and knowledge on HIV/AIDS and STDs. The targets have not been achieved due to lack of sustained planning and implementation on adolescent awareness creation and knowledge on HIV/AIDS and STDs. It seems that the focus now is on care and support than on prevention. This is worrying as this will reverse the gains that have been achieved.
6. Increase adolescent awareness and knowledge on contraception from 80% to 95%	Data from UNFPA???

Challenge

- Lack of policy guidance and clear institutional mandate to undertake IEC/ BCC activities

Component 6: Health Management, Management Information Systems and M&E

An effective and efficient management system is crucial to the achievement of the goals of the health sector. This implies the improvement in knowledge and skills in the areas of policy formulation, planning, budgeting, financial management, programme implementation and monitoring and evaluation at federal, regional, zonal Woreda and health facility levels. A review in this area shows that the implementation of the civil service reform is well underway at all levelsof the health system.

6.1 Health Management

The HSDP III targets and their implementation status are shown below.

Specific HSDP III Targets	Implementation Status
1. Implement the five Civil Service Reform Programmes in the health sector to ensure efficient, effective, transparent, accountable and ethical civil service at all levels of the health system.	Four CSR programmes: i) top management leadership performance improvement ii) Service provision performance improvement iii) Financial Management performance improvement iv) Ethical performance improvement have been designed and are under implementation.
2.Staff 100% of WHOs and RHBs by health managers with appropriate professional knowledge and skills that are governed by professional ethics and discipline at all levels of the health service structure	All RHBs and WHOs have been staffed with health managers. Leadership trainings have been given to those managers. As a result the sector wide, Woreda-based Core Plan preparation processes for EFY 2001 and 2002 have been led and closely followed by them.
3.Establish Health Management Boards/committees and health councils at all levels of the health system	Management board members have been elected by local communities (hospital constituencies) in many hospitals.

6.2 Health Management Information System (HMIS)

Specific HSDP III Targets	Implementation Status
1.Develop and implement a comprehensive and standardized national HMIS and ensure the use of information for evidence -based planning and management	This has been one of the Core Processes of the BPR. Forms worth of 20.0 million ETB have been printed and distributed to health facilities. A total of 7,779 health professionals have been trained and 44 hospitals and 82 health centers are currently implementing HMIS.

2.Review and strengthen the existing HMIS and at federal, regional Woreda, health facility and	Review and strengthen the existing HMIS and at federal, regional Woreda, health facility and community levels The HMIS has been redesigned and the plan to scale up in all regions has been started. Detailed implementation plans have been by RHBs. Execution has been delayed. Full implementation is expected to be started in all regions before the end of HSDP III. But delay in completing and implementing BPR, availing the necessary human resource for the process which includes the employment of health information technicians and renovating of physical facilities and procurement of furniture and equipment such as computers were the major bottlenecks.
3.Achieve 80% completeness and timely submission of routine health and administrative reports	There has been mixed findings by the JRM on the use of information and reporting gaps and inconstancies. On one hand excellent data collection, monitoring and reporting in high performing health posts and health centers and at Woreda Health Offices in SNNPR. On the other hand, use of information is quite limited in most of the Woredas and health facilities visited by the JRM.
4.Achieve 75% of evidence-based planning	This target has been fully achieved as this has taken place in 810 Woredas in EFY 2001 and 2002

6.3 Monitoring and Evaluation

Specific HSDP III Targets	Implementation Status
1.Develop and implement comprehensive and integrated M&E guideline at all levels of the health system	This has been done in the first two years of HSDP III.
2. Establish WJSC and form linkages between Woreda - regional and central joint Steering committees	This is an area that has lagged behind and has to be pushed by FMOH and RHBs.
3.Conduct regular supervision and review meetings at Woreda and HF level	Complete information not found. But discussions with informants say that this is not yet done
4. Conduct JRM, ARM , Final evaluation of HSDP III and regular FMOH donor consultative meetings	There has been good progress in undertaking joint activities with development partners. In the last planning process, 78% of DPs participated. Some 56% of DPs request separate planning documents.
5. Harmonize donor-government reporting cycles and M&E systems	As noted in the JRM report of EFY 2001, progress has been observed in terms of implementing key activities of harmonization and alignment. A Joint Financing Agreement (JFA) has been agreed and signed by seven

	DPs, The total pledged resource for the MDG Pool Fund has reached 1.0 billion ETB. The MDG Pool Fund is working well. Many of the indicators set to measure harmonization and alignment which include planning, budgeting and reporting have improved although some problems still linger.

Challenges

- The long time taken by regions in the preparation of the BPR has brought about delays in the implementation of the health information system.
- Inability of some regions to hire health information technicians; and consequently the failure to perform other related HMIS scaling up activities.

Component 7: Health Care Financing

7.1 Health Care Financing (HCF) Reform

Health Care Financing (HCF) Reform and Health Insurance component of HSDP III aims at consolidation and expansion of health care financing and introduction of social and community based health insurance in Ethiopia. This is to address the critical and chronic problem of financial resources in the health sector. It is part of the Resource Mobilization Core Process of the BPR. The design of the process has been completed and implementation has been started. The reform components include retention and utilization of revenue, administration of the fee waiver system and establishment of functioning facility governance bodies.

Accordingly, implementation of the financing reforms is already underway in some regions, namely Oromia, Amhara and SNNP; activities during the past fiscal year were geared towards strengthening capacity of implementers at regional, Woreda, and facility levels to implement components of the reforms. These regions have already put in place the necessary legal frameworks, operational guidelines, health facility governance, organizational structures and staffing**.**

7.2 Health Insurance

To start the whole process of establishing and institutionalization of an insurance system in Ethiopia, studies and experience sharing visits were undertaken to various African and Latin American countries which included Ghana, Senegal, Rwanda and Mexico.

Activities for the establishment and institutionalization of the health insurance system have been started. The activities include establishment of a health insurance agency, coverage of permanent government employees with social health insurance (SHI), piloting the implementation of

community based health insurance (CBHI) in twelve selected Woredas, undertaking awareness raising and sensitization activities on health insurance, implementing alternative resource mobilization strategies for medical care in federal health institutions, completing and implementing the study results on financial resource mobilization and utilization and completing and using the results of National Health Accounts Study. Development of these publicly managed health insurance schemes in Ethiopia is aimed at mitigating the risks of out of pocket health spending by employees of the formal and informal sectors as well as rural populations engaged in agriculture and pastoralism. The following have been s far achieved.

Preparatory works have been intensively underway for establishment of SHI and CBHI.

SHI proclamation has been drafted and submitted to the Council of Ministers and waiting approval. The SHI background document contains recommendations regarding premium levels, the benefits packages and the institutional structure of the Federal Insurance Agency. As suggested by the Council, the next step was to involve stakeholders in the discussion of the draft and the background document.

A draft law and regulation have been revised and improved and presented for discussion to selected relevant stakeholders in two stages for sensitization of heads of institutions on social health insurance and to get feed backs. Continuing discussions have been conducted in Addis Ababa and the regions and around 2000 people have participated in the discussion forums. The legal framework has been improved based on the inputs from the various discussion forums and submitted to the Council of Ministers for the second time for its endorsement and subsequent ratification by the Federal Parliament

Parallel to the work on social health insurance, various activities are being performed to pilot the community-based health insurance and based on the results in pilot areas, to replicate the experiences throughout the country. Twelve Woredas have been selected for this purpose in the four pilot regions (Tigray, Amhara, Oromia and SNNPR). A detailed three year plan has been prepared for implementation and evaluation of CBHI pilot. A technical background document has been prepared; training manual has been developed for regional and Woreda level CBHI leadership.

In addition, regional feasibility studies have been finalized, and CBHI legal documents, and financial and management systems have been developed. A Regional Steering Committee has been established in three of the pilot regions, while adequate preparations have been made in Amhara Region to establish the committee. The Steering Committee is expected to oversee and support the implementation of the CBHI scheme. The members of the committee have been briefed on the implementation plan of CBHI, the duties and responsibilities of the steering committee and about future activities.

Since CBHI will be implemented by the community activities are being carried out to build the local capacity beforehand. Accordingly, TOT that will be run for seven days will be conducted for

professional personnel drawn from various regional bureaus in each pilot region. The trainers will train members of Woreda health insurance steering committees, Woreda health insurance board and management committees, kebele health insurance mobilization committees, and kebele health insurance management committees. Training will also be given for members of Woreda health insurance steering committees established in each pilot Woredas in each region.

To ensure the acceptability and sustainability of the CBHI, feasibility studies have been made in the four pilot regions and the reports of the studies have served as inputs to the whole process of designing the scheme. .

Each region will decide on the type of health services to be provided, premiums or contributions to be paid by members, and financial support to be given to these health insurance institutions based on the results of the studies.

Since it is appropriate for the CBHI schemes to be established at Woreda level, internal regulations and establishment papers, draft papers and guideline that will enable them to get legal recognition have been prepared. In addition, draft guideline on financial administration has been prepared for use by the health insurance institutions.

7.3 Retention and Utilization of Revenue

Up to end EFY 2001, 73 hospitals and 823 (90%) health centers have started retaining revenue and 95% have utilized the revenue they have collected. This shows that the utilization rate of revenue by these facilities is quite high. The following table shows the distribution of hospitals and health centers collecting and using their revenue.

Status of Health Facility Revenue and Utilization by Region, EFY 2001[44]

Regions	Collecting Revenue		Utilizing Revenue	
	Hospitals	Health Centers	Hospitals	Health Centers
Tigray	12	100	12	100
Afar	0	0	0	0
Amhara	16	140	16	140
Oromia	22	300	22	300
Somali	0	0	0	0
Benishangul-Gumuz	2	18	0	0
SNNPR	16	242	16	242
Gambella	0	0	0	0
Harari	0	0	0	0
Addis Ababa	5	23	0	0
Dire Dawa	0	0	0	0
TOTAL	**73**	**823**	**66**	**782**

[44] FMOH, ARM EFY 2001 Report, 2009

The table below illustrates HSDP III targets and their implementation status.

Specific HSDP III Targets	Implementation Status
1. Increase overall health expenditure per capita from 5.6 USD to 9.6 USD	As illustrated in the 2001ARM Report, the total (from all sources) per capita allocation for health is only ETB 38.03. This becomes only USD 3.27 at the current exchange rate of about ETB 12.60 to one USD. But the per capita public expenditure on health stands at ETB 26.6 in EFY 2002. This does not include resources from other sources such as out of pocket spending by individuals, expenditure from the private sector, NGOs and international organizations. Figure 10 below shows the trend on this matter.
2. Double the share of health as a proportion of total government budget (domestic spending and direct budget support)	There has been a continuous increase in the allocation of budget to the health sector from the Government. As shown in the MTR Report (June 2008), the budget allocation was ETB 1.258 billion in EFY1997, and 3.892 billion in EFY 2000. Figure 11 below shows the trend in this regard.
3. Ensure retention and utilization of 100% of revenue generated at hospitals and HCs	At EFY 2001, out of 172 potential hospitals, only 73 (42.4%) and out of 2193 potential health centers only 823 (37.5%) collect revenue. Similarly, out of 172 potential hospitals 66 (38.4%) and out of 2193 potential health centers 782 health centers utilize their revenue. These figures show that progress is far behind the target.
4. Expand special pharmacies to cover 100% of hospitals from the current level of 82% and 100% of HCs from the current level of 58%	No recent figures available. But it is expected to increase significantly due to the motivational essence the initiative has.
5. Design and implement social health insurance for employees in the formal sectors and pilot test community health insurance	Design and legal working documents for the establishment of a social health insurance (SHI) scheme is completed and submitted to the Council of Ministers. Discussions in 15 forums have been conducted with stakeholders for comments and inputs and for familiarization purposes. It is expected that the proposal will be soon be approved by the Council of Ministers.
6. Step up HIV/AIDS fund at all levels of the health sector and advocate its establishment in other sectors	According to HAPCO's Annual Report of EFY 2001, out of 11,246 public sector institutions, 5,312 (47%) have established the Fund. Similarly, Out of 701 NGOs, 106 (15%) have established the Fund[45].

[45] HAPCO, Multisectoral HIV/AIDS Response Annual Monitoring and Evaluation Report, EFY 2001

Figure 16: Trend in Per Capita Public Expenditure for Health, EFY1998-2001[46]

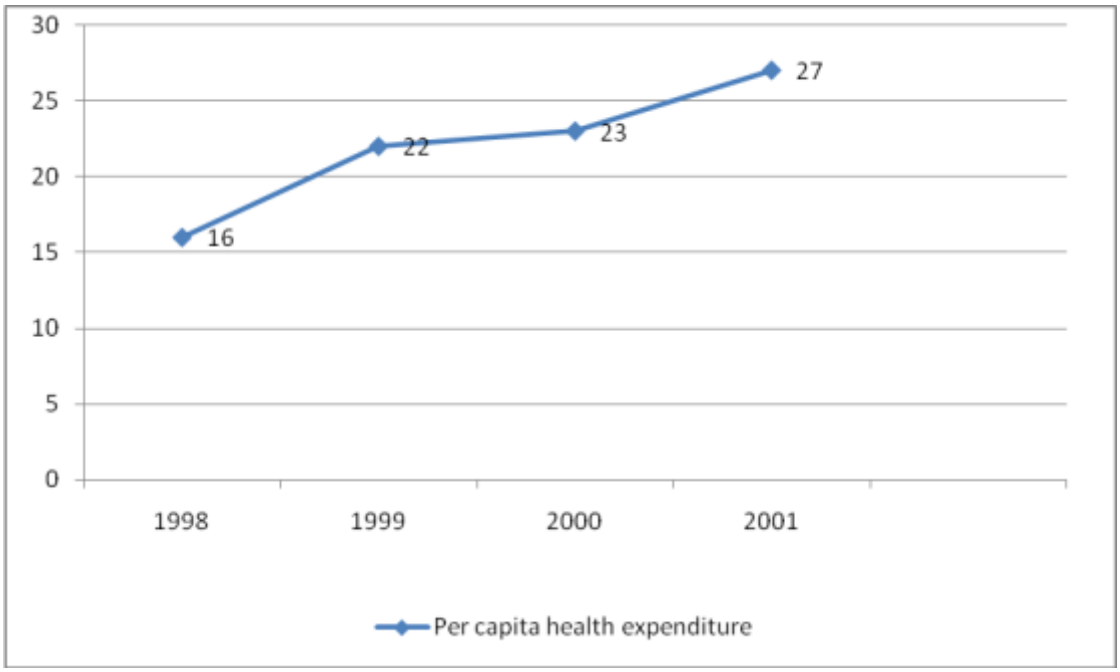
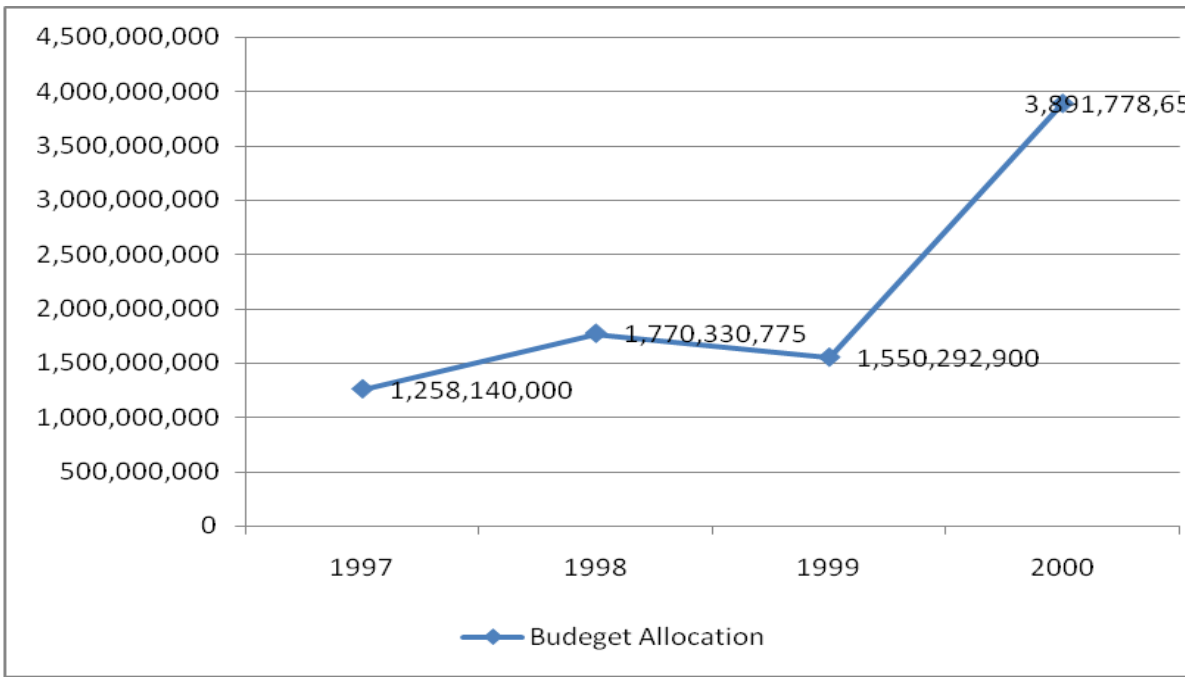


Figure 17: Trend in Budget Allocation to Health in ETB, EFY 1997-2000[47]



[46] FMOH, ARM EFY 2001Report
[47] Independent Review Team, MTR Report, 2008

Key challenges

- Delay in approving the SHI legal framework.
- Delay in the establishment of CBHI Steering Committees at regional level.

Component 8: Crosscutting Issues

8.1 Gender

The objective was to mainstream gender at all levels of the health system.

Accordingly, the preparation of a training manual on physical violence and analytic framework on gender and health, compilation, analysis of data on female workers and use the data for advocacy purposes have been completed. The final version of the document will be published and distributed upon completion of the revision work.

In order to prevent physical abuse on women and to provide adequate health services for the victims, rapid assessment study has been completed and based on the results of the assessment and the identified gaps, a draft training manual for use by health workers has been prepared and refined through a consultative workshop attended by all concerned stakeholders.

8.2 Nutrition

Nutritional disorders are the main causes of morbidity and mortality. The major problem is protein-energy malnutrition and micronutrient deficiencies such as vitamin A, iron, and iodine. The 2005 Ethiopian Demographic and Health Survey (DHS) showed that 47% of children under five years were stunted and some 27% of all women of child-bearing age were found to suffer from chronic energy deficiency. Similarly, amongst children who were under five years, about 5% had wasting and 64% were stunted, about 1% had vitamin A deficiency and 17% of the pregnant and lactating mothers had anemia[48].

Institutional strengthening, human resource capacity building, conducting nutritional assessment and studies, supporting regional laboratories and supporting health facilities in the distribution of micronutrients and vitamins are the priority areas for the National Nutrition Programme, which is part of HSDP III. Based on this, achievements during the programme are the following:

- The National Quality Laboratory System was strengthened and operational plan was developed and implemented.
- A Regional Help Desk has been established for full regional support.

[48] FMOH, National Nutrition Strategy, January 2008

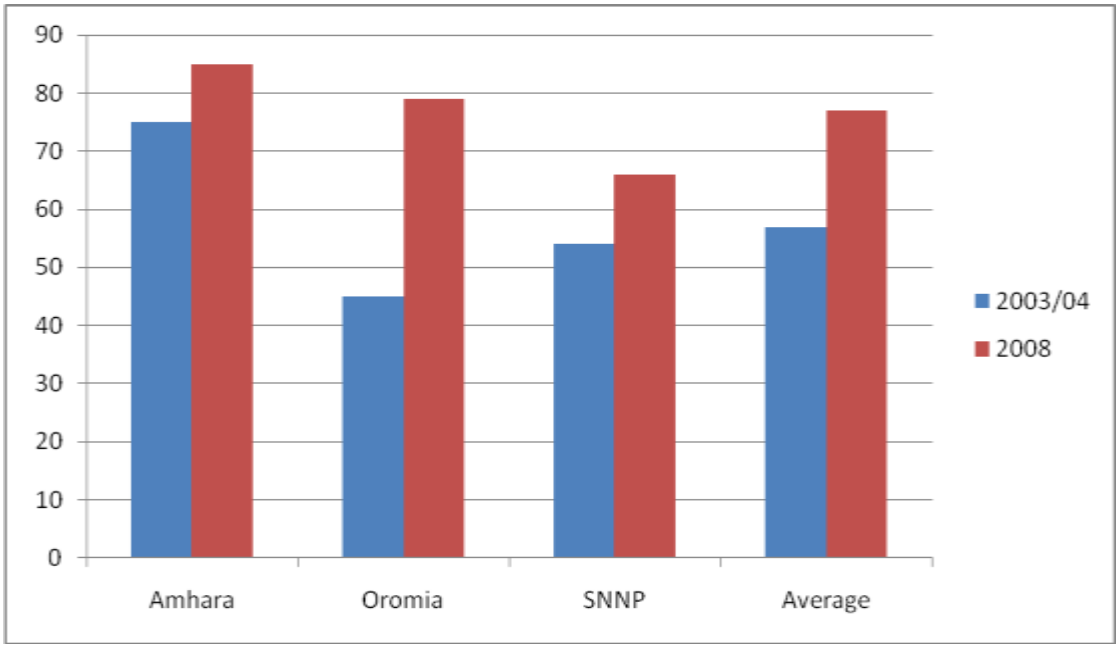
- Twenty Regional laboratories and ART monitoring laboratories were enrolled in national and external Quality Assurance (EQA) schemes.
- The alternative National Algorithm for rapid HIV testing has been adopted based on new test kits.
- A customized training module for national training on scaling up HIV rapid testing has been prepared and the relevant laboratory personnel have trained.

HSDP III targets and their Implementation Status

The following table illustrates the status of the targets under this sub-component of HSDP III

Specific HSDP III Targets	**Implementation Status**
1. Reduce stunting, wasting and low birth weight of children by 50% of its current status of 47%, 11% and 13.5% respectively	No survey conducted to show the current status. However, early detection and rehabilitation activities are widely undertaken at community level. The trend is positive. The prevalence of stunting, wasting and low birth weight among children is expected to significantly decline.
2. Create access for 90% of children 6-59 months for nutritional screening	Nutritional screening is underway every three months at HP level. It is planned to screen more than 95% of the 6-59 months children.
3.Increase the proportion of infants 0-5 months exclusively breast fed from 38% to 63%	The prevalence of exclusive breast feeding is 76% in the four big regions (Amhara, Oromia, SNNP and Tigray). The 2008 USAID/ESHE sponsored survey also showed a77% prevalence in Amhra, Oromia and SNNPR. The figure below shows the trend in 2003/04 and 2008.
4. Increase the proportion of infants 6-11 months breast fed from 75% to 80%	Complementary feeding is 83% in the four big regions. The trend is positive.
5.Increase the proportion of children aged 6-59 months getting vitamin A prophylaxis from 38% to 54%	Out of the eligible population of 6-59 months children, the coverage for two rounds of Vitamin A was 95% in EFY 2001. The highest 100% coverage goes to Afar and Gambella and the lowest 72% to Dire Dawa.
6. Reduce iodine deficiency disorders by achieving 100% access to iodized salt	This is an area where much has not been done. According to DHS 2005, only 4.2% of HHs has access to iodized salt.
7. Reduce maternal anemia by 50% of its current status	The current level of maternal anemia is 27%. The procurement for Iron foliate is underway. 80% of the HPs are expected to distribute the iron foliate. In addition to anemia among mothers, the prevalence of anemia among children aged 6-59 is 54% (20% mild, 25% moderate and 4% severe)

Figure 18: Trend in the proportion of Children up to Age 6 months Exclusively Breast Fed in Amhara, Oromia and SNNP Regions, 2003/04 and 2008[49]



8.3 Harmonization and Alignment

Harmonization and alignment has been an important agenda in Ethiopia over the last decade. The Ethiopian Plan for Sustainable Development to End Poverty 2005 (and later the PASDEP) created an added impetus for better coordination and alignment of external support. In 2005, the Ministry of Health and Partners developed HSDP III as a single programme framework for coordinating sector health action (one plan). The goals, targets and costing of HSDP-III are aligned with health MDGs. Subsequently, a Code of Conduct was signed to guide the conduct of all partners in support of HSDP. Afterwards, an operational manual entitled "HSDP Harmonization Manual" that focuses on ensuring one-plan, one-budget and one-report at all levels of the health system, including development partners, has been developed and endorsed by all stakeholders.

As part of HSDP-III, Government and development partners agreed to establish the MDG Performance Fund to move towards a broader harmonization and alignment. It includes support to (i) the Health Extension Programme (ii) Maternal health and (iii) Technical assistance. Subsequently, a Code of Conduct was signed to guide the conduct of all partners in support of HSDP.

The objective of this component is to focus on key priorities and reduce fragmentation of planning, implementation, financing and monitoring and evaluation activities implemented by different

[49] USAID/ESHE, Household End-line Survey, Synthesis Report, September 2008

stakeholders in the health sector. HHM calls "one plan, one budget and one report". Key achievements during HSDP III are the following:

- The Health Harmonization Manual (HHM) has been finalized through extensive consultative process and endorsed by FMOH and HPN Donor Group.
- The EFY 2000 and 2001 and 2002 health sector plans of actions have been prepared in line with the principle of "one plan" of the HHM and based on the initially agreed priorities and targets.

Challenge

- Poor progress in terms of adopting a common budgetary framework among DPs and in the use by development partners of a common reporting format
- Slow response of many DPs to join the IHP Compact and JFA
- Low disbursement of committed funds (55.4%) by development partners in EFY 2001.
- Weak planning monitoring and follow-up capacity at regional and Woreda levels

8.4. Operational Research

The aim of operational research in health is to identify priority problems and produce evidence that would help to improve health services.

Operational research was conducted in the areas of causes of maternal mortality (Maternal death audit), prevalence of cervical cancer, coverage of child and TT immunization, coverage and impact of the expanded programme of immunization, EPI coverage survey, effect of Misoprostol, choice of family planning, nutritional surveillance, traditional medicine, HIV/AIDS, TB, and malaria, surveillance of major public health problems and health commodity tracking, annual Joint Review Missions and other studies and assessments have been done.

Other studies include EOS coverage validation survey, national nutrition baseline survey, effectiveness of Coartem, effectiveness of residual DDT spray, and cost of health services.

V. Challenges, Constraints/obstacles in Planning and Implementation of HSDP III

The major challenges and constraints with regard to the planning and implementation of HSDP III are the following:

1. Weak implementation of the number of national policies, strategies and programmes at lower levels especially at Woreda and community levels due to full knowledge and familiarization of documents

2. Lack of full implementation of policies, strategies and programmes by local NGOs

3. Absence of guideline to establish strong and effective public private partnership (PPP)

4. Lack of a policy on monitoring and evaluation that defines the roles and responsibilities of the various institutions with in the health system

5. Lack of sufficient funding for the implementation of the HMIS

6. Institutionalization of a right-based approach of planning and implementation which will address the equity issue in the health sector

7. Effectiveness and efficiency are poorly addressed at various levels of the health system although much work has been done on those areas

8. Poor utilization of health services of the different types at different levels which require the need to work on demand creation and overcoming constraints and obstacles to health service utilization

9. Challenges related with achieving the health MDGs. The MTR of HSDP III has noted that improvements in the area of maternal health will be more difficult to achieve as they rely on a comprehensive improvement of the health system , rural infrastructure, the supporting systems and long term actions in the areas of human resource development, planning and infrastructure, logistics and adequate referral systems.

VI. Opportunities for Planning and Implementation of HSDP III

The following were the opportunities that prevailed for the planning and implementation of HSDP III:

- The 1993 Health Policy which focuses on the development of preventive and promotive health delivery services
- The 20- Health Strategy that provided programmatic direction i.e. missions, vision, goals and objectives
- Decentralization Policy which enhanced bottom up, participatory and evidence-based planning and defined roles and responsibilities at federal, regional, Woreda, health facility and community levels,
- Democratization process for popular participation at federal, regional, Woreda and community in health care development planning and implementation and ensuring ownership in the delivery and monitoring of services

- The Civil Service Reform Programme (CSRP) designed to improve the quality of of service delivery to the beneficiary at all levels of the health system
- Good leadership at all levels that helped scale up best practices

VII. The Role of HSDP III in Socioeconomic Development of the Country

Overall programming to achieve the MDGs in Ethiopia is through the National Programme of Accelerated and Sustained Development to End Poverty (PASDEP). HSDP III is aligned to the PASDEP. Hence, the HSDP III is expected to contribute towards national development and poverty reduction. Regions are monitoring the progress through their annual progress reports, and have aligned their current five-year strategic plans with the MDGs and the HSDP III.

The sector monitors the percentage of children under-five years that are underweight or stunted. It is hoped that this figure will be collected through routine data sources but the last national figure was through the DHS. Regions do report screening for underweight children both routinely and through campaigns. Achieving MDG 1 i.e. eradicating extreme hunger, requires a multi-sectoral approach. The health sector is working very vigorously on both addressing the impact of extreme hunger through treatment of malnutrition but also through moving to address the causes of malnutrition and implementing more preventive strategies.

The fate of newborns, mothers, and children is closely linked poverty and hence, support must be focused to promote integrated maternal and child health package to reduce missed opportunities in the context of continuum of care approach and to provide services both at home and health facility levels and at every stage of life.

As mentioned in the MTR Report, experts have recommended universal access to skilled care to achieve MDG 4 and 5 by 2015. As the government HRH assessment report (FMOH, 2007) indicates, achieving health related MDG targets, especially reduction of maternal and associated newborn mortality reduction seems to be a daunting task, considering the huge gap in the supply and demand for human resource to meet the minimum staffing pattern for scaling up basic and emergency obstetrics and newborn care services in health centres and hospitals.

The national response to HIV/AIDS has been re-oriented in the context of the MDG 6 towards achieving a universal access focusing on three instrumental strategic approaches: the HEP, health facility expansion and capacity development (human resources). Progress on HIV/AIDS and malaria is commendable; however TB control needs attention if MDG targets for case detection are to be met.

The health sector is making impressive achievements towards targets of MDG 7 (environmental sustainability), especially in the areas of increasing access to safe water and the proportion of people with access to improved sanitation.

VIII. Best Practices and Lessons Learned in HSDP III

The following are a synthesis of the best practices and lessons learned during the planning and implementation of the various components of HSDP III in different regions.

i. The training and deployment of HEWs in 16 packages of interventions that are broadly categorized under four core areas; hygiene and environmental sanitation, family health, disease prevention and control, and health education and communication have been instrumental to achieve the various annual targets of the HSDP III.

ii. Proper utilization of these HEWs supported by community leaders and direct support provided by community health volunteers have contributed to increased community access to ANC and family planning services. The role of community health volunteers particularly in community mobilization for outreach services, providing information on any vital event taking place in their community and in improving the health care seeking behavior of the community has been very crucial- (SNNPR and Amhara Region).

iii. Conducting maternal death review/audit is a mechanism for quality improvement. This is a mechanism that has to be developed and regularly used by midwives and obstetricians at health center and hospital levels. However, full scale implementation may increase workload of existing staff.

iv. Intensive campaign and social mobilization have immensely facilitated the construction of HPs and improving the hygiene and environmental sanitation activities in many areas particularly in North Shewa zone of Oromia region.

v. It has been learned from health facilities in Oromia and Tigray Regions the provision essential services to communities can be started without being fully equipped and provided that the critical human resource is available at those facility levels.

vi. High commitment of health managers at all levels and the direct involvement of communities, health facilities (health centers and hospitals), NGOs, HEWs in the development and execution of Woreda annual plans ensures ownership by lower levels of the health system and contributed to overall achievement of targets.

vii. Better collaboration between the finance and health offices at Woreda level in some regions has facilitated the Woreda-based planning and budget allocation processes and for joint ownership, monitoring and supervision support of programmes and services.

viii. Good monitoring and supervision system at zone and Woreda levels improves performance at health facility level. In East Gojjam, the Woreda monitors health centers on a monthly basis and the zone monitors Woredas on a quarterly basis. Both Woreda and zone provide written and oral feedbacks.

ix. Pre-deployment training and candid discussions with doctors helped in reversing the brain drain and migration of health workers from the public sector. The candid discussion helped to enlist commitment and mutual understanding between FMOH and the doctors. The candid discussion also helped to know the root causes of the brain drain and the health workers migration from the public sector and also to reach to consensus on the solution of both problems.

x. Communities are quite aware of the sign and symptoms of TB and what to do with TB. Therefore involvement of communities in the TB control programme is important.

xi. The integration of HIV and TB has increased the TB detection rate in some regions and that this approach has to be adopted in all regions.

IX. Recommendations as inputs to HSDP IV

These have been recommendations from the various ARMs and HSDP III Mid Term Review of 2008 which focused on laying foundations for improving access to better trained skilled birth attendance and B/CEmONC services, and for an overall improvement of services in the health system.

9.1. Improving Maternal and Child health Services

i) Improving the midwifery training quality for midwives and clinical nurses to enable them to be skilled birth attendants (for example, through TOT), better practical training by improving service quality in training centers so as to attract more clients for childbirth); establishing nationwide standards for midwifery certification, addressing leakage of midwifery trained nurses to other nursing areas.

ii) Improving access, quality and use of B/CEmONC services.

- Implement a stepwise increase in access to obstetric and newborn care, by designating selected health centers and hospitals as 'Strategic' B/CEmONC centers' based on an emergency obstetric and new born care needs assessment;

- Consolidate available resources by deploying to the strategic centers, trained staff in sufficient numbers, with equipment and facilities to provide 24 hour services; link them with HEWs for referral and provision of clinical support;

- Progressively increase the number of these 'strategic facilities.

iii) Sustain CEmONC: Support trained CEmONC teams through twinning arrangements.

- Implement Interim Period Strategies: While health system capacity is being built to utilize available resources, including the HEP, VCHW, and HIV/AIDS programme to prevent maternal and newborn death and disability:

- Improve maternal and neonatal health services through better coordination with HIV/AIDS

- Strengthen:

  - HEP with focus on birth preparedness, recognition of danger signs and community mobilization for referrals,
  - Collaboration between HEWs and Traditional Birth Attendants (TBAs) to improve cleanliness, early recognition and referral of complications, and management of third stage labour;
  - HEP focus on improving tetanus toxoid (TT) coverage, providing iron supplementation and nutrition counseling, and
  - Post Natal Care (PNC) & newborn care with 24-48 hours so as to reach every woman that ho gives birth/newborn in the kebele covered by an HEW

iv) The quality of IMNCI implementation in health facilities, and the effectiveness of community IMCI in changing health seeking behaviour need to be assessed through studies, and appropriate remedial measures. Treatment of pneumonia should be extended to health posts level to increase access to life saving measures for rural children.

v) Immunization: Immunization scope and coverage have increased, although still below targets for herd immunity. Better coordination between health centers and the HEP would improve drop-out tracing. Locally appropriate measures are needed in pastoralist and insecure areas and to ensure the Expanded Programme of Immunization (EPI)

reaches children living in those areas. The lack of maintenance of the cold chain, due to lack of qualified cold chain technicians, spare parts and more important, a comprehensive and robust maintenance system, requires urgent attention to preserve the potency of vaccines. Regional cold chain maintenance plans supported by appropriate resource mobilization are needed.

vi. Adolescent and Youth Health is a new programme and implementation needs to be accelerated through integration with reproductive health, EmONC and PMTCT programmes and support to regions for planning and for capacity building.

vii. Concerning family planning; some progress has been observed in this area, although much below the expected targets. Improving counseling aimed at fears of side effects and health problems, and tailoring contraceptive advice to the real needs of clients would improve acceptor and continuation rates. There is also a need to strengthen involvement of men in the use of family planning and empower women and their families to make informed decisions and have the means to attain optimum sexual reproductive health. Imaginative use of local leaders, including priests, and innovative approaches aimed at the 15-24 age groups are also needed.

9.2. Policy Changes

A number of policy changes have taken place at the national level but have not been fully implemented at the regional and Woreda levels. In many instances, documents regarding new policies are absent in the regions and Woredas and staff are unable to implement them and are still following previously available guidelines.

Similarly local NGOs are not familiar and well-informed of the national policy developments in the health sector. Therefore, there is a need for a policy and guidelines to guide public private partnership in terms of delivery of services and establishing roles and responsibilities for regulations and reporting responsibilities. This is especially urgent as the private sector is growing in Ethiopia.

A policy on monitoring and evaluation of the sector as a whole needs to be developed and implemented. This should outline the role of different partners and the methods and tools to be used. This should also link with tracking the sector's progress towards MDGs and HSDPIII targets. There is also a need for a policy decision on the adoption of a uniform HMIS system for the country both in the public and private sectors, and allocate appropriate funding to implement it.

A policy on the adoption of new technologies, including ICT and the use of alternative power sources and the adoption of technologies which are more appropriate to the national and local environment in which services are to be delivered. In addition, the sector requires a policy on plant and equipment maintenance. There are already initiatives in this area under the 'blueprints' for hospital management developed through the Clinton Foundation Initiative.

A health sector financing policy will provide an overview of how all sources of health sector financing can be used to the best benefit for the sector as a whole. This includes the role of social health insurance, protection of basic services, and prioritized public health sector financing towards the delivery of core basic services to the most poor and vulnerable in the country. Policy decisions need to be taken to extend the funding of waivers and exemptions to include other out-of pocket expenditure to promote access to essential services for the most vulnerable, Alternative types of financing such as demand side financing need to be considered under broader health sector financing strategies.

The existing population policy needs to receive increased attention in the health sector.
Although the sector is expanding coverage of services to the population at an accelerated rate this is against an ever increasing population which means that comprehensive coverage of essential services constantly needs to expand. This has serious implications for planning and budgeting of services, including what targets and indicators are set to monitor progress of the sector. Population issues, including family planning, and early-marriage, need greater inclusion in curriculum in training institutions and schools.

The adoption of a rights-based approach to health needs policy guidance. This is where patients become claimants on the health sector and the sector is held accountable to provide services on an equitable basis. Such an approach will need to address issues of gender, poverty and discrimination in a more holistic and coordinated way.

There is need to follow-up not just implementation of policies and strategies, but also the means of monitoring and evaluating their implementation when national policies are developed, There is also a need to move from using health information systems towards broader sector monitoring and evaluation, which needs to develop capacities to carryout non-routine surveys and assessments, such as national health accounts, public expenditure reviews, and public expenditure tracking surveys.

9.3. Addressing the Equity Issue

Equity is being addressed with the policy of first building health posts in the under-served areas and providing them with HEWs who target households. But equitable access to key curative services

needs to be strengthened by ensuring consistent strengthening of health centers and hospital services and provision of referral systems and mechanisms, increased supply of essential drugs, equipment and building adequate capacity of health staff especially at the lower level, where the majority of poorer people access health care.

The current exemption of essential services and the fee waiver system is also addressing equity of access, however both need strengthening in terms of range of services fully exempted and availability of funding to cover the cost of waivers. The pastoralist strategy is in place and focal persons are assigned. The implementation of the pastoralist strategy needs further acceleration both in terms of quality and coverage/accessibility so that those more underserved populations can be reached.

Very low utilization of services by the poor in urban areas suggests that supply-side interventions are inadequate to address equity of access if implemented in isolation. There are indications that investing in demand side interventions may prove more effective to increase access than expanding coverage and quality of care only. The GOE plans to address these issues through the expansion of a combination of community-based approaches (the health promoters' package) and enhanced use of the media. Health promoters are trained to support activities that promote behaviour and value change by utilizing resources from both the public and the private sectors. These demand side promotion initiatives may need to be complemented with further financial incentives to poorer non-users to help them use services.

9.4. Efficiency, Effectiveness and Quality Improvement

As observed in ARM of 2001, the concept of efficiency and effectiveness is shading light to additional dimension for improving quality of services in the health sector. While in the health care, efficiency can be looked at as either producing a desired output at a minimum cost or else combining available inputs efficiently so as to achieve the maximum benefit, efficiency now seems to get focus putting effectiveness before efficiency not the other way round and the need to conceptualize and promote this thinking is fundamental to development. FMOH is expected to communicate this thinking to all levels of the health system. All plans should be prepared and reviewed in light of this thinking. Adoption of the various essential health services package as cost effective interventions to address the highest disease burden is an efficient use of limited resources.

Therefore, defining the levels of care and packages to be delivered at all levels in the sector is crucial for effectiveness and efficiency and eventually for improving quality of service in the health system. It is important for the sector to consider changes in delivery mechanisms even though they may have the desired output but they may not be an efficient way of achieving that output.

How inputs are combined or coordinated can also lead to inefficient and ineffective use of resources. The current expansion of physical infrastructure and certain cadres of staffing without the balance of health systems strengthening to support them in their work may also have an inherent level of inefficiency and in the short-term are ineffective at reaching the targets that this investment in the sector is expected to achieve.

Improving routine support services can have a positive impact on efficiency and effectiveness. While much work is being done at the national level to address the overall efficiency of the sector, especially within the context of the civil service, there is also need for the sector to address efficiency and effectiveness at the programme and implementation level. There is a need to set and monitor programme targets to define effectiveness of implementation. The M&E system needs to be appropriate to monitor such effectiveness. Adoption of new technologies and new procedures can increase efficiency; this means that continuing medical education in new technology and treatment practices can increase both the efficiency and effectiveness of health workers and needs continuing support. Task transfer from one cadre to another can also be more efficient use of available resources.

9.5. Health Status Changes and the MDGs

The main health status indicators being monitored by the health sector relate to infant and child mortality rates, maternal mortality ratio and total fertility rates, all of which are collected through surveys such as the DHS.

The sector monitors the percentage of children under-five years that are underweight or stunted. It is hoped that this figure will be collected through routine data sources but the last national figure was through the DHS. Regions do report screening for underweight children both routinely and through campaigns. Therefore, expanding and strengthening the monitoring system of the changes in the health status indicators is crucial.

9.6. The Right to Health Care

As member of the United Nations Ethiopia has ratified major international conventions such as Convention of Civil and Political Rights, Convention on Economic and Social and Cultural Rights, the Universal Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women, a rights-based approach and principles have not been incorporated into the HSDP III. This, notwithstanding, provisions are made that show the commitment of the government to cardinal principles of Human Rights.

Representation, participation and capacity building were critical in the development of plans and most regions reported capacity support and inclusiveness in preparation of the plans.

Participation is encouraged from the Woreda level upwards and this provided the such needed accountability framework where inadequacies in relation to services and equipment were identified for action. Physical access to health facilities has improved since the health posts were constructed in the communities to minimize travel distance.

Creating awareness and accessing information about the available services at the community, kebele and Woreda levels including the urban population and building the capacity of all staff at all levels on human rights concepts and rights-based approach to provision of health care and appoint focal persons on human rights is crucial.

9.7. Emerging Chronic Diseases

Ethiopia is on the process of transforming from a low income to a middle income country. As observed in the developed world the balance between communicable and non-communicable diseases is expected go in favor the emergency of non-communicable diseases such as cardiovascular diseases coronary/ischemic heart disease (heart attack), cardiovascular disease/stroke, hypertension, heart failure, rheumatic heart disease), diabetes mellitus, cancer and other chronic diseases are now on the increase and causing fatality.

Although there is great scarcity on population-based statistics in Ethiopia, chronic non-infectious diseases are emerging in a remarkable proportion of the total disease burden, causing important morbidity, and mortality as well as high expenses to the health sector. For instance, the study conducted in Butajira Rural Health Project showed chronic non-infectious diseases (including cardiovascular diseases) 24.0% of the morbidity and 14.2% of mortality. In addition, a prospective study of Ethiopian medical patients 60 years and over found cardiovascular diseases especially hypertension and its complications in 20% of patients[50].

Smoking, hypertension, diabetes, obesity, abnormal lipids, inadequate consumption of fruits and vegetables, and physical inactivities accounts for most of the risk of cardiovascular diseases, diabetes mellitus and cancers. In addition to these, the economic and social context of the country, urbanization, economic transformation and population aging present favorable environment for the spread of chronic disease risk factors and the ensuing diseases[51].

These studies indicate the importance of chronic diseases, which are expected to increase as infectious diseases and malnutrition controlled and life expectancy increases. Hence, these calls the attention of the health sector undertake the necessary preparedness. Some of the major

[50] Ethiopian Heart Association, Draft Strategic Plan, 2008
[51] FMOH/WHO-Ethiopia, A Situation Analysis on Chronic Diseases and their Risk Factors in Ethiopia, 2008

recommendations of National Technical Working Group alleviate the severe shortage of health workers throughout the health system in the country, training of mid-level health workers such as nurses in specialty areas to function as diabetic nurses, cardiac nurses and the likes, organize in-service training programmes to health care providers and managers on the clinical management, prevention and control of chronic diseases, development of uniform guidelines and protocols to standardize the clinical care as well as the prevention and control of chronic diseases, promote awareness among the public about the growing burden of chronic diseases, design and implement population-based interventions targeting the main behavioral and intermediate risk factors, develop a strategic plan for the prevention and control of chronic diseases, and provide support to private health service providers with favorable policies and guidelines on the import of drugs and medical equipment as well as with a system of reporting and referral[52].

9.8. Neglected Tropical Diseases

Participants of the EFY 2001 ARM have expressed their concern that some known tropical disease have been neglected and that some other unknown tropical diseases as the one that occurred in Tigray region are emerging in the country. These diseases have reported to be monitored and nominal intervention undertaken by development partners. There for it becomes imperative for FMOH and RHB to reinvigorate their involvement in the control and prevention of the neglected and emerging tropical disease.

9.9. Support to Emerging Regions

The weak capacity to deliver maternal and child health service to contribute to the achievement of the maternal and child health MDGs in the emerging regions and the need to get support from FMOH has been mentioned in ARM 2001. Neither the human resource nor the experience to tackle maternal problems exists in those regions. Mothers go to health facilities; but no services are provided. Mothers are therefore discouraged to go to health facilities. Although they are referred to other hospitals in other regions, they die before they reach to those hospitals due to the long distance to travel and problems related with means of transport. Therefore the need to give attention to emerging regions in terms of building their critical mass and providing human resource support from the center in interim period has been found to be crucial.

9.10 Preparations of HSDP IV

The following were recommendations of the MTR of HSDP III which are important to the preparation of HSDP IV.

[52] FMOH/WHO-Ethiopia, A Situation Analysis on Chronic Diseases and their Risk Factors in Ethiopia, 2008

- Revise the overall governance/coordinating system of HSDP III, including the management of all funding sources under one decision-making body (provisionally called in this report "HSDP+/Coordinating Committee"); strive for the establishment of a 'unified coordinating system' at federal and regional levels with clear lines of communication;

- Continue negotiations with the Development Partners on the International Health Partnership (IHP) and their funding of the MDG Performance Package Fund (PPF); build confidence and credibility of the government budgeting, financial management and procurement systems; mobilize funding to pay for a waiver system for the poor; initiate a 'fiduciary risk assessment' of the performance of the financial and logistic support systems at short notice.

- Together with Ministry of Finance and Economic Development (MOFED), revise the component structure of HSDP IV in order to allow the allocation of funds (and priority setting) to the respective themes, by harmonizing it with the Government of Ethiopia (GOE) finance structure (chart of accounts);

- With health infrastructure and staff in place, decide on how to incorporate the new coordinating and implementing functions related to Nutrition, Population and Emergency Preparedness into the FMOH and RHB structures;

- Take gender, nutrition, population and pastoralists out of the cross-cutting issues and mainstream them into the new HSDP IV document. Bring IEC and BCC under HEP and other components.

- Add 'Planning' as one of the support functions in the new HSDP IV, as it has not been included as a system in its own right within HSDP III. It will benefit and strengthen from specific attention and funding.

- Consider developing the HSDP IV from a bottom-up approach (starting with Woredas).

X. CONCLUSIONS

Progresses have been made towards achieving some of the targets set for family planning, ANC and post natal services although they have been found uneven across regions. But the progress in increasing delivery by skilled attendants has been little.

With regards to neonatal and child health, most of the regions seem to be very near to some of the targets set for child health (i.e. measles immunization and Penta 3 coverage). This success story is mainly attributed to the efforts exerted by the health extension workers since they were involved in active mass mobilization. However, there are concerns sinec many health facilities do not provide IMNCI services.

Regarding with the control and prevention of communicable diseases, significant progress has been noted since EFY 1997 particularly in the control of HIV/AIDS and malaria. The number of health facilities involved in HCT and ART has steadily increased. Likewise, the number of people that received HCT services and PLWHA receiving ART has increased every year. The scaling up of LLINS and ACT has significantly reduced the number of malaria cases and deaths in all age ages. Ethiopia is now known to have as the highest net coverage in Sub-Saharan Africa after Togo and Sierra Leone. Nevertheless, the utilization rate seems to be low as sample surveys in the big regions show a 60% utilization rate.

While progress in meeting target set for TB treatment success rate (85%) seems to be fairly acceptable, detection rate remains very low (34%). Similarly, there has been progress in the control of leprosy and trachoma although the set targets for the respective diseases have not been met. Much remains to be known about the status of the other communicable diseases which include dranculosis and onchocerciasis. These diseases have been mentioned in the ARM EFY 2001 as neglected tropical diseases (NTDs). Limited control activities on these disease are undertaken by Development Partners particularly WHO.

The training and deployment of health workers seems to fall short of meeting the numbers and qualification requirements set in the BPR in the various directories. As a result of this, many recommended posts remained vacant, and the deployed staff is not been found to be generalist enough to address public health concerns.

Significant progress has been made in achieving the targets set for accelerated expansion of primary health care facilities. Of the total 1,455 health centers (HCs) planned to be financed through FMOH HC, 78 % percent of them are under construction and 22% (326 HCs) are completed. Of the

total 1,101 HCs planned to be financed through RHB as matching HCs, 65% (715 HCs) are under construction and 21% (238) have been completed. The financing of 343 matching health centers is yet to be secured. While the construction process is ongoing, there seems a slow procurement of equipment through the FMOH and furniture through RHB financing. At the Woreda level, the allocation of sufficient budget to furnish constructed health posts by using the evidence-based planning process is taking root. Nevertheless, it has been mentioned that FMOH should strengthen its follow up on PFSA to fast track the procurement of equipment of HPs and HCs. More effort has been suggested to synchronize the construction and upgrading of health facilities with equipping and staffing, and to ensuring access to water and electric supplies to Health facilities.

PFSA is able to undertake commodity procurement of its plans both for health commodities using RDF and program funds. The procurement of health center equipment through PFSA was reported slower as compared to its procurement plan but found to be much more cost effective than the previous arrangement. There was also some but slow progress in strengthening warehousing and distribution of health commodities, human resources deployment and LMIS improvement. Still, further efforts are required to strengthen the capacity of the agency to provide demand-driven procurement and distribution of health commodities.

Progress has been noted in strengthening the Woreda Planning process. The sector managed to support and to develop plans for 801 Woredas. The Woreda based planning process is being considered as the best example for the public sector planning both at the federal and regional levels. There has been relatively better collaboration between stakeholders at Woreda level. However, there was limited participation and involvement of health facilities, NGOs when Woreda plans were developed at Woreda level, and limited capacity of health facilities and Woreda health offices to negotiate with the region and the Woreda.

Some progress has been also made in getting some of the human resource training programs initiaited. Training of Health Officers on Integrated Emergency Obstetric and Surgery (IEOS) has been initiated in three universities. Preparations are underway to scale up HEW retraining and to enroll 300 midwives and 500 HOs per year.

The implementation of HMIS is progressing. The design of an electronic health record, geographical information system, tele-medicine and education has been completed and piloting has been started in some health facilities. About 44 hospitals and 82 health centers are partially implementing the system. The training of HMIS staff and the printing and distribution of the necessary forms and registers to health facilities has been completed. Nevertheless, it is constrained by lack of adequate financing at the regional level to hire health information officers.

Progress has been made in the area of establishing and institutionalizing a health insurance system in the country. A draft proclamation has been submitted to the Council of Ministers, implementation guidelines have been prepared and preparatory activities for piloting the

community-based health insurance is also completed. The collection and retention of revenues has been started in 73 hospitals and 823 health centers. The utilization of revenues has been started by 66 hospitals and 782 health centers.

Per capita health expenditure has continued to steadily increase for the last four years of HSDP III implementation. It was ETB 16 in EFY 1998. It has ETB 27 in EFY 2001. Budget allocation to the health sector has increased markedly in EFY 2000 and 2001.

Progress has been also registered in the area of gender mainstreaming. A training manual on physical violence and analytical framework on gender and health has been prepared. A rapid assessment and a draft training manual for use by health workers on physical abuse on women have been completed.

Similarly, institutional strengthening and human resource capacity building have been completed for health and nutrition-related researches and assessments and for laboratory quality control.

A significant progress was achieved in EFY 2001 in terms of putting the right frameworks and agreements that will push forward the alignment and harmonization agenda. The International Health Partnership roadmap was finalized and its Compact signed at the beginning of the year. However, alignment of program implementation by all stakeholders at lower levels especially at community level remains to be a challenge.

Annex: Detailed Programmatic Indicators and Targets of HSDP III

Impact	Indicator	Baseline	Target	Achievements
Improve the health status of the population	Reduce maternal mortality ratio	871per 100,000 LBs	600 per 100,000 LBs	No recent data available apart from that of EDH 2005. But some studies and interventions suggest that this objective has been achieved during HSDP III period.
	Reduce under five mortality rate	123 per 1000 population	85 per 1000 population	No recent figure available. But reductions are anticipated as a result of the implementation of EPI and nutrition interventions and involvement of HEWs.
	Infant mortality rate	77 per 1000 population	45 per 1000 population	Same as above
	Reduce total fertility rate	5.4	4	TFR of 5.3 (EFY 2000 Health and Health Related Indicator)
Outcome	**Indicator**	**Baseline**	**Target**	**Achievements**
Reduce the major disease burden in the country	Morbidity attributed to malaria	22%	10%	MIS showed a malaria parasite prevalence rate of 0.7% in all ages. The EFY 2000 Nine Months HSDP III Implementation Report shows malaria morbidity rate reduction of 48%.
	Case fatality rate of malaria in under five children	5.2%	2%	MIS reported 22.3% of children <5 had fever in the two weeks prior to the study.
	Case fatality rate of malaria in age groups 5 years and above	4.5%	2%	Reduction by 55% in malaria mortality(The EFY 2000 Nine Months HSDP III Implementation Report)
	Mortality attributed to TB	7% of all treated cases	4% of all treated cases	PTB mortality of 4% (EFY 2000 Health and Health Related Indicator)
Output	**Indicator**	**Baseline**	**Target**	**Achievements**
Improve health service coverage	Primary health care coverage	72%	100%	At least one type of health facility is available in about 85% of the kebeles Amhara, Oromia, SNNP and Tigray

				Regions (L10K Survey)
	Proportion of rural kebeles implementing HSEP		100%	70% of the kebeles have had HPs and 92% of the kebeles have at least one HEW in 2008 (L10K Survey). The training and deployment of 31,831 (103%) HEWs implies 100% coverage (ARM EFY 2001 Report)
	Scope of mainstreaming of HSEP in HSDP		100%	HEP mainstreamed at all levels of the health system
	Proportion of pastoralist population with access to HSEP	0	100%	Preparatory activities have been completed to implement HEP in the pastoral areas of the country
	Proportion of health centers upgraded and provide CEOC services	0	30%	No data available
	Proportion of hospitals and HCs providing PMTCT Services	8.6% (49)	100% hospitals and 70% HCs	Out of 1,596 HFs, 843 (52.8%) provide PMTCT Service.
	Proportion of hospitals and HCs providing VCT services	59.8%	100% hospitals and HCs	All hospitals and HCs provide VCT. The number increased from 129 in EFY 1998 to 1,596 in EFY 2001(ARM EFY 2001 Report)
	Number of HIV sentinel surveillance sites	66	120	82 (FHAPCO Report 2001)
	Health service coverage of DOTS/MDT	53.6%	72%	DOTS geographic coverage is 100% while HF coverage is 92% (TB Annual Bulletin, 2009)
	Proportion of health facilities implementing IMCI	36%	90%	81 hospitals and 930 HCs (26.5% of HFs) implement IMCI (ARM EFY 2001 Report)
	Proportion of districts implementing C-IMCI	12%	50%	Out of 810 Woredas 215 (26.5%) Woredas implement C-IMCI (Same source)
Strengthen the prevention and control of communicable diseases	Incidence of HIV	0.68%		0.27 (Health and Health Related Indicator)
	Prevalence of HIV	3.5%		2.1 (Same source)
	Number of PLWHA receiving ART	13,000 (3%)		152,471 (ARM EFY 2001 Report). The ART sites increased from 93 in EFY 1998) to 481in EFY 2001 (FHAPCO Report 2001)
	Proportion of STI cases properly treated	20%	30%	Focus has not been given to STI prevention in the last five years (FHAPCO

				Report). Status not known
	Proportion of people who used condom with one regular sex partner in the last intercourse	17%	49%	10.5% in EFY 1997 and 31.2% in EFY 1999. Health and Health Related Indicator)
	Proportion of patients receiving antibiotics for opportunistic infections	20%	50%	No data available
	Proportion of malaria epidemics detected and contained within 2 weeks of onset	55%	100%	All epidemic outbreaks are detected within two weeks
	Case detection rate of new smear positive pulmonary TB patients	34%	50%	34%
	Number of TB patients notified and treated	118,000	178,000	130,554 Tb cases of all forms are notified and treated in EFY 2001 (TB Annual Bulletin 2009)
	Treatment success rate of all types of TB cases	76% cured or completed	85% cured or completed	84% (ARM EFY 2001)
	Reduce the prevalence of leprosy	-	To less than 1/10,000	9o% of the expected leprosy patients are being identified and put on treatment (TB Annual Bulletin)
	Reduce the prevalence of leprosy grade II disability	12%	<10%	Prevalence reduced to 7% (WHO Team), 9% TB Annual Bulletin)
	Therapeutic coverage of onchocerciasis control in all CDTI areas	65%	Above 65%	No data found
	Cataract surgical rate (CSR)	350/million population per year	600/million population per year	No specific data found. But 37,000 cataract surgeries have been performed in EFY 2001 (ARM EFY 2001 Report)
	Contraceptive prevalence rate	25.2%	45%	56% (ARM EFY 2001 Report)
Strengthen the maternal and child health services	ANC service coverage	42.1%	80%	66% (same report)
	TT2 coverage for pregnant women	43.3%	75%	In Amhra, Oromia, SNNPR and Tigray, 42% of women received at least two doses of TT1 during pregnancy, 54% of women are protected against neonatal tetanus. , (L10K Survey)
	TT2 coverage for non pregnant women	25.8%	67%	34% of pregnant women received TT2 from HEWs (Same source)
	Proportion of deliveries attended by	12.4%	32%	26% (ARM EFY 2001)

	skilled attendants			
	Proportion of clean deliveries	10%	50%	No data found
	Post natal care service coverage	13.6%	31%	34% (ARM EFY 2001)
	Proportion of pregnant women getting folate supplementation	6%	52%	No data found
	Proportion of women referred for obstetric complications	1%	24%	No data found
	Proportion of pregnant women getting treatment for iron deficiency anemia	5%	36%	Ditto
	DPT 3 coverage	70.1%	85%	81.6% (ARM EFY 2001)
	Measles immunization coverage	61.3%	75%	76.6% (Same source
	Proportion of fully immunized children	44.5%	54%	65.5% (Same source)
	• BCG=65% • Measles=30% • DPT=20% • TT=10% • OPV=15%	To less than 20% for BCG and measles To less than 10% for DPT, TT and OPV	Vaccine wastage rate	No data found on vaccine wastage
	Proportion of pregnant women using ITNs	2%	49%	67% of pregnant women use ITNs (MIS 2008)
Strengthen the maternal and child health services	Proportion of under five children utilizing ITNs	2	63	Over 33% of children under the age of 5 slept under ITNs (same source)
	Proportion of children from HIV+ mothers getting PMTCT (nevirapin and replacement feeding or exclusive breast feeding)	0.1	25	Out of 68,136 children living with HIV, 17,264 need ART. The intensified ART program has reached 24,904 (36.5%) children and 8,761 (12.9%) are on ART in 2001 (FHAPCO Report 2001)
	Proportion of children who got Hib and Hepatitis vaccine	0%	54%	No data found
	Proportion of children getting proper temperature management including KMC	10%	40%	Ditto
	Proportion of children aged 6-9 months initiated on complementary foods on top of breast feeding	75%	80%	45% of mothers with children 0-11 months reported having initiated breastfeeding within an hour after birth (L10K Survey)
	Proportion of children aged 6-59	10%	54%	87% (L10K Survey)

	months getting vitamin A prophylaxis			
	Proportion of pregnant mothers getting treatment for iodine deficiency in pregnancy	5%	25%	19% of children live in households using adequately iodized salt (DHS 2005)
	Proportion of children aged 0-5 months on exclusive breast feeding	34%	63%	49% of children under 6 months are exclusively breastfed. 22% of children 6-23 months are fed according to the recommended three IYCF practices (DHS 2005)
	Proportion of children who got zinc for diarrhea management	0%	25%	No data found
	Proportion of children aged 6-11 months on optimum breast feeding	75%	80%	96% of children are breastfed. 86% are breastfed within 24 hrs of birth. Length of breastfeeding was 26 months (DHS 2005)
	Proportion of infants with complementary feeding	34%	63%	57.8% children in Amhara, 7.3% in Oromia, 12.2% in SNNP and 23.3% Tigray (average 30.2% got anything to drink other than breast milk (L10K Survey).
Strengthen the hygiene and environmental health services	Latrine coverage	29%	80%	Coverage stands between 37% and 86% (national 56%).
	Proportion of water sources checked for portability	36%	90%	No data found
Improve availability , safety and efficacy of essential drugs	Proportion of public health facilities with essential drugs	80%	100%	100%
	Percentage of expired drugs in public health facilities	8%	1%	No data found
Improve the availability of adequate human resource in the sector	HEWs to population ratio	1:26,687	1:2,500	1:2,054 (calculated based on 2007 Census and no. of HEWs trained in EFY 2001)
	Doctors to population ratio	1:29,777	1:14,662	1:36,374 (calculated based on the 2007 census and number of physicians indicated in Health and Health Related Indicator EFY 2000)
	Proportion of health professionals teaching institutions providing pre-service IMCI	66%	95%	No data found
IEC/BCC that ensures effective social mobilization to tackle	Scope of adaptation and implementation of the National	0%	100%	100% of the target has not been achieved. But a plan has been developed and a

diseases of public health importance designed and implemented	IEC/BCC Strategy at all levels of the health system			taskforce has been established to undertake and popularize, adapt and implement the National IEC/BCC Strategy at all levels.
Health information used for making decision	Scope of implementation of the five sub-programmes of CSP in the health sector		100%	100% (ARM Report 2001)
	Scope of staffing Woreda Health Offices and RHBs by skilled professionals as per the standard		100%	Staffing is underway based on CSR and BPR . All RHBs and WHOs have been staffed with health managers.
	Completeness and timely submission of routine health and administrative reports		80%	Gaps and inconsistencies observed (JRM 2009 Report)
	Completeness and timely Achieve 75% of evidence-based planning		75%	The evidence-based Woreda Annual plan of EFY 2002 has been developed in all (810 Woredas).
Comprehensive and integrated Monitoring and Evaluation system designed and implemented	Scope of development, adaptation and implementation integrated M&E GL and revision of PIM	0%	100%	100% done in the first two years of HSDPIII.
	Scope of harmonization of donor – government reporting cycles, accounting procedure and monitoring and evaluation system (one plan-one report)	-	75%	Many of the indicators set to measure harmonization and alignment which include planning, budgeting and reporting have improved although some problems remain.
Adequate resource mobilized , efficiently utilized and sustained for the health sector	Scope of institutionalization of HCF	0%	100%	The institutionalization of the different components of HCF is underway in Amhara, Oromia and SNNP regions. Legal frameworks have been developed and steering committees for social health insurance are being established.
	Scope of generation of resource for the sector through: – Increasing proportion of health facilities with SPs – Retention of revenues generated at health facilities – Implementation of appropriate	82% hospitals and 58% of health centers	100% of hospitals and health centers Retention of revenues at 100% of health facilities	73 hospitals and 823 HCs collect revenues. 66 hospitals and 782 HCs utilize their revenues. Not yet implemented

	HCF scheme at all districts		50% of districts	
Health emergencies(epidemics, outbreaks etc.) properly contained	The proportion of Woredas having emergency preparedness strategy document and guidelines	0%	100%	Not yet implemented
	Proportion of Woredas having and implementing emergency preparedness and response plans	10%	80%%	Current number is not known
	Number of Woredas with rapid response team	10%	80%	Current status not known
	Proportion of outbreaks/epidemics with laboratory investigation /result	50%	80%	No data found
	Proportion of Woreda Health Offices submitting timely and complete surveillance reports	72%	80%	Incompleteness and inconsistency reported
	Proportion of HEWs trained on IDSR	0%	100%	Not data found
	Proportion of outbreaks of epidemic prone diseases notified to Woreda within two days of surpassing the epidemic threshold	60%	100%	100% achieved

REFERENCES

1. FMOH, HSDP III, Health Sector Strategic Plan, 2005/6-2009/10, September 2005
2. FMOH, Annual Performance Report of HSDP III, EFY 2001
3. Federal Democratic Republic of Ethiopia Population Census Commission, Summary and Statistical Report of the 2007 National Housing and Population Census Report, December 2008
4. HAPCO, Single Point Estimate, 2007
5. FMOH, HSDP III, Nine Months Implementation of 2000 EFY Report
6. Independent Review Team, HSDP III, 2005/06-2010/11 Mid-Term Review Report, 05 May -06June 2008
7. FMOH, TB Prevention and Control Programme, Annual Bulletin, Vol. 1, No.1, March 24, 2009
8. Transitional Government of Ethiopia, Health Sector Strategy, April 1995
9. FMOH, The Joint Review Mission Report, July 2009
10. JSI, Research and Training Institute Inc., Baseline Household Health Survey, Amhara, Oromia, SNNP and Tigray Regions, The Last Ten Kilometers Project (L10K), August 2009
11. FMOH, HSDP III, Woreda-Based Annual Core Plan, EFY 2002
12. CCM/E, Round 8 Malaria Proposal to the Global Fund, August 2008
13. Ethiopia Makes Striking Strides in Malaria Control, August 12, 2008
14. Nejmudin Kedir et al, Assessment of Performance in Selected Hospitals, A Comprehensive Analysis, 2009
15. USAID/ESHE, Household End-line Survey, Synthesis Report, September 2008
16. WHO Ethiopia Country Office and Jimma University, Community-Based Survey of Injuries in Urban and Rural Areas in Jimma Zone, Southwest Ethiopia, A Pilot Study Report, January 2007
17. Safe Motherhood Working Group, National EmONC Baseline Assessment, 26 March 2009
18. FMOH, National Nutrition Strategy, January 2008
19. Ethiopian Heart Association, Draft Strategic Plan 2008
20. FMOH/WHO-Ethiopia, A Situation Analysis on Chronic Diseases and their Risk Factors in Ethiopia, National Technical Working Group on Chronic Diseases in Ethiopia, December 2008
21. FMOH, Health and Health Related Indicators, 1997, 1998, and 2000
22. FMOH, Reports on the Proceedings and Results of the Tenth and Eleventh Annual Review Meetings of HSDP, October 2008 and October 2009
23. HAPCO, Multisectoral HIV/AIDS Response Annual Monitoring and Evaluation Report, EFY 2001
24. FMOH, Policy and Practice, Information for Action, Quarterly Health Bulletin, Volume 2, No. 2. June 2009

25. FMOH, ESOG, JSI, Addressing Community Maternal and Neonatal Health in Ethiopia, Report from National Scoping Exercise and National Workshop to Increase Demand, Access and Use of Community Maternal and Neonatal Health Services, May 2009
26. HAPCO, Summary of Achievements in HIV/AIDS Prevention in Ethiopia-August 2006 to February 2009.
27. CSA and Macro-USA, Ethiopia Demographic and Health Survey 2005, September 2006
28. MOH/HAPCO, AAU, CSA and EPHA, HIV/AIDS Behavioral Surveillance Survey (BSS) Ethiopia 2005, Round Two
29. USAID and MACRO, Evaluating HIV Seroprevalence Estimates from Ethiopia, Further Analysis of the 2005 EDHS, April 2008
30. FMOH, The HSDP Harmonization Manual (HHM), September 2005
31. DACA, PowerPoint Presentation on EFY 2001 Performance and EFY 2002 Plan
32. Children's Health and Nutritional Status, A new look at data from the 2005 DHS

Documents Reviewed

33. FMOH,Annual Performance Report of HSDP III,EFY 1999
34. FMOH, Annual Performance Report of HSDP III,EFY 2000
35. The Lucile & Packard Foundation, Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005
36. USAID and MACRO, Trends in Demographic and Reproductive Health Indicators in Ethiopia, Further Analysis of the 2000 and 2005 DHS Data
37. USAID and MACRO, Changes in HIV-Related Knowledge and Behavior in Ethiopia, Further Analysis of the 2000 and 2005 DHS Data
38. USAID, The Impact of Education on Health Outcomes, A new look at data from the 2005 DHS
39. USAID, Fertility and Family Planning in Ethiopia, Further Analysis of the 2000 and 2005 DHS
40. USAID, Essential Services for Health in Ethiopia, Health care Finance Reform End-line Survey, Synthesis Report, September 2008
41. USAID, Essential Services for Health in Ethiopia, Health Systems Performance Improvement End-line Survey, Synthesis Report, September 2008
42. FMOH, National Adolescent and Youth Reproductive Health Strategy, 2007-2015