ETHIOPIA'S 1ST ANNUAL NATIONAL CONFERENCE ON URBAN HEALTH

CONFERENCE PROCEEDINGS

APRIL 3-4, 2017 HILTON HOTEL

ADDIS ABABA, ETHIOPIA

Federal Democratic Republic of Ethiopia
Ministry of Health

USAID
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JSI
JOHN SNOW, INC.

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CONFERENCE ORGANIZERS

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ABBREVIATIONS AND ACRONYMS

AAMSP	Addis Ababa Mortality Surveillance Program
AAU	Addis Ababa University
AAU/SPH	Addis Ababa University/School of Public Health
CBHI	Community Based Health Insurance
CBHIS	Community Based Health Information System
CD	Communicable Disease
CSA	Central Statistics Agency
DALY	Disability Adjusted Life Years
E.C.	Ethiopian Calendar
EDA	Emmanuel Development Agency
ETB	Ethiopian Birr
FHT	Family Health Team
FMOH	Federal Ministry of Health
GTP	Growth and Transformation Plan
HDA	Health Development Army
HEP	Health Extension Program
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSTP	Health Sector Transformation Plan
JSI	John Snow Incorporated
MCD	Major Communicable Disease
MNCH	Maternal, Neonatal, and Child Health
MoEFCC	Ministry of Environment, Forest, and Climate Change
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization

PHC	Primary Health Care
PHSA	Private Health Sector Association
PPP	Public-Private Partnership
QALY	Quality Adjusted Life Years
RHB	Regional Health Bureaus
SEUHP	Strengthening Ethiopia's Urban Health Program
SNNPR	Southern Nations, Nationalities, and Peoples' Region
UHEP	Urban Health Extension Program
UHE_ps	Urban Health Extension Professionals
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WASH	Water Sanitation and Hygiene
WDA	Women Development Army
WHO	World Health Organization

SNAP SHOOTS


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NATIONAL CONFERENCE ON URBAN HEALTH
APRIL 3-4, 2017, HILTON HOTEL, ADDIS ABABA, ETHIOPIA


Integrated WASH with livelihood
On progress
Achievements

EXECUTIVE SUMMARY

POEM GIVEN BY TAGEL SEIFU

While Tagel Seifu, a renowned Ethiopian artist, present a poem about the UHE-ps role in Amharic "Lek ende beteseb" it is to mention the extent of the UHE-ps support and follow up as a family member to their clients.

BACKGROUND

Urban health impacts the livelihoods of all persons living within a city and requires the involvement of numerous actors to ensure its growth and protection. Growing global cities, such as Addis Ababa, represent locations of opportunity for all persons. Both laborers and industry perceive the city as the location with the highest chance of success. This emotive concept of hope is drawing millions into urban centers and is projected to tilt the historical norm of the human habitat with nearly 66 percent of the global population living in cities by the year 2050. Ethiopia is poised to become Africa's top economic power and will boast one of the world's largest populations with a number projected to be near 190 million in the next 40 years with the majority expected to reside in urban areas.

While this outlook is positive, the current health problems facing populations within Ethiopia's urban centers are numerous and expected to compound. Air pollution, poor sanitation, issues of water purity, and injury from road accidents are some of the many problems threatening the health status of millions of Ethiopians. For Ethiopia to rise to meet the challenges and hopes of its future, actions need to be taken to tackle these growing health issues within its cities. In partnership with the Federal Ministry of Health; JSI implemented Strengthening Ethiopia's Urban Health Program with funding from USAID organized a two-day national conference on urban health in Addis Ababa, Ethiopia. The participant audience of this conference includes:

- Mayors of selected cities and towns.
- Policymakers and Ministers; Ministry of Health, Ministry of Finance and Economic.
- Development, Ministry of Urban Development, Ministry of Water Resource, Ministry of Labour and Social Affairs, Ministry of Women's Affairs, Ministry of Youth.
- Donors and partner organizations.
- Academics working in the fields of urban health.
- Staff at the Agencies; Environmental Protection Authority.
- Agency, Food Medicine Health Care Administration and Control Authority.
- Industry leaders and Private Corporations.
- Civil Society Organizations.
- Professionals associations.
- Health care providers and community representatives.
- Representatives from regional health bureaus, city/town health offices, health facilities.

OBJECTIVES

This conference sought to share lessons and experiences from different scientific and experiential backgrounds in urban health and apply them to the current case of Ethiopia's growing cities. As the first conference on urban health in Ethiopia, the event will serve as a foundation to current and future efforts in improving the lives of the country's urban population. The objectives of the conference are:

- Strengthen discussions surrounding urban health problems in Ethiopia and outline benchmarks for future reference.
- Recognize the complexity of urban demographics and urban health and discuss intersectional problems facing the sector.
- Advocate for healthy cities and towns.
- Identify action points to be implemented at different levels to improve urban health in the country.

CONFERENCE OUTPUTS

The conference was expected to produce tangible deliverables;

- The conference informed the discussion concerning urban health in Ethiopia and fostered an environment where connections and collaboration could begin. Government officials, academics, professionals, relevant private actors, and community members had the opportunity to continue their conversations surrounding urban health which will hopefully result in positive and targeted action.

- Conference organizers recorded thoughts, points, debates, and concepts discussed during plenary sessions in a final document for distribution to policymakers and partners. The document is intended to streamline the efforts of the multiple partners represented at the conference and offer actionable items and ideas to the governing bodies within urban health in Ethiopia's cities.

- Videography, photos, and publishable materials that will be used to further JSI's efforts in enhancing the current urban health program.

- The conference served as a forum to discuss the challenges towns and cities are facing in promoting urban health and key next steps to address the challenges.

ABSTRACT OF KEYNOTE SPEECHES

Dr. Hibret Alemu

Chief of Party, John Snow Inc. /
USAID's Strengthening Ethiopia's
Urban Health Program

JSI is a USAID funded NGO and is found in more than 70 countries. Our organization supports actions in both the education and health sectors JSI has been present in Ethiopia for more than 17 years and has been steadfast partner for the health programs taking place. Currently, there nine JSI projects in Ethiopia including SEUHP. Our work in SEUHP begins at the community level with the UHE_ps and a focus on quality and accessibility. It also works on behavioral change communication strategies and awareness creation along with health system strengthening system strengthening, evidence generation and improving urban sanitation and hygiene.

The current demographic shift in line with economic growth coupled with the challenges and opportunities of urbanization indicate the rapidly developing future of Ethiopia. At this time, 20 percent of the Ethiopian population resides in urban areas, however within ten years that figure will rise to 30 percent. This shift indicates that we need to invest today for tomorrow and must take opportunities to learn from countries in our similar position. The current circumstances if not properly managed at the present time, will only compound in severity and scope. This conference is intended to discuss the available evidence, tools, tactics and lessons needed to move forward. There are more than 250 participants present during these two days. We have the FMOH and high government officials, health professionals, researchers, non-governmental partners, media, artists, private sector, USAID, Regional health bureaus, UHE_ps. For this conference, different research outputs, best practices, challenges, innovative ideas, will be put forward. Furthermore, best practices will be presented in the poster exhibition outside the hall. My hope is that from this conference, all parties involved can take ideas, lessons and inspiration back to their respective communities and sectors. I believe this conference will help bring together ideas that can create livable and healthy cities for its inhabitants. I would like to extend my thanks to the FMOH, USAID, the regional health bureaus, the UHE_ps, and the conference organizing committee.

Ms. BethAnne Moskov

Chief of Health, Population, and Nutrition
USAID

Over the past 25 years, Ethiopia has made a concerted effort to improve total population health. Around Africa and the world, Ethiopia is considered a model for health programs. The country has seen reductions in maternal mortality and child mortality and many other achievements. However, with the growth of urbanization at the annual average 4.7 growth, city growth poses a challenge to these achievements. By 2030, Ethiopia will have 39 million living in urban areas. The growth of cities is faster than provision of support mechanisms. It is important to note that urbanization does bring benefits, and that the concept is not a negative progression. It creates opportunities in employment, education, and information. We must remember however, that the challenges of urbanization are compounded for the urban poor; food prices, settlement security, water, sanitation, crime become an even more essential service needed for these groups. USAID understands these problems and has supported JSI (in seven regions) in its efforts for WASH, child health, and major communicable diseases such as HIV/AIDS and TB. It's impressive and a model for the world.

I would like to take a moment to express how the UHE_ps have been amazing. We have seen growth in support, networks and new programs from this group. An example of a beneficiary of these programs can be found in Fania, a 35-year-old mother in Debre Markos. She was excited to move into a new area however, upon her arrival, she and her neighbors began having problems with the lack of a toilet in the neighborhood. The lack of sanitation meant more problems for children and the community at large. After JSI support and the introduction of low cost toilets and handwashing, her sanitation improved. This is only one story of the numerous lives that have been improved from the existence of these programs. This conference will be an excellent way to enhance the existing benefits and find new ways of improving urban health.

H.E. Dr. Kebede Worku

State Minister of Federal Democratic Republic of Ethiopia Ministry of Health

In the past two decades, the Ethiopian government has drafted numerous health policies which have been and are currently being implemented. These policies focus on prevention and ensuring health service access for poor and economically disadvantaged populations. The urban/rural poor are a main concern of the ministry. Since the launch, many successes have been seen including achievement of the millennium development goals such as reductions in under-5 morality by 67 percent. There have also been significant reductions in maternal mortality, and an increase in life expectancy from 45 to 64 years. In terms of service delivery, the country has significantly improved skilled delivery and family planning utilization with an uptake of 37 percent for the latter. Reductions in morbidity and mortality for HIV, malaria, TB and other MCDs have also been positive. Mortality from HIV has decreased by more than 50 percent. For example, there have been no malaria outbreaks for the past 13 years. To strengthen the Ethiopian health system has undertaken the training and deployment of more than 38, 000 health extension workers in all rural and urban kebeles. The introduction of the Women Development Army (WDA) into communities have also supported health. The launch of Health Sector Transformation Plan (HSTP) in 2015/2016 will continue to operate until 2020. The plan focuses on ensuring quality in health service delivery with the priority being MNCH. At the present time, urbanization is continuing to grow. Within ten years, it is expected that 30 percent of the Ethiopian population will reside in urban areas. This in turn will prompt an epidemiological shift consisting of MCD, NCD, injuries, and accident centered within urban areas. This urbanization will pose challenges to climate change, water, pollution, and food. To tackle these issues, implementation of the Green Economy Strategy can ensure the strong, controlling and regulation of the system. Growth in industry within urban areas must be capitalized upon and synchronized within the green economy to ensure public health.

The training and deployment of 5,000 health extension professionals in specifically urban areas has taken place through the implementation of urban health extension packages. To further strengthen this program, the Ministry has also piloted primary health care reform in three primary health care units in Addis Ababa. These reforms need investment in human resources both financially and in terms of personnel. Experiences and examples have been taken from Brazil and Cuba; both countries are exemplarily in their primary health care system structure. As the country moves towards these models in primary care, the Ministry asks that universities and research institutes support these efforts. In general, the improvement of the urban health program relies on the integration of numerous sectors. The experiences, research and challenges discussed at this conference will undoubtedly chart a way forward. The Ministry hopes to continue these conversations in the coming years and include all stakeholders in our conversations in urban health. I would like to thank USAID and the organizing committee for the conference and the support they have given to the Ministry.

Dr. Tabor Gebremedhin

Speaker of Addis Ababa City Council

In order to decrease urban poverty, a multi-level approach of national, regional and municipal approaches is required. At the city level, urban growth is exponential and can be seen in the cities inhabitants. Cities at this time are growing not just in numbers but in resources. This growth can be seen in the achievements of the city which include renovating buildings, expansion of roads, transport, electricity, construction, water, and building health facilities. Beyond this, economies are growing and markets are becoming wider. This fast growth is encouraging rural to urban migration at a rapid pace.

Different strategies are needed to tackle the heath challenges facing the urban populace. Addis Ababa has its own strategies to tackle its own problems. There are national and international organizations in the city which present another set of issues. We as a city, need to be an example for other countries because of the spotlight we are in. Many conferences and gatherings occur here.

Health policies focused on prevention is one of the main tools of the city of Addis Ababa with examples such as primary health care. Since 2001ec the UHE_ps have been a huge help to city health and will continue to be. The program needs attention at all levels in order for it to remain sustainable. Before, it was difficult to provide care to so many different persons in a city area. Now, these workers have streamlined the process and helped build their communities. In order to support this further, Addis Ababa has constructed 75 new health centers which has improved coverage to 98 percent. The city has also renovated many hospitals within the city which narrowed the gap of bed shortages. There is also a plan to construct 19 health centers and three referral hospitals in the future. To improve urban health, all sectors have to be involved. NCD growth is on the rise and conference participants are expected to pay the bill. Support is needed for these endeavors. In summary, this conference shows the level of attention the government gives to urban health and the need for all of us to collaborate for better health outcomes.

OFFICIAL OPENING OF THE CONFERENCE

H.E. Ato. Muktar Kedir

Office of the Prime Minister; Good Governance, Justice, and Social Sector Policy, Planning and Evaluation Minister of Federal Democratic Republic of Ethiopia

In recent years, the economic growth of Ethiopia has rapidly taken place. With this increase it is expected that by 2025, Ethiopia is expected to become a middle-income country. To prepare for this, Ethiopia has created different policies and strategies. The conclusion of the first growth and transformation plan (GTP) has prompted the implementation of the second growth phase (GTP II), In the GTP II, the fast growth of cities has created new opportunities for innovation, development, and unity that will be built upon. Based on figures from the Central Statistics Agency (CSA), five years ago there were 15.2 million people living in urban areas. In 20 years, this figure is projected to grow to 42.3 million. This rapid growth of urbanization will create opportunities for productive employment in urban areas which in turn will realize the government's plan of large-scale industry construction in urban areas.

The government has already provided strategies concerning water, electric, transport, infrastructure expansion, urban housing and more. In health sectors, in line with the focus of national policies, productive and healthy communities will be supported and maintained.

Urban complexity poses a great challenge for urban populations. Water, sanitation, solid and liquid waste, traffic accidents, work place accidents, air pollution, and mental health are all interconnected with the subject of urban health. MCD, NCD, injury, mental, and occupational hazards are all risks. The launch of the Health Sector Transformation Plan is also working to engage with these challenges along with the Urban Health Extension Program (UHEP). The UHEP was established in 2001ec and has been a great support. The program is expected to improve accessibility and utilization of health services by urban communities, especially by the urban poor. Ethiopia possesses little experience in implementing an urban-focused plan. Therefore, sector convergences are essential; water sector, urban development and construction, road and transport sector, especially hygiene and environmental health needs focused on by all stakeholders and leaders at all levels. Rural health extension has been a success and now it is time to move forward with the urban health improvement plan. Lastly, the government will provide support to all efforts that seek to improve the urban health of our cities

INTEGRATED URBAN HYGIENE AND SANITATION STRATEGY AND NATIONAL ENVIRONMENTAL HEALTH AND HYGIENE STRATEGIES LAUNCH

State Ministry representatives sign the Integrated Urban Hygiene and Sanitation Strategy and National Hygiene and Environmental Health Strategy

The Integrated Urban Sanitation and Hygiene Strategy and National Environmental Health and Hygiene Strategies are preparing for the second wave of Ethiopian growth. Different actors were involved in the ideation and drafting process for these documents. A technical working group was established and drawn from a number of different sectors. A concept note was drafted by the technical working group, and approved by the state ministers of respected organizations, and soon after, international experts were consulted in collaboration with UNICEF. These experts went and visited different sectors and towns in Ethiopia and analyzed the data brought forward. Discussion forum was organized with the regional counterparts and the draft documents were enriched based on the suggestions given. Finally, the documents were distributed to respective ministries for their comments. Once the comments were

collected, they were incorporated into the documents and the strategy improvement was finalized. These strategic documents have taken a lot of time and consultation and were thoroughly prepared and it is a must that all stakeholders adhere and implement according to this document. These strategies are signed and launcheda by all the ministries in order to promise the pursuit of urban health. Sectors present to sign the Integrated Urban Health and Sanitation Hygiene Strategy and National Hygiene and Environmental Health Strategy: Ministry of health, Ministry of Urban Development and Housing, Ministry of Education, Ministry of Culture and Tourism, Ministry of Finance and Economic Cooperation, Ministry of Water, Irrigation and Electricity, Ministry of Environment, Forest, and Climate Change.

PANEL I: ETHIOPIA'S URBANIZATION, DEMOGRAPHIC SHIFT, CAUSES OF DEATH, SOCIETAL CHANGE, AND ITS IMPLICATIONS ON HEALTH

Moderated by Dr. Helina Worku

Deputy Team leader of Health System Strengthening in USAID

DEMOGRAPHIC DYNAMISM OF URBAN POPULATION IN ETHIOPIA AND ITS IMPACT

Dr. Atsede Desta, Assistant Professor Department of Population Studies, University of Gondar

The forces surrounding the causes and dynamics of urbanization are currently being witnessed in Ethiopia's urban centers. Africa is one of the worlds least urbanized areas, however this is quickly changing. Fueled by rural-to-urban migration and a natural increase of births, some of the fastest urbanization growth rates can be found in sub-Saharan Africa. Historically, Ethiopia has been characterized by a low proportion of urban dwellers but a high rate of urbanization. The predominance of peasant agriculture that has been the historical means of livelihood for the population, has reinforced rural life. This has resulted in the country being one of the least urbanized nations in the world. While Ethiopia possesses a relatively slow growth rate (4.64 percent), the pressures associated with urbanization are well underway. Both benefits and challenges can be observed during Ethiopia's current urban population expansion; people are being provided with various opportunities for inclusion in economic development while also being exposed to new threats. Environmental degradation as well as a lack of service capacity for sectors such as water, sanitation and waste disposal expose communities to risk. The fast-paced rate of urbanization increases the likelihood of informal settlements to begin to form within cities. These areas, proverbially known as "slums" typically consist of; poor housing with small, overcrowded houses built very close together using inadequate materials and with uncertain electricity supply; little or no access to water supplies, sanitation/latrine facilities and no solid waste disposal; increased risk of both MCD and NCDs and; inadequate health care facilities which, coupled with the poor living conditions, increases sickness and high death rates. In order to combat the challenges presented by urbanization, it is important that first, cities recognize the rapid rate of urbanization taking place in Ethiopia. Second, the creation of off-farm employment opportunities in rural areas will help reduce rural-to-urban migration and inevitably decrease pressures on cities. Fourth, present action to improve service delivery on basic amenities such as water, transport, housing, and power will yield benefits in the long term concerning population pressures. Lastly, adequate and reliable health data will ensure evidence based policy can support cities in their mission to promote health and wellness for its populations.

DEMOGRAPHIC PATTERNS: CAUSE AND EPIDEMIOLOGIC TRENDS OF MORTALITY AMONG ADULTS OF ADDIS ABABA, ETHIOPIA: 2007-2015

Dr. Bilal Shikur Assistant Professor, Addis Ababa University School of Public Health

Understanding the epidemiological trends associated with adults living in Addis Ababa can offer insights into city living and the health profiles of its inhabitants. According to data collected since

2006 by Addis Ababa University (AAU) through the Addis Ababa Mortality Surveillance Program (AAMSP), HIV/AIDS has seen significant declines in mortality since 2007. However, there currently exists a triple burden of disease with existing MCD burdens along with NCDs and injuries/accidents. As MCD illness burdens, such as HIV/AIDS, and TB continue to decline, NCD are growing at an alarming rate. In fact, 60 percent of deaths in Addis Ababa are attributable to NCD. For city-dwellers aged 35-54, cause of death is more likely to result from NCD than historically predominant MCD illnesses. While these NCD burdens are concerning, MCDs are still prevalent in city-dwellers of younger age groups. In addition, the concentration of populations in smaller spaces heightens the risk of injuries and accidents (e.g. traffic, violence, workplace).

CAUSES OF DEATH IN HARAR: URBAN HEALTH DEMOGRAPHIC SURVEILLANCE SYSTEM (HDSS)

2013-2016

Dr. Nega Assefa, Assistant Professor, Haromaya University School of Public Health

The case of Harar presents an interesting illustration of what the future of health in Ethiopian cities may look like. Presently, Harar is experiencing health trends synonymous with a middle- income nation. A declining birth rate due to lower neonatal and under-5 mortality rates along with reductions in death from infectious and parasitic illness have dramatically changed the health profile of the Harar population. In addition, mental health issues are heavily present in the 15-25- year-old age group with self-harm being the primary cause of death. Tuberculosis and HIV/AIDS are still the leading causes of mortality for persons aged 26 – 65 years, while for elderly populations, the seven leading causes of death are chronic conditions. Comparisons of the Harar population pyramid and the Ethiopian National pyramid display the contrasts between the age distribution of both populations. When comparing to future projections of the Ethiopian population, Harar technically lies fifteen years ahead of the Ethiopian population in terms of demographic composition. The rapid change in composition necessitates the creation of services tailored to needs of the city's populations which include pensions, elderly care, mental health services, and more robust care chains for NCD treatment. Furthermore, Skilled delivery should be emphasized as the leading causes of neonatal death are prematurity, bacterial sepsis and birth asphyxia.

URBANIZATION AND SOCIETAL CHANGE IN ETHIOPIA

Dr. Mirgessa Kaba, Assistant Professor, Addis Ababa University, School of Public Health

Recognition of both the benefits and challenges of urbanization in regards to social institutions offer opportunities to improve the urban development agenda and address several key issues pertaining to urban health. Housing, employment, and service provision impact the maintenance of health in cities and when properly supported, can yield to positive health outcomes. Urban areas are economically more prosperous than their rural counterparts due to a higher concentration of talent and skills, services and technologies. Cities also have the potential to possess improved housing and sanitation systems. They can provide citizens with better educational institutions and opportunities. Lastly, urban centers offer better employment prospects and women's participation in the labor force. While the potential of cities is understood, the distribution of these benefits to the Ethiopian urban population is less than satisfactory. In urban settings, the service, industrial and agricultural sectors employ 63 percent, 24 percent and 14 percent of the population respectively. However, access to a formal job in Addis Ababa is poor with 23.5 percent adults remaining unemployed. In addition, the role of wage/formal job and informal, self-employment on investment remains questionable. These problems are further jeopardized by continuing in-migration from rural areas. Infrastructural development in Ethiopian cities also remains poor due to the speed at which urban expansions outpaces the provision of health services, water, sanitation, and education. The lack of these services results in the creation of an urban poor populace. This

populace will typically congregate in areas within or on the periphery of cities creating informal settlements also known as "slums." Most slum dwellers (80.4 percent) used unimproved sanitation facilities and 8.2 percent practice open defecation. These locations can be highly unstable and result in a reduction of the health security for its inhabitants. While these pressure impact directly on the upkeep of health in cities, social relations and structures are also being adversely affected. The historical composition of the nuclear family is changing and yielding single, and non-marital cohabitation strategies in cities. Relocation of slum populations into condominiums offer little in terms of collaboration and community that slums once offered. Relocation also can disconnect persons from their work rendering their previous places of employment inaccessible. Evidently, addressing the societal factors presented is neither an easy nor sole solution for the improvement of urban health. Evidence based programming that relies on measurement of living standards, political power, equity, and economics can better address the multifaceted issues found within urban health. Urban health is more than health and once that fact is recognized, meaningful work can begin on its provision and preservation.

PANEL I: DISCUSSION SUMMARY

Following the four presentations, some questions and comments were forwarded from the audience and conference participants. The questions are summarized as follows.

1. Concerning total fertility in Harar, why are the fertility figures fluctuating at such a fluid pace? How is this possible?
2. How do we address the challenges surrounding industrial waste management and urban hygiene? These were not discussed in your presentations.
3. Why are you not using the internationally recognized measure of Disability Adjusted life- years (DALYs) in your presentation? Not using DALYs can be misleading and simply looking at mortality is sometimes not enough.
4. Why are you only following up on 10 percent of the reported deaths in your study? Isn't this figure a little low for Addis Ababa?
5. The sole use of verbal autopsy seems to be lacking in academic rigor. Are your results reliable in confirming cause of death?
6. It's not clear from the presentation which cities are rural and urban in your presentation about Harar. Is the sample size generalizable to the total population of the city?
7. Evidence and data on NCDs is changing and showing that their burden is growing in Ethiopia. What are universities doing in tandem with health bureaus to combat this development? What can be built upon that is currently taking place in terms of national strategic documents?
8. Is the shift from collectivist culture to individualistic a benefit or drawback to urban centers?
9. How did rapidly developing countries handle the issues encountered in urban health in an efficient and timely manner?

Fertility levels fluctuate based on recorded numbers. It is important to note that these are not aggregate levels at the national level. The total population is 58,000 and we only sampled 12 percent, therefore the numbers will shift quite visibly. Also, the year cutoffs on Gregorian and Julian calendars are important and can affect the figures.

Major causes of death are important and the question about the deeper reasons need to be explored. It is true, we are not covering that. In terms of industrial waste, areas that use it are heavily at risk for contamination however, these issues are not heavily present in Harar. Rather a lack of sports and physical activity contributes to obesity. Utilizing verbal autopsy means that

close relatives will confirm that a person died from whichever illness was recorded at a health facility/hospital/clinic etc. While it is not the best form of confirmation, it is recommended by the WHO and considered adequate for resource poor settings.

Concerning work between regional health bureaus and universities, our data is on a four-year time scale which is in the process of being narrated and finalized. However, we are about to submit a policy brief and are intending on using local media to promote health lifestyles in Harar. At the national level, a NCD strategy exists which discusses numerous issues of NCD prevalence, its magnitude, prevention tactics, and a detailed implementation plan. In addition, calls for discussions surrounding the Health Sector Transformation Plan, in which NCDs are a part of, are currently being made due to a lack of depth concerning the issue.

DALY and QALY issues are important however capacity issues render these measurements, inaccessible. Morbidity surveillance is also important. Following-up with 10 percent of the surveyed population was scientifically chosen as the appropriate figure which is quite sizeable in an Addis Ababa context. This was incorporated into the sample size calculation.

The urban social shift can be seen in numerous ways. The pivot from the nuclear towards single family has its challenges. Attitudes will shift according to schools of thought and simply looking at behavior will not represent a holistic picture of this change. The balance between collectivist and individualistic formations of society will be at odds. In the Ethiopian context, the change will be small but there is a chance that more troublesome problems could emerge from more individualistic cultures. Even though we may be becoming more urban, people in Ethiopia still possess family in rural or peri-urban areas. This connects persons with the rural and adds complexity to the gap between rural and urban locations.

SUMMARY

The session was summarized by Dr. Helina Worku, Chair of the Panel Discussion.

Urbanization is rapid and brings both challenges and opportunities. While the demographic and economic dividend is within reach, WASH programs, fertility, housing, employment and society will continue to face challenges. It is essential for policy makers to look for strategies within these challenges and work to improve the situation of urban dwellers utilizing evidence based management.

PANEL II: ETHIOPIA'S URBAN HEALTH EXTENSION PROGRAM: FROM WHERE TO WHERE?

Moderated by Dr. Taye Tolera

Director General of Armauer Hansen Research Institute, Addis Ababa, Ethiopia

ETHIOPIA'S URBAN HEALTH EXTENSION PROGRAM, EVOLUTION, CURRENT STATUS AND IMPLEMENTATION CHALLENGE

Dr. Zufan Abera, Director, Health Extension and Primary Health Service Directorate, FMOH

The Health Extension Program (HEP) is the vehicle for achieving universal coverage of primary health care (PHC) for the Ethiopian population. The HEP is an innovative, home, family and community based approach for increasing access and utilization of health services. The program is comprised of basic and essential promotive, preventive and basic curative health services targeting mainly poor and underserved populations. It is a bridge that connects the community and health facilities and is a core component of the broader urban health system. The Urban Health Extension Program (UHEP) was launched in 2009 and is expected to provide fifteen packages of services that are grouped into four thematic areas. The goal of the program is to improve the health status of Ethiopia's urban population through the implementation of family- centered basic health services. Its objective is to address health equity by generating demand for essential health services through the provision of health information at a household level and access to services through referrals to health facilities. In terms of personnel, the Urban Health Extension Professionals (UHE_ps) are trained at a diploma-level in nursing and are refreshed in public health competence for three months. Currently, around 5036 female UHE_ps have been deployed in approximately 400 cities/ towns. On average, one UHE-p is assigned to 500 households. They also cover schools and youth centers. The UHE_ps provide door-to-door health education and related services and refer clients to health centers as necessary. In 2011, the Ministry of Health launched the Women Development Army (WDA) in order to promote health and create demand for health services. The WDA creates networks of up to five households, led by one that is recognized and designated as a "model family." The model family is expected to lead the group of households by example and influence them with positive attitudes and skills for healthy behaviors. The UHEP has made a significant impact on promoting active community participation, behavioral change, creating health awareness, community organization and mobilization and more. Some challenges that the program has encountered consist of weak coordination among different sectors, such as municipality, water and sanitation, education programs, inconvenient working environment and limited capacity building activities. For the UHE_ps, limited motivation and incentive mechanisms, the lack of community-based health information system to monitor UHE-p performance and the complexity of the urban context make it difficult for UHE_ps to effect desired change. As socio-economic, demographic, and epidemiological transitions occur and urbanization accelerates, the demand for quality health services will also grow. It is important that PHC reform begins to take place, the HSTP transformation agenda is realized, and that clarity and support is offered for the role of the UHE_ps in their efforts to improve the health outcomes in the communities they serve.

URBAN HEALTH EXTENSION PROFESSIONALS: BASIC TRAINING, PROFESSIONAL DEVELOPMENT, CAREER LADDER AND ASSOCIATED CHALLENGES

Dr. Getachew Tollera, Director of Human Resource Directorate, FMOH

The Health Extension Program (HEP) was launched in 2003 to improve access to preventive essential health services and to create a healthy environment. Taking the lessons from the rural health extension program, a customized program has been started in the urban set-up and has been operationalized for more than five years. Initially, urban health extension worker training had no occupational standard and curriculum, but level 3 or 4 nurses had been recruited and trained on health extension

packages for about three months. Those nurses had a nursing background and their mind-set is to work as a nursing care provider at hospital or health center but not for community setting at household level. To solve such problems, the Ministry of Health's high level leaders have agreed to have a generic training program tailored for Urban Health Extension Program (UHEP). The candidate for level IV UHEW training expected: to have completed 10th or 12th grade and score cut point for this level training per national Ministry of Education requirements; be female (age >18 yrs.); speak the local language and be a resident of the village and; have a willingness to serve within the same kebele that they have been recruited in. The career structure of UHE_ps can either build upon the nursing career structure or the Health Extension worker structure based on their interests. However, both options require COC of level 4 nursing or Health extension to join BSc in clinical nursing or family health nursing. Some of the major systemic challenges facing the current UHEP workforce include; lack of standardized service delivery; absence of service delivery tools; job aids and manuals are affecting the quality provision of services by the UHEW; HRM challenges related to deployment (recruitment and training) and; career plan, motivation and retention schemes and technical competency that are affecting the HRM systems and functions. Some of the service challenges include; almost all UHEW compares themselves with hospital and health center based nurses; problems are emanated from their generic training mind-set that prepare themselves for hospital or facility based nursing care. The goals of the generic training program are to improve equity and access to essential health interventions at the community level by ensuring ownership and participation of the community; provide appropriate preventative, promotive, and rehabilitative services targeting urban dwellers at households, youth centers and schools, with strong referral linkages to health facilities; to lead the community to the adoption of positive behavior and improved health outcomes; to improve utilization of PHC services and promoting life styles which are conducive to good health and; to promote healthy life style. While these goals are ambitious, the challenges that face the generic training program are numerous and include high dropout rates, a general lack of interest in joining the UHEP, and bottlenecks in relation to attitude, skill and availability of logistics at all levels. Moving forward, if any progress is to be made in the UHEP training system, the challenges facing the program and its participants need to be addressed.

JSI IMPLEMENTED USAID'S STRENGTHENING ETHIOPIA'S URBAN HEALTH PROGRAM: LESSONS AND RECOMMENDATIONS

Dr. Hibret Alemu, Chief of Party of John Snow, Inc. (JSI)/SEUHP

The Strengthening Ethiopia's Urban Health Program (SEUHP) is a bilateral program funded by USAID. The program is a 5-year Cooperative Agreement from July 2013 to June 2018 which was built on its predecessor USAID/UHEP which was operational from 2009 – 2012. This flagship program covering 49 cities/towns in 7 regions which reaches over 1.6 million households. The prime implementer is JSI and its subcontractors are AAU/SPH and EDA. The focus of the project is to improve the health status of Ethiopia's urban population by reducing HIV/TB-related and maternal, neonatal and child morbidity and mortality and the incidence of MCD/NCDs. Goals of the program include improving the quality of community-level urban health services, increasing demand for facility-level health services, strengthening regional platforms for improved implementation of the national urban health strategy, and the improvement of sectoral convergence for urban sanitation and waste management. The numerous accomplishments of the project have also presented new discussions on how to better equip both the program and those administering it. Some of these accomplishments include the development of strategic documents, implementation manuals, training materials, the referral and support of a relationship between UHE_ps and health centers, and the use of evidence based program implementation to

name a few. Strategies concerning the inclusion of schools and youth centers in the program need to be realized. Attention to service delivery, networks, and capacity building also need to be discussed in reference to the UHEP implementation manual. Lastly, community engagement and the functioning of the Urban WASH program need to be discussed. Recommendations for the program include an evaluation of the UHEP, clear identification of the current challenges, implementation of models to enhance motivation, promotion of innovative approaches, scale-up of best practices from other countries, collaboration among sectors, and enhancing acceptance of UHE_ps within the communities they work in. Lastly, the role of UHE_ps in the urban WASH program requires a serious rethinking in terms of their connection to public latrines, capacity to address such issues and generating support prior to engagement.

CASE PRESENTATION BY URBAN HEALTH EXTENSION PROFESSIONALS (UHE_ps)

S/R SEBLE TAMIRU & S/R AZEB TSEGAYE

Discussing their personal experiences with the UHEP and their time as UHE_ps, Sisters Azeb Tsegaye and Seble Tamiru spoke to the Ethiopian National Health Conference and candidly gave their perspectives on the success and challenges facing their cohort on the road ahead.

UHE_ps Staff Honour H.E. Dr. Kebede

S/R SEBLE TAMIRU

Harari Region

"We first studied as nurses and it took me 3 months to get trained on urban Health issues. At the start of the program, it was difficult to adjust to the work and to go from house to house. It was very strange. We encountered a lot of hesitation at the start of our rounds. People were cautious to let us in or to speak to us. However, there were people within the community who supported us and helped their neighbors understand what we were there to do. We worked with the city authority to try and organize and strengthen our presence. Going between houses in our respective neighborhoods became more accepted. Slowly, the communities began understanding the benefit of us being there. Firstly, we just gave awareness training and collected baseline data. We then moved on into model household training. It didn't change all at once but slowly things got better. We integrated with kebele managers to prepare a village map and a basic community profile. Using this we were able to organize a plan with the participation of the community. We also conducted house to house visits. Some achievements we saw included

- Production of many model households by giving training on 15 urban health extension packages.
- New latrines constructions and the reduction in MCDs.
- Expansion of services beyond education to include postnatal, family planning, HIV testing and counseling.
- Proper waste management within households.
- Better linkages between health centers and UHE_ps.

With growing issues in urban sanitation and hygiene, the challenges go beyond households and include city institutions, business and government offices. This goes beyond our scope of work but needs to be tackled in order for city dwellers to remain healthy.

S/R AZEB TSEGAYE

Adama, Oromia Region Some problems we faced were related to the health system;

- Weak support from health centers due to institutional overload.
- A lack of equipment and an absence of attention from town health offices.
- Unstable and inconvenient working environment for UHE_ps offices.

- Absence of community based monitoring tools for health information systems.
- The complexity of delivering services and training for urban hygiene and sanitation due to the wide berth of the field (need for sectoral collaboration).
    - UHE_ps credentials questioned when a lack of service on urban sanitation and hygiene is exposed however, this goes beyond the scope of their practice.

Challenges related to the urban setting;

- Economic and social context are widely different from the rural context and the program lacks a contextual approach.
- Urban dwellers need higher quality of care and curative services.
- Inequality present urban poor who cannot afford certain services.

ISSUES THAT NEED ATTENTION IN THE FUTURE

In the future, we need support from all levels of government, especially the relationship between UHE_ps and the health centers. This relationship needs to be systemically designed. Sectoral integration will aid in the filling of many of the gaps we are currently experiencing. An accountability framework for all stakeholders could also support this. On the operational side of our position, we lack the resources to set up a stable work environment. Simple things like tables, chairs, and locked cabinets for medicine could make our jobs significantly better. On the individual level, better pay, benefit packages and education must be given to UHE_ps in order to improve the program.

PANEL II: DISCUSSION SUMMARY

Health systems need to be viewed in a holistic manner and as the urban health extension program is a part of the health system, it needs to be linked to the broader health system. In urban settings, the curriculum of the UHEP needs to also focus on the clinical aspects of health and not simply the preventative. A lack of motivation from UHE_ps needs to be taken seriously and research into the reasons behind the high dropout rate of these professionals needs to be conducted. A lack of respect and unclear scope of work appears to have impacted the motivation and attrition of many of the UHE_ps. It was suggested that these workers engage in recurring training and engagement exercises to improve their working environment and consequentially, their circumstances. Dr. Mengasha, professor and director the International Primary Health Care Institute, also discussed the transference from rural to urban work as an option for women.The years spent in the field could be taxing and offer a litany of experience for the urban context. Training sites could also be equipped with the use of demonstration/models for the UHE_ps to engage in practical experiencing sharing. Following Dr. Mengasha's point, one participant raised the same issue in regards to the high turnover rate. He suggested that improving the capacity of the training college, receiving multi-sectoral support, and developing motivational packages could improve the work environment. Simply focusing on the career structure is not enough to improve the motivation of the UHE_ps. He added the points by saying using the research and available evidence, the root causes for the demotivation should be analyzed and solved from the bottom up. A participant from Wollo University, stated that focusing on the clinical aspects as well as public aspects was very important. He suggested that the clinical aspects such as family planning can be done by the existing UHE_ps. For public health aspects, such as environmental health, we need specialized professionals for example environmental health experts.

Urban extension includes all cities and equity. There are some areas that are not supported by JSI. Areas that receive support from JSI and other organizations are functioning well however, cities that do not have that backing are struggling. It is the opinion of some that

all cities be included in the program and that urban health is improved equally. In addition, in order to make the UHEP program more functional, it is essential that it is linked with health centers and collaborate as a team. These partnerships need leadership and oversight. The approach of service delivery by the UHEP needs to be revised and formatted on a needs-based principle.

Although the implementation of the current revised UHEP Manual is underway, concerns exist regarding the procedure. He mentioned one of the reasons for not implementing the manual was due to sectors who are not following their roles and responsibilities even though they are clearly outlined. This stems from a lack of integration amongst stakeholders and sectors. An absence of knowledge of the program is cited as a main reason for this challenge.

A UHE_ps participant in the conference cited support from other sectors as a crucial element for their programs' success. For instance, she mentioned she could make the Woman Development Army functional by herself but, without the help of other groups involved the projects it is not possible. The fact the communities she works in accept her and therefore she can do her job. However, the lack of acceptance or support between the sectors renders her efforts obsolete. Another point she stressed was the documentation and scaling up of best practices. The current practice is not supportive of this endeavor and needs to be amended.

Dr. Hagos Godefy, Head of Tigray Regional Health Bureau, believes there was a problem in selecting the UHE_ps from the beginning. This in turn has affected the current motivation and retention levels for the program. He also suggested that before generic training becomes scaled- up, motivation and inspiration of the existing UHE_ps needs to occur.

> *"As leaders, we have not done much in support of the UHEP. For example, today we are discussing the career development of these UHE_ps but it has been eight years since this program started. Rather than just talking about these problems, we need to extract challenges that we believe we can work on, and start the process."*

He also suggested adjustments on the operational side of the UHE_ps which would include working environment, facilities, and supervision. According to Dr. Hagos, the UHE_ps should be placed in the health centers in order to give legitimacy, stability, and close support. He also stated that the change from rural to urban needs to be managed in a delicate fashion due to the complexities presented by both contexts. Evaluation of the program should be presented at an upcoming similar conference. Ato Mohammed Ahmed, the Harar Health Bureau Head stated that:

> *"…the main challenge of the program is us as leaders. We don't consider the UHE_ps are as a profession. A profession has a clear scope of work, job description. In this case, it doesn't exist for them. SDGs mainly relies on quality, equity, and universal health coverage. In the case of Ethiopia, the UHEP is a means for that. We have to strengthen the program itself. Related to issues of training, we didn't set a clear career path for the UHE_ps so it's' forcing them to learn by themselves. We need to adjust their salary after they completed the given requirements. For example, in Harari regions, we could manage the salary once they've upgraded their level of education. Because of that, some of the UHE_ps are extremely motivated and doing satisfactory work. We also designed benefit packages like provision of mobile cards (25birr). We have to work on community acceptance of health extension program. This can only be achieved by answering the communities demands or questions.*

We can't conclude that the program has already failed; they did their side through the promotion of healthy lifestyles, creating health awareness, but due to lack of sectoral integrations, some of the communities asking the health

professionals questions which are out of the scope of their work. As leaders, we didn't give the UHE_ps appropriate leadership in the program. Generic training is not the only solution for the current predicament. "

Responses from the panel began with Sister Seble and Sister Azeb, both of whom are UHE_ps, detailed the difficulties they faced in their communities. S/r Seble questioned the sustainability of the program at the current rate and the need for better support mechanisms for her and her

co-workers. She also discussed the inequity between her position and those within the greater health system e.g. doctors, nurses, clinicians etc. The lack of respect at times was difficult however, she stated she loved her work and knew she was making a difference. The need for all involved to claim ownership of the program was made as her final point. Similarly, S/r Azeb discussed her working hours and how she felt a duty to those within her community to ensure their health. She discussed the pressures of being on-call and available 24/7 and how mismatched that was from the expectations that were originally outlined.

Dr. Zufan Abera, Director of Primary Health Extension and Primary Health Service Federal Ministry of Health, outlined the following points based on the questions and statements raised. Dr. Zufan addressed the regional component of addressing the challenges witnessed within the UHE_ps. She believes that it is the sole duty of all to engage and fix the system. She also suggested that the movement on the HSTP was slow and that sectors need to collectively pick the pace for it to be completed within the remaining 3 years. On the subject of collective city growth in Ethiopia, Dr. Zufan discussed the sustainability issues presented in supporting cities in their growth trajectories. Organizations like JSI can offer training and support however, this is on a timeline and temporary basis. All cities cannot receive support but by focusing on large centers, support can be given to the greatest number of the urban populace.

Dr. Getachew Tollera, Human Resources Manager at the Federal Ministry of Health, highlighted the ministries general direction regarding human resources for the UHEP. Generic training of the UHE_ps is one of the ministries priorities and they have a plan to scale up the program. This generic training was started based on joint assessments findings from the Ministry of Health and JSI SEUHP. He also suggested that in order to tackle the dropout rate for UHE_ps, organizers needed to address community acceptance issues.

Human resources development plan for health should be discussed. How this will fit is definitely a question to be asked. Ensuring education/pay or a career for these women is essential to securing their buy in. We need to give them major projects and respect so the community can learn to respect. It's not their job to make the community accept them. We need to create an environment that allows for a community to already respect these people.

Dr. Hibret emphasized the exceptional nature of the day considering the presence of ideas and perspectives on the urban health. All stakeholder are present and numerous ideas have been presented. We need to continue to come together and discuss these problems. It wasn't a problem of resources or will, we just needed to do it. The cost was high but the benefit will hopefully be seen in the following year when we meet and talk. In the coming years, I hope we cannot just talk about the problems, but also the solutions we have implemented in our respective communities. Change can come if we understand what we want to see in urban health.

PANEL III: ETHIOPIA'S URBAN PRIMARY HEALTH CARE: A DEVELOPMENT AGENDA

Moderated by Ato Eshete Yilma

Team Leader of Health System Strengthening
USAID, Ethiopia

THE PRIMARY HEALTH CARE SYSTEM IN URBAN ETHIOPIA

Dr. Desalegn Tegabu Zegeye

The primary health care system in urban Ethiopia is provided through health centers, UHE_ps, private clinics, and non-profit clinics. One public HC is expected to serve up to 40,000 people and provide promotive, preventive, and curative services. The way PHC is set up in urban areas varies from place to place. Each health center has an average of 15–20 UHE_ps which depends on the population covered. Health centers are led by a medical director and governing board and have units responsible for preventive, curative, administration and finance. In Addis Ababa, 60 technical staff work within health centers while in regional towns, there are about 30. Health centers report directly to sub-city health offices, who then follow up with the Woreda Health Office, and at the top are the RHB.

Over the last 20 years, the country has successfully implemented its strategy of expanding and rehabilitating primary health care facilities. To this effect the government has constructed and created, 16,440 health posts, 3,547 health centers and 311 hospitals. In parallel to the construction of health facilities, investments in human resource development and management have also been scaled up.

Some current activities within the system include the Urban Health Extension program, Health Center Reform, Primary care Clinical Guideline and Ethiopia Primary care Alliance for quality. Among these practices, the Family Health Team Approach is an adopted program from the Brazilian health care system. FHT gives emphasis on provision of essential health services by different health professionals organized as a team. The team offers a mix of skills of various professionals and the community and is responsible for the provision of essential health services for predetermined number of families located at a specific geographic area.

Some guidelines and best practices for the system include The Ethiopian Health Center Reform Implementation Guideline (EHCRIG) is comprised of 81 selected standard management functions that are considered essential for the creation of the best performing private health care units based on the currently available health resources in the country. The Ethiopian primary care Clinical guideline, is a comprehensive clinical practice guideline that aims to equip health workers to diagnose and manage common adult conditions at a primary level. And lastly, the Ethiopian Primary Care Alliance for Quality which aims at creating high performing PHCUs across the country in line with the Woreda transformation agenda of the HSTP.

Challenges to PHC include the engagement of the private and non-governmental sector in PHC, the standard of care, knowledge level of health extension packages by UHE_ps, equipment stock outs, drug procurement, and staffing in regional towns.

URBAN PRIMARY HEALTH CARE REFORM: IMPLEMENTATION IN PILOT SITES AND CONSIDERATION FOR SCALE-UP

Ato Temesgen Ayehu, Assistant Director of Health Extension and Primary Health Service Directorate, FMOH

The urban population in Ethiopia is increasing rapidly with nearly 19 percent of the total population residing in cities. It is expected that by 2028, 30 percent of the country's population will reside in urban areas. While urban population growth presents a huge opportunity for multiple sectors, it may also pose a demographic challenge to provide health care, jobs, services, and housing to rapidly increasing population. The triple burden of illness possesses a threat to the general population of cities and is expected to negatively impact urban health in the coming years.

In order to preemptively combat these issues, a new primary health care model was envisioned by the FMOH. Experiences from Cuba and Brazil were considered as best practices and

were incorporated into the new Ethiopian Primary Health Care model. Examples of such best practices include the Family Health Team approach crafted in Brazil and the client categorization approach taken from Cuba. Based on these lessons & the experiences from the Urban HEP, four key areas of focus were identified as critical for developing a new and improved PHC system in Addis Ababa; introduction of team-based approach to provide targeted services, the creation of service packages and modality of service provision, implementation status of the PHC reform, recommendations for scale-up.

Challenges to these reforms include; inadequacy of human resources to staff the family health team; a lack of office space to reorganize outpatient clinics according to the family health team's arrangement; little follow-up support from health offices; financial constraints (or absence of fee waiver system) for providing medications for indigent people identified during visits by team; transportation problems; a shortage of supplies and; a weak referral network between the health center and hospitals.

Some recommendations to streamline the reform processes consist of validation and simplification of the client categorization approach, the clear definition of the FHT role, the safeguarding of inter-sectoral collaboration, the implementation of community health information system and incentive packages that can motivate FHTs.

THE ROLE OF PRIVATE SECTOR ON URBAN PRIMARY HEALTH SERVICE DELIVERY

Dr. Wondwossen Assefa, Private Health Sector

The demographic expansion of Ethiopia is expected to push its population to 141 million people by 2030. Connected with these factors is the anticipated growth of urban centers and consumerism within the emerging middle class. Consumeristic enterprise prompts the creation of businesses focused on the delivery of medical care. Some examples of this will include preventative care, rehabilitative care, wholesale retail, laboratory, radiology and the list goes on. The expansion of this industry will contribute to the country in numerous ways including; increases in investment; retention of high level professionals within Ethiopia; increase in number of tax payers; self-reliance and; corporate social responsibility to name a few. Currently, there are 12,432 medical facilities with an estimated 59 percent of outpatient services occurring in the urban area and 34 percent occurring in rural areas. A general expansion of primary clinics to general hospitals could yield a total employment opportunity to more than 120.000 people. One area of interest is the Ethiopian pharmaceutical market. Currently the market value sits at 800 million USD with a 25 percent growth rate. In addition, health spending currently sits at 1.4 billion USD and is expected to rise to 4 billion USD in 14 years. 37 percent of this is out of pocket expenditures which is around 10 billion ETB. In terms of the emerging health profile of Ethiopian cities, the triple burden of illness which consists of MCD, NCD, and injuries/accidents is internally shifting with MCDs decreasing in severity while NCDs are expected to rise in the next 14 years. Globally, health care is making leaps and bounds in the areas of service delivery, pharmaceuticals, P-4 medicine and more. Reactivity in health is being replaced by advanced prevention and clinicians are being trained to produce personalized health care services for their patients. This could be in the not too distant future for Ethiopia however, rapid economic growth has outpaced service provision and progression has been arrested by new government policies which inhibit the private sector development within health. While private ventures exist in the country, free enterprise must begin to be fully recognized as an important player in the development of urban health sectors. Integration of the private sector can lead to benefits in incorporating cutting edge international health trends currently taking place such as innovations in mental health, preventative care, CBHIS and voucher schemes.

ETHIOPIA'S HEALTH INSURANCE AND ITS IMPLICATION ON ACCESS TO PRIMARY HEALTH CARE INURBAN AREAS

Ato Abdulijelil Reshad, Deputy Director General, Ethiopia's Health Insurance Agency

In Ethiopia, health service utilization is below the standard WHO health standards. Financial barriers are a key reason for this low utilization. Studies indicate that there are catastrophic levels of out of pocket expenses at the current time. The main aim of this scheme is to reduce these expenditures, to improve quality of service and ownership in equity. It would also support the establishment of a sustainable financial resources for health facilities. So far, the current status of CBHI implementation in Ethiopia has national guidelines and scale up strategy already prepared. Scale ups have occurred in 415 woredas/districts in both rural and urban locations. After a recent assessment, promising results from these locations were found which support the plan to scale up to the national level. In Addis Ababa and Dire Dawa, the preparations have been finalized from start to the implementation. In Addis Ababa, regulation and implementation manuals have been contextualized and endorsed, the structure has been staffed, necessary materials have been procured and registration distributed. In addition, community mobilization has been carried out. It is expected to implement in selected sub-cities in the near future. Similarly, in Dire Dawa, regulations and implementation manuals have been developed, staff has been recruited, and necessary materials for registration have been distributed. The target in Dire Dawa is inclusive of all rural and urban districts. Importantly, administrative costs will be covered by the government. The CBHI is expected to be feed into the existing system. Challenges that have been presented are a lack of awareness and health facility readiness, a lack of ownership by health professionals and the delays that have occurred during the launch. In addition, services become more expensive. There is a definite need for a political leadership commitment to the project in order for it to achieve its intended goals.

PANEL III: DISCUSSION SUMMARY

Sister Hewan Geta from Dire Dawa, stated that she worked as a UHE_ps for seven years and that she does not have the equipment to scan for NCDs however, she and other UHE_ps are being told to administer care. She posed the question of how could she and her team care for NCDs when the resources are not provided.The UHE_ps possess the capacity to make change as seen with reductions in maternal and child health, but we need support. UHE_ps S/r Rahel from Bahr Dar also asked questions about the role of the private sector in preventative care. While there are 126 clinics in Bahr Dar and we must refer patients to the private clinics, what is the private sector doing in terms of preventative care and in providing training? Dr. Wondesson Asefa, President of the Private Health Sectors Association, responded by citing that the work is being done in PPPs such as the blue star network of clinics which give family planning clinics. These networks exist also for HIV and TB. He stressed that a main goal of the private sector is to integrate into the existing system. He believes they possess answers that they want to contribute. On the question of prevention, Dr. Wondesson stated that he and his associates want to take part by offering training if it is permitted.

A question regarding ethics and the private sector was raised by Solomon from the Addis Ababa Bureau. He detailed the instances of over-prescription of antibiotics by health professionals in an attempt to acquire more cash from patients with the possible result being increased risk of microbial resistance. When the element of business is introduced into health, certain ethical questions arise. Ato Meseret asked a question concerning the lack of updating training on the part of the private sector. He cited an example of trainers being sent to an exercise with UHE_ps that were not well versed on the issues being discussed. Ato Mohammed Ahmed discussed the problem with private sector clinics dumping their patients into the public sector once diagnostic services had been procured. He believed this practice exemplifies the issue of a lack of quality care services in private health centers.

Dr. Yousuf, the deputy head of the Dire Dawa health bureau, raised the issue of pricing in the health care industry. The integration of business into health introduces a profit motive that can be seen in two clear areas; the concentration of private health services in urban areas due to the higher use of service, and the pricing disparity that exists between health services across numerous private clinics. He suggests that there needed to be an indirect focus on business but a maintain interest in the public good.

Dr. Wondesson again responded to the numerous questions by first addressing the issue of ethics in the private sector. He confirmed that yes, unethical practices are present in the sector. However, these problems do not nullify the benefits of the sector. He emphatically stated that the private health sector was prepared to stand with the public and create strategies to fix the existing problems. He believes that those who obey the law will gain and those who break it, will lose.

On the issue of transparent costing, Dr. Wondesson believes that there needs to be a standard available for all clinicians to abide by. While it will be complex, the system needs to be operationalized and the introduction of payments systems, practice monitoring and so on need to be incorporated. In fact, Dr. Wondesson stated that private involvement is higher than 30 percent and therefore could be better built upon. On the subject of preventative care packages, he stated that they have been designed and created and need clearance to be implemented.

Questions were also raised around the Family Health Team format with concerns surrounding the logistics, supply, personnel, community based health information systems, transport services, and human resources. Ato Temesgen Ayehu, Deputy Director of Health Extension and Primary Health Services, responded by summarizing the WHO's pillars of health care reform. These were leadership reform, universal health service, and health information reform. In urban primary health care reform, the ministry focused on universal health service and health information reform but chose to leave out the leadership component. He also mentioned the rational for implementing this reform such as the epidemiological shift of the urban population, the demand of the communities in better quality services, to strengthen the urban health program, and to implement responsive health systems for the current need. While these reforms were adopted from abroad from places such as Brazil and Cuba, they were taken from their earlier health organizational structures to better suit the current state of Ethiopian development. These two systems have been identified as some of the world's best in terms of primary health care and are considered by the Federal Ministry of Health as the path to universal health coverage. He suggests customizing reforms in a contextual manner that incorporates the needs of the regions. A focus on schools and youth centers was also discussed as a possible avenue for better service delivery by the FHT. He also discusses that the WDA needed revisions for the urban settings to ensure that reforms are more functional. Cost benefit analysis was another issue he discussed which believes can lead to a better scale up in the future.

Ato Eshete Yilma discussed the need for a timely and scaled up version PHCU reform that would require support from all levels as well as continuous evaluation. On the issue of CBHI, while he believed the subject was too vast for just a singular discussion panel, he stated that the intiative was not moving as well as it was planned and needed to have more effort. Lastly, Ato Eshete mentioned the importance of the private sector within health and the need to have them involved in the PHC system.

PANEL IV: INITIATIVE TO IMPROVE ETHIOPIA'S SANITATION AND WASTE MANAGEMENT

Moderated by Ato Birhanu Teshome

Urban Climate Change Impacts Resilience Bureau, Ministry of Urban Development and Housing

INTEGRATED URBAN SANITATION AND HYGIENE STRATEGY

Dr. Zufan Abera, Health Extension and Primary Health Service Directorate, FMOH

The Integrated Urban Sanitation and Hygiene Strategy was developed by following a comprehensive situation analysis. An extensive literature review was undertaken along with consultations with key stakeholders, and rapid assessments of 11 towns across 6 regions in Ethiopia. The findings from the situational analysis helps to address the urgent need to draft a realistic and sustainable Action Plan that takes account of all stakeholders. Issues around sanitation and hygiene are complex due to cross sector intervention and oversight between towns. While it may be difficult, the successful implementation of the strategy will have a positive impact on the economy, natural environment, health and wellbeing of all urban dwellers, including most of the vulnerable. This success is hedged on the effectiveness of the institutions created to manage and follow urban sanitation standards across the country in an integrated and efficient manner. In the strategy, all interventions are encouraged to be based on; city and town development plans; taking advantage of economies of scale; sharing of best practices within the country; involvement of the private sector and Community Based Enterprises (CBEs) and; financing sanitation at the city and town level. Some key areas of the strategy include liquid waste service delivery, solid waste delivery, safe management of drainage, and promotional/behavior change. Guided by principles of sustainability, equity, and partnership, the goals of the IUSHS include;

- To bring sustained behavioral change for better hygienic practices.
- To ensure open defecation free cities and towns by 2020.
- To ensure that 100 percent of urban households in any given town or city have access to improved latrines by 2020.
- To increase the fecal sludge management systems to 70 percent coverage by 2025.
- To Reduce, Recycle or Reuse 50 percent of all solid waste generated in medium and large towns and cities by 2025.
- To dispose of 100 percent of the remaining solid waste in controlled tipping and sanitary landfill sites that fully comply with 2014 Guidelines by 2030).
- To ensure safe disposal of 100 percent health care waste from all health care facilities by 2025.
- To establish an effective and reliable monitoring system and sanitation data base.

The institutional arrangement which would include high level coordination, integration and alignment at the federal, regional and town level. The monitoring and evaluation component of strategy would be conducted at all levels and would exist at the town or sub-town level to track progress.

URBAN JOB CREATION AND DEVELOPMENT OF SAFETY NET PROGRAM AND ITS INTEGRATION WITH URBAN SANITATION

Ato Abraham Petros, Director of Urban Safety Net Program Directorate /Ministry of Urban Development and Housing.

Main objective of the Safety Net Program in Ethiopia is to ensure food security in urban areas. The strategy was developed and endorsed in April 2015 where a ten-year project aimed

to support families below the poverty line. The program covers 972 towns/cities and more than 4.7 million people. Currently, it is being implemented in 11 major towns. Besides ensuring food security, it is also aimed at improving the livelihood of poor communities. It focuses directly on supporting the poorest and most economically disadvantaged. The support also includes provision of currency which can sustainably improve the families' income.

The selection criteria and approach of beneficiaries is based on geographic location, village committee, self-reporting based on the criteria and income/economic status evaluation.

Currently, the Implementation status of the program at the federal level has been revitalized and a project team has been established. Manuals, documents and guidelines are in the process of being finalised and ministerial council has been established consisting of 22 ministers. In addition, an Environmental Development Technical committee, Direct Support Technical Committee and a Sustainable Livelihood Improvement Committee have been established. A central management committee coordinates the activities of the aforementioned teams and communicate to the regional levels of the safety net program, which are also in development.

URBANIZATION AND ITS EFFECT ON THE ENVIRONMENT

Assefa Gudina, Ministry of Environment, Forestry, and Climate Change: Senior Water Pollution Expert Markets for agricultural and industrial goods

Urbanization possesses many advantages including a wide range of cost-effective services including health, education, water supply etc., opportunities to non-farm employment, industrialization and labor specialization, and centers for artistic, scientific and technological innovations and of culture and education.

Even though urbanization has a lot of benefits, unguided urbanization, like in most developing countries, negatively affects the natural environment and livelihoods of the community. These impacts are: land use change due to expansion of cities and community displacement, water quality problem due to pollution, waste dumping, squatter settlements, depletion resources both in quality & quantity, inadequate housing and overcrowding, and crime and diseases e.g., HIV/AIDS.

The impacts of urbanization on climate change must also be considered. Sectors contributing greenhouse gas emissions in urban areas: road transport, fright, construction vehicles, private passengers, power sector, the use on and off-grid diesel generators administered by Ethiopian electric utility, cement, textile and leather, building sector, emission related to solid and liquid waste, the use of private generators in cities, and demolition of building during construction and maintenance

Some ongoing activities which are attempting to manage the effects of greenhouse gas emissions are pollution monitoring and control of the Mega practice, environmental audits, the release of the State of the Environment, and charcoal production from wastes using briquette machine.

In order to maintain the inclusion of the environment within urbanization processes, a number of things need to occur. Proper maintenance of awareness creation at all levels must occur, coordination issues must be given due consideration, encouragement of energy production from different wastes, buffer zone project to reduce different pollutions, a focus on transport sector with more emphasis on mass transport & age limit to import cars, and taking a project based approach.

PANEL V: ROLE OF DIFFERENT ACTORS TO IMPROVE URBAN WASH

Moderated by Ato Haile Fiseha

General Manager of Addis Ababa City Administration Municipality

SECTORAL INTEGRATION AND ROLE OF CITY ADMINISTRATIONS' LEADERSHIP FOR BETTER URBAN WASH SERVICE

Ato Tewdros Gibaba, Mayor of Hawassa Town, SNNPR

Inter-sectoral collaboration within WASH programs is needed to increase their impact and efficiency. Stakeholders in urban sanitation and waste management consist of city administrators, municipality, health department, water and sanitation enterprise, environmental protection and forest development office and city administration community participation organization steering committee. The need for sectoral collaboration in addressing the full chain of sanitation and waste management improving urban sanitation and waste management have positive health impacts, economic benefits and social benefits, environmental benefits, sustainable development of the country.

Mayors can play an important role in coordinating and leading urban sanitation and Waste Management Service delivery. Some of the major roles of city mayors consist of;

1. Lead town /city/WASH steering committee which is comprised of her/his cabinet and should also make the technical committee functional.
2. The Mayor should facilitate city authorities to set policy directions aiming for resource efficient, recycle-based society if they are to provide a clean, healthy and pleasant living environment to its citizens for current and future generations.
3. City leaders should tackle the problems of urban WASH that have impacts on health, economy and environment by allocating sufficient budget for urban sanitation.
4. City leader should develop meaningful partnership with private sector, informal workers and Communities for effective implementation of ISWM and 3RS.
5. The Mayor should integrate the urban WASH program with that of 17 community mobilization and participation agenda because those agenda that are contributing for fast growth of cities will also help to ensure better urban WASH.

Some Challenges with coordination of the different sectors for Urban WASH will include: the rapid increase in volume and changing characteristics of municipal waste due to fast urbanization rate, poor coordination and sectoral convergence among sector actors, a lack of clarity in the role and lack of commitment of each stakeholder sector and a shortage of finance.

To make cities clean, green and livable the role of community is vital. City leaders must first accept the 17 agendas as a crucial tool and then mobilize the community by integrating those agenda with urban WASH program to ensure the sustainable developments of city. Numerous benefits accrue from the proper integration of sectors in health, environmental, and economic spheres. Therefore, to realize the goals and vision of our country towards sustainable development there should be sectoral integration among various sectors of city administrations.

ROLE OF PRIVATE SECTORS ON URBAN SANITATION AND WASTE MANAGEMENT SERVICE DELIVERY

Dr. Dagmawi Lemma, ROSE Business Group, Addis Ababa

ROSE Business Group is an umbrella for a group of business collaborators which started its main operation in 1995 E.C through the establishing of its first businesses lines in Solid and Liquid Waste Collection & Transport Service and Construction Machineries Rental. ROSE is a pioneer private waste management service provider in Addis Ababa, and Ethiopia in general. Cliental include governmental institutions, private organizations, NGOs and more. The adapted strategy of the organization is based on the 3R's of reduce, reuse, and recycle.

Opportunities within the sector involve training and consultancy, waste solutions, litter bins, segregation, waste transfer service, cleaning service, and laboratory services. Due to the relatively young age of the industry there are many challenges. Lack of existing public private partnership complicates service provision. Public ignorance towards beautification efforts along with institutional disorder and complacency also render efforts to enter the sector difficult. In addition, the entry of too many sectors and unorganized nature of their activities complicates mandates.

In the future, ROSE wishes to further grow its services for cities and intends on being a strategic partner in the current and future efforts of urban health and sanitation.

PUBLIC LATRINE MANAGEMENT AND THE ROLE OF SMALL AND MEDIUM ENTERPRISE

Ato Mulualem Birhane, Addis Ababa City Water and Sewerage Authority

Addis Ababa can be considered the center of African diplomacy, economics, and politics. It is the host of many conferences and is seen to be an example of African cities. Currently, it is estimated that nearly three million people live within the city.As this figure is expected to grow, challenges in service delivery are beginning to arise. Beside this, Addis Ababa has shown improvements in infrastructure construction, tourism, health, education, telecom, and general social services. While in terms of infrastructure, the city is faring well, investment in the beautification of the city are needed. These investments would also improve foreign investment and tourism, both of which are an important to the capital. A key component of beautification efforts is the provision of public latrines and an adequate water and liquid waste management system. Currently the city has no sufficient and standard public latrine system. This in turn poses health challenges to the community and the efforts to improve the perception of the city.

The Initiative of Public Latrine Construction started in 1940ec. However, until 2001ec, it was not systematically managed to respond to community's demands.

- The authority has designed a strategy to scale up the public latrine management. Under the strategy, public latrines are being constructed in areas where households at one time could not construct latrine due to low income and the scarcity of land. Furthermore, mobile public latrines are being constructed on main roads, public places and bus stations.
- Mobile public latrines have integrated mini cafés, drinking water, and recreational area for communities along with their services. This in turn changed the negative attitude and image of communities towards latrine. Since these latrines have clean water and hand washing facilities, transmission of water borne diseases will be greatly reduced. The majority of areas where public latrines were originally constructed could be considered rubbish and unsafe for community health.These new public latrines are efficient and are accessible facilities that can cater to needs of persons with disabilities, children, and women. In addition, these latrines are being managed by an organized an association of 5-10 individuals and have created job opportunities for more than 1500 persons. A total of 760 public latrines are planned to be constructed for 2009 E. C.

GENERATING SUPPORT FROM THE COMMUNITY USING CHAMPIONS FOR IMPROVING URBAN SANITATION

Artist Sileshi Demisse (Gash Abera Molla) Goodwill Ambasador for Hygiene and Sanitation

Drawing from his experiences in community organizing, Artist Sileshi Demisse also known as Gash Abera Molla spoke to conference participants about the upkeep and beautification of Ethiopia's cities. During his successful music career, it became clear to him that Addis Ababa was experiencing issues with sanitation and cleanliness. Litter, garbage, and other forms of debris were scattered across the city and had dampened what could be considered a beautiful African capital. His analysis of the abnormal becoming normal in regards to the presence of trash, solidified his resolve to find a solution to the problem. Through the mobilization of over 18,000 youth, Gash Abera took to the streets and began an intensive and targeted trash collection program focused on key streets and locations in Addis Ababa. He also partnered with schools to integrate climate change and pollution into both the curriculum and within extra-curricular activities. His efforts garnered attention from leaders within the Addis Ababa city bureau and beyond including officials within the federal ministries. Non-governmental organizations such as New Addis City, also wanted to get involved in the program and contribute. Over time, the efforts of all parties involved began to improve the sanitary conditions of Addis Ababa. Leaders who came to the capital remarked on how clean the city had become. Later on, he expanded his initiatives to Dire Dawa and Mekele and reaped similar achievements. His work in Ethiopia gained him national and international accolades. Using his experience, Gash Abera outlined three recommendations of moving forward in Ethiopia's urban health program; advocacy at the community level, accountability, and the integration of sectors.

PANEL IV & V: DISCUSSION

A participant from Debre Markos raised the issue of sectoral convergence and why the governance of urban hygiene and sanitation are decentralized in various committees. He also questioned the lack of regulations on plastic bags in cities, an issue which is growing considerably. His last point concerned the regulation of older vehicles on the road and whether or not there were steps being taken to combat the emissions.

A participant from Haromaya University asked whether or not environmental impact assessments were being carried out prior to large-scale construction projects in the city.

A participant from Urban Construction and Development asked which sector manages industries such as factories and facilities. He also had questions about the implementation status of the Solid Waste Management Proclamation. In addition, he questioned the cost/benefit analysis of the ROSE company.

A participant from Water, Irrigation and Electricity discussed liquid waste management and the poor attention it is given within the ministry. She asked what was the role of mayors and Urban Development and Housing. How do they control the waste management system?

Dr. Helina Worku discussed her observations from the field concerning the lack of upkeep of communal latrines and she questioned the mechanisms in place to ensure oversight of these facilities.

A participant from the Federal Ministry of Health commented that the poor urban hygiene and sanitation stems from a lack of environmental health professionals, proper promotional/behavioral change activities, and a lack of professionals that specialize in health education.

Ato Tewdros Gibaba, Mayor of Hawassa, established a system of liquid waste management and the mayor was confident in the plan. He used an example of the previous year when a cholera outbreak took place in some cities but in Hawassa, they were able to control it before it spread to more than one person. This was a sign of having good waste management mechanisms. He did mention that the challenge of a lack of equipment and personnel capable of support still persists. He emphasized the importance of leadership in crafting sectoral convergence and that leaders need to be facilitators and not implementers. Bringing groups together to get work done should be their main goal.

Dr. Zufan Abera mentioned that the Ministry of Health gives good attention to urban hygiene and sanitation as it is stated in the HSTP. She used the example of the Woreda transformation which is a pillar of the HSTP. In this implementation manual, by creating model Kebeles and making them open-defection free, key deliverables can be achieved. She also mentioned that the ministry with other sectors has achieved the Urban Hygiene and Sanitation Strategy. In the strategy, sectoral collaboration is clearly stated and she expects that this is a good place for sectoral group to realize the urban hygiene and sanitation in general. In her last point, she mentioned that the FMOH has developed a Climate Change Adaptation Plan. This plan includes issues of urban hygiene and sanitation. Thoughts also needs to be given to mechanisms used to fine and punish those who intentionally litter in streets.

Artist Sileshi Demisse (Gashabera Molla) who is a goodwill ambassador of urban health, stated that in order to realize good urban hygiene and sanitation practices, professional ethics, and accountability would be essential. The involvement and ethical adherence of all sectors would be required.

An official from the Addis Ababa Water Supply and Sewage Authority mentioned the management of public latrines is given to the Water Supply and Sewage Authority. However, he mentioned some of the challenges related to management and individual societal attitudes towards public latrines. He believes advocacy needs to take place in order for more public support. This public latrine plan is planned to be expanded on strategically selected sites as well as areas of future construction which would also include mobile facilities.

In regards to older vehicles on the road, Ato Haile Fiseha stated that research is currently underway and once results have been culminated, decisions will be made. An Indian organization that has partnered with the Ministry of Transport has outlined research that has looked at the emissions and are awaiting the research results in order for recommendations to be crafted. He also addressed the issue of plastic bags and stated that bags thinner than 0.03 mm are already banned. If the Ministry were to ban all bags, there would need to be some sort of alternatives.

Participants questioned the existence of a model city, community, or village in the Urban Safety Nets Development Program. Ato Abraham Petros responded that, there is a system to create model cities/community/villages and that there is a recognition system, selection criteria, however, there is no outstanding locations at the present time.

Ato Birhanu Teshome discussed that the landfill system is only applicable for the 3R's which consist of reduce, reuse, and recycle. In larger cities, there are landfill systems in places like Debre Zeit, Adama, Debre Markos etc. which have seen good practices in sanitation. However, he mentioned that waste management oversight is still a problem. He also discussed environmental protection proclamation and the green economy which all support the proper management of waste in urban areas. He asked the participants to refer to those guidelines to enhance their knowledge on the issue.

PANEL VI: DISCUSSION ON THE WAY FORWARD

H.E Dr.Kebede Worku, State Minister of FMOH

Panelists

Ato Kemeradin Shifa, Representative of Oromia RHB

Dr. Abebaw Gebeyehu, Head of Amhara RHB

Wro. Gezashign Mekonnen, Representative of SNNPR RHB

Dr. Hagos Godefy, Head of Tigray RHB

Dr. Jemal Adem, Head of Addis Ababa City Administration HB

Dr. Muluken Argaw, Head of Dire Dawa City Administration HB

Ato Mohammed Ahmed, Head of Harari RHB

Ato Salah Ismael, Head of Benishangul Gumuz RHB

Dr. Oman Amulu Akway, Head of Gambella RHB

Summary of the entire conference was given by **Dr. Kebede Worku**, State Minister of FMOH, along with representatives of regions who were invited to speak on their thoughts of the conference and respective regions. Dr. Kebede started by discussing community health in urban settings with the focus being on the UHEP. He stated the only deploying more UHE_ps would not increase effectiveness; political support would be necessary to achieve this endeavor. He added that originally, UHE_ps were clinicians/nurses but after their training and had experience in the field, they are now public health practitioners. He reflected on the gradual introduction of the rural extension and stressed the need for a similar method to occur in the UHEP through the provision of on-the-job training. Currently, integrated refresher training for UHE_ps has already started and should be continued into the future. In addition, he identified the need for the scale- up of generic training for UHE_ps. However, this scale up does not nullify or remove the clinicians training; this group needs to be kept in the system. He stated that the ministry must take steps to secure the future careers of the UHE_ps. Regarding the motivation of UHE_ps, he believes that a motivation package needs to be designed which is based on intensive research findings. Strengthening the link between health centers and UHE_ps could also help remedy the current problems in motivation. He stated that the health centers and UHE_ps should jointly be considered as the primary health care unit. The UHE_ps should receive the necessary technical support from the health center. He also detailed the working environment for UHE_ps and suggested that the regional and district bureaus should take part in supporting the improvement of these environments for the UHE_ps. Dr. Kebede also mentioned the revised UHEP implementation manual and recommended that its implementation required follow-up and support. Another point he raised concerned school health and the integration of youth centers into the UHEP. The current draft strategy for school health could support the integration of UHEP in schools.

Regarding waste management in urban areas, he agreed with what the audience and panelists said, however he suggested that communities take ownership of their respective cities to increase accountability. Dr. Kebede stated that while the private sector does require a bottom-line profit motive, he believes that transparent pricing practices and professional ethics would need to be maintained. The establishment of proper regulations and controlling apparatuses for the sector would only increase accountability and clarity.

Regarding urban primary health care reform, Dr. Kebede stated that the initiative needed additional investment and that the system must be ready to respond to the additional requirements of human resources, infrastructure etc.

While the establishment of Community Health Information Systems in urban areas may have passed their optimal time, Dr. Kebede stated that the initiative is being finalized and prepared for implementation.

Dr. Hagos Godefy stated that national standards would need be maintained in any urban health endeavor. Therefore, he stressed the need for the federal government to be present in conversations concerning regional urban health strategies and that the optimal outcome could benefit the country as a whole. He then discussed the predicament facing the UHEP, and the UHE_ps position. He discussed both the long and short term progression. For instance, he believes that the compensation and education for UHE_ps could be discussed and improved within the short term. Long term would include more systemic issues. He also cautioned the utilization of current health practices in countries such as Brazil and Cuba. He believed that while the goal is to reach the levels seen in these partner countries, Ethiopia needs to undertake a strategy that is reticent of the state of Brazil 15-20 years ago in order to reach or surpass that level in the coming years. He also touched on the need to support the private sector and not to simply denigrate their

efforts in entering the Ethiopian health market. He also stated that the private sector needs to support the primary health care system before taking on more tertiary level roles. Lastly, he discussed the practicality of integration and moving beyond theoretical approaches in regards to regional health bureaus and the FMOH and other sectors. Moving forward, Dr. Hagos asked that people return to the following years conference with success stories that can encourage and inspire future policy ideas in urban health.

Ato Mohamed, Head of the Harar Health Bureau talked about the need for leadership commitment to ensure the maintenance of urban health. He mentioned that there needed to be a specific urban master plan and that construction and waste management should adhere to such a plan. He also mentioned the need for enforcement laws and building codes for safety for example, after the construction of large scale building projects, the building may not be up to code in terms of septic tanks, latrines and proper sewage systems. There also needs to be a focus on dry and liquid waste dumping in open areas that stems from a lack of focus on beautification standards in urban areas. Lastly, he discussed the UHE_ps are educating people and creating awareness however, the systemic structure need to be emplaced in order to actually deal with the current problems of waste and unhygienic practices. The poor attitude that exists in reference to sanitation also emerges from a lack of land designated for waste management. Furthermore, he stated that UHE_ps need special support from the leadership.

Dr. Abebaw Gebeyehu, Head of Amhara Regional Health Bureau started his summary with identifying four key problems in urban health; pollution in cities, youth substance addiction, the growing rate of NCDs, and marginalized populations and areas. He suggested how the UHEP could involve these four areas to achieve a better outcome for all. He also highlighted the need for academic and research institutions to study these areas to understand not just the solutions but the root causes of these challenges. Following this, Dr. Abebaw discussed the problem of waste and their two major sources which are households and institutions. Households were identified as outputting 32000g per capita which is an unsettling high figure. He stressed the need for services that could deal with these pressures. Institutions were also mentioned along with

poor business practices that negatively impact the waste problems in Ethiopian cities. He suggests three points to manage the waste. First was to strategically link the UHE_ps service in managing at the household and institutional levels of waste collection, second was to have professional trained on environmental and sanitation health, lastly was the integration of sectors. Similarly, Dr. Abebaw discussed the notion of UHE_ps being centered at either the Kebele or health center. On this issue, he stated that in his belief, UHE_ps should be at the health center in order to make the system more functional, ensure that UHE_ps receive support, and to foster a sense of team.

He stated that although it would be difficult to adapt the WDA to an urban context, the benefits would be numerous. He suggested that organizing youth could help support peer to peer education in order to combat unhealthy lifestyles involving substance abuse. Another focus he discussed was school health and the use of school health clubs to promote health living habits and behavioral change. Even though the service delivery point is at the household level for UHE_ps, Dr. Abebaw believes attention should be given for institutions such as work places and the packages should be defined within the context of specified institutions. For example, work place packages should include activity, mental health and diet. Home based services should also be tailored for example, NCDs are prominent among elderly populations therefore packages should be heavily focused on the subject. Lastly, he recommended that a sanitation surveillance program be crafted for

communities to engage with the maintenance of their own neighborhoods.

Ato Salah Ismael, Head of Benishangul Gumuz Regional Health Bureau, discussed the struggles that exist in health extension and urban sanitation. He identified leadership, lack of support, unclear curriculum, and non-uniform systems at the national level as reasons behind some of the implementation issues. He stated that he believed the health bureaus needed to have the ability to design and implement their own contextualized health approach due to the complex variances that exist between Ethiopia's regions. The UHEP would be a good way to provide health services to urban dwellers. His final suggestion was to build upon the current model and ensure that both the public and political sphere are involved.

Dr. Muluken Argaw, Head of Dire Dawa City Administration Health Bureau, agreed that a motivational package needed to be created for UHE_ps which could improve their working environment in addition to better oversight and leadership mechanisms. He stated that starting generic training should not be the ultimate goal and that establishing a clear career structure for the UHE_ps was important. He also agreed with the sectors integration in urban hygiene and snatiation but he believes that it needs commitment and persistence. Dr. Muluken also discussed the scaling up of best practices of intra and inter-city experiences.

Ato Kemeradin Shifa, from Oromia RHB began his points by highlighting the fact that the UHE_ps present at the conference had only given a sliver of information about what they encounter on a day to day basis. He touched on how there was once a hope that the UHE_ps would receive PhDs in

community health and how that has slowly been disappearing. He discussed the declines in the Health Development Army and questioned how it could be reimagined and brought back on a larger scale. He also discussed the Family Health Team program and the need for regions to have the ability to approach their own cities and craft plans specifically designed for their health needs.

Dr. Oman Amulu Akway Head of Gambella Regional Health Bureau emphasized the point that the key solutions can come from clear leadership within urban health. He also mentioned the importance of equity within health and the impacts that can be seen from waste management in urban areas. The economic cost incurred by the implementation of proper waste management practices is lower than the costs accumulated by ignoring the issue altogether.

Wro Gezashein Makonnen, representative of SNNPR Regional Health Bureau talked about the support that can be offered through proactive leadership. Unlike rural health, urban health had not been supported therefore, she believes it needs a greater emphasis from leaders. She stated that in order to motivate UHE_ps, organizing regular festivals, activities, and events as well as recognizing outstanding workers would be an important avenue to explore. As a region, SNNPR has a plan for the current year which will hopefully continue in subsequent years. Regarding the urban primary health care reform, the region already contextualized the implementation manual and has conducted sensitization workshops for stakeholders. A challenge that they are currently facing is providing adequate space for UHE_ps within health centers. She stated that they were utilizing innovative approaches to ensuring that UHE_ps could still maintain a connection with health centers within their regional context. She also suggests that the FMOH prepares guidelines on upgrading the payment and career structure of the UHE_ps.

Dr. Jemal Adem, Head of the Addis Ababa City Administration Health Bureau, discussed the need for Addis Ababa to be a model for other cities. There are many challenges to this due to size and growth of the very heterogeneous city. The inequality gap is most profound in Addis and are filled with migrants, daily laborers,

urban poor. This coupled with the triple burden of disease makes for a complex urban health layout. He mentioned that Addis has had a good start in tackling these challenges and provide access to health services and in extending the urban health program. He boldly spoke about leadership, support and focus of the program. In Addis, they have already integrated the urban HEP to the health centers and they have started working as a team. They have also shifted some tasks from hospitals to health centers in an effort to share the load. These range from minor procedures to surgery. Therefore, he requested the FMOH to revise the health center protocols such as the essential drug list and health center standards. He believes the integration of sectors for the successful implementation of urban hygiene and sanitation but it requires political leadership and a mass community mobilization.

Dr. Kebede, wrapped up the conference by emphasizing the capability of Ethiopia to establish a strong primary health care system and took examples from countries who are economically poor but are considered to have the best PHC. Primary health care is very important for the marginalized and neglected populations of cities. Dr. Kebede highlighted the need for inter- sectoral collaboration to begin immediately due to the promises made at the conference. This conference met its objectives and can be considered a success and notes taken from this workshop will be included in the plans concerning urban health improvement in the country.

FINAL CEREMONY

The conference was concluded by selecting the host city for the following year. After a vote between the nominated cities of Mekele, Harar and Wolaita Sodo, Harar was selected by majority to be the next National Urban Health Conference host city.

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NATIONAL CONFERENCE ON URBAN HEALTH

APRIL 3-4, 2017, HILTON HOTEL, ADDIS ABABA, ETHIOPIA

ETHIOPIA'S URBANIZATION AND ITS IMPLICATION ON HEALTH: ACTING NOW TO SAVE THE FUTURE

AGENDA

DAY I: APRIL 3, 2017	
9:00 – 9:05	**SOLIDARITY TO PEOPLE AFFECTED BY THE RECENT GARBAGE DUMP SLIDE IN ADDIS ABABA**
9:05-9:30 AM	**SONG BY GROUP OF YOUTHS ORGANIZED BY MULU GEBEYEHU AND POEM PRESENTATION BY TA-GEL SEIFU**
9:30 -10:00 AM	**OPENING REMARKS** Key Note Addresses • Dr. Hibret Alemu, Chief of Party, John Snow, Inc. / USAID's Strengthening Ethiopia' Urban Health Program. • Ms BethAnne Moskov, Chief of Health, Population, and Nutrition, USAID • H.E. Dr. Kebede Worku, State Minister of Federal Democratic Republic of Ethiopia Ministry of Health • Dr. Tabor Gebremedhin, Speaker of Addis Ababa City Council **OFFICIAL OPENING** • H.E. Ato Muktar Kedir, Office of the Prime Minister; Good Governance, Justice, and Social Sector Policy, Planning, and Evaluation Minister of Federal Democratic Republic of Ethiopia Master of Ceremony: Ato Ermias Getahun, Addis Ababa City Administration
10:00 – 10:15 AM	**SIGNING AND LAUNCHING CEREMONY:** Integrated Urban Hygiene and Sanitation Strategy and National Hygiene and Environmental Health Strategy • Overview by Dr. Zufan Abera, Director of Health Extension and Primary Health Care Directorate, Ministry of Health. • Signing of the two documents by State Ministers of; Ministry of Health, Ministry of Urban Development and Housing, Ministry of Education, Ministry of Culture and Tourism, Ministry of Finance and Economic Cooperation, Ministry of Water, Irrigation and Electricity, and Ministry of Environment, Forest and Climate Change.
10:15 AM – 11:00 AM	**Tea Break, Exhibition and Press Release**

Federal Democratic Republic of Ethiopia
Ministry of Health

USAID FROM THE AMERICAN PEOPLE

JSI JOHN SNOW, INC.

	BOOTH ONE: URBAN HEALTH EXTENSION PROGRAM OF ETHIOPIA **Presenters** • Ato Temesgen Ayehu, Assistant Director of Health Extension and Primary Health Service Directorate, Ministry of Health • Sr. Rahel Franco, Bahir Dar, Amhara region • Sr. Meaza Abraham, Hawassa, SNNPR • Sr. Kiros Tesfay, Adigrat, Tigray region • Sr. Meseret Tesfaye, Yeka Subcity, Addis Ababa • Sr. Hewan Getachew, Dire Dawa
	BOOTH TWO: USAID'S STRENGTHENING ETHIOPIA'S URBAN HEALTH PROGRAM (SEUHP) WHICH IS IMPLEMENTED BY JOHN SNOW, INC (JSI INC.) **Presenter:** Dr. Mebratu Bejiga, Technical Director, SEUHP, John Snow, Inc. (JSI)
	BOOTH THREE: ROLE OF UNIVERSITIES IN URBAN HEALTH **Presenters:** Ato Dawit Seraw, Coordinator of Urban Health Project, Addis Ababa University School of Public Health (AAU/SPH) and Ato Akalu Melketsadik, Wollo University
	BOOTH FOUR: PRIMARY HEALTH CARE REFORM **Presenter:** Solomon Deresa, Director of Entoto #2 Health Centre, Addis Ababa
	BOOTH FIVE: QUALITY IMPROVEMENT INITIATIVE **Presenters:** • Dr. Helina Tadesse, Quality Directorate, FMOH • Ato Ayele Shanko, Director of Wolayita Sodo Health Centre, Southern Nations, Nationalities, and Peoples Region
	BOOTH SIX: ROLE OF PRIVATE HEALTH SECTORS IN URBAN HEALTH **Presenter:** Ato Mohammed Tusi, Executive Director, Ethiopian Private Health Facilities Employers Association
	BOOTH SEVEN: INNOVATIVE URBAN SANITATION AND HYGIENE INTERVENTIONS **Presenters:** • Ato Solomon Tesfaye, Emanuel Development Association, Addis Ababa, Ethiopia • Dr. Dagmawi Lemma, Rose Business Group, Addis Ababa, Ethiopia • Ms Mistre Gossaye, Bemistre Home Accessories, Addis Ababa, Ethiopia • Ato Honelegn Tilahun, Dream Light PLC, Bahir Dar, Ethiopia • Ato Atiku Legesse, Addis Ababa Beautification Agency, Ethiopia
11:00 AM - 1 PM	**PANEL I: ETHIOPIA'S URBANIZATION, DEMOGRAPHIC SHIFT, CAUSES OF DEATH, SOCIETAL CHANGE AND ITS IMPLICATIONS ON HEALTH** **Moderator:** Dr. Helina Worku, Deputy Team Leader of Health System Strengthening, USAID
11:00 - 11:15 AM	**PRESENTATION 1: DEMOGRAPHIC DYNAMISM OF THE URBAN POPULATION IN ETHIOPIA** **Speaker:** Dr. Assefa Hailemariam (PhD), Associate Professor, Center for Population Studies, Addis Ababa University
11:15 - 11:30 AM	**PRESENTATION 2: CAUSE OF DEATH IN ADDIS ABABA, ETHIOPIA** **Speaker:** Dr. Bilal Shikur, Assistant Professor, Addis Ababa University School of Public Health

11:30 AM - 12:00 PM	**PRESENTATION 3: CAUSE OF DEATH IN HARAR, ETHIOPIA** **Speaker:** Dr. Nega Assefa, Assistant Professor, Haromaya University School of Public Health
12:00 – 12:15 PM	**PRESENTATION 4: URBANIZATION AND SOCIETAL CHANGES IN ETHIOPIA** **Speaker:** Dr. Mirgessa Kaba, Assistant Professor, Addis Ababa University, School of Public Health
12:15 - 1:00 PM	Discussion
1:00 - 2:00 PM	**Lunch**
2:00 – 4:00 PM	**PANEL 2: ETHIOPIA'S URBAN HEALTH EXTENSION PROGRAM: FROM WHERE TO WHERE?** **Moderator:** Dr. Taye Tolera, Director General of Armauer Hansen Research Institute, Addis Ababa, Ethiopia
2:00 - 2:15 PM	**PRESENTATION 1: ETHIOPIA'S URBAN HEALTH EXTENSION PROGRAM; EVOLUTION, CURRENT STATUS AND IMPLEMENTATION CHALLENGES** **Speaker:** Dr. Zufan Abera, Director of Health Extension and Primary Health Service Directorate, FMOH
2:15 - 2:30 PM	**PRESENTATION 2: URBAN HEALTH EXTENSION PROFESSIONALS: BASIC TRAINING, PROFESSIONAL DEVELOPMENT, CAREER LADDER AND ASSOCIATED CHALLENGES** **Speaker:** Dr. Getachew Tolera, Director of Human Resource Directorate, FMOH
2:30 - 2:45 PM	**PRESENTATION 3: STRENGTHENING ETHIOPIA'S URBAN HEALTH PROGRAM: LESSONS AND RECOMMENDATIONS** **Speaker:** Dr. Hibret Alemu, Chief of Party of John Snow, Inc. (JSI)/SEUHP
2:45 - 3:00 PM	**PRESENTATION 4: CASE PRESENTATION BY URBAN HEALTH EXTENSION PROFESSIONALS** **Speakers:** Sr. Azeb Tsegaye, Adama, Oromia Region and Sr. Seble Tamiru, Harari region
3:00 - 4:00 PM	Discussion
4:00-4:15 PM	Tea break
4:15 – 6:00 PM	**PANEL 3: ETHIOPIA'S URBAN PRIMARY HEALTH CARE: A DEVELOPMENT AGENDA** Moderator: Ato Eshete Yilma, Team Leader of Health System Strengthening, USAID, Ethiopia.
4:15 - 4:30 PM	**PRESENTATION 1: THE PRIMARY HEALTH CARE SYSTEM IN URBAN ETHIOPIA** **Speaker:** Dr. Desalegn Tigabu, Director of Clinical Service Directorate, FMOH
4:30-4:45 PM	**PRESENTATION 2: URBAN PRIMARY HEALTH CARE REFORM: IMPLEMENTATION IN PILOT SITES AND CONSIDERATIONS FOR SCALE-UP** **Speaker:** Ato Temesgen Ayehu, Assistant Director of Health Extension and Primary Health Service Directorate, Ministry of Health
4:45 - 5:00 PM	**PRESENTATION 3: ROLE OF THE PRIVATE SECTOR ON URBAN PRIMARY HEALTH SERVICE DELIVERY** **Speaker:** Dr. Wondosen Assefa, Private Health Sector Association
5:00 - 5:15 PM	**PRESENTATION 4: ETHIOPIA'S HEALTH INSURANCE AND ITS IMPLICATION ON ACCESS TO PRIMARY HEALTH CARE IN URBAN AREAS** **Speaker:** Ato Abduljelil Reshad, Deputy Director General, Ethiopia's Health Insurance Agency
5:15 - 6:00 PM	Discussion

DAY 2, APRIL 4, 2017	
9:00 – 10:30 AM	**PANEL 4: INITIATIVES TO IMPROVE URBAN SANITATION AND WASTE MANAGEMENT** **Moderator:** Ato Birhanu Teshome, Urban Climate Change Impacts Resilience Bureau, Ministry of Urban Development and Housing
9:00 - 9:15 AM	**PRESENTATION 1: ETHIOPIA'S INTEGRATED URBAN HYGIENE AND SANITATION STRATEGY** **Speaker:** Dr. Zufan Abera, Director for Health Extension and Primary Health Service Directorate, FMOH
9:15 - 9:30 AM	**PRESENTATION 2: URBAN JOB CREATION AND DEVELOPMENT SAFETY NET PROGRAM AND ITS INTEGRATION WITH URBAN SANITATION AND BEAUTIFICATION** **Speaker:** Ato Abraham Petros, Director of Urban Safety Net Program Directorate, Ministry of Urban Development and Housing
9:30 - 9:45 AM	**PRESENTATION 3: URBANIZATION AND ITS EFFECT ON THE ENVIRONMENT** **Speaker:** Ato Assefa Gudina, Ministry of Environment, Forest and Climate Change
9:45 - 10:30 AM	Discussion
10:30 - 10:50 AM	Tea break
10:50 AM - 12:45 PM	**PANEL 5: ROLE OF DIFFERENT ACTORS TO IMPROVE URBAN WASH** **Moderator:** Ato Haile Fiseha, General Manager of Addis Ababa City Administration Municipality
10:50 - 11:05 AM	**PRESENTATION 1: SECTORAL INTEGRATION AND ROLE OF CITY ADMINISTRATIONS' LEADERSHIP FOR BETTER URBAN WASH SERVICES** **Speaker:** Ato Tewdros Gibaba, Mayor of Hawassa Town, SNNPR
11:05 - 11:20 AM	**PRESENTATION 2: ROLE OF PRIVATE SECTOR ON URBAN SANITATION AND WASTE MANAGEMENT SERVICE DELIVERY** **Speaker:** Dr. Dagmawi Lemma, ROSE Business Group, Addis Ababa
11:20 -11:35 AM	**PRESENTATION 3: PUBLIC LATRINE MANAGEMENT AND ROLE OF SMALL AND MEDIUM ENTERPRISE** **Speaker:** Ato Mulualem Birhane, Addis Ababa Water Supply and Sewerage Authority
11:35 - 11:50 AM	**PRESENTATION 4: GENERATING SUPPORT FROM THE COMMUNITY USING CHAMPIONS FOR IMPROVING URBAN SANITATION** **Speaker:** Artist Sileshi Demisse (Gash Abera Molla)
11:50 AM - 12:45 PM	Discussion
12:45 – 2:00 PM	Lunch
2:00 - 4:30 PM	**PANEL 6: DISCUSSION ON WAY FORWARD** **Moderator:** H.E. Dr. Kebede Worku, State Minister Of Federal Democratic Republic of Ethiopia Ministry of Health **Speakers:** • Dr. Dereje Duguma, Head of Oromia RHB • Dr. Abebaw Gebeyehu, Head of Amhara RHB • Dr. Abraham Alano, Head of SNNPR RHB • Dr. Hagos Godefay, Head of Tigray RHB • Dr. Jemal Adem, Head of Addis Ababa City Administration HB • Dr. Muluken Argaw, Head of Dire Dawa City Administration HB • Ato Mohammed Ahmed, Head of Harari RHB • Ato Salah Ismael, Head of Benishangul Gumuz RHB • Ato Ali Hussien Waesa, Head of Afar RHB • Dr. Oman Amulu Akway, Head of Gambella RHB • Ato Abdifatah Mahamud, Head of Somali RHB
4:30 – 4:45 PM	**CLOSING: CLOSING REMARK BY H.E DR. KEBEDE WORKU, STATE MINISTER OF FMOH & SELECTION OF THE CITY THAT WILL HOST THE NEXT NATIONAL URBAN HEALTH CONFERENCE**