



Federal Democratic Republic of Ethiopia  
Ministry of Health

# HSDP IV ANNUAL PERFORMANCE REPORT



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Major Theme of ARM: Transforming the Ethiopian health sector |  
Realizing equitable and quality health service



EFY 2007 (2014/15)

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**HEALTH SECTOR DEVELOPMENT PROGRAMME IV**  
**ANNUAL PERFORMANCE REPORT**  
**EFY 2007 (2014/15)**

**VERSION 1**

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# ACRONYMS

<b>ACT</b>	Artemisinin-based Combination Therapy	<b>ePHEM-HMIS</b>	Electronic Public Health Emergency Management-Health Management Information System
<b>AFP</b>	Acute Flaccid Paralysis	<b>EPHI</b>	Ethiopian Public Health Institute
<b>AIDS</b>	Acquired Immunodeficiency Syndrome	<b>EPI</b>	Expanded Program on Immunization
<b>ANC</b>	Antenatal Care	<b>EQA</b>	External Quality Assessment
<b>ARM</b>	Annual Review Meeting	<b>ETB</b>	Ethiopian Birr
<b>ART</b>	Antiretroviral Therapy	<b>EU</b>	European Union
<b>ARV</b>	Antiretroviral	<b>FF</b>	Family Folder
<b>AusAID</b>	Australian Aid	<b>FMHACA</b>	Food, Medicine and Healthcare Administration and Control Authority
<b>AZT</b>	Azidothymidine / Zidovudine	<b>FMOH</b>	Federal Ministry of Health
<b>BCC</b>	Behavioural Change Communication	<b>FP</b>	Family Planning
<b>BEmONC</b>	Basic Emergency Obstetric and Neonatal Care	<b>GAVI</b>	Global Alliance for Vaccines and Immunization
<b>BSC</b>	Balanced Score Card	<b>GC</b>	Gregorian Calendar
<b>CAR</b>	Contraceptive Acceptance Rate	<b>GDP</b>	Gross Domestic Product
<b>CASH</b>	Clean and Safe Health	<b>GIS</b>	Geographic Information System
<b>CBHI</b>	Community Based Health Insurance	<b>GMP</b>	Good Manufacturing Practice
<b>CBN</b>	Community Based Nutrition	<b>GOE</b>	Government of Ethiopia
<b>CBNC</b>	Community Based Neonatal Care	<b>GTP</b>	Growth and Transformation Plan
<b>CCBN</b>	Comprehensive Community Based Nutrition	<b>HAPCO</b>	HIV/AIDS Prevention and Control Office
<b>CDC</b>	Centre for Disease Control	<b>HC</b>	Health Center
<b>CDR</b>	Case Detection Rate	<b>HCF</b>	Health Care Financing
<b>CEmONC</b>	Comprehensive Emergency Obstetric and Neonatal Care	<b>HCT</b>	HIV Counselling and Testing
<b>CFR</b>	Case Fatality Rate	<b>HDA</b>	Health Development Army
<b>CHD</b>	Community Health Day	<b>HEP</b>	Health Extension Program
<b>CHIS</b>	Community-based Health Information System	<b>HEW</b>	Health Extension Worker
<b>CIFF</b>	Children's Investment Fund Foundation	<b>HF</b>	Health Facility
<b>CLTS</b>	Community Led Total Sanitation	<b>HIQIP</b>	Health Information Quality Improvement Plan
<b>CMAM</b>	Community-based Management of Acute Malnutrition	<b>HIT</b>	Health Information Technician
<b>CNR</b>	Case Notification Rate	<b>HIV</b>	Human Immunodeficiency Virus
<b>CPD</b>	Continuing Professional Development	<b>HMIS</b>	Health Management Information System
<b>CPR</b>	Contraceptive Prevalence Rate	<b>HO</b>	Health Officer
<b>CSA</b>	Central Statistical Agency	<b>HP</b>	Health Post
<b>DFID</b>	Department for International Development	<b>HPN</b>	Health, Population and Nutrition
<b>DP</b>	Development Partner	<b>HR</b>	Human Resources
<b>DTC</b>	Drug and Therapeutics Committees	<b>HRD</b>	Human Resources Development
<b>ECCN</b>	Emergency Critical Care Nursing	<b>HRH</b>	Human Resources for Health
<b>EFETP</b>	Ethiopian Field Epidemiology Training Program	<b>HRIS</b>	Human Resources Information System
<b>EFY</b>	Ethiopian Fiscal Year	<b>HRM</b>	Human Resources Management
<b>EHAQ</b>	Ethiopian Hospitals Alliance for Quality	<b>HSC</b>	Health Science College
<b>EHIA</b>	Ethiopian Health Insurance Agency	<b>HSDP</b>	Health Sector Development Program
<b>eHMIS</b>	Electronic Health Management Information System	<b>HSS</b>	Health Systems Strengthening
<b>EHRIG</b>	Ethiopian Hospital Reform Implementation Guideline	<b>HSTP</b>	Health Sector Transformation Plan
<b>eIDSR</b>	Electronic Integrated Disease Surveillance and Response	<b>ICCM</b>	Integrated Community Case Management
<b>ELISA</b>	Enzyme-Linked Immunosorbent Assay	<b>ICT</b>	Information and Communication Technology
<b>eMCS</b>	Electronic Mobile Care Solution	<b>IDSR</b>	Integrated Disease Surveillance and Response
<b>EmONC</b>	Emergency Obstetric and Neonatal Care	<b>IESO</b>	Integrated Emergency Surgery Officer
<b>EMR</b>	Electronic Medical Record	<b>IFMIS</b>	Integrated Financial Management Information System
<b>EOS</b>	Enhanced Outreach Strategy	<b>IHP</b>	International Health Partnership
		<b>IMNCI</b>	Integrated Management of Neonatal and Childhood Illnesses



<b>IMR</b>	Infant Mortality Rate	<b>PHCU</b>	Primary Health Care Unit
<b>IRS</b>	Insecticide Residual Spraying	<b>PHEM</b>	Public Health Emergency Management
<b>ISO</b>	International Organization for Standardization	<b>PLHIV</b>	People Living With HIV
<b>IST</b>	In-Service Training	<b>PMTCT</b>	Prevention of Maternal to Child Transmission of HIV
<b>IT</b>	Information Technician	<b>PNC</b>	Postnatal Care
<b>ITN</b>	Insecticide Treated Net	<b>PPD</b>	Policy and Planning Directorate
<b>IUCD</b>	Intra-Uterine Contraceptive Device	<b>PPP</b>	Public-Private Partnership
<b>IVR</b>	Interactive Voice Response	<b>PV</b>	Plasmodium Vivax
<b>JCCC</b>	Joint Core Coordinating Committee	<b>QA</b>	Quality Assurance
<b>JCF</b>	Joint Consultative Forum	<b>QC</b>	Quality Control
<b>JFA</b>	Joint Financial Arrangement	<b>RDF</b>	Revolving Drug Fund
<b>JRM</b>	Joint Review Mission	<b>RDQA</b>	Routine Data Quality Assessment
<b>JSC</b>	Joint Steering Committee	<b>RDT</b>	Rapid Diagnostic Test
<b>LIS</b>	Laboratory Information System	<b>RF</b>	Relapsing Fever
<b>LLIN</b>	Long-Lasting Insecticide-treated Net	<b>RHB</b>	Regional Health Bureau
<b>LQAS</b>	Lot Quality Assurance Sampling	<b>RUTF</b>	Ready-to-Use Therapeutic Food
<b>MARP</b>	Most-At-Risk Population	<b>SBA</b>	Skilled Birth Attendance
<b>MCH</b>	Maternal and Child Health	<b>SHI</b>	Social Health Insurance
<b>MDG</b>	Millennium Development Goals	<b>SIA</b>	Supplementary Immunization Activity
<b>MDG PF</b>	MDG Performance Fund	<b>SLD</b>	Second Line Drug
<b>MDR TB</b>	Multi-Drug Resistant TB	<b>SLMTA</b>	Strengthening Laboratory Management Towards Accreditation
<b>MDSR</b>	Maternal Death Surveillance and Response	<b>SMART</b>	Specific, Measurable, Assignable, Realistic, Time-related
<b>MDT</b>	Multi Drug Therapy	<b>SNNPR</b>	Southern Nations, Nationalities and Peoples Region
<b>M&amp;E</b>	Monitoring and Evaluation	<b>SOP</b>	Standard Operating Procedure
<b>mHealth</b>	Mobile Health	<b>SPA</b>	Services Provision Assessment
<b>mhGAP</b>	Mental Health Gap Action Programme	<b>SSA</b>	Sub-Saharan Africa
<b>MMR</b>	Maternal Mortality Ratio	<b>TB</b>	Tuberculosis
<b>MNCH</b>	Maternal, Newborn and Child Health	<b>TFR</b>	Total Fertility Rate
<b>MOE</b>	Ministry of Education	<b>TLPC</b>	Tuberculosis and Leprosy Prevention and Control
<b>MOFED</b>	Ministry of Finance and Economic Development	<b>TOT</b>	Training of Trainers
<b>MOU</b>	Memorandum of Understanding	<b>TSR</b>	Treatment Success Rate
<b>MRU</b>	Medical Record Unit	<b>TWG</b>	Technical Working Group
<b>MSD</b>	Medical Service Directorate	<b>UHC</b>	Universal Health Coverage
<b>MT</b>	Metric Tons	<b>USMR</b>	Under-5 Mortality Rate
<b>MTCT</b>	Maternal to Child Transmission	<b>UN</b>	United Nations
<b>NAC</b>	National Advisory Committee	<b>UNFPA</b>	United Nations Population Fund
<b>NBB</b>	National Blood Bank	<b>UNICEF</b>	United Nations Children's Fund
<b>NBTS</b>	National Blood Transfusion Service	<b>USD</b>	United States Dollar
<b>NCD</b>	Non-Communicable Disease	<b>VAS</b>	Vitamin A Supplementation
<b>NGO</b>	Non-Governmental Organization	<b>VDPV</b>	Vaccine Derived Polio Virus
<b>NICU</b>	Neonatal Intensive Care Unit	<b>WaSH</b>	Water, Sanitation and Hygiene
<b>NMEI</b>	New Medical Education Initiative	<b>WDA</b>	Women Development Army
<b>NMR</b>	Neonatal Mortality Rate	<b>WDG</b>	Women Development Group
<b>NN</b>	Neonatal Nursing	<b>WHO</b>	World Health Organization
<b>NNP</b>	National Nutrition Programme	<b>WoFED</b>	Woreda Finance and Economic Development
<b>NTD</b>	Neglected Tropical Disease	<b>WorHO</b>	Woreda Health Office
<b>ODF</b>	Open Defecation Free	<b>ZHD</b>	Zonal Health Department
<b>OI</b>	Opportunistic infection		
<b>OPD</b>	Outpatient Department		
<b>OR</b>	Operational Research		
<b>PBS</b>	Promoting Basic Services		
<b>PCV</b>	Pneumococcal Conjugate Vaccine		
<b>PF</b>	Plasmodium Falciparum		
<b>PforR</b>	Program for Result		
<b>PFSA</b>	Pharmaceutical Fund and Supply Agency		
<b>PHC</b>	Primary Health Care		



# EXECUTIVE SUMMARY

# EXECUTIVE SUMMARY

This Annual Performance Report of the fourth Health Sector Development Program (HSDP) (2010/11-2014/15) gives an overview of the performance of the health sector in the Ethiopian Fiscal Year (EFY) 2007 (2014/2015).

As in previous years, the development process of the Annual Performance Report for EFY 2007 was widely consultative, involving Regional Health Bureaus (RHB), the various Directorates of the Federal Ministry of Health (FMOH), and agencies accountable to the FMOH as well as Development Partners (DP). The report highlights the major achievements and challenges of the health sector in EFY 2007, under the three Strategic Themes: (i) Health Service Delivery and Quality of Care; (ii) Leadership and Governance; and (iii) Health Infrastructure and Resources.

## HEALTH SERVICE DELIVERY AND QUALITY OF CARE

This Strategic Theme comprises of the Health Extension Program (HEP), maternal and new-born health services, child health services, national nutrition programme, prevention and control of communicable and non-communicable diseases, public health emergency preparedness and response, and quality of health services. The performance of the sector during EFY 2007 was as follows:

### Health Extension Program

1. Organizing women Health Development Army (HDA) was one of the main strategies to strengthen community ownership of health programs in Ethiopia. The HDA structure includes a group of 30 women as Women Development Group (WDG). Each WDG is composed of networks containing 6 women (one-to-five network). Organizing women in such manner and making them functional with their own health improvement plans was among the main activities for EFY 2007. Accordingly, in Tigray Region, 30,206 WDG were established, with the formation of 151,095 one-to-five networks. Similarly, in Amhara Region 121,445 Development Groups and 600,559 one-to-five networks were created. Likewise, in Oromia Region organized women in 195,864 WDGs and 880,975 one-to-five networks, while in Southern Nations, Nationalities and Peoples (SNNP) Region a total of 84,871 Development Groups with 434,285 one-to-five networks were formed during the fiscal year. Similarly, a total of 10,634 WDGs with 62,556 one-to-five networks in Addis Ababa, 2,221 HDA groups with 13,920 one-to-five networks in Dire Dawa and 1,609 WDGs with 9,658 one-to-five networks in Harari Region were established during the fiscal year. Meanwhile, looking the implementation status of the four Developing Regional States, a total of 6,253 Development Groups and 168,135 one-to-five networks were formed in Benishangul Gumuz Region. Similarly, in Gambella Region 1,037 Development Groups with 13,376 one-to-five networks were formed. A different type of approach called Community Mobilization is implemented in Afar and Somali Regions focusing on pastoralist communities.

Households have been graduated as model families, a strategy through which households are selected and provided with basic training on the 16 HEP packages then monitored regularly to be as model. Accordingly,

during EFY 2007, a total of 781,421 model households were graduated at national level. As a result, the cumulative number of graduated model households reached 6,141,783 at the end of the fiscal year.

2. Various hygiene and environmental health activities were carried out in EFY 2007 both at household and community levels. One of these activities was to implement Community Led Total Sanitation (CLTS) initiative through organized community movement. As a result, a total of 5,177 kebeles were declared as Open Defecation Free (ODF) during the fiscal year.

### **Maternal and New-born Health Services**

3. Improving the health of mothers and newborns is among the main priorities of HSDP IV. Number of high impact and cost effective initiatives were applied during EFY 2007 focusing mainly on increasing service utilization for Maternal, Neonatal and Child Health (MNCH) services. Encouraging results were attained during the fiscal year. Antenatal care (ANC) coverage (at least one visit) though slightly decreased from EFY 2006 performance (98.1%) to 96.9% in EFY 2007 was significantly high. The increase observed on ANC coverage (at least four visit) from 52.4% to 67.9% in EFY 2007 was also a positive result. Similarly, the percentage of deliveries attended by skilled health personnel increased from 40.9% to 60.7% and PNC coverage increased from 66.2% to 90.0% during the same year. In EFY 2007, clean and safe delivery coverage (by Health Extension Workers (HEW)) further declined from 8.8% in EFY 2006 to 3.9%. The decline is mainly because mothers are being referred to Health Centers during labour. Summing up, 64.6% of pregnant women delivered with the assistance of trained health worker during the fiscal year.

Looking at the performance of family planning services, Contraceptive Acceptance Rate (CAR) increased from 63.0% in EFY 2006 to 69.9% in EFY 2007. This denotes that the number of women who are in the reproductive age group using family planning methods was increasing.

The proportion of pregnant women counselled and tested for the prevention of mother to child transmission (PMTCT) of HIV increased from 57.0% to 92.6% and the percentage of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy to prevent Maternal to Child Transmission (MTCT) of HIV also increased from 60.6% in EFY 2006 to 64.9% in EFY 2007. Out of these maternal health indicators, ANC (at least one visit) coverage, PNC coverage and proportion of pregnant women counselled and tested for PMTCT surpassed the target set for the year and HSDP IV.

### **Child Health Services**

4. EFY 2007 plan included interventions believed to improve the health status of children. Strengthening the Enhanced Program for Immunization (EPI) and increasing the coverage and effectiveness of neonatal care services were among the initiatives. A general increase in immunization coverage was observed from EFY 2006 to EFY 2007 for pentavalent 3 vaccine (from 91.1% to 94.4%), pneumococcal conjugate vaccine (PCV) 3 (from 85.7% to 93.9%), rotavirus vaccine 2 (from 39% to 88.8%), measles vaccine (from 86.5%, to 90.3%), as well as for the percentage of fully immunized children (from 82.9% to 86.4%).

The cumulative number of health centers (HC) providing Integrated Management of Neonatal and Childhood Illnesses (IMNCI) also increased from 2,967 in EFY 2006 to 3,033 in EFY 2007.

### **National Nutrition Program**

5. The national Vitamin A Supplementation (VAS) coverage among children aged 6-59 months increased from 71.7% in EFY 2006 to 89.5% in EFY 2007, but below the target set for the year (99.0%). Conversely, The de-worming coverage of 2-5 year children (75.2%) was lower than the previous year (82.4%) and short fall from the target (98%) for the fiscal year.

### **HIV/AIDS Prevention and Control**

6. According to the “HIV related estimates and projections for Ethiopia-2012”, the adult HIV prevalence is estimated at 1.1% (0.8% in males and 1.5% in females) and the adult HIV incidence at 0.03% in 2015. The number of HCT services increased from 9,664,519 in EFY 2006 to 10,844,067 in EFY 2007; however, it was slightly below the target (11.1 million) set for the year at the national level.
7. A linear increase observed in the number of People Living With HIV (PLHIV) ever enrolled, ever started and currently on ART over the past years; in particular, there was an increase between EFY 2006 and



EFY 2007 from 805,948 to 871,334 for PLHIV ever enrolled in HIV/AIDS care (+65,386), from 492,649 to 535,069 for those ever started (+42,420), and from 344,344 to 375,811 for those currently on ART (+31,467). Out of 453,821 who need ART, 375,811 PLHIV were currently on ART at the end of EFY 2007, with 82.8% coverage.

### **Malaria Prevention and Control**

8. In EFY 2007, a total of 17.2 million Long Lasting Insecticide Treated Nets (LLIN) were distributed which was more than the amount distributed in EFY 2006 (11.7 million). This increased the cumulative number of distributed LLINs to more than 75 million. With regards to vector control, the plan is to cover 5.9 million unit structure with IRS. A total of 5.3 million unit structure (89.8% out of the target) in malaria endemic areas were sprayed. This performance was above EFY 2006 performance.

On the other hand, total number of laboratory confirmed plus clinical malaria cases and deaths were 2,174,707 and 662 respectively with Case Fatality Rate (CFR) of 0.03%. Out of the total malaria cases reported during the fiscal year, 1,867,059 (85.9%) were confirmed by either microscopy or rapid diagnostic tests (RDT). Of the total confirmed cases, 1,188,627 (63.7%) were caused by *Plasmodium falciparum* (PF) and 678,432 (36.3%) by *Plasmodium vivax* (PV).

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

9. In EFY 2007, a total of 135,831 TB cases (all forms) were reported with a TB case notification rate of 151 per 100,000 population; this performance was higher than in EFY 2006 (133 per 100,000 population). Out of the 135,831 cases reported in EFY 2007, 35.1% were smear positive pulmonary TB, 32.4% were smear negative pulmonary TB, 29.8% were extra pulmonary TB and 2.7% were previously treated TB cases. The TB case detection rate reached 67.3%, which was more than the previous year (53.7%) but below the target set for the year (83.0%). TB treatment success rate (TSR) in EFY 2007 showed the same performance as EFY 2006 (92.1%). On the other hand, TB cure rate increased from 69.1% to 77.9% in the same period.
10. A cumulative number of 2,156 MDR TB patients were enrolled in second line drug (SLD) treatment and 597 MDR TB patients were enrolled in SLD treatment in EFY 2007. There were 40 hospitals providing MDR TB treatment services during the fiscal year.
11. A total of 3,817 new leprosy cases were detected in EFY 2007. This was higher than EFY 2006 performance (3,080).

### **Prevention and Control of NTD**

12. Providing enough attention to Neglected Tropical Diseases (NTD) in the integrated manner was one of the main activities planned for EFY 2007. Over 9.9 million and over 1.5 million people took drugs for the prevention of onchocerciasis and lymphatic filariasis respectively. A total of 2.6 million and 5.3 million School age children received Praziquantal and Mebendazole for Schistosomiasis and STH de worming respectively. Furthermore, over 28 million people living in 248 trachoma endemic woredas were covered with Zithromax MDA and over 83,000 people have been operated for trachomatous trichiasis.

### **Prevention and Control of NCD**

13. In accordance with the 2011 UN political declaration on NCDs the FMOH has developed and launched the national NCD prevention and control strategy. EFY 2007, the government started conducting nationwide stepwise survey to determine the magnitude of NCD risk factors and selected NCDs in the country. Ethiopia is also a signatory of the Framework Convention on Tobacco Control (FCTC) and following the proclamation by the Peoples Representative of the FDRE on tobacco use, FMOH developed an implementation/execution guideline. Tigray regional state parliament has ratified the guideline and started implementation while other regions are on process. As part of the effort to fight cancer, a total of 22,818 women aged 30-49 undergone cervical cancer screening; out of whom 2,801 (12.3%) had signs of the disease and 1,348 (5.9%) were identified as full-blown cancer. Furthermore, preparations to introduce cancer registry were finalized. A pilot population based cancer registry started in Addis Ababa City Administration. Hawassa University Hospital started facility based cancer registry. Various tasks were also performed during the fiscal year towards integrating mental health services with PHCU.



## **Public Health Emergency Preparedness and Response**

14. For the epidemic prone diseases under surveillance, the number of cases reported in EFY 2007 was as follows: a total of 32,222 laboratories confirmed and epidemiologically linked measles cases were reported nationally with 199 deaths. Compared to EFY 2006, there was an increase by 23.9%. On the other hand, a total of 772 stool samples of suspected Acute Flaccid Paralysis (AFP) cases were received at national laboratory for investigation. The national non polio AFP rate was 1.9/100,000 under five children in the fiscal year which was below WHO standard (2.0). Besides, one type 2 Vaccine Derived Polio Virus (VDPV2) case was confirmed from Fik Woreda, Nogob Zone of Somali Region. There were a total of 267,489 dysentery cases reported from all regions and 229 deaths with CFR of 0.1% in the same period. Furthermore, a total of 1,875 suspected meningococcal meningitis cases and 61 deaths with CFR of 3.3% were also reported with slight increase from the previous year. Alternatively, a total of 848 suspected anthrax cases and 50 deaths with CFR of 5.9% were reported with slight decrease from the previous year. Similarly, a total of 2,684 suspected rabies cases and 53 deaths with CFR of 2.0% were reported with slight decrease from EFY 2006. There were also a total of 2,958 suspected Relapsing Fever (RF) cases and 33 deaths with CFR of 1.1% reported with marked decrease in the number of cases from the previous year in the same period.

## **Quality of Health Services**

15. Among 124 Ethiopian Hospital Reform Implementation Guideline (EHRIG) standards, 83% were achieved in EFY 2007 indicating performance slightly more than in EFY 2006 (76%). However, wide variation among hospitals was observed on the implementation of these set of standards.
16. To eliminate deaths due to lack of safe blood and to contribute to the quality of health care service delivery a total of 127,851 units of blood (79.9% of the target set for the year) were collected. Out of the total collected units of blood, 48,267 (37.8%) were collected through the National Blood Bank (NBB). This exceeded the previous year's performance by 6,326 units of blood. There was also major increase in the proportion of voluntary blood donors from 70% in EFY 2006 to 95% in EFY 2007. As the same time, there was a significant decrement of the proportion of replacement blood donors from 30% to 5% during the same period.
17. A total of 43,463,879 OPD visits were offered with an average of 0.48 OPD visit per person per year in EFY 2007. This achievement is more than the performance in EFY 2006 (0.35 OPD visit per person per year).

## **National Laboratory System**

18. Concerning the national laboratory system, as part of the on-going laboratory quality assurance mechanism, a total of 185 laboratories were assessed to qualify for WHO/AFRO qualification and in order to be accredited by ISO starting from STAR 1 TO STAR 5. Accordingly, 65 laboratories were identified for the qualification to meet the standardization. Of which 57 were assessed by an independent organization and 3 laboratories qualified as 4 STARS; 13 as 3 SATRS; 19 as 2 STARS and 22 as 1 STAR.

## **LEADERSHIP AND GOVERNANCE**

The Leadership and Governance chapter comprises of evidence-based planning, monitoring, evaluation, policy formulation and implementation. It also includes the development and implementation of the regulatory framework. Different activities were performed in EFY 2007.

### **Evidence Based Decision Making**

1. The major achievement in EFY 2007 was the initiation and the revision of the existing health policy of the country by considering the coming 20 year health sector vision.
2. The status of implementation of the fifth year of HSDP IV was monitored by the FMOH and regions using various monitoring and reporting mechanisms. The FMOH held regular Joint Steering Committee (JSC) meetings with Regional Health Bureaus (RHB) every two months, and bi-weekly Executive Committee Meetings with agencies. FMOH also held quarterly Joint Consultative Forum (JCF) meetings with Development Partners (DP), and bi-weekly Joint Core Coordinating Committee (JCCC) meetings. In

addition, to facilitate information for decision making, the FMOH and Agencies started the Accountability Scorecard flagship initiatives using the project management software in order to increase transparency and accountability.

3. One of the major planning activities performed during EFY 2007 was the preparation of the Health Sector Transformation Plan (HSTP) for the coming five-year period (EFY 2008-2012) as part of the 2035 vision of the health sector. Besides, based on the priority of HSTP, the EFY 2008 woreda based plan was also exercised.
4. Concerning the Health Management Information System (HMIS), draft HMIS diseases list was prepared in context with the 10th version of International Classification of Diseases (ICD-10). In addition, with a focus on improving health data quality, the FMOH has prepared Health Information Quality Improvement Plan (HIQIP) and in line with this, national HMIS Quality Improvement Mentor-ship Guide was also prepared to implement jointly with stakeholder working on monitoring and evaluation of the health sector.
5. The Community Health Information System (CHIS) implementation already covered all agrarian areas of the country; however, implementation was not fully covered in pastoralist' area as a different model is under design for this community group. Though implementation of family folder started in EFY 2003, its implementation was slow moving with only 78% coverage at the end of EFY 2007.

### **Operational Research**

6. In EFY 2007, the operational research focused on HIV/AIDS, TB, malaria, traditional medicine, nutrition, and policy. In particular the assessment of threshold project has been finalized. The finding of the assessment revealed that the amount of HIV drug resistance increases from what the disease distribution earlier on. Besides, the analysis of 2014/2015 data from antenatal care-based HIV, the status of PMTCT is on different stages across regions with a general decrease of mothers to child transmission at national level.

### **Regulatory System**

7. The regulatory system has been strengthened, and a number of activities related ensuring safety and quality in the delivery of health services, products and practices had been accomplished. In order to ensure quality assurance products, certificate of pre and post marketing authorization were given on food items, medicine and medical devices, pharmaceutical products and condom.

In order to control health and health related institution, minimum requirements of health facilities manual has been approved for implementation and on pre and post licensing inspection were conducted and certificate of competence was issued for 8,043 different types of health services.

Professional license was issued and renewed to 16,414 and 8,458 respectively. Furthermore, establishment and strengthening of ethics committees at federal and limited regional level undertaken. As a result, a total of 37 health professional ethical breach issues were reviewed and decision were undertaken.

### **Gender Main-streaming**

8. With respect to gender main-streaming, several activities have been implemented, including the creation of the coalition of different working groups (forums). In the same manner, sharing and expanding the best practices among the forums by preparing experience sharing stages. In addition, different activities have been conducted by giving due consideration to the full implementation of the laws, regulations, instructions that are designed to ensure the beneficiaries of the women.

## **HEALTH INFRASTRUCTURE AND RESOURCES**

### **Health Infrastructure**

1. In EFY 2007, a total of new 196 HPs were constructed and making a cumulative number of HPs 16,447. On the other hand, the total number of available HCs reached 3,586 of which 3,547 (98.1%) are functional. With regard to hospitals, a total 234 public hospitals are available of which 189 (80.8%) are functional. A total of 147 hospitals are under construction.

## **Human Capital and Leadership**

2. With regard to Human Resource Development (HRD), 3,117 new medical students were enrolled in 27 public medical schools in EFY 2007, making the total medical students on training 14,940. The physician to population ratio improved from one physician per 20,970 populations in EFY 2006 to 1 per 17,160 populations in EFY 2007.
3. The Integrated Emergency Surgery and Obstetrics (IESO) training aims at improving the provision of emergency obstetric care and surgical services at primary hospital level. So far, 252 health officers have completed the training and have been deployed in different health facilities, while, in EFY 2007, 132 IESO students were enrolled in 11 training institutions, with a total of 489 being under training.
4. In EFY 2007, 126 Level “V” nurse anaesthetists and 151 degree graduates have been trained and deployed. A total of 159 nurse anaesthetists are under training, while 705 trainees are attending Bachelor of Science Program in twelve universities and one Health Science College (HSC) in the same year.
5. To maintain 2 HEWs per HP, a total of 3,644 students were enrolled for level III replacement training in 2007 EFY. To improve the quality of health extension services at community and household level, a total of 8,647 Level III HEWs were enrolled to be upgraded to Level IV qualifications. Out of enrolled in last 3 years, a total of 3,667 graduated and deployed back to their respective HPs. The remaining 4,970 are on training and will be graduated at the end of 2015.
6. In the framework of the Ambulance Service and Emergency Care/Paramedics Training to improve pre-hospital emergency care in managing all emergencies, including maternal emergencies, 281 students were enrolled in six training centers and will be graduated at the end of 2015. In addition, 1,176 health information technicians (HIT) in 19 HSC, 250 Biomedical technicians in 2 colleges and 441 students in different nursing specialties in 11 training centers and 185 field epidemiologists in 8 Universities/Colleges were on training in 2007 EFY. In the same fiscal year, a total of 5,092 health professionals were deployed, including 948 general practitioners, 91 anaesthetists, and 74 IESO officers.

## **Pharmaceutical Supply and Services**

7. It was planned to procure ETB 7.7 billion worth of pharmaceuticals (RDF and Health Program). Of these, the Agency procured a total amount of ETB 6.6 billion worth of pharmaceuticals (ETB 2.4 billion and ETB 4.2 health program). In addition, the Agency has received pharmaceuticals that worth ETB 6.9 which was procured by development partners. Overall, the Agency has acquired pharmaceuticals that worth a total amount of ETB 13.5 billion worth of pharmaceuticals.
8. In line with this, it was planned to distribute a total amount of ETB 12.2 billion worth of pharmaceuticals. Accordingly, pharmaceuticals worth a total amount of ETB 12.6 billion (ETB 2.7 billion RDF and 9.9 billion health program) has been distributed to health facilities during the budget year which was beyond 100% of the plan.

## **Health Information Technology**

9. The Health Information Technology Initiative covers a wide range of applications, such as telemedicine, tele-education, mobile health (mHealth), electronic HMIS (e-HMIS), Electronic Medical Records, Geographic Information System, and Human Resources Information System. Concerning tele-education, three university hospitals (St. Paul's, Adama and Yirgalem) were connected via Woreda-net in EFY 2007 to teach basic science courses for pre-clinical students. The number of facilities implementing eHMIS increased from 2,345 in EFY 2006 to 2,700 in EFY 2007.

## **Health Care Financing**

10. Revenue retention is additional to the block grant budget allocated from treasury, and it is used strictly for quality improvement activities. Currently, a total of 3,288 health facilities (169 hospitals and 3,119 HCs) are retaining and utilizing internally generated revenues to improve the quality of health services.

Fee waiver scheme is being implemented as a mechanism for financial risk protection to promote equity of access to health services. A total of 1,836,117 beneficiaries being screened and the government allocated a budget of ETB 44,225,098 for fee waiver beneficiaries. Out of the identified beneficiaries 48.8% received the health services. The scheme is implemented in all regions and in total 151 Hospitals and 2,733 HCs currently provides the service.

## Health Insurance

11. To tackle financial barriers to health care access, the government has initiated and is implementing two types of health insurance systems, namely, the Community Based Health Insurance (CBHI) for the rural population and urban informal sector, and the Social Health Insurance (SHI) for the formal sector employees. Since EFY 2004, CBHI is being piloted in 13 woredas of four regions (Tigray, Amhara, Oromia and SNNP), further expansion was made on 185 woredas and a total of 1,374,325 households have been registered at the end of EFY 2007. The CBHI scheme has generated ETB 196,234,617.69 in EFY 2007, with more than 100% increase as compared to ETB 29,402,451.40 in EFY 2006.

## Public Budget Allocation

12. The percentage of total budget allocated in the health sector at regional level was 11.1%, which was higher than in EFY 2006 (10.3%). In EFY 2007, the per capita health allocation was ETB 122.78, increasing from ETB 116.43 in EFY 2006.

## Development Partners' Contribution

13. A total amount of USD 445.96 million was committed and a total amount of USD 269.07 million (60.3%) was disbursed using channel 2 modality to the health sector in EFY 2007 that was lower than EFY 2006 commitment and disbursement (USD 558.33 and USD 612.87, respectively).

## CHALLENGES

Some of the major challenges encountered during the implementation of the EFY 2007 include:

- Disparity among regions on the implementation of HDA;
- Shortage of human resources in terms of number, capacity, and professional skills;
- Gaps in midwives, doctors and anaesthetists for provision of BEmONC and CEmONC services;
- Limited utilities (sanitation facility, water, electricity, etc...) in many health facilities, especially in HCs and HPs;
- Inadequate quality of diagnostic laboratories;
- Low utilization of out-patient services;
- Limited capacity to provide on time supportive supervision and monitoring at each level;
- Limited capacity in data collection and analysis and in information use for decision making purposes; especially at lower level of the health tier system;
- Failure to submit liquidation reports on time;
- Weak referral system;
- Lack of standard medical equipment management system; and
- Limited capacity to maintain cold chain system.

There has been a remarkable improvement in health status in Ethiopia over the past years during HSDP IV. While struggling for development and better health, Ethiopia is an example that low-income countries can achieve better health and improved service coverage if policies, programs and strategies are supported by political will, community involvement, and commitment at all levels with harmonized efforts of all stakeholders. However, despite the progress achieved so far, there is the unfinished Millennium Development Goals (MDG) agenda around mortality reduction, particularly maternal and newborn mortality, and challenges are still to be addressed in improving the health of the population across the life course, in improving quality of care, and in addressing health inequalities.

Learning from the past, the future development agenda recognizes the monitoring and reduction of inequalities as a priority. It is for this reason that improving quality and addressing inequalities are the organizing principles around the next Health Sector Transformation Plan (HSTP) 2015/16-2019/20 built in the framework of the vision of the health sector in the next 20 years.

Hence, Universal Health Coverage (UHC) is a key approach to address the health gap in reduction of inequalities and improving quality. Strengthening primary health care and bringing health services physically accessible, financially affordable and acceptable to patients is the core agenda to attain UHC. To this end, according to the context of HSTP, it is high time to address the current limitations of health equity and quality.





# CHAPTER 1



# INTRODUCTION



# INTRODUCTION

The end of EFY 2007 marks the conclusion of the fifth year of the Health Sector Development Program (HSDP IV) covering the period of 2010/11- 2014/15 (EFY 2003-2007). In addition, the wrapping up of the 20th year's long term development plan and internationally set targets for the Millennium Development Goals (MDG). Since its official launching in 1998 G.C (EFY 1990), the HSDP has been continually reviewed through joint exercises as Mid-Term Reviews (MTR), final evaluations, Joint Review Missions (JRM) and Annual Review Meetings (ARM). The present ARM is the seventeenth in the series of annual reviews that took place since the implementation of the HSDP I.

This annual performance report describes the implementation status of the HSDP IV in 2014/15 according to the three Strategic Themes: (i) Health Service Delivery and Quality of Care; (ii) Leadership and Governance; and (iii) Health Infrastructure and Resources. The report is structured in ten Strategic Objectives of the health sector under the three Strategic Themes in line with HSDP IV:

1. Improve access to health services;
2. Improve community ownership;
3. Improve quality of health services;
4. Improve public health emergency preparedness and response;

5. Improve pharmaceutical supply and services;
6. Improve evidence-based decision making, harmonization and alignment;
7. Improve regulatory system;
8. Improve health infrastructure;
9. Improve human capital and leadership; and
10. Maximize resource mobilization and utilization.

The report gives an overview of the performance of the sector on addressing the strategic objectives. It also highlights how the various activities conducted during the year have contributed to the improvement of the health status of the Ethiopian people. Besides, it examines the progress made, the efforts that are underway and the challenges faced by the sector in the promotion of health, and in the organization, financing and governance of health services. In particular, the report provides information on:

- Health service coverage levels for priority programs;
- Performance against target set in the core plan, using national and regional level indicators;
- Trends of achievements and regional comparisons; as well as
- Status of the health sector support systems;

The theme of the 17th Annual Review Meeting (ARM) is “Transforming the Ethiopian Health Sector: Realizing Equitable and Quality Health Service” and therefore, special attention has been given to the analysis of the level of achievement of health Millennium Development Goals (MDG) and to the post-2015 development agenda in the framework of the next 20-year health sector vision and HSTP.

On the process of this report preparation, a uniform structure of presentation is followed by indicating under each section the background, targets, achievements, challenges and the way forward. The report contains 29 Tables and 53 Figures that depict regional comparisons and trends of indicators selected for monitoring the implementation of the conclusion of HSDP IV or GTP1 with especial focus for the fifth year, EFY 2007, implementation.

Both quantitative and qualitative data were being used in the preparation of this report, whose primary source was the Health Management Information System (HMIS) aggregated monthly, quarterly and annual reports for the EFY 2007, with the exception of data for certain program areas that were not covered by the HMIS (i.e. administrative reports, surveys and studies undertaken by different institutions). Population figures are used based on the estimates from the fiscal year provided by the Central Statistical Agency (CSA) as well as conversion factors from the same source. This was a

precondition for the appropriate analysis of population-based indicators, such as comparison across regions and over time. However, different population estimates are sometimes being used at the local level from local surveys and other data sources of various reliability; these estimates are not applied at national level mainly, because they would undermine the comparability across regions and over time.



# CHAPTER 2



# HEALTH SERVICE DELIVERY AND QUALITY OF CARE

# HEALTH SERVICE DELIVERY AND QUALITY OF CARE

Under the Strategic Theme “Health Service Delivery and Quality of Care”, the provision and management of curative, preventive, rehabilitative and emergency health services as well as the promotion of good health practices are discussed. This section provides information on the status of provision of maternal, neonatal, child, youth and adolescent health services and public health emergency services.

## 2.1. HEALTH EXTENSION PROGRAM

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Health Extension Program (HEP) is an innovative community-based strategy which aims to deliver preventive and promotive services and selected high impact curative interventions at community level. It brings community participation through creation of awareness, behavioural change, and community organization and mobilization. It also improves the utilization of health services by bridging the gap between the community and health facilities through the deployment of Health Extension Workers (HEW). The main objective of the program is to improve access to essential health services provided at community and household levels, contributing to the improvement of the health status of the families, with their full participation, using local technologies and the skill and wisdom of the communities. In this context, with the aim to promote community ownership of the health programs and adoption of healthy lifestyles, a major initiative undertaken by the Ethiopian Government is the implementation of the Health Development Army (HDA).

### 2.1.1. IMPLEMENTATION OF HEALTH DEVELOPMENT ARMY

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HDA is an organized movement of the community through participatory learning and action meetings to improve community ownership by enabling the community to produce and maintain its own health. HDA is one of the blood lines to realize the goals of HSDP. In line with this, HSDP further focuses on the provision of improved primary health care services to mothers and children, as well as on prevention and control of communicable diseases in order to attain the desired results.

One of the main activities planned for EFY 2007 was to organize women in Development Groups. Development Group is a community structure composed of 30 women representing their families. The women in each Development Group are clustered in one to five networks. The one-to-five networks develop their own health improvement plan which is further cascaded to each individual woman in the network. These plans contain individual targets in line with Health Extension Packages. Members of the network implements and continuously monitor their performance with close follow up and technical support from HEWs.



The progress made by regions in terms of organizing women in Development Groups and one-to-five networks during the fiscal year outlined as follows.

In Tigray Region, 30,206 Women Development Groups (WDG) were established, with the formation of 151,095 one-to-five networks. Similarly, in Amhara Region 121,445 Development Groups and 600,559 one-to-five networks were created. Similarly, in Oromia Region organized women in 195,864 Development Groups and 880,975 one-to-five networks, while in Southern Nations, Nationalities and Peoples (SNNP) Region a total of 84,871 Development Groups with 434,285 one-to-five networks were formed during the fiscal year.

Likewise, a total of 10,634 HDA groups with 62,556 one-to-five networks were established in Addis Ababa. Furthermore, in Dire Dawa, 2,221 HDA groups with 13,920 one-to-five networks were formed, while 1,609 HDA groups with 9,658 one-to-five networks were established in Harari Region during the same fiscal year.

These groups have developed and implemented their health improvement plans. HEWs and health professionals working in health centers supported the Development Groups in terms of providing information, inputs and rendering services. The political and administrative structure at all levels of the sector also supported and supervised the activities of the development groups.

Meanwhile, looking at the implementation status of the four Developing Regional States, a total of 6,253 Development Groups and 168,135 one-to-five networks were formed in Benishangul Gumuz Region. Similarly, in Gambella Region 1,037 Development Groups with 13,376 one-to-five networks were formed. A different type of approach called Community Mobilization is implemented in Afar and Somali Regions focusing on pastoralist communities. The status of implementation in the four Developing Regional States on both HDA and Community Mobilization approaches is however not satisfactory.

Summing up, a total of 454,140 Development Groups with 2,334,559 one-to-five networks were formed at national level in EFY 2007.

The HDA improves community ownership of health programs through enabling the community to produce and maintain its own health. Accordingly, considerable and encouraging improvements were observed as the result of the increase in the number of functional development groups at the community level. The HDA contributed to the increase in utilization of maternal and child health services and community led hygiene and sanitation interventions. The HDA activities include:

- Identifying and linking pregnant women and children under five with primary health care providers;
- Promoting family planning services at neighborhood level;
- Organizing and conducting various experience sharing and learning sessions such as Pregnant Women's Conference, CLHS meetings and nutrition learning sessions;
- Mobilizing the community in terms of contributing resources used to make health facilities mother friendly; and
- Applying traditional ambulance and ensuring effective utilization of modern ambulance service where available.

Furthermore, households have been graduated as model families, a strategy through which households are selected and provided with basic training on the 16 HEP packages then monitored regularly to be as model. This model family package is based on the diffusion theory, the process by which an innovation is communicated through certain channels over time among members of a social system, and proceeds by steps in the community because not all people in a social system adopt an innovation at the same time. Accordingly, during EFY 2007, a total of 781,421 model households were graduated at national level. As a result, the cumulative number of graduated model households reached 6,141,783 at the end of the fiscal year.

## **CHALLENGES**

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

## WAY FORWARD

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- Undertake capacity building measures on HDA implementation for management staff;
- Improve the process and quality of training and graduation of model households;
- Strengthen the process of model kebeles graduation;
- Implement level III HEP competency testing and certification;
- Revise Urban Health Extension Program;
- Strengthen regular supporting supervision at woreda and kebele levels; and
- Strengthen collaboration among sector offices.

### 2.1.2. HYGIENE AND ENVIRONMENTAL HEALTH

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Various hygiene and environmental health activities were carried out in EFY 2007. With regard to Open Defecation Free (ODF) kebeles, a total of 5,177 kebeles were declared as ODF in EFY 2007.

Other activities carried out in EFY 2007 include:

- A training manual on business model of improved latrine design and upgraded sanitation products was prepared.
- Based on the experience obtained from Brazil, study was conducted in Amhara, Tigray, Oromia and SNNP Regions on the business model of improved latrine design and upgraded sanitation products.
- Five year strategic plan and implementation guideline were prepared on hygiene and environmental health.
- Survey was conducted on climate change vulnerability and adaptation.

## CHALLENGES

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- Inadequate number of environmental health professionals at all levels;
- Absence of regular and integrated Monitoring and Evaluation (M&E) activities;
- Inadequate implementation of the hygiene and environmental health package in HEP;
- Limited attention on urban sanitation;
- Inadequate capacity to scale-up best practices; and
- Uncoordinated support from partners.

## WAY FORWARD

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

## 2.2. MATERNAL AND NEW-BORN HEALTH SERVICES

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HSDP IV has devised a set of key inter-related performance indicators to monitor the progress made in improving maternal and new-born health. A measure of contraception - contraceptive acceptance rate (CAR) - is presented as a tracer of reproductive health. Antenatal care (ANC) (both at least one and four visits) coverage provides a measure of access and quality to the health system and is critical to identify maternal risks and improve health outcomes for the mother and the new-born. Measures of coverage of skilled care at birth and birth attendance by HEWs, as well as postnatal care (PNC) services, are critical elements of the continuum of care. Human immunodeficiency virus (HIV)-related indicators are included to emphasize the need towards

a more holistic approach to health care, and to promote further integration of the programs to prevent mother to child transmission (MTCT) of HIV and maternal health services. These indicators are summarized in Table 1 indicating baseline, performance and target, as well as the overall HSDP IV targets for EFY 2007.

ANC coverage (at least one visit) slightly decreased from 98.1% in EFY 2006 to 96.9% in EFY 2007, but ANC coverage (at least four visit) increased from 52.4% to 67.9% in the same period. Similarly, the percentage of deliveries attended by skilled health personnel increased from 40.9% to 60.7% and PNC coverage increased from 66.2% to 90.0% in the same period. Likewise, CAR increased from 63.0% in EFY 2006 to 69.9% in EFY 2007; the proportion of pregnant women counselled and tested for the prevention of mother to child transmission (PMTCT) of HIV increased from 57.0% to 92.6% and the percentage of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy to prevent Maternal to Child Transmission (MTCT) of HIV also increased from 60.6% in EFY 2006 to 64.9% in EFY 2007. Contrariwise, clean and safe delivery coverage (by HEWs) further declined from 8.8% in EFY 2006 to 3.9% in EFY 2007.

Out of these maternal health indicators, ANC (at least one visit) coverage, PNC coverage and proportion of pregnant women counselled and tested for PMTCT surpassed the target set for the year and HSDP IV (Table 1). Figure 1 shows the trend in maternal health indicators observed between EFY 2002 and 2007.

Although the maternal service showed significant progress in most aspects, the service quality and the regional disparities remained a serious challenge and therefore needs a bigger effort to avert the situation in the coming years.

Table 1:

### Maternal Health Indicators

(2007 Baseline, Performance and Target and HSDP IV Target)

Indicators	EFY 2007 Baseline	EFY 2007 Performance	EFY 2007 Target	HSDP IV Target
Antenatal 1+ care coverage	98.1%	96.9%	90.0%	90.0%
Antenatal 4+ care coverage	52.4%	67.9%	87.0%	86.0%
Percentage of deliveries attended by skilled health personnel	40.9%	60.7%	72.0%	62.0%
Clean and safe delivery coverage (percentage of deliveries attended by HEWs)	8.8%	3.9%	-	38.0%
Postnatal care coverage	66.2%	90.0%	84.0%	78.0%
Contraceptive acceptance rate	63.0%	69.9%	85.0%	82.0%
Percentage of pregnant women counselled and tested for PMTCT	57.0%	92.6%	86.0%	83.0%
Percentage of pregnant Women tested positive for HIV who received ART to prevent Maternal to Child Transmission (MTCT)	60.6%	64.9%	82.0%	77.0%

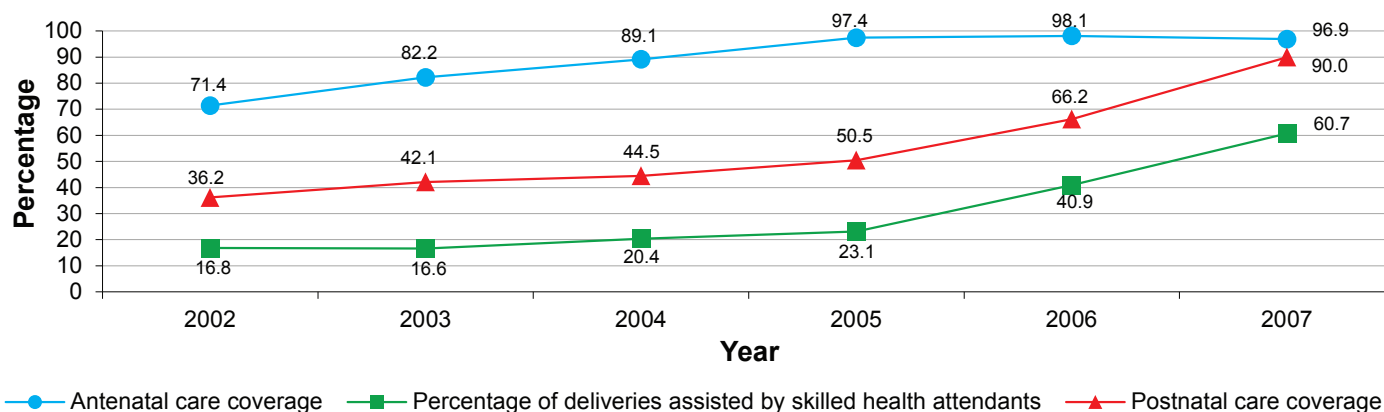


Figure 1: Trend in Antenatal Care Coverage, Percentage of Deliveries Attended by Skilled Health Personnel and Postnatal Care Coverage (EFY 2002-2007)

## 2.2.1. REGIONAL DISTRIBUTION OF ANTENATAL CARE COVERAGE

As it was noted in the previous years, ANC (at least one) coverage showed wide variation across regions, ranging from 51.9% in Somali to 100% in Tigray, Amhara, Oromia, Benishangul Gumuz, SNNPR, Harari, Addis Ababa and Dire Dawa in EFY 2007. When the performance is compared to the baseline, five regions (Afar, Amhara, Oromia, Benishangul Gumuz and Gambella) improved their performance and the other five regions (Tigray, SNNPR, Harari, Addis Ababa and Dire Dawa) remained the same from EFY 2006. However, only Somali Region performed below the previous year (Figure 2).

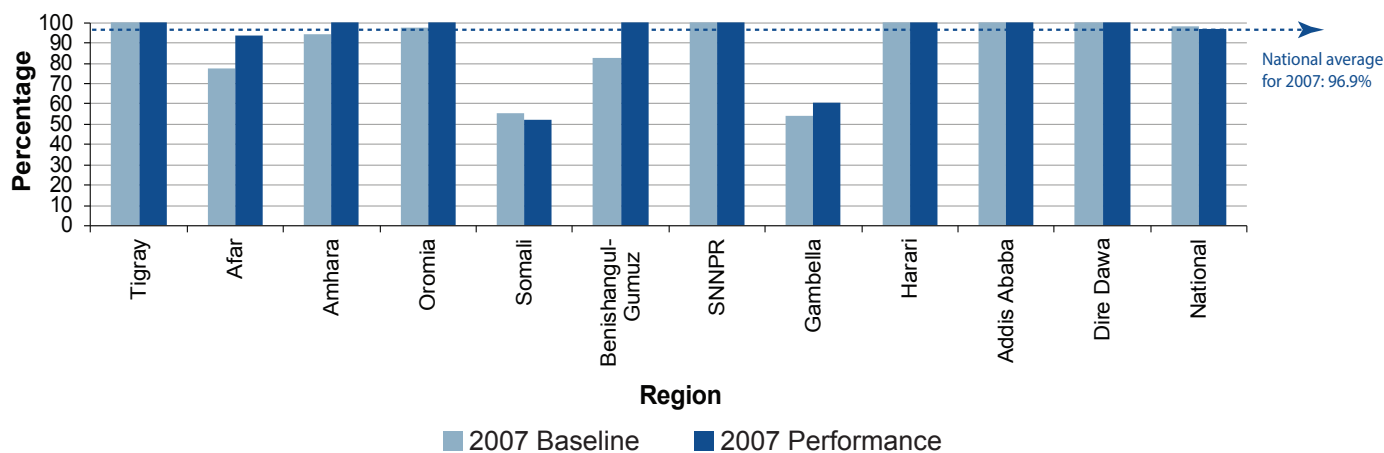


Figure 2: Comparison of Baseline and Performance of Antenatal Care 1+ Coverage by Region (EFY 2007)

Similarly, ANC (at least four visits) varied across regions from 13.6% in Gambella Region to 100% in Addis Ababa. Except Addis Ababa, the remaining 10 regions not achieved their annual target. On the other hand, except Somali and Gambella Regions the remaining nine regions improved their performance in EFY 2007 (Figure 3).

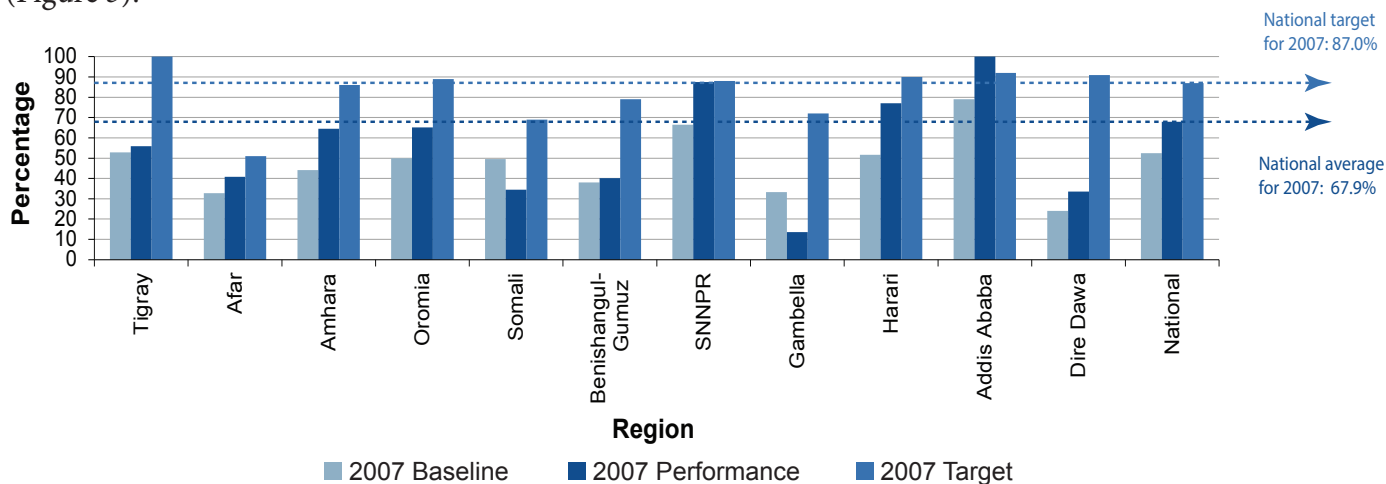


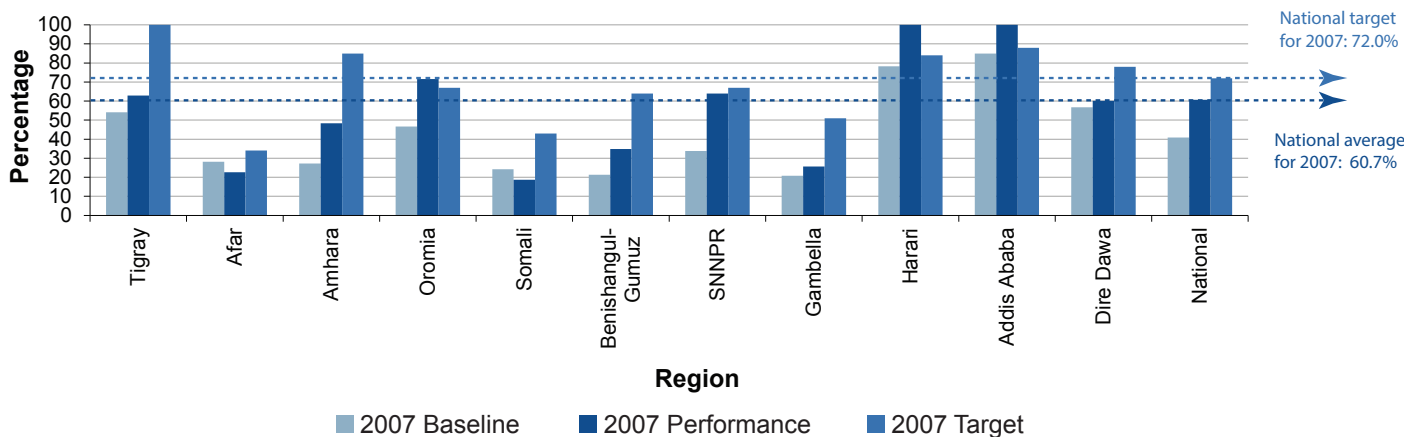
Figure 3: Comparison of Baseline, Performance and Target of Antenatal Care Coverage 4+ by Region (EFY 2007)

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

The percentage of deliveries assisted by skilled health personnel at national level showed a steep increase between EFY 2006 and EFY 2007 (from 40.9% to 60.7%); however, it remained below the target of 72% set for the year.

There was wide disparity across regions, ranging from 18.7% in Somali to 100% in Harari and Addis Ababa. Oromia (71.1%), Harari (100%) and Addis Ababa (100%) exceeded their

Except Afar and Somali, the remaining regions improved their performance from the previous year. Besides, Oromia (71.1%), Harari (100%) and Addis Ababa (100%) exceeded their regional target of 67%, 84% and 88% respectively (Figure 4).



**Figure 4: Comparison of Baseline, Performance and Target of Percentage of Deliveries Assisted by Skilled Health Personnel by Region (EFY 2007)**

The remarkable progress in skilled birth attendance service coverage was mainly because of the enormous contribution of the community through HDA. The WDGs/HDAs and one-to-five networks were working with HEWs to provide the necessary follow up for pregnant women.

During labour, the WDGs/HDAs call the ambulance services to transfer pregnant women to the nearby health centers. The health centers prepare waiting rooms for the family of the pregnant women where they can prepare their traditional ceremony like cooking porridge, coffee ceremony, etc...

Another reasons for the increase in the service coverage is attributed to the increased availability of maternity waiting areas in many hospitals and HCs. The Maternity Homes are used by pregnant women coming from remote villages and by those considered as high-risk for obstetric complications. Those mothers in labour were placed in the waiting room until they deliver.

The national rural road expansion project was also assisting for a smooth transfer of mothers to health facilities, contributing to avoid the maternal delay. Similarly, traditional ambulances were being used for the same purpose in areas where the terrain poses a significant challenge.

On the other hand, health care providers were trained and regularly monitored to ensure mothers get appropriate care on time once they arrive at health facilities. This avoided unnecessary referral for labouring mothers especially in towns, and strengthened the professional assistance between health centers and hospitals.

To tackle the deeply rooted traditional practices that hinder mothers to seek appropriate medical care, monthly conferences with all pregnant mothers, along with the mobilization of HDA, were implemented successfully in different regions.

In general, the significant progress made so far was mainly the result of the HDA at community level. Furthermore, sustainability of the service provision was ensured at facility level by arranging the necessary inputs including human resources.

### **2.2.3. REGIONAL DISTRIBUTION OF CLEAN AND SAFE DELIVERY SERVICE COVERAGE**

Even though skilled attendance at birth is the most important intervention to reduce maternal mortality, some mothers are unwilling or unable to access a facility (HC or hospital) where skilled birth delivery services are provided. In these cases, in order to minimize home delivery, clean and safe delivery attendance by HEWs has been implemented. For this purpose, HEWs have been also trained to identify pregnant women with obstetric complications and ensure their timely referral.



Hence, there was decline in clean and safe delivery service coverage from 8.8% in EFY 2006 to 3.9% in EFY 2007. Besides, wide variations were observed across regions, ranging from 0.6% in Gambella to 7.30% in Benishangul Gumuz (Figure 5).

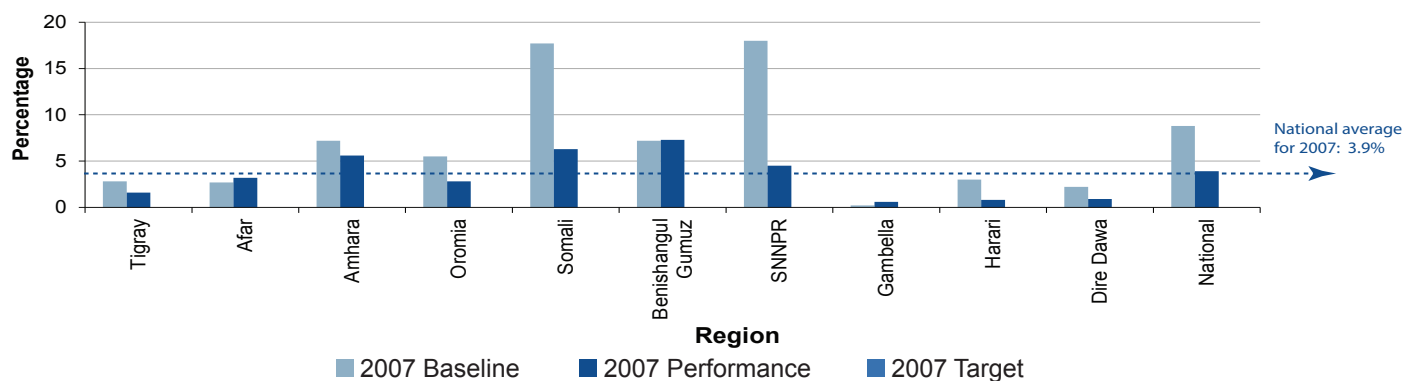


Figure 5: Comparison of Baseline and Performance Target of Clean and Safe Delivery Service Coverage by Region (EFY 2007)

## 2.2.4. REGIONAL DISTRIBUTION OF POSTNATAL CARE COVERAGE

PNC coverage at national level increased from 66.2% in EFY 2006 to 90.0% in EFY 2007 and above the target set for the year (84.0%). With respect to the regional distribution of PNC services, the highest coverage in EFY 2007 was observed in Oromia, Harari and Addis Ababa (100.0%) and the lowest coverage was observed in Gambella (12.8%). Except two regions (Somali and Gambella), the remaining nine regions increased their performance from the previous year. On the other hand, five regions (Afar, Oromia, SNNP, Harari and Addis Ababa) achieved the target set for the year (Figure 6).

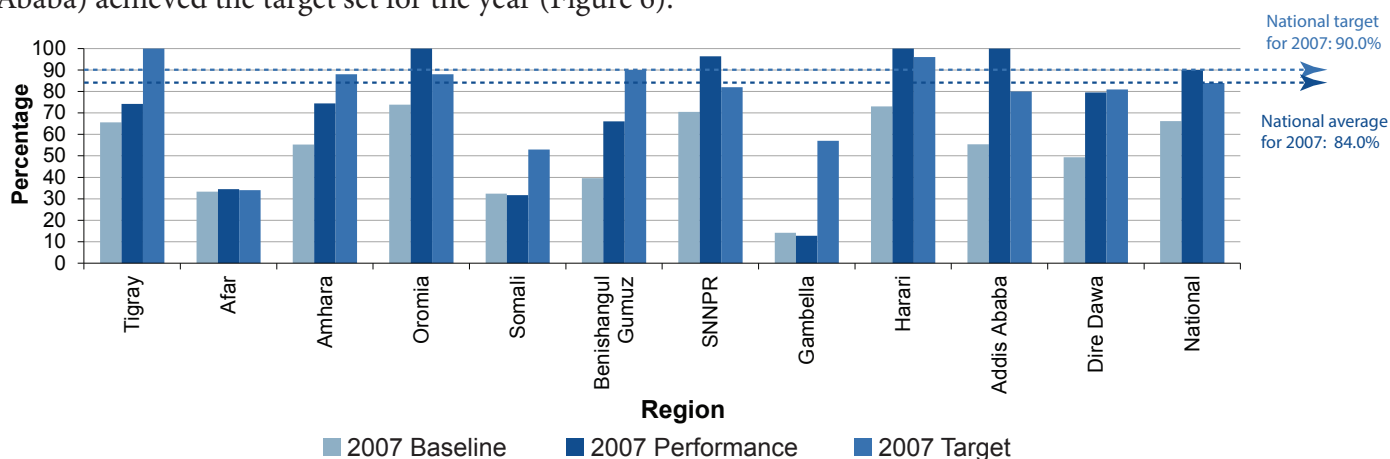


Figure 6: Comparison of Baseline, Performance and Target of Postnatal Care Coverage by Region (EFY 2007)

## 2.2.5. TREND IN THE CONTRACEPTIVE ACCEPTANCE RATE

CAR increased from 63.0% in EFY 2006 to 69.9% in EFY 2007; however, below the 85.0% target set for the year (Figure 7).

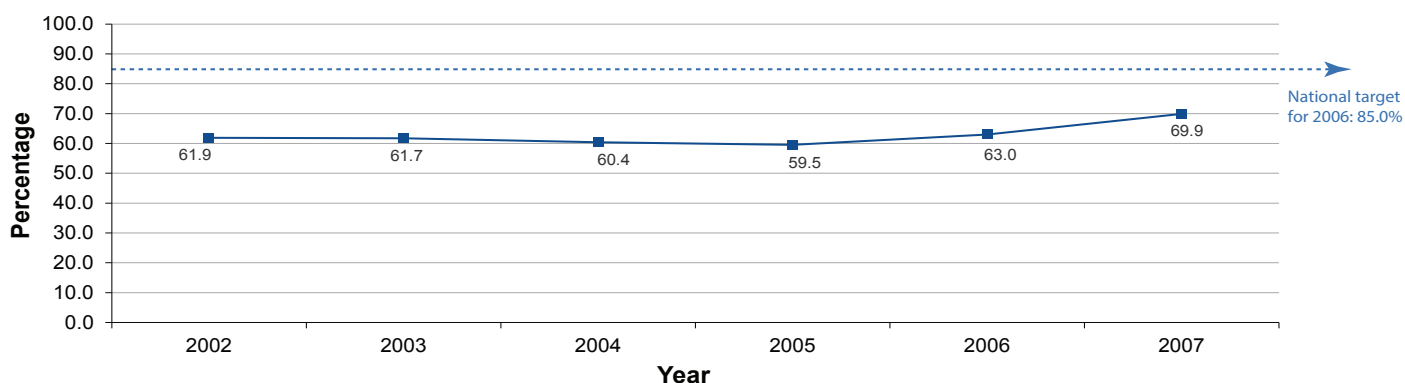


Figure 7: Trend in Contraceptive Acceptance Rate (EFY 2002-2007)

## 2.2.6. REGIONAL DISTRIBUTION OF CONTRACEPTIVE ACCEPTANCE RATE

Disparities were observed across regions in EFY 2007. Like the previous year, the lowest rate (5.7%) being reported from Somali Region, and the highest (97.2%) reported from Amhara Region. Except Somali Region the remaining ten regions increased their performance from EFY 2006. Besides, except Amhara Region, the other regions performed below their annual targets (Figure 8).

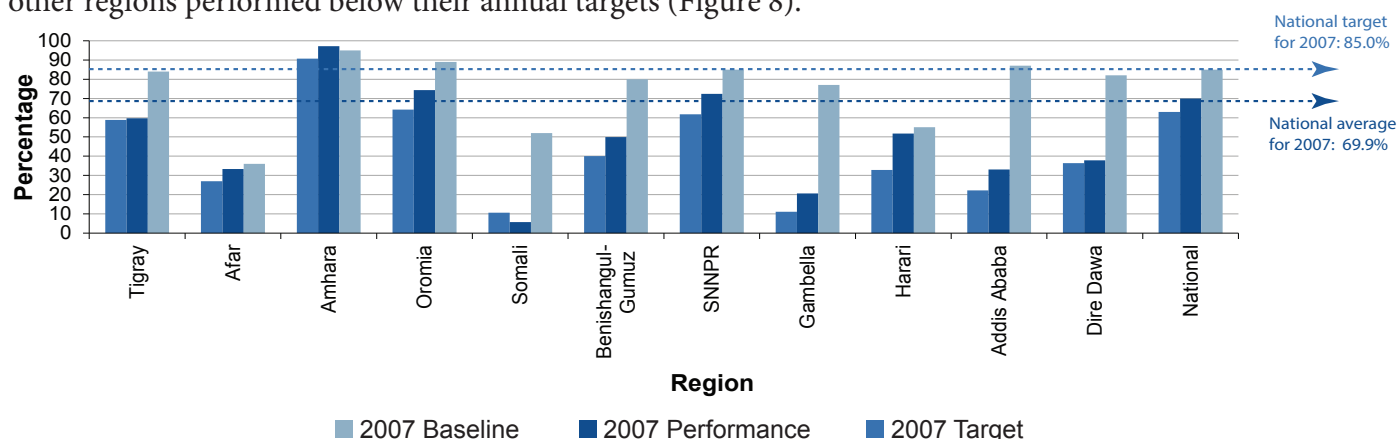


Figure 8: Comparison of Baseline, Performance and Target of Contraceptive Acceptance Rate by Region (EFY 2007)

## 2.2.7. PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV

The proportion of pregnant women counselled and tested for the prevention of mother to child transmission (PMTCT) of HIV out of the eligible increased from 57.0% in EFY 2006 to 92.6% in EFY 2007. Out of 2,937,814 pregnant women who received at least one ANC visit, 2,807,345 (95.6%) pregnant women tested for HIV. The percentage of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy to prevent Maternal to Child Transmission (MTCT) of HIV was estimated at 64.9% in EFY 2007 (19,190 out of the estimated 29,556 HIV-positive pregnant women eligible) (Figure 9). Besides, a total of 3,124 mothers were on either maternal AZT prophylaxis or triple ART prophylaxis.

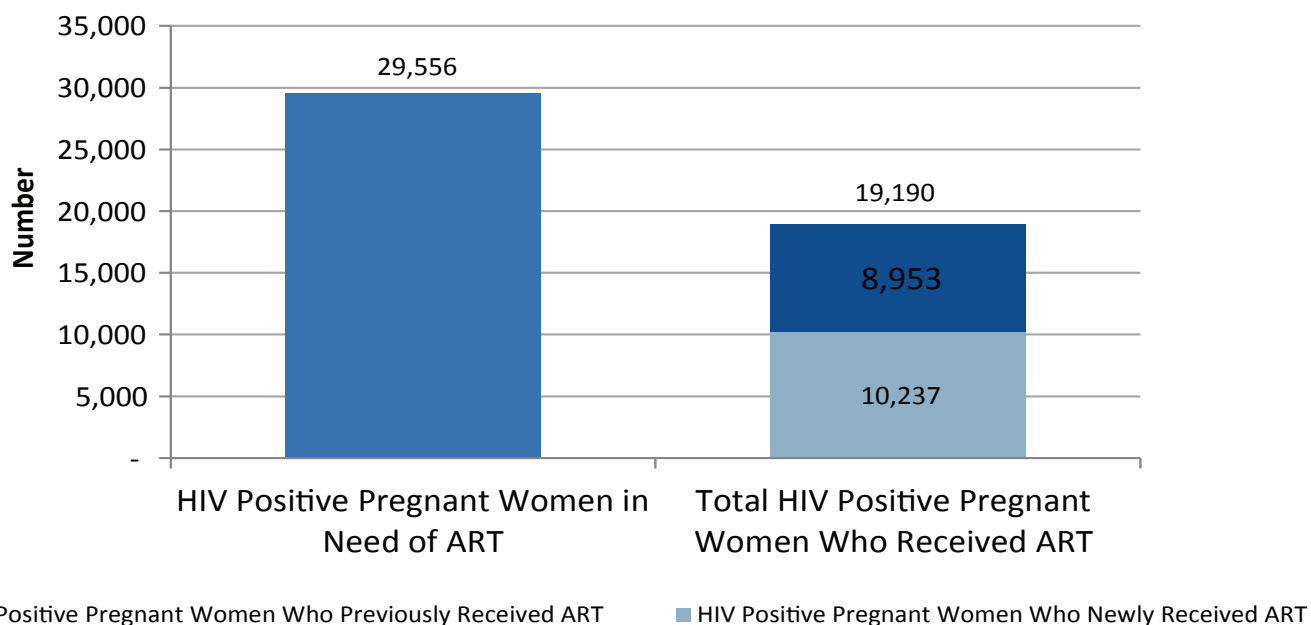


Figure 9: Status of Pregnant Women Tested Positive for HIV Who Received ART to Prevent Maternal to Child Transmission (MTCT) (EFY 2007)

## 2.2.8. SAFE ABORTION SERVICE

A total of 221,533 women received comprehensive abortion service in EFY 2007 which was above the number of women received in EFY 2006 (181,812). The technical and procedural guideline for safe abortion services was completed and distribution was started in the fiscal year. During the fiscal year, 791 health care providers were trained on safe abortion procedure.

## 2.2.9. OTHER ACTIVITIES

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### Maternal Death Surveillance and Response

The Maternal Death Surveillance and Response (MDSR) was implemented in 29 zones of five regions (Oromia, Amhara, Tigray, Harari and SNNP Regions) and two city administrations (Dire Dawa and Addis Ababa City Administrations). In addition, MDSR reporting system was integrated with the existing Public Health Emergency Management (PHEM) system. Furthermore, to expand the reporting system from the already started 29 zones to 83 zones, regional TOT and cascade trainings on MDSR/PHEM were conducted to 23 health care providers and 262 PHEM officers.

### Fistula Service Provision

In EFY 2007, a total of 2,527 fistula patients and 372 utero-vaginal prolapse cases were identified and linked to health facilities during the second round of measles immunization campaign. Furthermore, the five year national strategic plan document on fistula elimination and implementation guideline on fistula patients' identification are under development.

## CHALLENGES

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- Shortage of human resources in terms of number, capacity, and professional skills;
- Limited utilities (sanitation facility, water, electricity, etc...) in many health facilities, especially in HCs and HPs;
- Shortage of transportation facilities (ambulance service) in rural settings;
- Lack of a separate new-born corner and absence of a neonatal unit in some health facilities;
- Low coverage of skilled delivery and new-born care;
- Inadequate skill on the part of HEWs and health professionals;
- Harmful traditional beliefs and practices affecting maternal health;
- Lack of regular supply of inputs to health facilities;
- Weak data collection, handling and analysis for decision making purposes;
- High turnover of trained staff;
- Low coverage of maternal health services in pastoralist areas;
- Limited access to services for early infant diagnosis of HIV; and
- Inadequate male partner involvement.

## WAY FORWARD

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- Scale-up the training of midwives and improve the availability of human resources (HR) capable to provide BEmONC services in all HCs;
- Establish a new-born unit in all hospitals and a new-born health corner in all delivery rooms and maternity wards of all health facilities;
- Provide comprehensive emergency obstetric and neonatal care (CEmONC) in all hospitals and selected HCs by putting up functional maternities, nurseries, maternity theaters and laboratory services;
- Ensure availability of water and electricity at HP and HC levels;
- Undertake skill upgrading training;
- Strengthen HDA;
- Ensure continuous the supply of inputs at regional and facility levels;
- Promote the use of information for decision making at point of data collection;
- Increase awareness creation, design culturally acceptable interventions (outreach or mobile services) and strengthen service availability in pastoralist areas;
- Encourage point of care testing for early infant diagnosis of HIV; and
- Advocate for male partner involvement through different media.

## 2.3. CHILD HEALTH SERVICES

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

### 2.3.1. IMMUNIZATION

In EFY 2007, pentavalent 3 immunization coverage was 94.4%, Pneumococcal Conjugate Vaccine (PCV) 3 immunization coverage was 93.9%, Rotavirus Vaccine 2 immunization coverage was 88.8%, measles immunization coverage was 90.3%, and the percentage of fully immunized children was 86.4% (Table 2).

Table 2:

#### Immunization Coverage Indicators

(EFY 2007 Baseline, Performance and Target and HSDP IV Target)

Indicators	EFY 2007 Baseline	EFY 2007 Performance	EFY 2007 Target	HSDP IV Target
<b>Pentavalent 3 Vaccine Coverage</b>	91.1%	94.4%	98.0%	96.0%
<b>Pneumococcal conjugated 3 Vaccine Coverage</b>	85.7%	93.9%	98.0%	96.0%
<b>Rota Virus 2 Vaccine Coverage</b>	39.0%	88.8%	97.0%	96.0%
<b>Measles Vaccine Coverage</b>	86.5%	90.3%	95.0%	90.0%
<b>Full Immunization Coverage</b>	82.9%	86.4%	95.0%	90.0%

As shown in Figure 10, there was an increase in pentavalent 3, measles and full immunization coverage rates; however, all immunization coverage never met the targets set for the year.

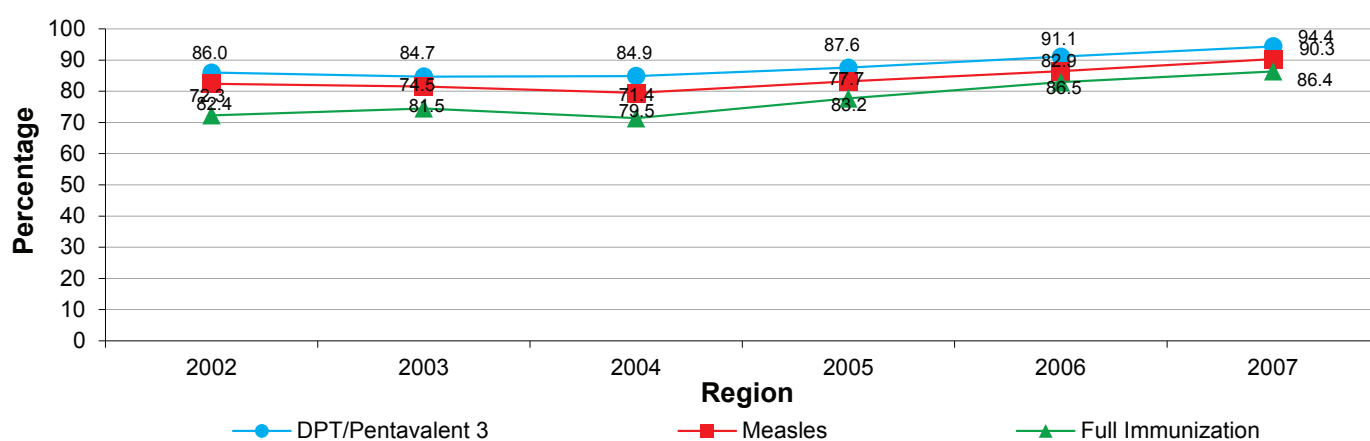


Figure 10: Trend in Pentavalent 3 Immunization Coverage, Measles Immunization Coverage and Full Immunization Coverage (EFY 2002-2007)

#### 2.3.1.1. REGIONAL DISTRIBUTION OF PENTAVALENT 3 IMMUNIZATION COVERAGE

Pentavalent 3 coverage was 94.4% at the national level in EFY 2007, above the performance in EFY 2006 (91.1%), but short of the target (98.0%) set for the year. The highest coverage (100.0%) was found in Oromia, SNNP, Harari and Addis Ababa, while the lowest coverage was observed in Somalia (48.7%) (Figure 11). Except Afar, Somali and Benishangul Gumuz, the remaining eight regions increased or equal to their performance from the previous year. On the other hand, except Oromia, SNNP, Harari and Addis Ababa Regions, all the remaining seven regions performed below the target set for the year.

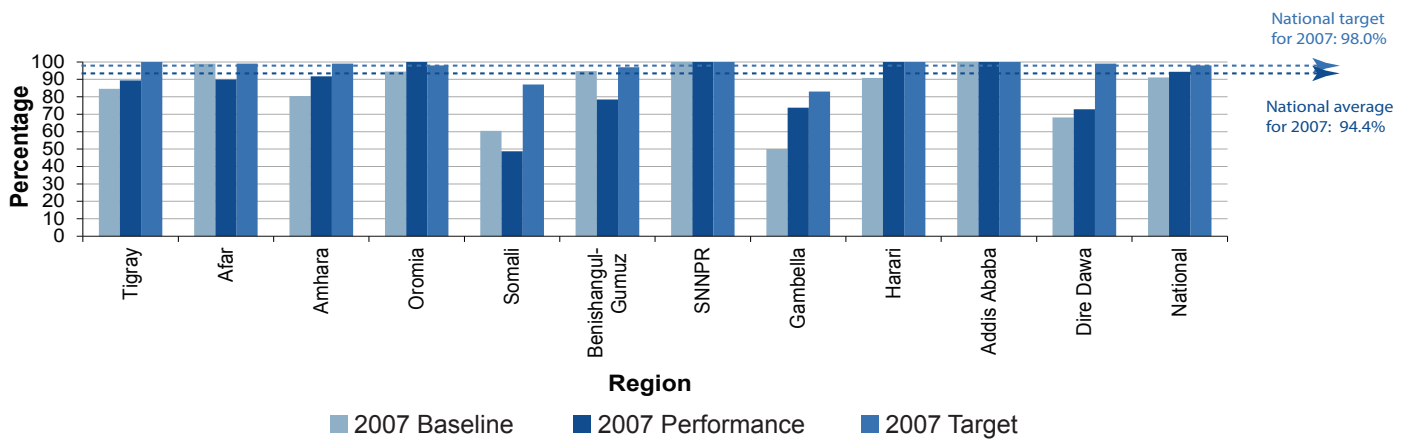


Figure 11: Comparison of Baseline, Performance and Target of Pentavalent 3 Immunization Coverage by Region (EFY 2007)

### 2.3.1.2. REGIONAL DISTRIBUTION OF PNEUMOCOCCAL CONJUGATE VACCINE 3 IMMUNIZATION COVERAGE

PCV3 coverage was 93.9% at the national level in EFY 2007, above the performance in EFY 2006 (85.7%), but below the target (98.0%) set for the year. The highest coverage (100.0%) was found in Oromia, SNNPR, Harari and Addis Ababa; however, the lowest one in Somali (48.2%) (Figure 12). Except Somali and Benishangul Gumuz, the remaining nine regions increased their performance, with five regions (Afar, Oromia, SNNPR, Harari and Addis Ababa) achieving their annual regional target set for EFY 2007.

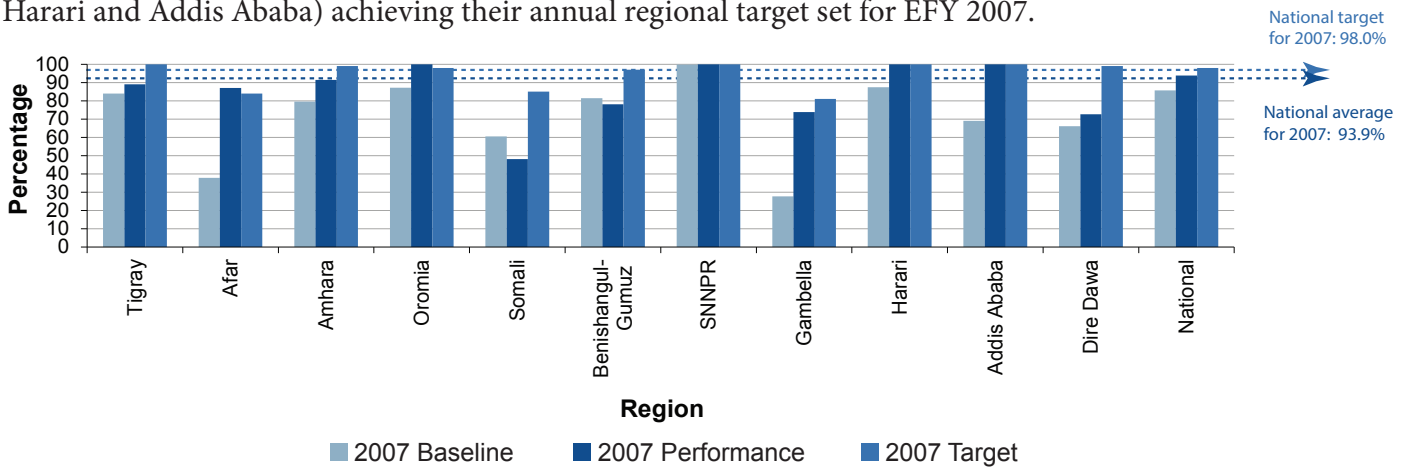


Figure 12: Comparison of Baseline, Performance and Target of PCV3 Immunization Coverage by Region (EFY 2007)

### 2.3.1.3. REGIONAL DISTRIBUTION OF ROTAVIRUS VACCINE 2 IMMUNIZATION COVERAGE

Rotavirus Vaccine 2 immunization coverage was 88.8% at the national level in EFY 2007, above the performance in EFY 2006 (39.0%), but below the target (97.0%) set for the year. The highest coverage (100.0%) was registered in Harari and Addis Ababa; conversely, the lowest coverage was documented in Somali Region (30.3%) (Figure 13).

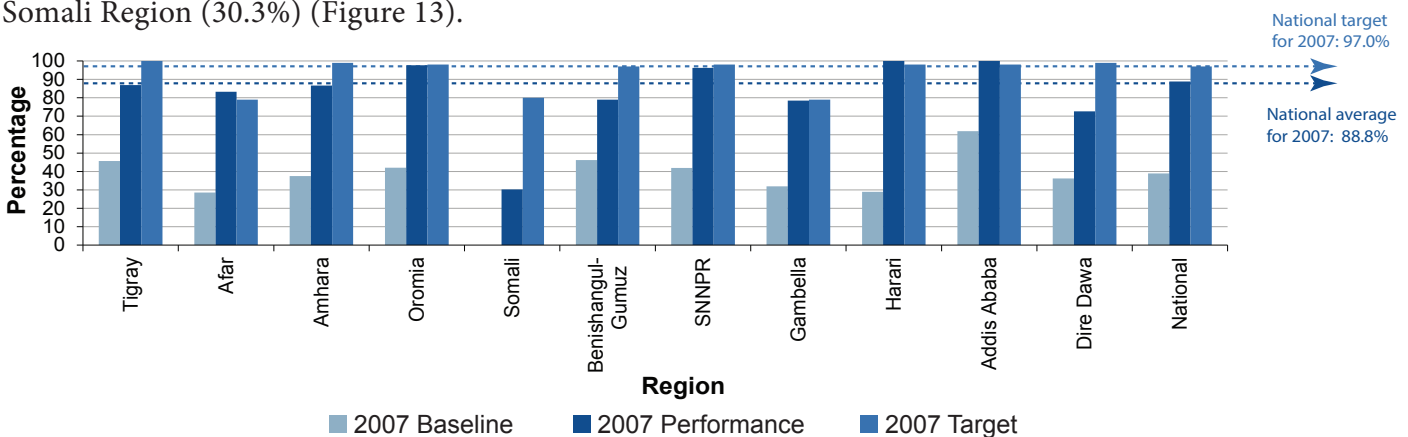


Figure 13: Comparison of Baseline, Performance and Target of Rota Virus Vaccine 2 Immunization Coverage by Region (EFY 2007)



### 2.3.1.4. REGIONAL DISTRIBUTION OF MEASLES IMMUNIZATION COVERAGE

In EFY 2007, there was an increase in measles immunization coverage (90.3%) from the previous year performance (86.5%), but below the target set for the year (95.0%). Regional distribution showed that SNNP, Harari and Addis Ababa were the best performing regions (100.0%) and Somali performed the least (35.9%) (Figure 14). Oromia, SNNP, Harari and Addis Ababa were the only regions which performed above their regional targets set for the year. On the other hand, eight regions showed a better performance in EFY 2007 than in EFY 2006 (Tigray, Amhara, Oromia, SNNP, Gambella, Harari, Addis Ababa and Dire Dawa).

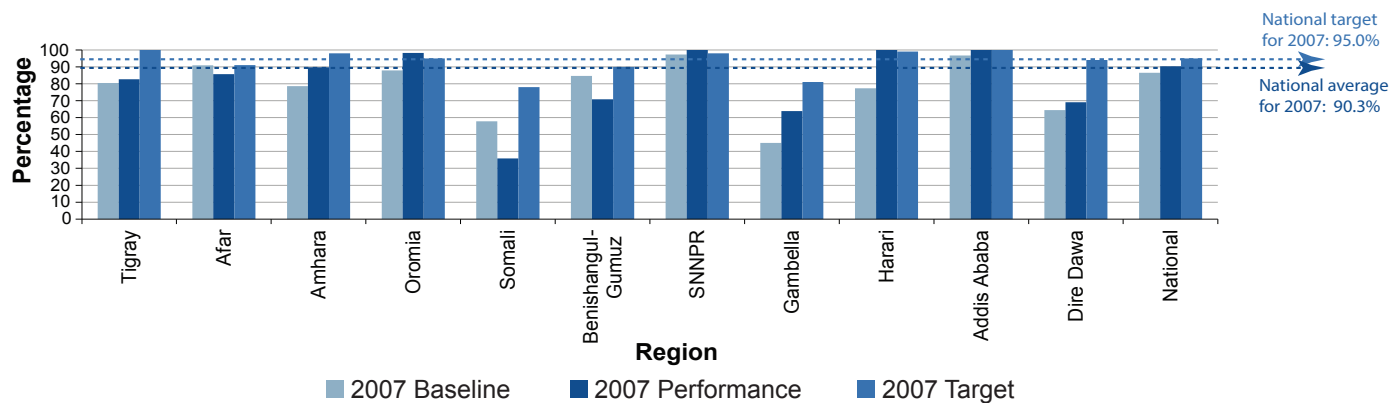


Figure 14: Comparison of Baseline, Performance and Target of Measles Immunization Coverage by Region (EFY 2007)

### 2.3.1.5. REGIONAL DISTRIBUTION OF FULL IMMUNIZATION COVERAGE

In EFY 2007, full immunization coverage reached 86.4%, which was above the EFY 2006 performance (82.9%) but below the target (95.0%) set for the year. The highest coverage was observed in Harari and Addis Ababa (100.0%) and the lowest one in Somali Region (33.8%) (Figure 15). Only Harari and Addis Ababa performed above or equal to their regional target set for the year. Eight regions (Tigray, Amhara, Oromia, SNNP, Gambella, Harari, Addis Ababa, and Dire Dawa) showed a better performance in EFY 2007 than in EFY 2006.

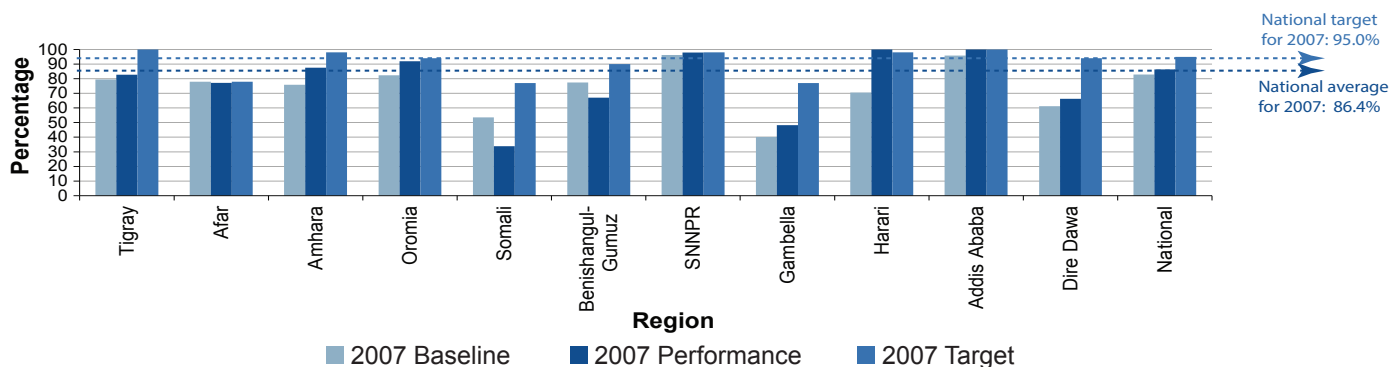


Figure 15: Comparison of Baseline, Performance and Target of Full Immunization Coverage by Region (EFY 2007)

## 2.3.2. THE INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESSES

The cumulative number of Health centers providing IMNCI increased from 2,967 in EFY 2006 to 3,033 in EFY 2007. (Table 3).

### 2.3.3. OTHER ACTIVITIES

Improving neonatal service delivery was another major priority in EFY 2007. As part of the implementation of Community-Based Neonatal Care (CBNC) and new-born sepsis management, training on CBNC provided to 14,332 HEWs. CBNC was fully implemented in 326 woredas of Amhara, Oromia, SNNP and Tigray Regions. Besides, 7,936 health posts found in these woredas were provided with appropriate supplies and equipment to implement the service.

The number of hospitals providing NICU service has increased from 30 in EFY 2006 to 90 in EFY 2007. Similarly, the number of health centers established new-born corner reached to 1,900 in the same period.

Table 3:  
**Distribution of Health Centers Providing IMNCI by Region**  
 (EFY 2007)

Regions	Cumulative Number of HCs Providing IMNCI in EFY 2006	Cumulative Number of HCs Providing IMNCI Service at End of EFY 2007
Tigray	187	221
Afar	73	73
Amhara	707	725
Oromia	1033	1033
Somali	146	146
Benishangul Gumuz	32	32
SNNPR	684	684
Gambella	28	28
Harari	8	10
Addis Ababa	53	65
Dire Dawa	16	16
<b>National</b>	<b>2,967</b>	<b>3,033</b>

Polio campaign as Supplementary Immunization Activity (SIA) was conducted in 30 zones located at the Ethiopian borders and polio vaccine was given to 4 million under five children. Besides, in Dolo zone of Somali region where the wild polio identified, the polio vaccination covered all the eligible children. On the other hand, on the second round national polio campaign, a total of 13.8 million children were vaccinated. Similarly, on the national campaign of meningococcal meningitis immunization, a total of 26.3 million people aged between 1 and 29 years were vaccinated.

## CHALLENGES

- Shortage of spare parts and accessories for refrigerators at HP level, and lack of proper concern for the cold chain system;
- Lack of daily vaccination services at HPs;
- Weak linkage between HPs and HCs;
- Inadequate data quality and use for action;
- High number of non vaccinated children and high dropout rate;
- Lack of automatic generator in areas with frequent power interruptions;
- Sub-optimal integrated supportive supervision at all levels;
- Inadequate access to service for mobile population;
- High turnover of experienced health workers;
- Inadequate knowledge and skills on neonatal care given to health professionals during their regular training prior to employment;
- Delay in distribution of ICCM supplies to HPs;
- Delay in implementation of new-born corners;
- Low coverage of NICUs in hospitals; and
- Inadequate space availed to NICU in some hospitals with limited equipment and material.

## WAY FORWARD

- Strengthen the cold chain management system through regular supply of spare parts and accessories for refrigerators at HP level;
- Provide daily vaccination services at HPs;
- Strengthen the linkage between HPs and HCs;
- Capacitate data management and use for action at all levels;
- Strengthen immunization services and decrease the number of drop outs by mobilizing HDA;
- Avail automatic generators in areas with frequent power interruptions;
- Strengthen regular integrated supportive supervision at all levels;

- Design strategies adapted to mobile communities to ensure access to services;
- Devise appropriate strategies for retention of experienced staff;
- Promote both pre-service and in-service training (IST) and transfer of skills on neonatal care to health professionals;
- Improve the supply chain management system for timely provision of ICCM supplies to HPs;
- Increase the number of new-born corners by providing additional training and new-born corner sets;
- Ensure the availability of NICUs in all hospitals by accelerating training and technical support; and
- Apply NICU standard prepared by the FMOH.

## 2.4. NATIONAL NUTRITION PROGRAM

Implementing Vitamin A supplementation (VAS) and de-worming as well as scaling up community-based nutrition (CBN) and salt iodization were the main activities planned in EFY 2007. Accordingly, the following activities were carried out in the fiscal year.

### 2.4.1. VITAMIN A SUPPLEMENTATION AND DE-WORMING

The national VAS coverage among children aged 6-59 months increased from 71.7% in EFY 2006 to 89.5% in EFY 2007, but below the target set for the year (99.0%). There was a wide difference observed across regions ranging between 23.4% in Afar Region to 100.0% in Tigray, Amhara, Oromia and Harari Regions (Figure 16).

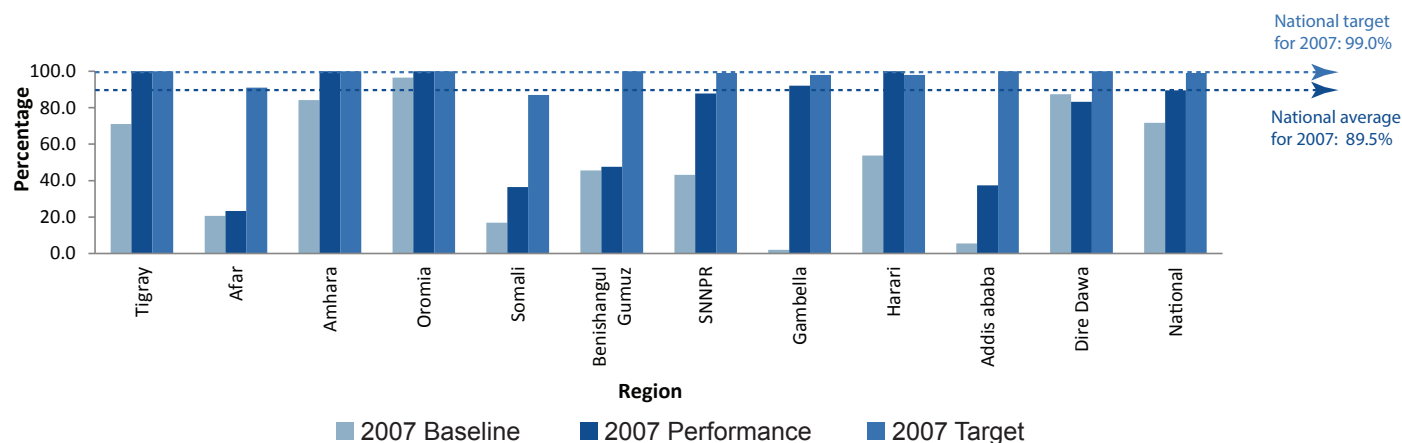


Figure 16: Comparison of Baseline, Performance and Target of Coverage of 6-59 Months Children Supplemented with Vitamin A by Region (EFY 2007)

In EFY 2007, the coverage of 2-5 year children de-wormed (75.2%) was lower than the previous year (82.4%) and short fall from the target (98%) for the year. There was also wide variation across regions from 4% in Gambella Region to 100% in Tigray, Amhara, SNNP and Harari Regions in the same period (Figure 17).

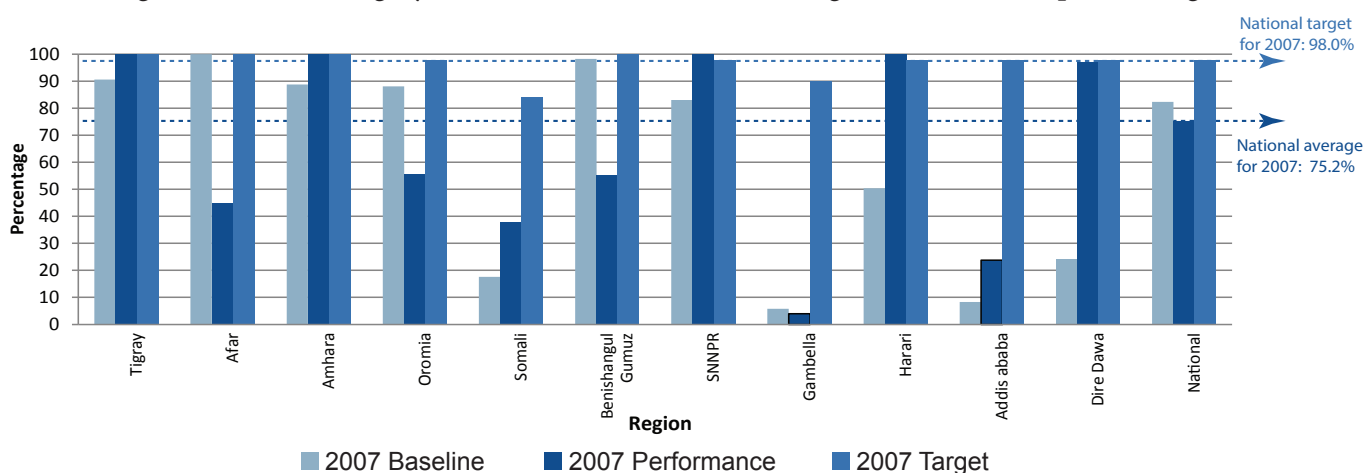


Figure 17: Comparison of Baseline, Performance and Target of Coverage of 2-5 Years Children De-wormed by Region (EFY 2007)

## 2.4.1.1. TRANSITION FROM ENHANCED OUTREACH STRATEGY TO HEALTH EXTENSION PROGRAM

In HSDP IV, the FMOH clearly indicated the need to integrate EOS/EEOS program into the routine HEP as a way of making VAS sustainable. Accordingly, the FMOH and its key stakeholders have developed the EOS transition plan for Vitamin A supplementation, de-worming and nutritional screening delivery mechanism from vertical EOS to routine HEP.

In EFY 2007, EOS shifted to Community Health Days (CHDs) in all 700 woredas of Amhara, Oromia, Tigray and SNNP Regions. In addition, CHD shifted to routine HEP which is a routine (daily) service delivery of VAS, mainly a mix of facility based and house to house, in 219 woredas of Amhara, Oromia and SNNP Regions. Besides, in all the 27 woredas of the three urban regions, CHD transitioned to routine delivery of VAS.

## 2.4.2. COMMUNITY BASED MANAGEMENT OF ACUTE MALNUTRITION

Out of 282,710 severely malnourished children who were treated in EFY 2007, 88.0% of them recovered, 1.8 % defaulted and 0.2% died.

As it was seen in the previous years, there has been a steady increase in community-based management of acute malnutrition (CMAM) sites, with 14,423 CMAM sites providing the service in EFY 2007 (Figure 18). Besides, the monthly admission rate trend indicated that seasonal increase in malnutrition was high in the same period.

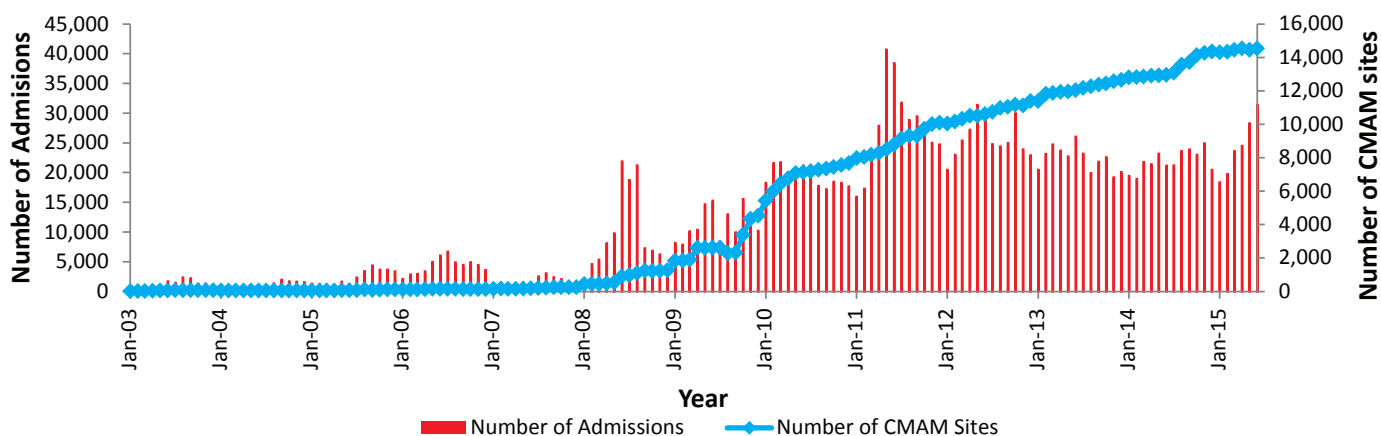


Figure 18: Number of Admissions and Number of CMAM Sites in Ethiopia (January 2003 to June 2015)

On the other hand, a total of 209,273 carton of RUTE, 3,487 cartons of F100, 3,171 cartons of F75 and 208,557 bottles of Amoxicillin were distributed for use in the treatment of severe acute malnutrition together with registration books and patient follow up forms.

## 2.4.3. COMPREHENSIVE COMMUNITY BASED NUTRITION

Comprehensive community based nutrition (CCBN) is an approach that links all nutrition programs (CBN and CHD) to the facility based service delivery (SAM management and ICCM). At this juncture, CCBN is CBN plus program where it uses the opportunity of the monthly Growth Monitoring Practice (GMP) of a child for nutrition screening and provision of Vitamin A and de-worming as necessary. Therefore, a child assessed for GMP will also be assessed for severe acute malnutrition.

The National Nutrition Program (NNP) places a critical importance on the CBN in order to prevent children from falling into malnutrition through family and community is the first line of protection.

In EFY 2007, CBN activities were implemented in 472 woredas. In these woredas mothers/caregivers with children under 2 years of age were monthly weighed and counselled based on the children nutritional status. Therefore, a total of 13,627,466 children under the age of 2 years in the four agrarian regions were assessed for their nutritional status in the same period.

In June 2015, a total of 1,219,803 children weighed with a participation rate of 49%. There was also underweight prevalence of 4% in the same period with consistent downward trend over years (Figure 19).

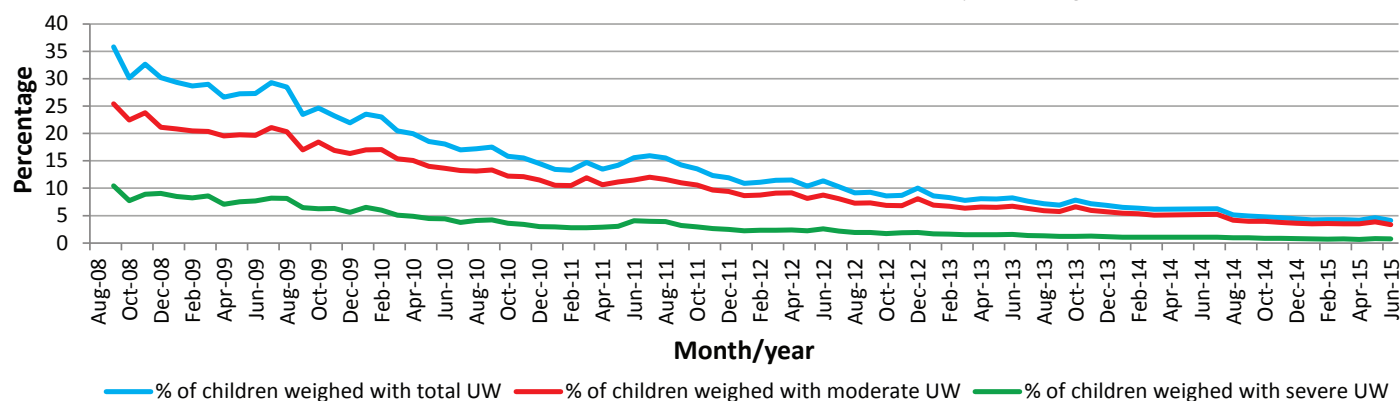


Figure 19: Trend in Percentage of Underweight Children Under Two Years of Age in CBN Woredas (August 2008 - June 2015)

## 2.4.4. SALT IODIZATION

In EFY 2007, a total of 4, 976, 400 quintals of iodized salt was produced in Afdera, Dobi and Gudusbo and distributed throughout the country. Due to limited concern on the use iodization technology (knapsacks) by local salt producers and delay in establishing proper Quality Assurance (QA)/ Quality Control (QC) mechanism, there was iodization quality gap that needed enforcement of the salt regulation. This quality related concerns can be corrected through strengthening the enforcement of salt regulation and it remained as the main focus areas of EFY 2008.

The cost recovery scheme to make potassium iodate supply self-reliant and sustainable has made marked progress in EFY 2007. So far, the program was totally independent from external donations and a total of 348 quintal of potassium iodate was distributed to salt producers in the three areas with prepayment in the same period.

## 2.4.5. OTHER ACTIVITIES

The following activities were also carried out to strengthen the NNP in EFY 2007.

- The NNP II has been developed.
- NNP implementation guidelines (Micronutrient guideline, acute malnutrition guideline, maternal, adolescent, infant and young children nutrition guideline) finalized.
- High level multi-sectoral nutrition coordination and linkage experience sharing visit was conducted in Uganda and Brazil.
- Under strengthening of the national food fortification programme, FMOH established a team who took the food fortification training from different sectors, agencies and authorities who could work the national food fortification programme plan of action in line with the NNP.
- GOE launched an initiative known as “The Seqota Declaration”, a declaration to End Child under-nutrition in Ethiopia by 2030 through improvements in nutrition to propel sustainable development; and in turn sustainable development can bring malnutrition reduction. Major components of the Declaration include:
  - Zero stunted children less than 2 years;
  - Hundred Percent access to adequate food all year round;
  - Hundred Percent increase in smallholder productivity and income;
  - Zero loss of food;
  - Sustainable food systems;
  - Education;
  - Water, Sanitation and Hygiene; and
  - Social protection.



## CHALLENGES

- Lack of integration among different interventions;
- Irregular nutrition supply flow and tracking;
- Poorly organized routine nutrition data collection and utilization;
- Lack of regional commitment to implement Vitamin A supplementation, de-worming and nutritional screening from CHD to routine service delivery as planned in the EOS transition plan;
- Low level of commitment of salt producers to improve quality;
- Delay in establishing functional QA/QC systems and weak enforcement of salt regulation and standards;
- Weak supportive supervision at all level and review meeting not conducted as planned; and
- Shortage of trained human resource in nutrition.

## WAY FORWARD

- Strengthen comprehensive community-based nutrition;
- Branding the first 1000 days as flagship initiative;
- Implement “Seqota declaration”;
- Improve the nutritional status of the community by promoting advocacy, social mobilization and BCC and by ensuring involvement and ownership of the community through HDA;
- Ensure smooth transition of VAS, de-worming and nutritional screening to routine HEP service delivery;
- Ensure supplies like Albendazole, plampynet, potassium iodate and other supplies are available at all levels and at all time;
- Ensure iodization QA/QC , strengthen enforcement of salt regulation; and
- Strengthen multi-sectoral coordination and linkage for nutrition.

## 2.5. PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

The following section explains what has been targeted and what has been achieved in the prevention and control of communicable diseases in EFY 2007.

### 2.5.1. HIV/AIDS PREVENTION AND CONTROL

HIV/AIDS was one of the top priorities of HSDP IV. According to the “HIV related estimates and projections for Ethiopia-2012”, the adult HIV prevalence is estimated at 1.1% (0.8% in males and 1.5% in females) and the adult HIV incidence at 0.03% in 2015.

#### 2.5.1.1. HCT SERVICE

The number of HCT services increased from 9,664,519 in EFY 2006 to 10,844,067 (Figure 20); however, it was slightly below the target (11.1 million) set for the year at the national level.

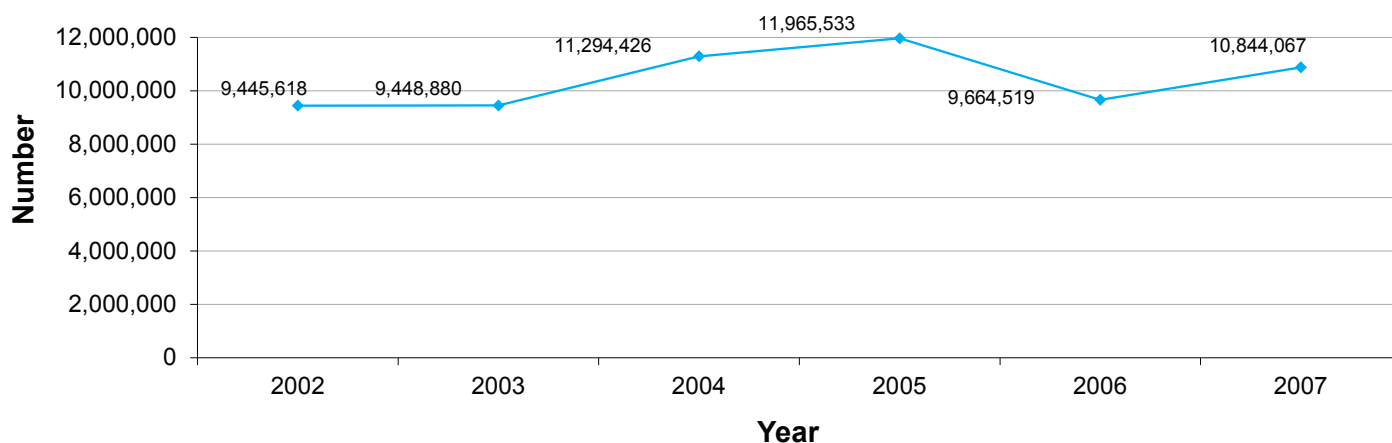


Figure 20: Trend in the Number of Clients Using HCT (EFY 2002 - 2007)

With the exception of three regions (Tigray, Amhara and Addis Ababa) the remaining eight regions increased the number of clients using HCT in EFY 2007 compared with the previous year (Figure 21). On the other hand, seven regions achieved their regional target (Tigray, Afar, Somali, SNNP, Gambella, Harari and Dire Dawa), while the remaining four regions (Amhara, Oromia, Benishangul Gumuz and Addis Ababa) performed below the target set for the year.

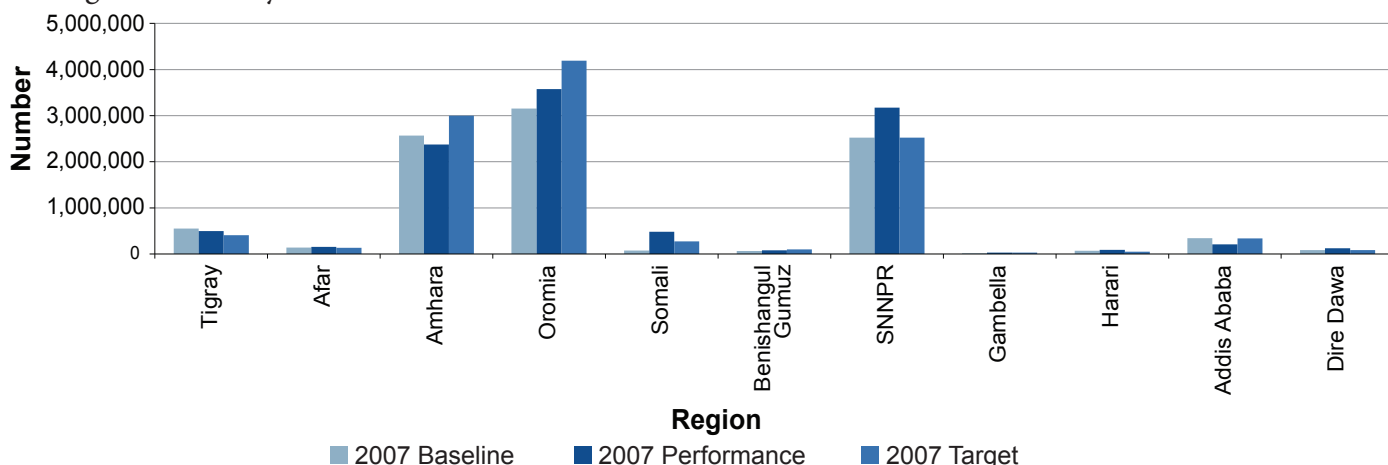


Figure 21: Comparison of Baseline, Performance and Target of the Number of Clients Using HCT by Region (EFY 2007)

### 2.5.1.2. ANTIRETROVIRAL TREATMENT

As it was seen in the previous years, a linear increase was observed in the number of People Living With HIV (PLHIV) ever enrolled, ever started and currently on ART over the past years (Figure 22); in particular, there was an increase between EFY 2006 and EFY 2007 from 805,948 to 871,334 for PLHIV ever enrolled in HIV/AIDS care (+65,386), from 492,649 to 535,069 for those ever started (+42,420), and from 344,344 to 375,811 for those currently on ART (+31,467).

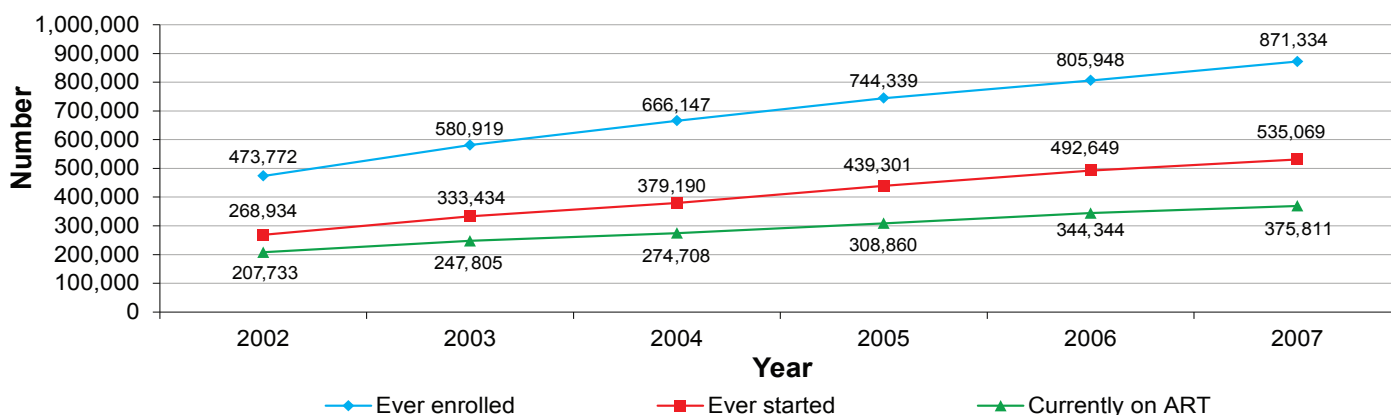


Figure 22: Trend in the Number of People Living With HIV who Accessed Chronic HIV Care (EFY 2002 - 2007)

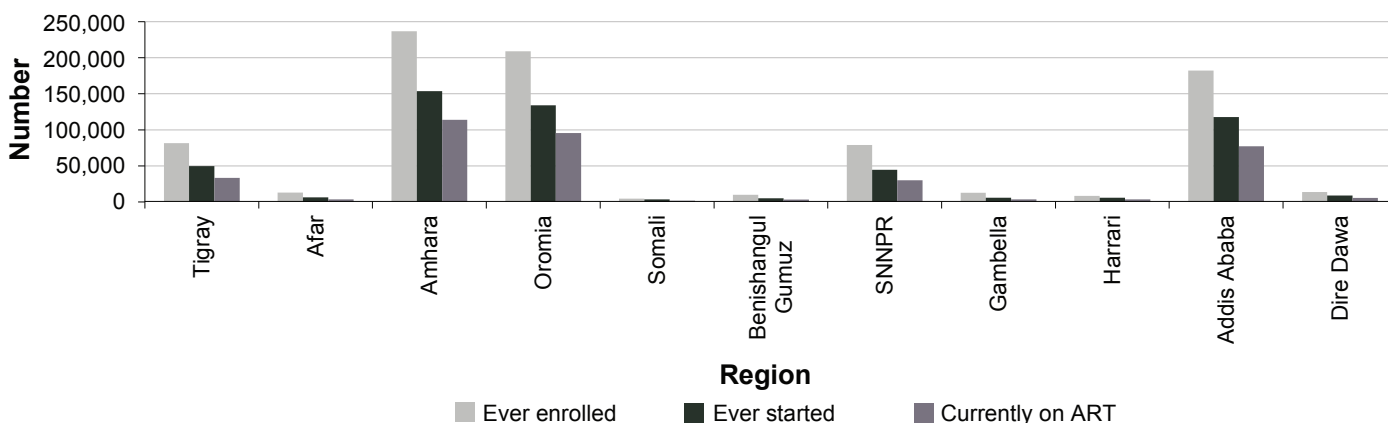


Figure 23: Distribution of PLHIV who Accessed HIV Chronic Care by Region (EFY 2007)

Figure 23 depicts the current pattern of access to chronic HIV care, showing the regional distribution of the cumulative number of PLHIV ever enrolled and ever started as well the number of those currently on ART in EFY 2007. As it was reported in EFY 2005 and 2006, the highest number of PLHIV ever enrolled, ever started and currently on ART was found in Amhara, Oromia, and Addis Ababa Regions, followed by Tigray and SNNP Regions.

Concerning PLHIV currently on ART, out of the target of 453,821 who need ART, 375,811 PLHIV were currently on ART at the end of EFY 2007, with a target achievement of 82.8%. Wide differences were observed across regions, with Amhara Region showing the highest number of PLHIV currently on ART (113,879) in EFY 2007 (Figure 24).

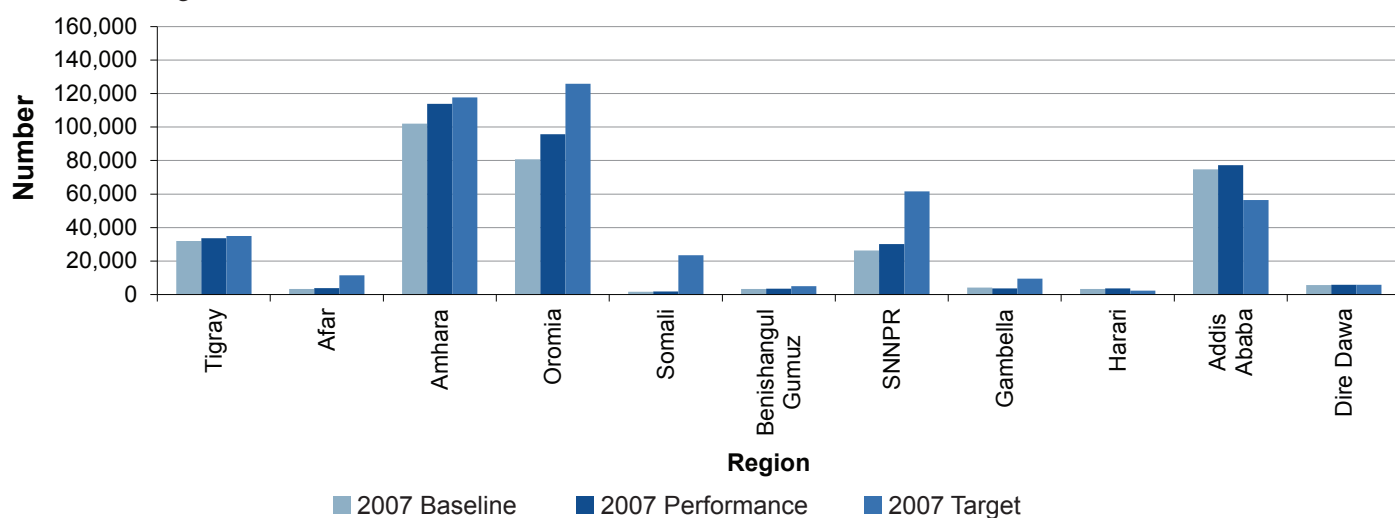


Figure 24: Comparison of Baseline, Performance and Target of the Number of PLHIV Currently on ART by Region (EFY 2007)

## CHALLENGES

- Inadequate implementation of supportive supervision;
- Shortage of condoms and rapid diagnostic kits;
- Inadequate continuum of care before, during, and after delivery;
- Delay in maintenance of CD4 count machines;
- Lack of revised operational procedure guideline on different HIV-related laboratory diagnoses;
- Shortage of budget to secure HIV test kits;
- Duplication of efforts in interventions on MARPs by different partners;
- Poor coordination and information gap among agencies and RHBs;
- Weak participation of partners on integration of multi-sectoral responses to HIV/AIDS;
- Difficulty in delivering services in pastoralist areas; and
- Limited capacity in data collection and use as well as in information dissemination.

## WAY FORWARD

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

## 2.5.2. MALARIA PREVENTION AND CONTROL

For EFY 2007 like in the previous years, the major activities planned for malaria prevention and control focused on expanding vector control and strengthening malaria case detection and treatment. In particular, increasing the availability and use of Long-Lasting Insecticide-treated Nets (LLIN) as well as implementing Indoor Residual Spray (IRS) are powerful vector control tools for reducing malaria transmission; furthermore, access to care for suspected malaria cases and appropriate diagnostic testing and therapeutic management at all places of care are needed to ensure that all patients with malaria receive prompt and effective treatment.

### 2.5.2.1. LONG-LASTING INSECTICIDE-TREATED NET DISTRIBUTION

In EFY 2007 a total of 17.2 million LLINs were distributed which was more than the amount distributed in EFY 2006 (11.7 million). This increased the cumulative number of distributed LLINs to 75,876,866 (Figure 25).

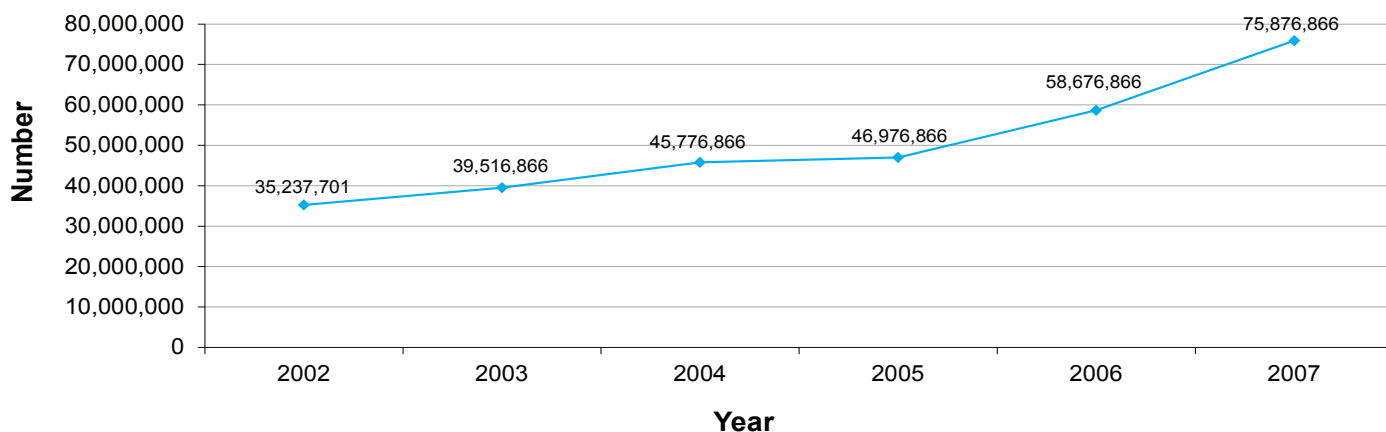


Figure 25: Trend in the Cumulative Number of Insecticide Treated Nets (ITN) Distributed (EFY 2002 – 2007)

With regards to vector control, the plan was to cover 5.9 million unit structure with IRS; however, a total of 5.3 million unit structure (89.8% out of the target) in malaria endemic areas were sprayed in EFY 2007 which was above EFY 2006 performance (3.9 million households).

### 2.5.2.2. TREND IN MALARIA CASES

In EFY 2007, the total number of laboratory confirmed plus clinical malaria cases were 2,174,707. In particular, the monthly pattern showed an increase in the first five months of the fiscal year reaching the highest peak in November, followed by a decrease until April (Figure 26). A total of 662 deaths were recorded in the same period, with a Case Fatality Rate (CFR) of 0.03%.

Out of the total 2,174,707 malaria cases reported in the fiscal year, 1,867,059 (85.9%) were confirmed by either microscopy or rapid diagnostic tests (RDT), out of which 1,188,627 (63.7%) were *Plasmodium falciparum* (PF) and 678,432 (36.3%) were *Plasmodium vivax* (PV). The monthly pattern showed an increase in the first five months of the fiscal year reaching the highest peak in November, followed by a decrease until April (Figure 27).

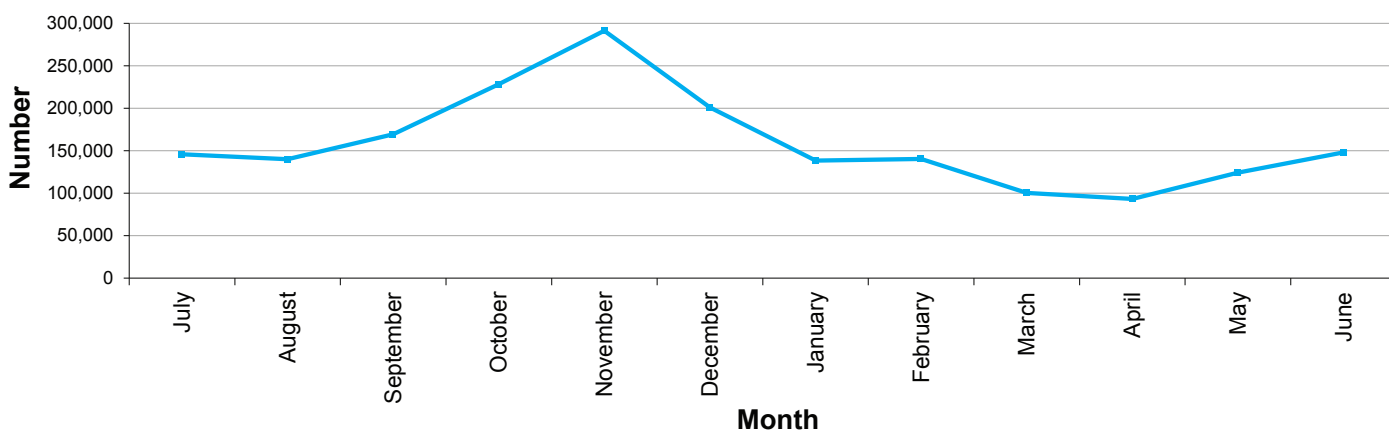
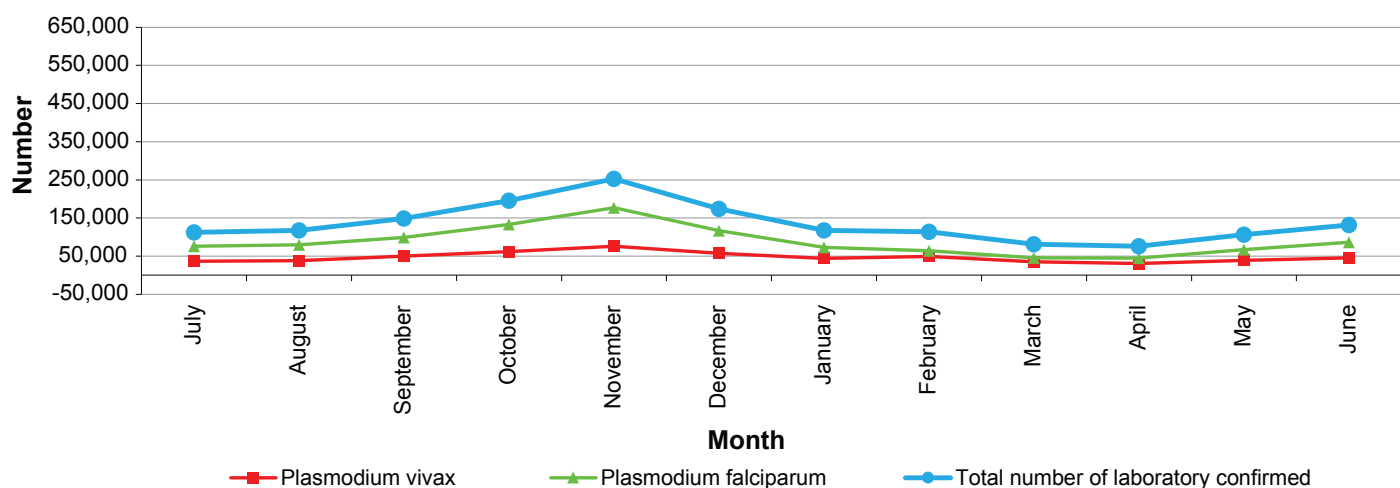


Figure 26: Trend in Laboratory Confirmed plus Clinical Malaria Cases by Month (EFY 2007)



**Figure 27: Trends in Laboratory Confirmed Malaria Cases, Plasmodium falciparum Malaria Cases and Plasmodium vivax Malaria Cases by Month (EFY 2007)**

In EFY 2007, the highest number of laboratory confirmed plus clinical malaria cases was reported from Amhara (610,486), followed by Oromia Region (430,969 cases), and SNNP Region (375,746 cases) (Table 4). In general, there was a decrease on the number of laboratory confirmed plus clinical malaria cases at national level.

Table 4:

#### Distribution of Laboratory Confirmed plus Clinical Malaria Cases by Region

(EFY 2007)

Region	Population at risk	Cases			Death		
		Number	Percent	Incidence per 100,000 at risk population	Number	Percent	CFR (%)
<b>Tigray</b>	3,763,267	300,904	13.8%	7,996	48	7.3%	0.02%
<b>Afar</b>	1,863,902	119,053	5.5%	6,387	12	1.8%	0.01%
<b>Amhara</b>	15,790,154	610,486	28.1%	3,866	85	12.8%	0.01%
<b>Oromia</b>	23,161,304	430,969	19.8%	1,861	214	32.3%	0.05%
<b>Somali</b>	4,912,248	66,984	3.1%	1,364	95	14.4%	0.14%
<b>Benishangul Gumuz</b>	815,589	209,664	9.6%	25,707	10	1.5%	0.005%
<b>SNNPR</b>	12,238,426	375,746	17.3%	3,070	166	25.1%	0.04%
<b>Gambella</b>	419,955	48,780	2.2%	11,616	20	3.0%	0.04%
<b>Harari</b>	186,963	4,265	0.2%	2,281	2	0.3%	0.05%
<b>Addis Ababa</b>	324,430	6,264	0.3%	1,931	6	0.9%	0.10%
<b>Dire Dawa</b>	210,298	1,592	0.1%	757	4	0.6%	0.25%
<b>National</b>	<b>61,429,786</b>	<b>2,174,707</b>	<b>100.0%</b>	<b>3,540</b>	<b>662</b>	<b>100.0%</b>	<b>0.03%</b>

A total amount of 6.8 million doses of artemisinin-based combination therapy (ACT), 35,000 vials of Artesunate injection, 1.17 million doses of chloroquine and 13 million RDTs were distributed to respective regions for malaria prevention and control.



## CHALLENGES

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

## WAY FORWARD

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

### 2.5.3. TUBERCULOSIS AND LEPROSY PREVENTION AND CONTROL

TB is among major public health problems throughout the world and its burden remains to be enormous. Ethiopia is the tenth high-TB burden country in the world, with an estimated of 201,914 new cases of TB (incidence rate 224 per 100,000 populations) reported in 2013. Cognizant of this, the Government of Ethiopia has given due attention to the control of TB and included the prevention and control of TB and Leprosy among the priority health programs in the country’s Health Sector Development Program (HSDP IV).

#### 2.5.3.1. TB PREVENTION AND CONTROL

##### 2.5.3.1.1. TB CASE NOTIFICATION

In EFY 2007, a total of 135,831 TB cases (all forms) were reported with a TB case notification rate of 151 per 100,000 population; this performance was higher than that observed in EFY 2006 (133 per 100,000 population). Out of 135,831 cases reported in EFY 2007, 35.1% were bacteriologically confirmed pulmonary TB cases, 32.4% were clinically diagnosed new TB cases, 29.8% were extra pulmonary TB and 2.7% were previously treated TB cases.

There was regional disparity in TB case notification, very high (>200/100,000) TB case notification rates per 100,000 populations were reported in major urban areas (Dire Dawa, Addis Ababa, Harari); whereas, Somali Region reported less than 100 TB cases per 100,000 populations, far lower than the national level. Among the major agrarian regions, highest TB CNR was observed in Tigray Region (Figure 28).

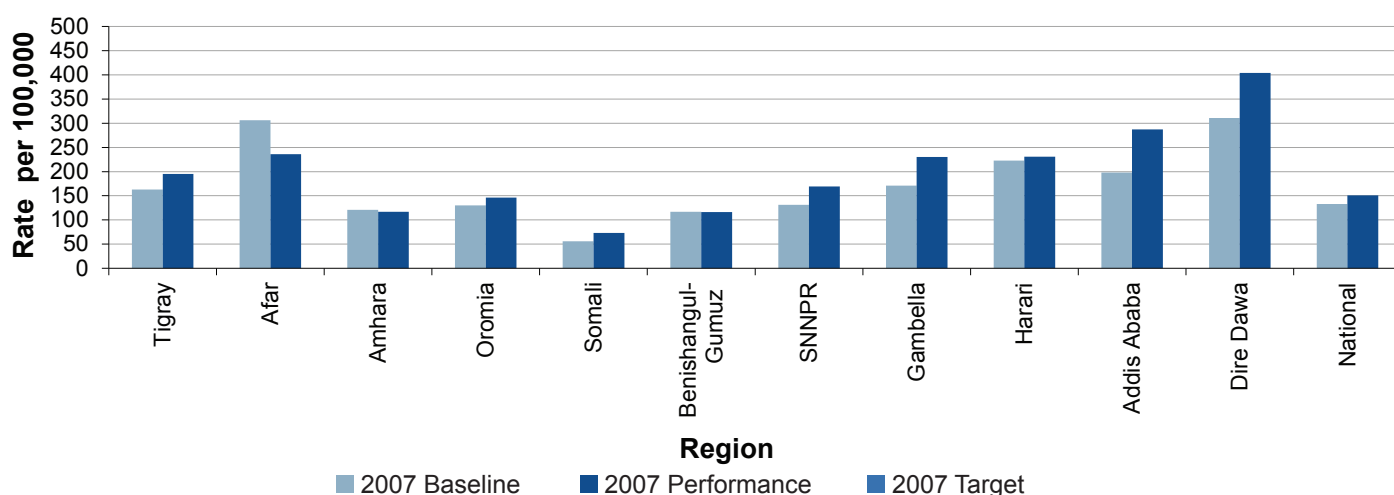


Figure 28: Comparison of Baseline and Performance of TB Case Notification Rate by Region (EFY 2007)

### 2.5.3.1.2. TB CASE DETECTION RATE

In EFY 2007, the TB case detection rate was 67.3%, which was more than last year (53.7%) but below the target set for the year (83.0%). Differences were observed across regions, ranging from 32.6% in Somali Region to over 100% in Afar, Gambella, Harari, Addis Ababa and Dire Dawa. The latter five regions (Afar, Gambella, Harari, Addis Ababa and Dire Dawa) achieved their target set for the year (Figure 29).

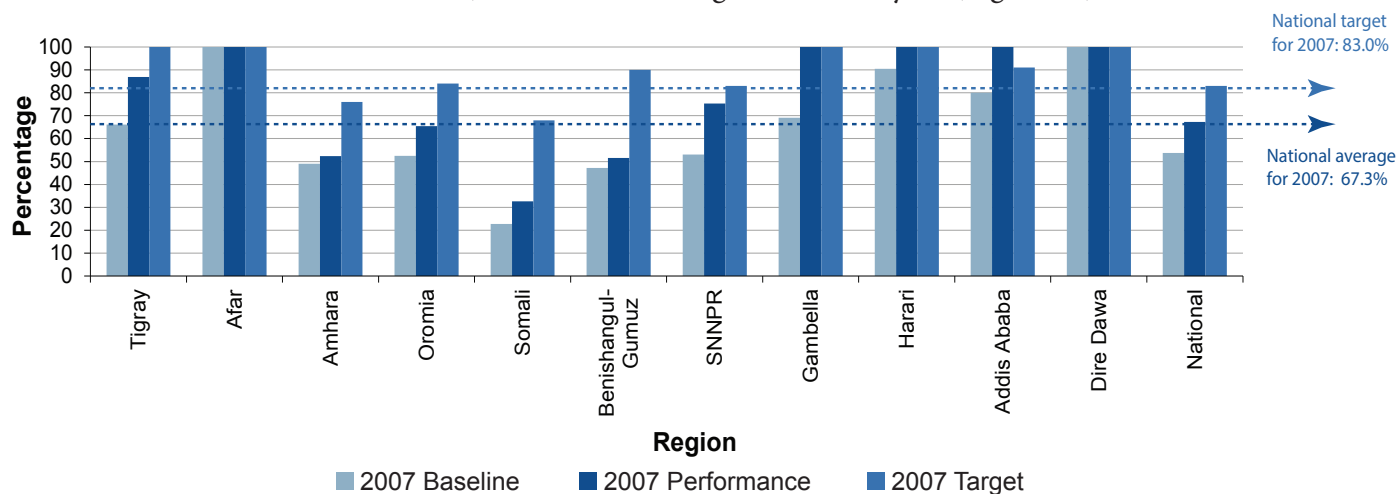


Figure 29: Comparison of Baseline, Performance and Target of TB Case Detection Rate by Region (EFY 2007)

### 2.5.3.1.3. TB TREATMENT OUTCOMES

In EFY 2007, TB treatment success rate (TSR) was similar to EFY 2006 (92.1%) and the trend shows the country has been maintaining very high treatment success rate for new bacteriologically confirmed PTB cases since EFY 2004. On the other hand, TB cure rate has increased from 69.1% to 77.9% in the same period (Figure 30).

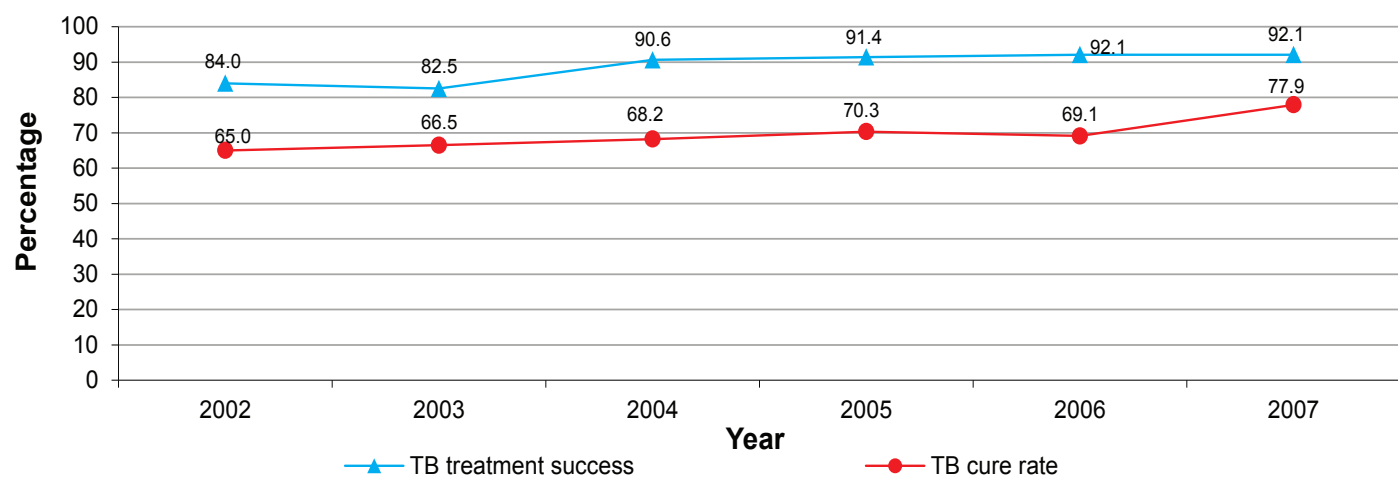


Figure 30: Trend in TB Treatment Success Rate and TB Cure Rate (EFY 2002 - 2007)

#### 2.5.3.1.3.1. TB TREATMENT SUCCESS RATE

TB TSR was equal to the performance in EFY 2006 (92.1%) in EFY 2007; however, below the target set for the year (97%). Disparities were observed across regions, with the highest performance being observed in SNNP Region (97.0%) and the lowest performance was observed in Gambella Region (66.8%). Six regions (Tigray, Afar, Oromia, Benishangul Gumuz, Gambella and Addis Ababa) showed a decreased performance while the remaining five regions improved performance in EFY 2007 from the

previous year (Figure 31). Of note is the fact that Tigray and Oromia Regions performed less than EFY 2006 performance (100%); however, the TSR was more than 90%.

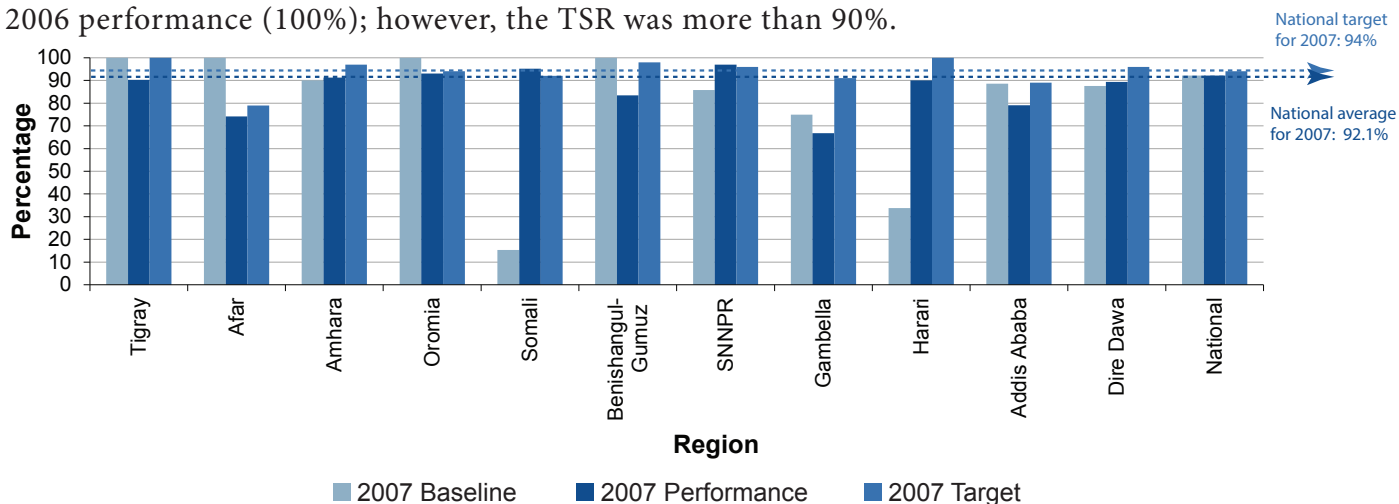


Figure 31: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2007)

### 2.5.3.1.3.2. TB CURE RATE

TB cure rate increased from 69.1% in EFY 2006 to 77.9% in EFY 2007; however, it was below the target set for the year (94%) (Figure 32). The best performance was seen in Amhara Region (87.0%) and Oromia Region (85.1%), while the lowest performance was observed in Afar Region (35.9%). Six regions (Tigray, Afar, Benishangul Gumuz, Gambella, Addis Ababa and Dire Dawa) decreased their performance in EFY 2007 from the previous year.

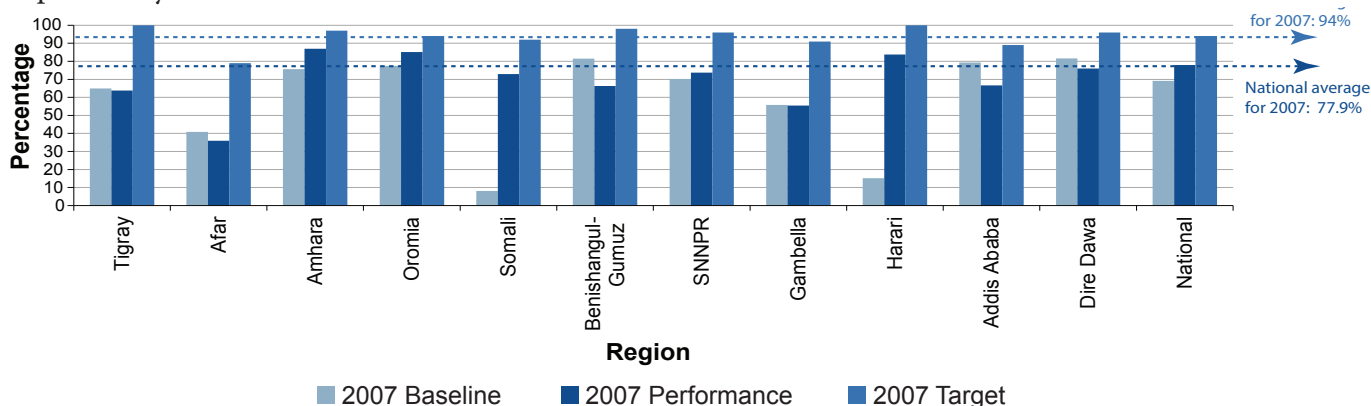


Figure 32: Comparison of Baseline, Performance and Target of the TB Cure Rate by Region (EFY 2007)

## 2.5.3.2. LEPROSY PREVENTION AND CONTROL

### 2.5.3.2.1. LEPROSY CASE DETECTION

In EFY 2007, a total of 3,817 new leprosy cases were detected which was higher than EFY 2006 (3,080) and the majority of whom being detected in Oromia and Amhara Regions (Figure 33).

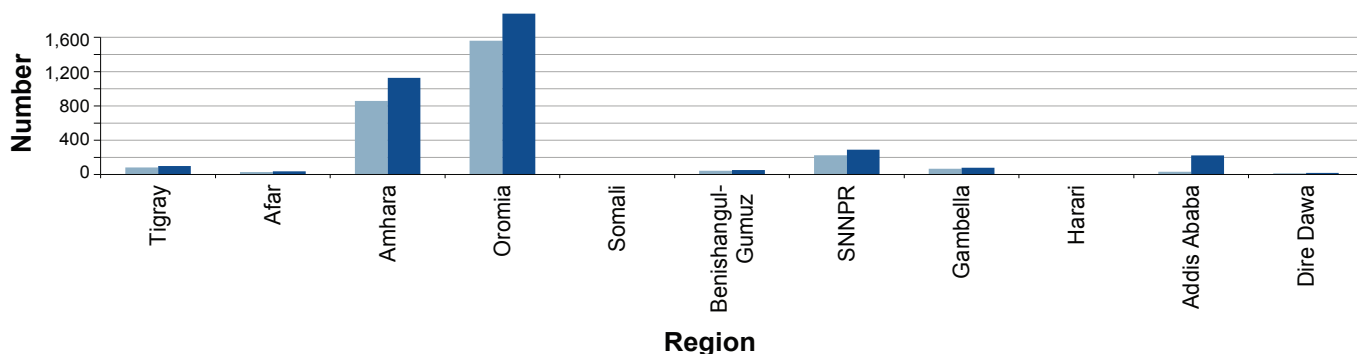


Figure 33: Comparison of Baseline and Performance of Leprosy Cases Detected by Region (EFY 2007)

### 2.5.3.3. OTHER ACTIVITIES

So far, a cumulative total of 2,156 MDR TB patients were enrolled in second line drug (SLD) treatment and 597 MDR TB patients were enrolled in SLD treatment in EFY 2007 (Figure 34).

In EFY 2007, there were a total of 40 hospitals providing MDR TB treatment services and additional 15 hospitals are under process to start the service in the coming year. GenXpert MTB/RIF detection of TB cases has been started in 105 hospitals and a total of 516 health professionals were trained on the appropriate utilization of GenXpert machine.

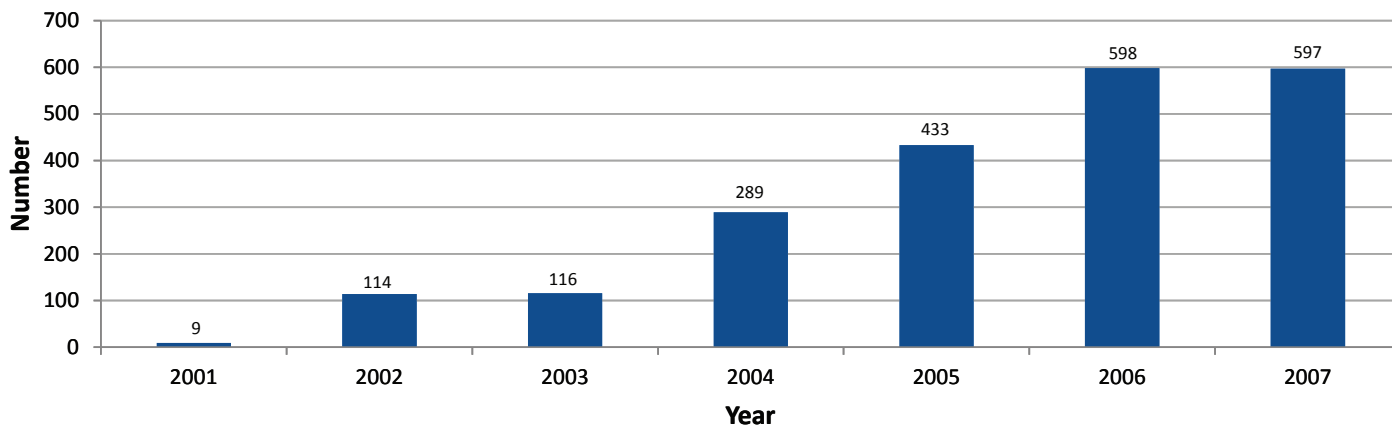


Figure 34: Trend in MDR TB Patients Enrolled to Second Line Drug Treatment (EFY 2001 - 2007)

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

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

### CHALLENGES

- Irregular supply of reagents;
- Centralized implementation of External Quality Assessment (EQA);
- Underutilization of TB culture diagnostic services and GenXpert machine due to insufficient sample transportation mechanism;
- Incomplete and delayed reporting from some health facilities (HF) and Woreda Health Offices (WorHO);
- Low MDR-TB case finding and declining quality of MDR TB treatment service at lower level;
- Limited community participation on suspected TB identification through HDA and community TB care expansion; and
- Inadequate implementation of daily observed treatment at facility level.

### WAY FORWARD

- Strengthen the supply of reagents;
- Improve the quality of laboratories through strengthening decentralized EQA and provision of quality microscopes;
- Strengthen sputum sample transportation to effectively utilize TB culture and GenXpert diagnostic facilities;
- Strengthen planning, M&E, reporting and implementation capacity;
- Strengthen MDR-TB case finding strategies in all eligible categories, and strengthen sample transportation system and program management capacity in all regions;
- Promote community participation on suspect TB identification through HDA and community TB care expansion; and
- Strengthen the implementation of daily observed treatment at facility level.

## 2.5.4. PREVENTION AND CONTROL OF NEGLECTED TROPICAL DISEASES

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Eight neglected tropical diseases require serious attention since they are among the main impediments for poverty reduction and some targeted for elimination by 2020. In order to integrate the prevention and control of these neglected tropical diseases within the health system, training was conducted to programme coordinators and HEWs were capacitated on the prevention of onchocerciasis and elephantiasis in EFY 2007. In addition, regional programme coordinators participated on the training organized to prevent elephantiasis, bilharzia and intestinal parasites. Moreover, fast track strategy is instituted so as to enable the elimination of blinding trachoma before the global target of 2020 while established the Ethiopia Onchocerciasis Elimination Expert Advisory Committee that would provide state-of-the art technical guidance so that the country achieves Onchocerciasis elimination by 2025.

In the reporting fiscal year, over 9.9 million and over 1.5 million people took drugs for the prevention of onchocerciasis and lymphatic filariasis respectively.

A total of 2.6 million and 5.3 million School age children received Praziquantal and Mebendazole for Schistosomiasis and STH de worming in six regions (Tigray, Amhara, Oromia, SNNPR, Somali and Benishangul Gumuz) of the country respectively.

Likewise, over 28 million people living in 248 trachoma endemic woredas were covered with Zithromax MDA; while over 83,000 people have been operated for trachomatous trichiasis, thereby averting blindness due to trachoma.

To prevent and control Visceral Leshmaniasis, 14,225 vials of SSG, 9,227 vials of Amphotericin B and 14,550 kalazar rapid test kits were distributed; while 2,454 VL patients were diagnosed and treated in five endemic regions (Amhara, Tigray, SNNPR, Oromia and Somali).

## CHALLENGES

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

## WAY FORWARD

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

## 2.6. PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

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

Realizing the existing problem associated with NCDs, in EFY 2007, the ministry had conducted a situational analysis study in the country to identify the magnitude of the problem. On the other hand, awareness creation efforts were carried out to control the spread of the NCD. To this juncture, different messages were conveyed to alert the public on the prevention and control mechanisms of NCD. Furthermore, level 4 manual for rural HEP on NCD was revised, consultative workshop conducted and NCD strategic action plan and prevention and control of cervical cancer guideline were launched and over 2,000 copies printed and distributed. Efforts are underway to integrate the treatment of non-communicable diseases with the basic health services and a treatment guideline and training manuals for the 4 major NCDs and cervical cancer prevention training



package were also prepared. In addition to this, 118 cryotherapy machines were procured and distributed in 36 facilities of which some have started the service.

To mitigate the grave tobacco related health, social and economic consequences and achieve the objectives of the convention and implement its provisions the Government of Ethiopia showed its solidarity and commitment regarding tobacco control by ratifying the Framework Convention on Tobacco Control on 21st January 2014 which it signed on 25th February 2004 through the WHO-FCTC Ratification Proclamation No 822/2014 which entered into force on 17th February 2014. The advertisement proclamation No. 759/2012 comprehensively bans the advertisement of tobacco products and prohibits promotion and sponsorship. Tobacco Control Directives were endorsed by FMHACA in March 2015. These legal frameworks provide the power to control the content of tobacco products, disclose information on tobacco products and emissions, prohibit advertisement, promotion and sponsorship, display pictorial health warnings on packages, prohibit smoking in public places.

A 5 year strategic plan has been drafted to ensure a coordinated response to the tobacco epidemic and harness the strengths of the various sectors and stakeholders. Initiatives like smoke free work places have been implemented in within the premises of Parliament, FMOH, FMHACA, Emmanuel Specialized Hospital and Federal Customs Authority. Additionally, most of the public places are posting “No smoking” labels.

In order to strengthen prevention and control of cancer, palliative treatment services initiated and a guideline that supports the screening of cervical cancer was prepared and distributed. Following this, a total of 22,818 women aged 30-49 have undergone the cervical cancer screening; out of whom 2,801 (12.3%) had signs of the disease and 1,348 (5.9%) were identified as full-blown cancer.

In EFY 2007, with regard to cancer registry, preparatory work was started and Hawassa University Hospital initiated facility based cancer registry services. A pilot population based cancer registry started in Addis Ababa from 2012 GC. On the other hand, six University Hospitals including Black Lion were preparing engineering design for expanding Radiation Therapy service and the procurement of all the necessary radiotherapy equipment is underway. Similarly, in selected Addis Ababa and other Regional Hospitals, preparation work was initiated to provide chemotherapy treatment.

Important preparatory work started to develop a series of strategies on guidelines on NCDs:

1. National cancer control plan drafted
2. A national strategy on prevention and control of viral hepatitis drafted
3. A guideline on prevention and control of viral hepatitis drafted
4. A guideline on prevention and control of major NCDs drafted
5. National eye health strategy drafted

Regarding mental health service intervention, a symposium was conducted in Addis Ababa to start mental health service at the PHCU level and a sensitization messages was transmitted through the mass media. A total of 152 PHCU have been trained in collaboration with 5 university hospitals and Amanuel Mental Specialized Hospital.

## CHALLENGES

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- Lack of NCD team in RHBs;
- Lack of muti-sectoral collaboration;
- Lack of technical and financial support;
- Low level of awareness on NCDs and their risk factors both in the general population and among health professionals; and
- Limited number of national and international partners working on NCDs.

## WAY FORWARD

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- Scale up the mental health services into the primary health care (PHC) system in all regions;
- Expansion of prevention and treatment of cancer services including VIA screening and cryotherapy treatment in all regions;
- Ensure quality care for Hypertension and Diabetes at PHC level;
- Ensure technical and financial support to NCD plan;
- Conduct intensive awareness raising campaign on NCDs and their risk factors nationwide; and
- Carry out high level advocacy to increase the number of national and international partners working on NCDs.

## 2.7. PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE

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

In EFY 2007, there were activities carried out with regard to public health emergency preparedness and response. Major activities include:

- Twenty six weekly bulletins were prepared and disseminated by all Regional Community Health Control Centres. Out of 583 expected feedbacks to the Regional Community Health Control Centres only 220 responses were issued. Laboratory confirmation feedback was issued to the Regional Health Bureaus on measles and polio test results.
- As Ebola virus has been a threat to most Western African countries, FMOH has communicated all RHBs with a stand by and warning letter to prevent and control the epidemic. Two medical centres were opened and fully equipped to prevent and control the epidemic and a training has also been conducted for 1,000 health professionals from all regions to enable them to make a strengthened surveillance.
- Sixty five Public Health Emergency accident rumours were identified and a confirmation communication action was also being made within 3 hours. Out of the rumours, 35 cases were being confirmed.
- Health Education materials on strengthening the Guinea-worm Eradication Programme were sent to Gambella Region to sensitize the community. Supportive supervision was conducted in collaboration with development partners to Guinea-worm prone woredas.
- A total of 98,017 people with the age of 6 months and above received vaccination to prevent Yellow Fever, after identifying Yellow Fever disease prone woredas.
- Efforts were made to reduce and minimize the high risk associated with flood in Afar and Somali Regions through the provision of all the necessary inputs and public Health professionals.

### 2.7.1. EPIDEMIC PREVENTION AND CONTROL

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#### 2.7.1.1. MEASLES

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A total of 32,222 laboratories confirmed and epidemiologically linked measles cases were reported nationally with 199 deaths with CFR of 0.6%. Compared to EFY 2006 (24,493 measles cases), there were an increase of measles cases by 7,729 (23.9%) in EFY 2007. Of these, more than half 19,020 (59.0%) of cases were reported from Oromia Region followed by Amhara Region 6,967 (21.6%) and Benishangul Gumuz Region 1,789 (5.6%). The national incidence rate was 24/10,000 under five children. The highest annual incidence rate was reported from Benishangul Gumuz and Harari (141/10,000 and 69/10,000 under five children respectively) (Table 5).

Table 5:

**Distribution of Suspected Measles Cases and Deaths by Region**

(EFY 2007)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 U5 Children)	Number	Percent	CFR
Tigray	732	2.3%	9	5	2.5%	0.7%
Afar	117	0.4%	4	9	4.5%	7.7%
Amhara	6,967	21.6%	23	43	21.6%	0.6%
Oromia	19,020	59.0%	37	52	26.1%	0.3%
Somali	908	2.8%	11	20	10.1%	2.2%
Benishangul Gumuz	1,789	5.6%	141	40	20.1%	2.2%
SNNPR	2,047	6.4%	7	7	3.5%	0.3%
Gambella	56	0.2%	9	0	0%	0%
Harari	234	0.7%	69	22	11.1%	9.4%
Addis Ababa	320	1.0%	7	0	0%	0%
Dire Dawa	32	0.1%	5	1	0.5%	3.1%
<b>National</b>	<b>32,222</b>	<b>100.0%</b>	<b>24</b>	<b>199</b>	<b>100.0%</b>	<b>0.6%</b>

In EFY 2007, the monthly trend of laboratories confirmed and epidemiologically linked measles cases was similar to that of EFY 2006 with slight increase from January to May. There were low number of measles cases during rainy season and started to increase from October. This can be due to school opening and high contact with low immune children. Similarly, the trend showed to decline starting from May (Figure 35).

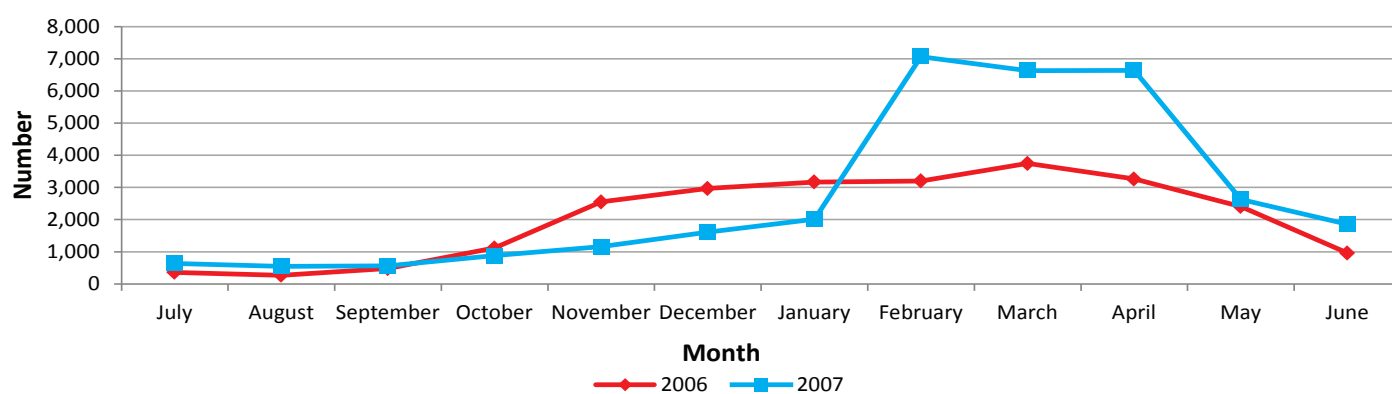


Figure 35: Trend in Suspected Measles Cases by Month (EFY 2006 and 2007)

**2.7.1.2. AFP/POLIOMYELITIS**

In 2007 EFY, a total of 772 stool samples of suspected Acute Flaccid Paralysis (AFP) cases were collected at national laboratory for investigation. To monitor the sensitivity of the surveillance system to detect polio, non-polio AFP rate of at least two or more per 100,000 in under five children should be detected according to the WHO standard. Meanwhile, the national non-polio AFP rate was 1.9/100,000 under five children in the fiscal year was slightly short of the standard (2.0). Only five regions attain this WHO standard (Amhara (2.4), Benishangul Gumuz (2.6), Gambella (2.6), Harari (2.0) and Somali (2.4)). In EFY 2007, one type 2 Vaccine Derived Polio Virus (VDPV2) case was reported and confirmed from Fik Woreda, Nogob Zone of Somali Region (Figure 36).

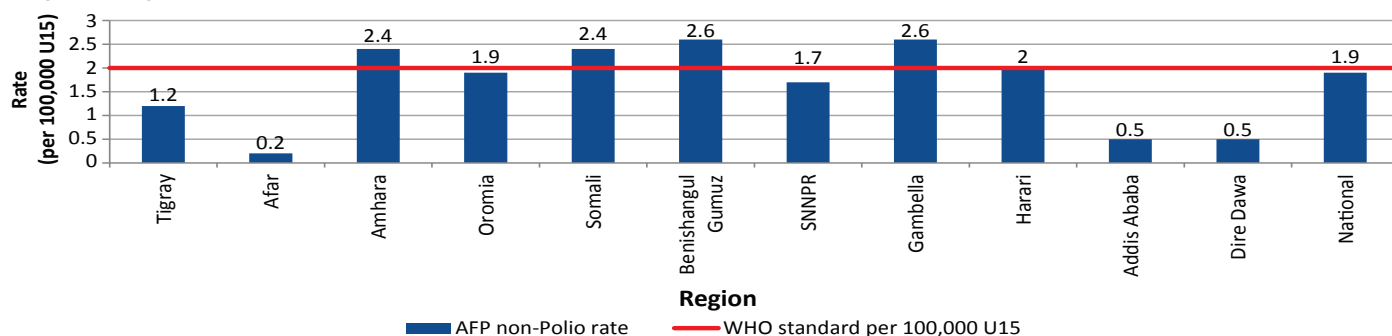


Figure 36: Comparison of Non-Polio Acute Flaccid Paralysis Rate Per 100,000 Children Under 15 Years by Region (EFY 2007)

### 2.7.1.3. DYSENTERY

A total of 267,489 dysentery cases were reported from all regions which was similar to EFY 2006 (268,353 dysentery cases) and 229 deaths with CFR of 0.1%. Majority of cases were reported from Oromia and Amhara Regions (83,980 (31.4%) and 60,877 (22.8%) respectively). The incidence rate was highest in Benishangul Gumuz Region (1,751/100,000 population) followed by Tigray and Harari (712.8/100,000 and 507.2/100,000 population respectively) (Table 6).

Table 6:

#### Distribution of Suspected Dysentery Cases and Deaths by Region

(EFY 2007)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	36,554	13.7%	713	28	12.2%	0.1%
Afar	8,083	3.0%	445	0	0%	0%
Amhara	60,877	22.8%	314	0	0%	0%
Oromia	83,980	31.4%	253	155	67.7%	0.2%
Somali	9,849	3.7%	185	11	4.8%	0.1%
Benishangul Gumuz	8,375,422	5.4%	1,751	6	2.6%	0.04%
SNNPR	1,976	0.7%	486	0	0%	0%
Gambella	39,718	14.8%	216	7	3.1%	0.02%
Harari	1,113	0.4%	507	22	9.6%	2.0%
Addis Ababa	9,283	3.5%	293	0	0%	0%
Dire Dawa	1,611	0.6%	395	0	0%	0%
<b>National</b>	<b>267,489</b>	<b>100.0%</b>	<b>303</b>	<b>229</b>	<b>100.0%</b>	<b>0.1%</b>

Monthly trend of Dysentery cases for EFY 2007 was similar to EFY 2006 with slight peak starting the month of April during EFY 2007 (Figure 37).

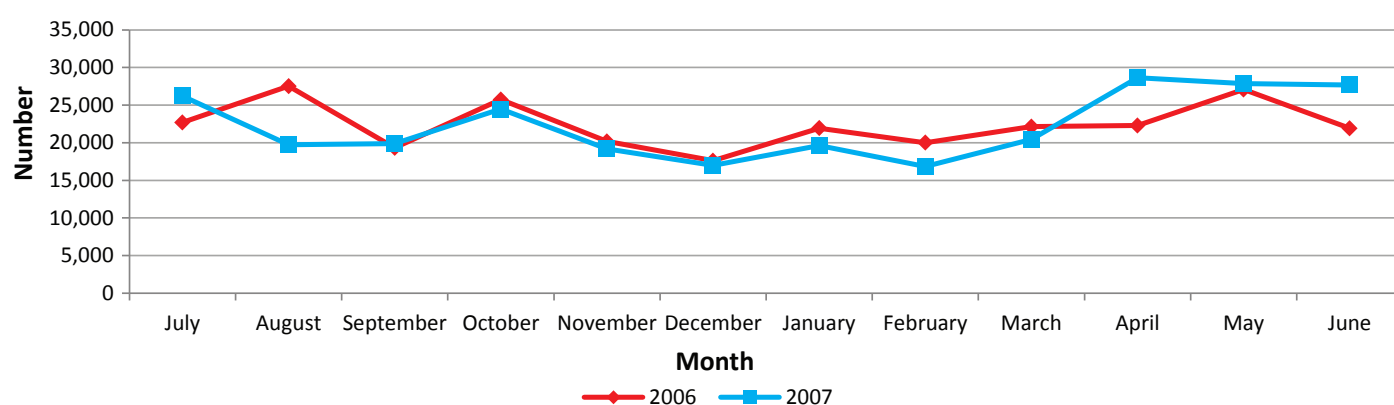


Figure 37: Trend in Suspected Dysentery Cases by Month (EFY 2006 and 2007)

### 2.7.1.4. MENINGOCOCCAL MENINGITIS

In EFY 2007, a total of 1,875 suspected meningococcal meningitis cases and 61 deaths with CFR of 3.3% were reported with slight increase in the number of cases from EFY 2006. The highest number of the cases were reported from SNNP and Oromia Regions (728 (38.8%) and 556 (29.7%) respectively). On the other hand, the incidence rate was 2.1/100,000 population with the highest incidence rate reported from Gambella Region (21.3/100,000 population) followed by Tigray Region (6.0/100,000 population) and SNNP Region (4.0/100,000 population). The CFR was also highest in Gambella Region (9.3%) followed by Benishangul Gumuz Regions (6.9%) in the same period (Table 7).

Table 7:

**Distribution of Suspected Meningitis Cases and Deaths by Region**

(EFY 2007)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	307	16.4%	6	0	0%	0%
Afar	4	0.2%	0	0	0%	0%
Amhara	142	7.6%	1	3	4.9%	2.1%
Oromia	556	29.7%	2	22	36.1%	4.0%
Somali	11	0.6%	0	0	0%	0%
Benishangul Gumuz	29	1.5%	4	2	3.3%	6.9%
SNNPR	728	38.8%	4	26	42.6%	3.6%
Gambella	86	4.6%	21	8	13.1%	9.3%
Harari	3	0.2%	1	0	0%	0%
Addis Ababa	8	0.4%	0	0	0%	0%
Dire Dawa	1	0.1%	0	0	0%	0%
<b>National</b>	<b>1,875</b>	<b>100.0%</b>	<b>2</b>	<b>61</b>	<b>100.0%</b>	<b>3.3%</b>

The monthly trend was similar to that of EFY 2006 except for the months July and April, there was an increase of meningococcal meningitis cases in EFY 2007 (Figure 38).

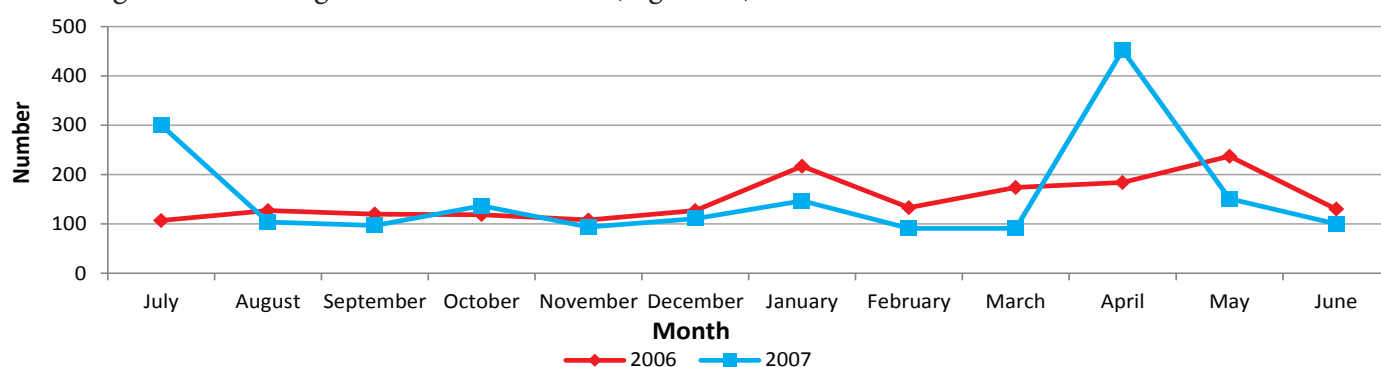


Figure 38: Trend in Suspected Meningococcal Meningitis Cases by Month (EFY 2006 and 2007)

**2.7.1.5. ANTHRAX**

A total of 848 suspected Anthrax cases and 50 deaths with CFR of 5.9% were reported nationally with slight decrease in the number of cases in EFY 2007. The highest number of cases were reported from Amhara and SNNP Regions (521 (61.4%) and 136 (16.0%) respectively). The incidence rate was 1.0/100,000 population nationally with the highest incidence rate reported from Amhara Region (2.7/100,000 population) followed by Tigray Region (2.3/100,000 population). The Case Fatality Ratio was highest for SNNPR 33.8% (Table 8).

Table 8:

**Distribution of Suspected Anthrax Cases and Deaths by Region**

(EFY 2007)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	116	13.7%	2.3	2	4.0%	1.7%
Afar	0	0.0%	0	0	0.0%	0.0%
Amhara	521	61.4%	2.7	2	4.0%	0.4%
Oromia	75	8.8%	0.2	0	0.0%	0.0%
Somali	0	0.0%	0	0	0.0%	0.0%
Benishangul Gumuz	0	0.0%	0	0	0.0%	0.0%
SNNPR	136	16.0%	0.7	46	92.0%	33.8%
Gambella	0	0.0%	0	0	0.0%	0.0%
Harari	0	0.0%	0	0	0.0%	0.0%
Addis Ababa	0	0.0%	0	0	0.0%	0.0%
Dire Dawa	0	0.0%	0	0	0.0%	0.0%
<b>National</b>	<b>848</b>	<b>100.0%</b>	<b>1</b>	<b>50</b>	<b>100.0%</b>	<b>5.9%</b>



The monthly trend for EFY 2007 showed fluctuation with a peak in April. This could be due to Ethiopian holiday (Ethiopian Easter) when most of people slaughter cattle as well as herds and eat raw meat during the period (Figure 39).

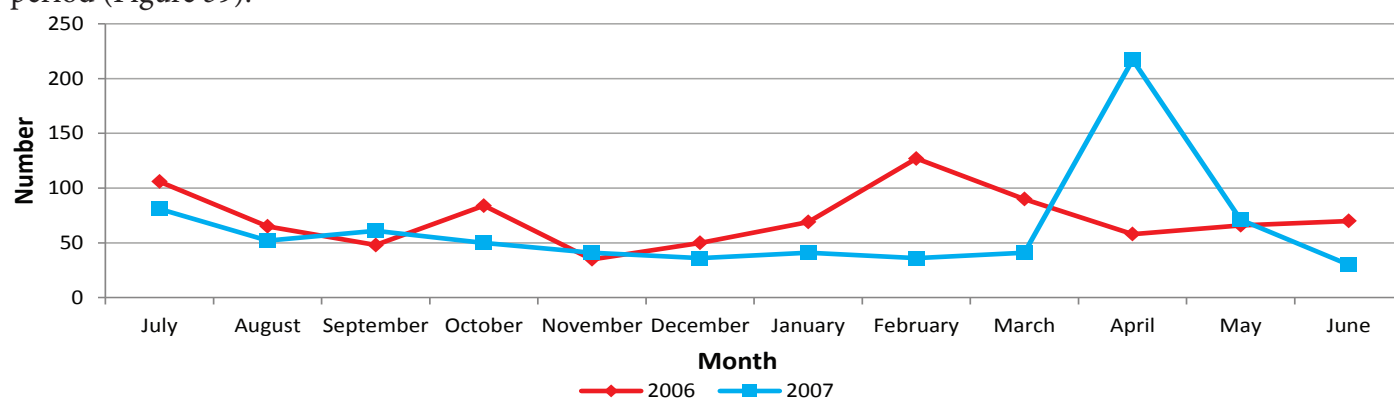


Figure 39: Trend in Suspected Anthrax Cases by Month (EFY 2006 and 2007)

### 2.7.1.6. RABIES

A total of 2,684 suspected Rabies cases and 53 deaths with CFR of 2.0% were reported nationally with slight decrease in the number of cases in EFY 2007. The highest 984 (36.7%), 696 (25.9%) and 644 (24.0%) of the cases were reported from Tigray, Amhara and Oromia regions respectively. The incidence rate was 3.0/100,000 population nationally with the highest 19.2/100,000 population incidence rate reported from Tigray region followed by Benishangul Gumuz region, 14.8/100,000 population. The Case Fatality Ratio was highest in SNNPR with 7.9% (Table 9).

Table 9:

#### Distribution of Suspected Rabies Cases and Deaths by Region

(EFY 2007)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	984	36.7%	19	9	17.0%	0.9%
Afar	0	0.0%	0	0	0.0%	0.0%
Amhara	696	25.9%	4	9	17.0%	1.3%
Oromia	644	24.0%	2	18	34.0%	2.8%
Somali	21	0.8%	0	0	0.0%	0.0%
Benishangul Gumuz	122	4.5%	15	0	0.0%	0.0%
SNNPR	215	8.0%	1	17	32.1%	7.9%
Gambella	1	0.0%	0	0	0.0%	0.0%
Harari	0	0.0%	0	0	0.0%	0.0%
Addis Ababa	1	0.0%	0	0	0.0%	0.0%
Dire Dawa	0	0.0%	0	0	0.0%	0.0%
<b>National</b>	<b>2,684</b>	<b>100.0%</b>	<b>3</b>	<b>53</b>	<b>100.0%</b>	<b>2.0%</b>

The monthly trend was similar for EFY 2006 and 2007. There was low case load for EFY 2007 except for the month of July, August and April (Figure 40).

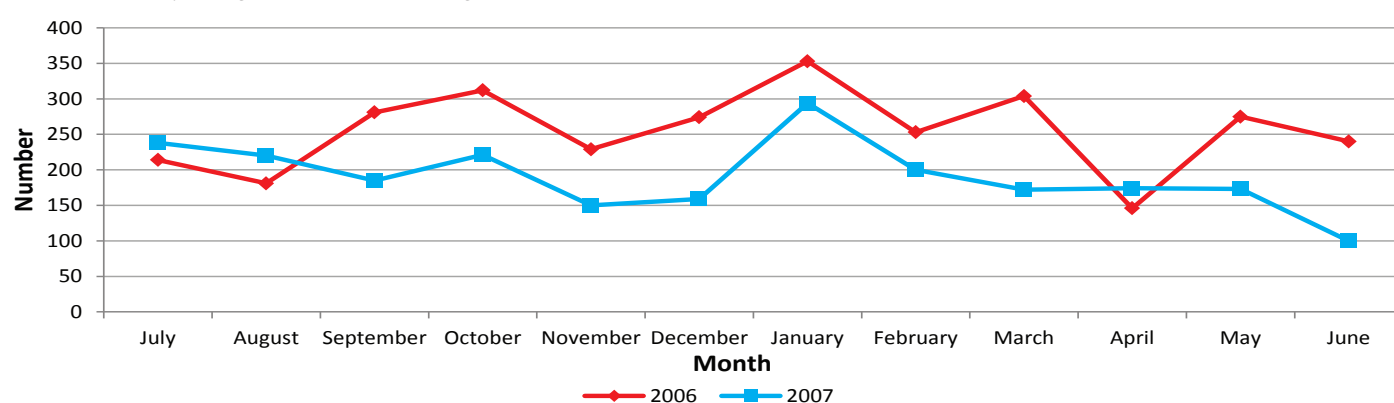


Figure 40: Trend in Suspected Rabies Cases by Month (EFY 2006 and 2007)

## 2.7.1.7. RELAPSING FEVER

A total of 2,958 suspected Relapsing Fever cases and 33 deaths with CFR of 1.1% were reported nationally with marked decrease in the number of cases in EFY 2007. The highest number of cases were reported from SNNP, Oromia and Benishangul Gumuz Regions (1,095 (37.0%), 945 (31.9%) and 341 (11.5%) respectively). The incidence rate was 3.4/100,000 population nationally with the highest incidence rate reported from Benishangul Gumuz and SNNP Regions (41.3/100,000 and 6.8//100,000 populations respectively). The Case Fatality Ratio was highest in Tigray with 2.5% (Table 10).

Table 10:

**Distribution of Suspected Relapsing Fever Cases and Deaths by Region**  
(EFY 2007)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
<b>Tigray</b>	161	5.4%	3	4	12.1%	2.5%
<b>Afar</b>	39	1.3%	2	0	0.0%	0.0%
<b>Amhara</b>	292	9.9%	2	0	0.0%	0.0%
<b>Oromia</b>	945	31.9%	3	23	69.7%	2.4%
<b>Somali</b>	0	0.0%	0	0	0.0%	0.0%
<b>Benishangul Gumuz</b>	341	11.5%	41	0	0.0%	0.0%
<b>SNNPR</b>	1,095	37.0%	6	6	18.2%	0.55%
<b>Gambella</b>	3	0.1%	1	0	0.0%	0.0%
<b>Harari</b>	15	0.5%	7	0	0.0%	0.0%
<b>Addis Ababa</b>	62	2.1%	2	0	0.0%	0.0%
<b>Dire Dawa</b>	5	0.2%	1	0	0.0%	0.0%
<b>National</b>	<b>2,958</b>	<b>100.0%</b>	<b>3</b>	<b>33</b>	<b>100.0%</b>	<b>1.1%</b>

The monthly trend for EFY 2007 showed fluctuation with low case load except for the months of January and April (Figure 41).

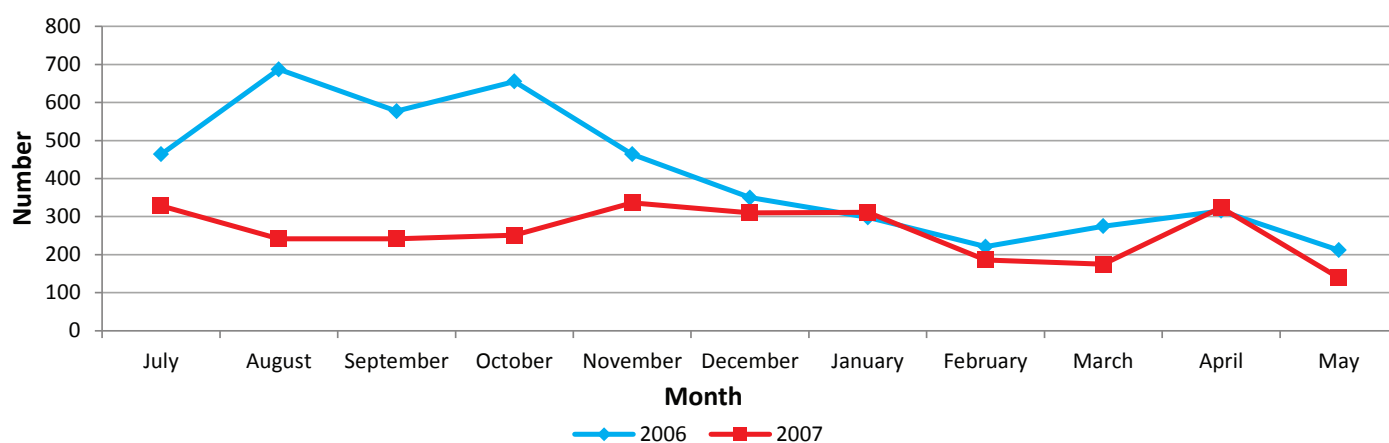


Figure 41: Trend in Suspected Relapsing Fever Cases by Month (EFY 2006 and 2007)

## 2.7.1.8. DENGUE FEVER

AFI cases were reported since May 27/2015, but it was difficult to determine the index case as Dengue fever. The pattern of the incidence showed that the number of AFI cases reported remained the same for the first 25 days (until June 20/2015) and then fast increment started as of June 20/2015 and reached peak after a week. The fast increase in the number of cases could be partly due to active surveillance when the health workers became more aware of the incidence and strong follow up by the RHB during the period.

Over all, the highest number cases were reported from June 20 to July 13/2015, with multiple high spikes of cases during this period (Figure 42).

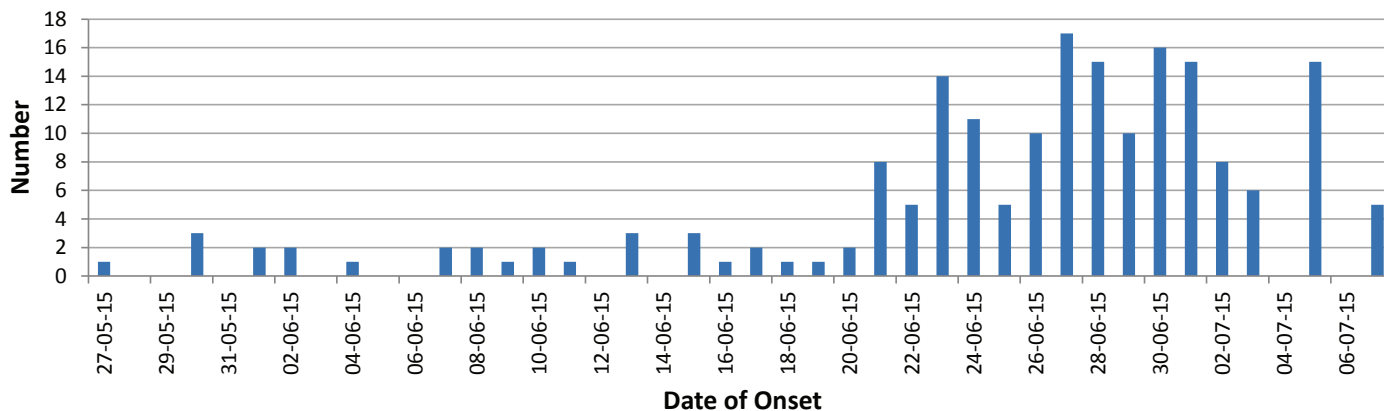


Figure 42: Distribution of Dengue Fever Cases by Date of Onset (Ginbot - Hamle 2007)

## CHALLENGES

- Low Completeness and Timeliness of reporting from some regions;
- Weak and un integrated development of electronic surveillance system;
- Inadequate documentation of surveillance data at all level;
- Inadequate data utilization, especially at lower level;
- Limited capacity of laboratory for timely confirmation of outbreaks; and
- Staff turnover.

## WAY FORWARD

- Implementation of electronic surveillance system;
- Provision of regular supportive supervision to regions;
- Strengthen data documentation through training of data manager;
- Provide training on data analysis and reporting; and
- Improve capacity of laboratory.

## 2.8. QUALITY OF HEALTH SERVICES

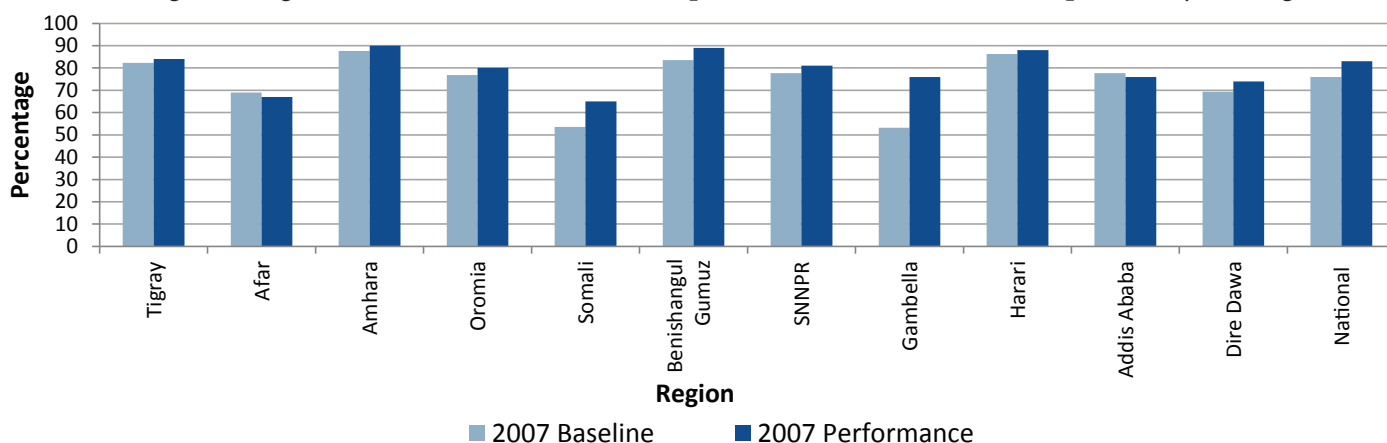
HSDP IV focused on a comprehensive and continuous quality monitoring mechanism that will enable all levels of the health system to look at all aspects of performance and quality of health services. Improving the quality of health services is realized through scrupulous implementation of tools, manuals and standards. In EFY 2007, the performance of the sector with respect to improving quality of services was as follows.

### 2.8.1 QUALITY IMPROVEMENT

In EFY 2007, quality improvement programmes were implemented in all hospitals. Efforts were made to improve service access to all segment of the population, focused on patient safety and patient oriented. Hospital boards were created through the involvement of the community.

The Ethiopian Hospital Reform Implementation Guideline (EHRIG) aims at strengthening hospital management as a foundation for ensuring high quality clinical care and improving patient satisfaction at hospital level.

Among 124 EHRIG standards, 83% were achieved in EFY 2007 which were more than in EFY 2006 (76%) with wide variation among hospitals in the implementation of these set standards. Except Afar and Addis Ababa, the remaining nine regions increased their EHRIG implementation status from the previous year (Figure 43).



**Figure 43: Comparison of Regional EHRIG Implementation Status (EFY 2006 and 2007)**

Hospital forum, Ethiopian Hospital Alliance for Quality (EHAQ), was established by regions to look and improve the existing disparity among regional hospitals. The main focus of the forum was to improve the service delivery in hospitals and 24 hospitals were selected to follow the implementation.

Major activities undertaken in EFY 2007 were:

- Over 325 surgical procedures including ophthalmology were performed;
- Over 50 hospitals initiated paediatric emergency service;
- Local and international experience sharing efforts were registered;
- Over 50% of the hospitals and all University Hospitals started a private wing health service provision;
- Guideline on hospital management and governance was prepared and follow up supports were provided;
- A physiotherapy guideline was prepared and training was given to strengthen the rehabilitation health care;
- Commissioning guideline was prepared for primary level hospitals;
- Service delivery status guideline for health facility management was prepared;
- Calibration guideline for medical equipment was prepared;
- Leadership and management training was conducted to matrons and head nurses;
- Curative health service initiative was established in five selected hospitals;
- Training was conducted on Lifesaving standards “FIRST AID”;
- Fire Burn management guideline was prepared and procurement of inputs for the initiative is under way;
- Provision of emergency medical services was initiated in five hospitals; and
- ALERT and St. Paul’s Hospital were being on the final stage of establishing a Trauma Centre.

### **2.8.1.1. CLEAN AND SAFE HEALTH (CASH) FACILITIES**

A national programme was initiated in the EFY 2007 to make all health facilities, particularly hospitals, clean and safe environment for providing medical service as well as a good working place for the staff. The issue of cleanliness should not only be left for cleanser since it has to be the responsibility of the hospital community as well as the public. The hospital environment must be considered as a healing place and should always be maintained clean and safe.

In EFY 2007, consecutive sensitization and brain storming forums were organized between different community groups and professionals that created consensus to bring about clean and safe environment in health facilities. CASH initiative was made official in all regions except Gambella, Harari, Benishangul Gumuz and Dire Dawa.

A total of 210 hospital cleaners and 22 supervisors participated in the training of CASH initiative. Ten out of the eleven hospitals started the initiative and the hospitals improved the service provision in the fiscal year.

One hundred fifty toilet rooms were maintained at national level and 34 standardized laundry machines were distributed. Furthermore, water supply systems were established in Bisidimo, Shashamene and St Paul's Hospitals to solve the prevailing problem of the provision of clean water. The implementation of "Standardized Infection Prevention" has grown from 54% to 75% in the fiscal year.

Delegation of Ambassadors to hospitals was initiated in EFY 2007 and government official, renowned persons, partner organizations were identified to be Ambassadors to hospitals so as to follow them. Furthermore, follow up tools and information data base was prepared by FMOH, Regions and respective hospitals to facilitate the monitoring in the same period.

### **2.8.1.2. IMPROVEMENT OF EMERGENCY SERVICE IN ADDIS ABABA**

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Emergency service is provided in case of casual incident that occur during pregnancy, car accident and during emergency situations within a households that requires an ambulance service. The intention is to curb death and minimize unnecessary risk of the situation. The service includes the provision of integrated ambulance service and strengthened referral and the delivery of life saving interventions within health facilities.

The existing emergency service provision is bound with many chronic problems such as unavailability of beds, water, electricity, etc., absence of physicians. In order to resolve this persistent problem, a discussion forum was organized with the concerned offices at different levels of Addis Ababa City Administration which discussed thoroughly on the prevailing problems and finally agreed and signed on the mechanisms to solve the existing problems.

In relation to the responsibilities vested on the health facility and the health professionals, a consensus was reached to introduce the already prepared legal framework to the health facility and to the health professionals. Important inputs for appropriate service provision like ambulance transport, important medical equipment and establishment of Intensive Care Unit (ICU) were available in most hospitals.

In terms of accountability, high level health professional teams were organized to work 24 hours to supervise and control if the already established system was functioning. The members of the professional team were 14 in number and they were highly disciplined, well experienced in hospitals services and took training on how to handle emergency hospital services. Two 4WD Patrol cars were assigned at their disposal for the intended supervision. The team was closely working with liaison officers and the community at large to receive complaints and taking appropriate action to resolve the problems. All the 11 hospitals of Addis Ababa were linked to one another to exchange referrals and to receive patients for admission in absence of beds in the referring hospital. Exchange of life savings medical supplies was becoming a tradition in all Addis Ababa Hospitals. Disciplinary and administrative problems were resolved on the spot and corrective measures were being taken on a daily basis.

### **CHALLENGES**

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- Inadequate engagement of senior health professionals in hospital reform activities;
- Marked variability in implementation of reform initiatives between regions and hospitals;
- Ambiguity of university hospitals management and poor reform implementation;
- Poor attitude of health workers in spite of the efforts;
- Weak referral system;
- Inadequate supply of essential pharmaceuticals;
- Delayed implementation of Electronic Medical Records (EMR) System;
- Delay in implementation of Health Centre Reform; and
- Poor facility management and medical equipment management in hospitals.

### **WAY FORWARD**

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- Promote the engagement of senior health professionals in hospital reform activities;
- Strengthen the implementation of reform initiatives at all levels;
- Promote hospital reform implementation in university hospitals according to the standards;



- Undertake corrective actions to improve performance of health workers;
- Strengthen the referral system;
- Ensure supply of essential pharmaceuticals;
- Speed implementation of EMR;
- Speed the implementation of Health Centre Reform; and
- Strengthen the capacity in hospital management and medical equipment management.

## 2.8.2. BLOOD SAFETY

Availing safe and adequate blood and blood products to all patients who need blood transfusion is one of the major activity carried out in EFY 2007 to eliminate deaths due to lack of safe blood and to contribute to the quality of health care service delivery.

In EFY 2007, the plan was to collect 160,000 units of blood and 127,851 (79.9%) units of blood were collected and this was greater by 46% from the previous year (Figure 44).

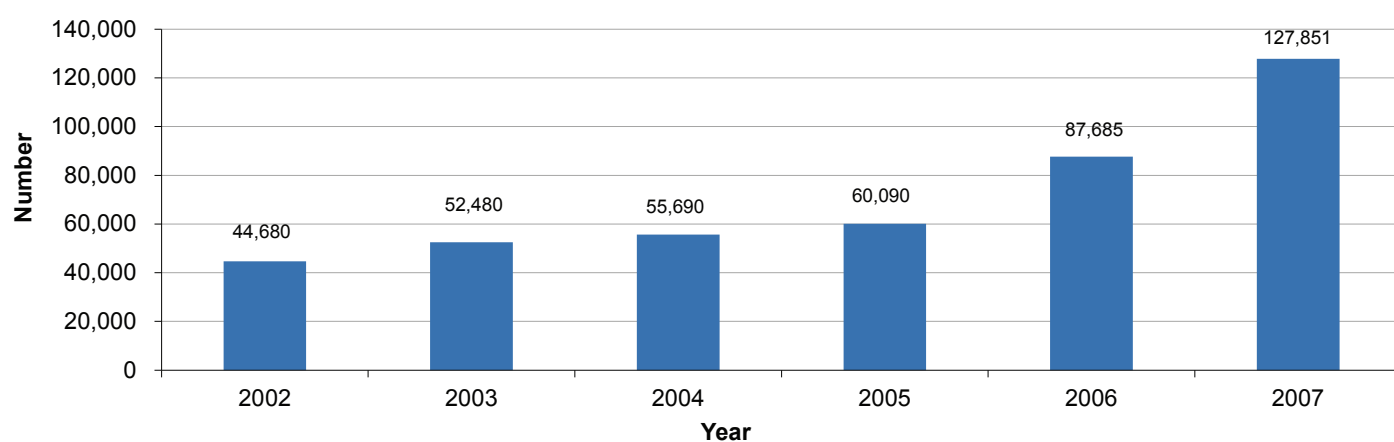


Figure 44: Trend in Number of Units of Blood Collected (EFY 2002 – 2007)

Out of the total, 48,267 units of blood (37.8%) were collected through the National Blood Bank (NBB) and the performance exceeded by 6,326 units of blood from the previous year.

There was also major increase in the proportion of voluntary blood donors from 70% in EFY 2006 to 95% in EFY 2007. As the same time, there was a significant decline on the proportion of replacement blood donors from 30% to 5% in the same period (Figure 45).

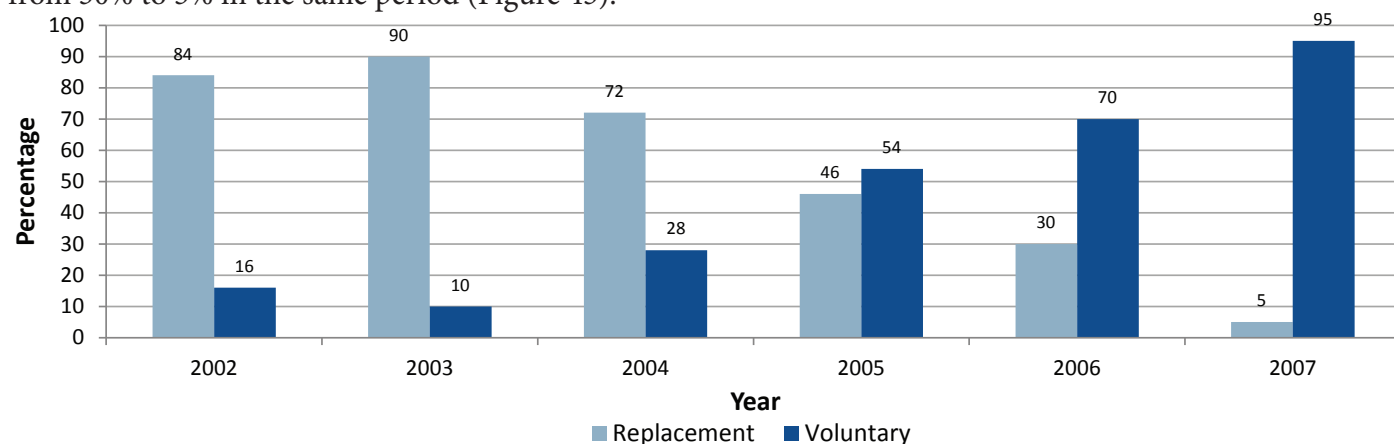


Figure 45: Trend in Percentage of Voluntary and Replacement Blood Donors (EFY 2002-2007)

A total of 120,305 (94.1%) units of safe blood was distributed to different private and government health facilities nationwide. Out of the total distributed units of blood, 115,364 (95.9%) units of blood were distributed freely; whereas, the remaining 4,941 (4.1%) units were replaced by family members.

The National Centre planned to prepare at least 50% blood components from the total collected units of blood (48,267 units of blood) and in the fiscal year a total of 19, 811 (41.1%) blood components were prepared. Quality assured screening for transfusion transmissible infections was performed on every blood donation using highly sensitive 4th generation Enzyme Linked Immuno - Assay (ELISA) technique for Hepatitis B surface antigen (HBsAg); Anti-hepatitis C antibody (anti-HCV antibody) ELISA test; Anti-HIV 1&2 Antigen/ Antibody ELISA test and syphilis Antibody ELISA test.

In order to encourage 100% voluntary blood donation, Television spots, drama and media advertisement were transmitted to the public using FM radio stations. Besides, a documentary film as well as questions and answers television program related blood donations were prepared and disseminated on “ebs Television”. Furthermore, a special arrangement of psalm/canticle clips which will encourage blood donation were prepared in collaboration with the National Theatre and given to different Media for transmission.

Infrastructure developments are an important step to encourage voluntary blood donation and to collect the required amount of units of blood by the sector. Accordingly, construction of 3 regional blood banks were started in the fiscal year. Preparatory work have also been started to build additional 12 new blood banks and central national blood bank.

### 2.8.3. UTILIZATION OF HEALTH SERVICES

To show the interaction between health care provider and the client, outpatient attendance per capita is an important indicator which also shows accessibility of health service delivery.

A total of 43,463,879 OPD visits were offered with an average of 0.48 OPD visit per person per year in EFY 2007; this achievement was more than the performance in EFY 2006 (0.35 OPD visit per person per year) (Figure 46)

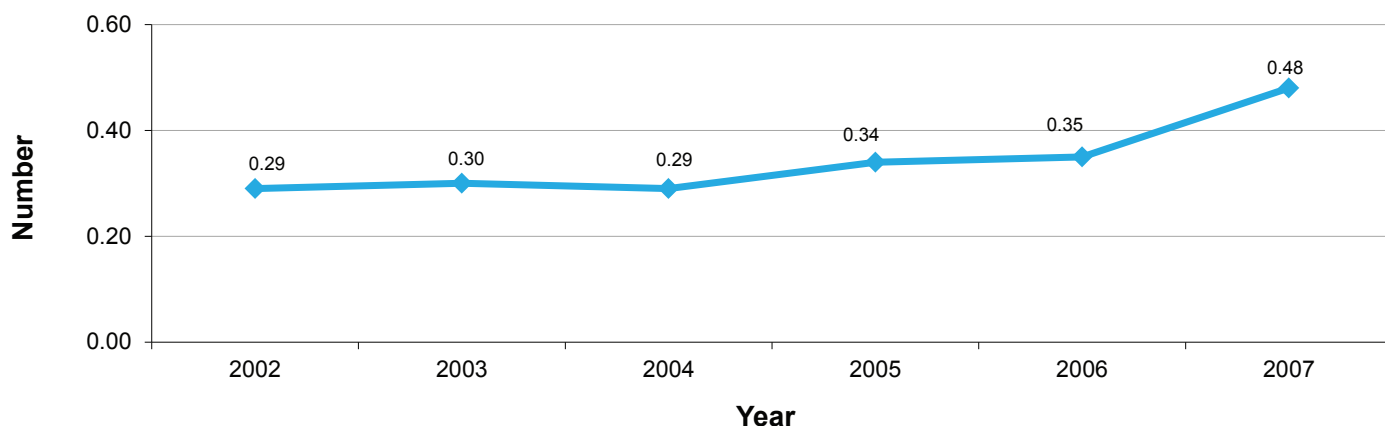


Figure 46: Trend in OPD Attendance Per Capita (EFY 2002-2007)

Wide variations were observed across regions, ranging between 0.05 visits per person per year in Somali Region and 1.3 visits per person per year in Addis Ababa (Figure 47).

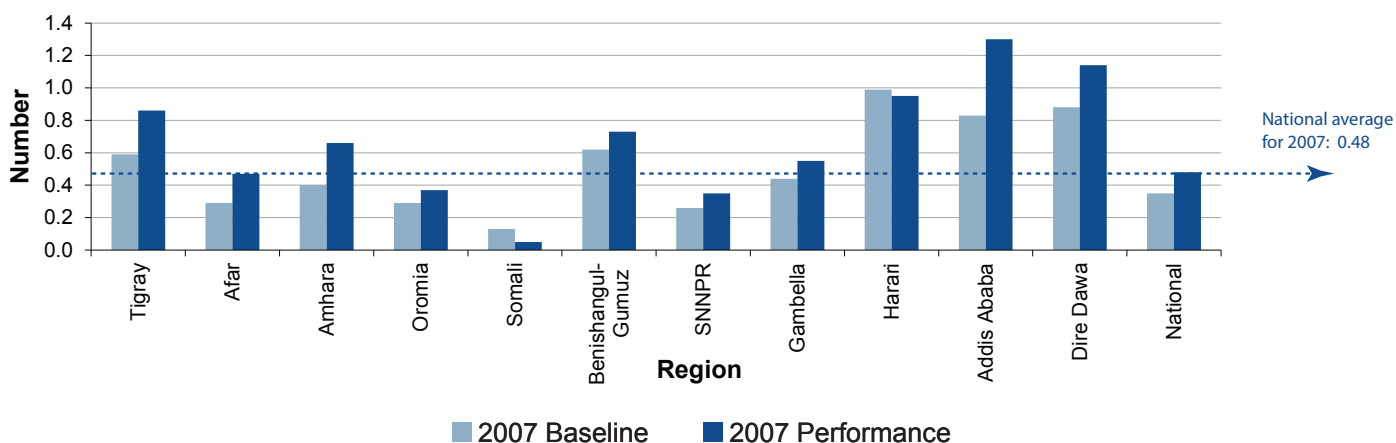


Figure 47: Comparison of Baseline and Performance of OPD Attendance Per Capita by Region (EFY 2007)

## 2.9. NATIONAL LABORATORY SYSTEM

A total of 185 laboratories were assessed to qualify for WHO/AFRO qualification and in order to be accredited by ISO starting from STAR 1 TO STAR 5. Accordingly, 65 laboratories were identified for the qualification to meet the standardization and 57 of them were assessed by an independent organization. Out of the assessed, 3 laboratories qualified as 4 STARS; 13 as 3 SATRS; 19 as 2 STARS and 22 as 1 STAR.

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

- 281 laboratory professionals on HIV testing and follow up;
- 173 laboratory professionals on TB testing;
- 285 laboratory professionals on malaria testing;
- 623 laboratory professionals on laboratory quality and control;
- 65 laboratory professionals on micro biology testing;
- 281 laboratory professionals on laboratory safety; and
- 47 laboratory professionals on utilization and maintenance of laboratory equipment.

In EFY 2007, the Ethiopian Public Health Institute (EPHI) conducted an in depth assessment to look into the problems of laboratory service provision. In line with this assessment, the EPHI built its capacity to establish a Backup Laboratory services. These laboratories are being well coordinated to take up laboratory tests from hospitals and highly reduced the burden of the patients from going to private laboratories for the laboratory tests.

Currently, Black Lion, Amanuel and St. Paul's hospitals are working closely with the EPHI to strengthen the Backup Laboratory services. To date on pilot implementation, 30,551 specimens were collected for laboratory tests and this has proven to be very effective. Subsequently, this initiative will be expanded to different hospitals in Addis Ababa and to the rest of the regions.



# CHAPTER 3



# LEADERSHIP AND GOVERNANCE

# LEADERSHIP AND GOVERNANCE

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

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

The outcome is the proper generation and use of evidence to address the critical health problems of the community at all levels of the health system, and the realization of “One-plan, One-budget and One-report”, with effective integration and alignment of health projects and programs.

### 3.1.1. REVISION OF HEALTH POLICY

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The existing health policy was drafted and ratified during the transitional governed back in 1993 G.C. Even though, the policy is successful in terms of improving the health status of the population, it is found important to revise it. Among the major reasons for revision is the change in terms of socio-economic and epidemiologic conditions in the country.

During the fiscal year, national advisory group was established to revise the policy. A revised draft policy is produced by the team and consulted with various stakeholders. The revised policy will be submitted to council of Ministry for approval.

### 3.1.2. PLANNING

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In EFY 2007, the Health Sector Transformation Plan (HSTP) was prepared for the coming five-year period covering for the period of 2015/16-2019/20 G.C (EFY 2008-2012) as part of the 2035 vision of the health sector, with strategic themes of excellence in health service delivery, excellence in quality assurance, excellence in leadership and good governance and excellence in health system capacity. Target setting and costing (in terms of finance, humans and medical equipment) was conducted using “One Health Tool”.

Since HSTP is part of GTP2, comments were incorporated to align with the overall GTP2 of the country. On top of this, wider stakeholders’ (universities, health professional associations, private providers) consultation workshops were organized and web based comments were also gathered through FMOH’s official website to



enrich HSTP. Besides, technical support was also provided for the regions on target setting and costing for the respective regional HSTP plan preparation.

In the fiscal year, the EFY 2008 woreda-based health sector planning was exercised. The focus areas of the EFY 2008 woreda-based health sector plan were based on the priority areas of HSTP, aiming at making primary health care services accessible to the whole population. On the other hand, the BSC guideline was revised for the preparation of 2008 EFY woreda-based health sector plan in the same period.

During EFY 2007, efforts were also made to institute the implementation of BSC at all level of the health tier system. At federal level, monitoring and follow up was made to cascade the plan from the institution to individual level for the entire directorate and the agencies of the FMOH. Furthermore, FMOH gave support to the regions on their BSC plan preparation to align with respective regional transformation plan.

In the fiscal year, FMOH developed BSC appreciation protocol to appraise BSC champion's using performance based system. In line with this, best performing woredas and health institutions were identified and awarded for their best performance.

### **3.1.3. ROUTINE DATA COLLECTION AND AGGREGATION**

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

In EFY 2007, FMOH together with important stakeholders prepared Health Information Quality Improvement Plan (HIQIP) and subsequently revitalized National Advisory Committee (NAC) with a focus on improving health data quality. In line with this, national HMIS Quality Improvement Mentor-ship Guide was also prepared to implement jointly with stakeholder working on monitoring and evaluation of the health sector.

On the other hand, effort was made to prepare the audio-visual training material to strengthen HMIS and improving health data quality. Moreover, sufficient amount of printing materials were distributed to regions (Especially to Afar, Somali, Benishangul and Gambella).

To address the growing need of timely, complete and accurate reporting across the various health networks, FMOH implemented the revised version of eHMIS software in EFY 2007. The eHMIS is an information system that enables health facilities, Woreda Health Offices (WorHO), Zonal Health Departments (ZHD), and RHBs to electronically compile, receive and send HMIS data electronically. In line with this, training of trainers was conducted in Menilik, Shashamene and Iteya Health Science Colleges for 115 Health Information Technicians (HIT) in the fiscal year. Subsequently, cascaded training was organized to the lower level of the health system. In general, a total of 2,026 HIT's and HMIS officers were trained. To this end, to maintain standardization at all levels follow up and supportive supervision was being conducted.

Community Health Information System (CHIS) has been designed to make the information system and decision making effective at the grass roots level. Taking into consideration the family centred provision of health service, family folder (FF) was designed to record health information related to the members of the family from birth to death as well as to housing condition. Even if, the CHIS implementation already covered all agrarian areas of the country, CHIS implementation was not fully covered pastoralists area due to their mobile nature of living. Though implementation of family folder started in EFY 2003, its implementation was slowdown with only 78% coverage at the end of EFY 2007.

In addition, due a delay of the implementation manual of the urban HEP, the urban CHIS have not yet implemented. However, efforts were being made to design the urban CHIS tools and guideline with the involvement of all stakeholder by considering as input the existing draft manual of the urban HEP.

In EFY 2007, the FMOH was working on revising the existing national disease list in context with the 10th version of International Classification of Diseases (ICD10). Thus, the FMOH conducted survey on the patient level data from selected hospitals. Accordingly, draft HMIS diseases list was prepared and the draft list was reviewed by health professionals (specialists) from specialized hospitals, professionals associations and institutions to enrich the disease list. The final disease list submitted for the management for approval.

### 3.1.4. PERFORMANCE MONITORING AND COORDINATION

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In accordance to the guideline of BSC, performance monitoring and coordination activities were carried out in all governance structures of the health system regularly in EFY 2007. Accordingly, the FMOH held regular JSC meetings with RHBs every two months, and bi-weekly Executive Committee Meetings with agencies. FMOH also held quarterly Joint Consultative Forum (JCF) meetings with DPs, and bi-weekly JCCC meetings.

Most of the RHBs undertook their annual performance review meetings with woredas, zones and other stakeholders. During these meetings, strengths and challenges of the respective regions were reviewed.

In EFY 2007, the 16th ARM was held in Dire Dawa (11-14, October 2014) with of 800 participants representing federal, regional, woreda, and community level organizations as well as DPs. The motto of 16th ARM was “ Crossing the finishing line and visioning beyond: Towards equitable and better quality health services in Ethiopia “.

As in previous years, issues of coordination, harmonization, financing and monitoring were addressed in EFY 2007 by the JCF between FMOH and Health, Population and Nutrition (HPN) Donors Group. Bi-annual and annual performance reports were submitted to the Prime Minister’s Office, and the annual of the fifth year report were submitted to MOFED.

In order to fill the gap on the health information and lack of standardize procedures for reporting, standard report writing protocol was developed. The protocol helped all reporting bodies to use uniform and standard format for reporting, date as well as schedule of reporting for each levels.

To implement the Accountability Scorecard and to facilitate information for decision making, the FMOH and Agencies started flagship initiatives using the project management software in order to increase transparency and accountability. During the preparation of the Scorecard, FMOH selected priority health indicators for the follow-up and monitoring of the health programs. The accountability of the Scorecard highlighted high-performing areas as well as low-performing areas showing bottlenecks to be periodically addressed through locally adapted solutions and the management to support the key bottlenecks for the low performance of the indicators. To this end, in EFY 2007, it was planned that to revise the accountability scorecard. Accordingly, the woreda plan was revised based on the selected priority health indicators and the BSC was prepared that included the measurement of these indicators. Besides, quarterly performance report of the scorecard were presented in colours and distributed to federal and regional levels. Finally, the performance of Scorecard was discussed on the JSC meeting at the presence of head of RHB’s.

The booklet “Health and Health-related Indicators” for EFY 2006 were disseminated using electronic copies for the entire user accordingly.

In order to enhance the use of information, a “Special Annual Review Meeting Bulletin” was published for the fourth time in October 2014. The bulletin was disseminated at the 16th ARM to inform participants on major progress updates, best practices, new initiatives, and abstracts of articles on key Operational Researches (OR), surveys and programme evaluations carried out in EFY 2006.

### CHALLENGES

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- Delay in implementation of CHIS in pastoralist and urban areas;
- Inadequate use of data quality assurance mechanisms at district and facility levels;
- Lack of integration of HMIS with pharmaceutical, regulatory, human resource, and other information systems;
- Gap in establishment and functioning of performance review teams;
- Poor documentation and dissemination of monitoring and evaluation, routine information, surveys, surveillance and operational research findings; and
- Limited practice of experience sharing and documenting, and scale up of best practices.

## WAY FORWARD

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- Speed the implementation of CHIS in pastoralist and urban areas;
- Promote integration of different information systems;
- Establish planning, monitoring and evaluation task force/technical working groups in all regions;
- Establish functioning performance review teams;
- Promote documentation and dissemination of results;
- Build information use capacity at national and regional level; and
- Strengthen the capacity of documenting and disseminating best practices

## 3.2. OPERATIONAL RESEARCH

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Operational research is performed in the health sector in order to identify and study priority problems of public health importance and produce evidence that would help decision-makers to improve the services, and develop realistic health sector policies and strategies. In EFY 2007, the following operational researches focusing on HIV/AIDS, malaria, traditional medicine and nutrition were conducted by EPHI.

- An assessment on threshold project has been finalized. According to the finding of the assessment, the amount of HIV drug resistance increases from what the disease distribution earlier on. The assessment has concluded to conduct further continual assessment on the efficacy of the HIV drug based on the study area which was Gondar.
- The assessment of 2014/2015 data from antenatal care-based HIV surveillance sites was completed. According to the finding of the study, the status of PMTCT is on different stages across regions, but all in all, it shows a decrease of mothers to child transmission even if AA and Gambella having a higher PMTCT coverage.
- National level assessment was being conducted on micronutrients-Iodine, Iron, Vit A and Zinc. For the assessment 4,026 data were collected and lab analysis was done.
- Operational researches on nutrition, traditional and modern medicines, such as a research on plants having anti-parasitic and anti-malaria effect were conducted. Furthermore, based on research findings, a manual was developed to determine the expiry date of two food products for babies.
- A research was completed regarding anti-rabies vaccine and human dose determination and duration of immunity is going on schedule, and 3,000 crude doses of anti-rabies vaccine were produced. While the crude dose was submitted for Debrezeit Institute for further multiplication of the drug. Therefore, EPHI no more expected to produce the anti-rabies for the animals.
- For health systems strengthening, a Service Provision Assessment (SPA) survey was completed. The result revealed that, there is difference between the health facility service provision and the skill of the health professionals. The result was communicated for the management for action.

## CHALLENGES

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- High attrition of professionals and inability to hire trained professionals;
- Delay in procurement of supplies for research purposes; and
- Weak monitoring and feedback mechanism at all levels of the HDA.

## WAY FORWARD

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- Speed up the approval and implementation of the incentive package aimed at retention of high level professionals;
- Speed-up the procurement process; and
- Strengthen BSC/M&E at all levels.

## 3.3. REGULATORY SYSTEM

The strategic objective is to ensure safety and quality in the delivery of health services, products and practices. It includes: (i) preventing professional malpractice; (ii) strengthening quarantine services; (iii) enhancing environmental health activities; (iv) enforcing regulations and prevention of drug abuse; (v) promoting collaboration among regulatory actors; (vi) controlling institutional solid and liquid waste disposal; and (vii) building HDA for quality assurance of health and health related products and services, promoting the public as well as government wing. To these end, major regulatory functions like Inspection, Quality Control, Registration and Licensing were being carried out on health and health related products, services/ premises and professionals to ensure safety and quality in the delivery of health services, products and practices.

### 3.3.1. QUALITY ASSURANCE OF PRODUCTS

In EFY 2007, a total of 76 food supplements and infant formula were given certificate of marketing authorization as major activity in quality assurance of food items. Besides, quality control post market test were conducted for samples of 65 edible oil, 164 iodized salts, 282 high risk food products and 867 potable water food. Moreover, 537 toxicology tests were also undertaken. Similarly, post marketing surveillance on food quality control was also undertaken on 1,626 iodized salt, 25 edible oil and 2 bottled mineral water.

After undertaking pre and post licensing, certificate of competence was issued to 252 (81 new and 171 renewal) food manufacturers. Similarly, after pre and post licensing inspection, certificate of competence was issued to 483 new and 750 renewal importer and wholesaler of food products. Likewise, inspection was also undertaken on 608 existing importer and wholesaler of food products. Also, inspection of Good Manufacturing Practice (GMP) was carried out on 324 existing local food manufacturers.

Moreover, risk base medicine and medical devices registration strategy was implemented to ensure safety, efficacy, quality and proper use of medicine and medical devices during the fiscal year. Accordingly, after evaluating their safety, efficacy and quality of 1,892 medicines and 1,005 medical equipment, marketing authorization certificates were issued to 481 & 131 medicine & medical devices respectively.

Pre-marketing physicochemical and microbiology tests were made on 287 and 386 samples to ensure the quality of pharmaceutical products and condom respectively. Actual consignment quality control or physicochemical tests were made of on 82 sample of pharmaceuticals, and quality control testing was conducted on 31 sample of condom. As post-marketing sample testing, quality control tests were undertaken on 85 and 142 samples of medicines (anti-microbial) and condom respectively. Good Manufacturing Practice (GMP) inspections were also conducted on 8 existing and 4 new local pharmaceutical manufacturers and 38 small scale manufacturers of pharmaceuticals.

Concerning licensing and inspection of pharmaceutical premise and supply chain, certificate of competence (new and renewal) was issued to 9 (1 new and 8 existing) local manufacturers. Additionally, certificate of competence (new and renewal) was issued to 505 medicine and medical device importers and wholesalers after undertaking pre and post licensing inspection. Likewise, certificate of competence (new and renewal) was issued to 5,202 different medicine retail outlets (789 pharmacy, 3,265 drug shop and 1,143 rural drug vendor).

In order to promote rational use of medicine, efforts have been made on developing, printing, promoting and distribution of standard treatment guidelines, list of essential medicine for Ethiopia, provision of training on rational use for medicine retail outlets etc...

Furthermore, as part of the control at the ports of entry and exit, import permit were given for a total of 1,370,310 tons of food items and ETB 11,644,700,000 medicine and medical equipments, after undertaking proper physical inspection on each consignment and quality control testing on selected and suspected products. Similarly, as part of quarantine services, it was planned to provide for 75,480 international passengers, while 1,281,579 received vaccine certificates were for yellow fever and for meningitis.

### 3.3.2. REGULATION OF HEALTH AND HEALTH RELATED INSTITUTIONS

In EFY 2007, manual for the implementation of minimum requirements health facilities was prepared, reviewed by the regional health bureaus and approved by the health sector JSC to control health and health related institution. Before commencing the implementations at the regional level, most of the regions conducted consultative forums and build consensus with the health service providers.

The implementation manual classifies each category of the minimum requirements for health facilities in Green, Yellow and Red. Thus, this classification was presented on the federal and regional joint forums and the way of implementation approved. In view of that, those score 75 and above will have a Green grade license, and those



score 50-75 will have a Yellow grade license with one year grace period to be shifted to Green, but otherwise the license will be rejected. Besides, those scored below 50, will be graded as Red, but within 6 months period to be shifted to Yellow and subsequently to Green, otherwise their license will be dissolved.

According to the implementation manual, all regions except Gambella have made an assessment on existing health facilities. Amhara and Dire Dawa regions have completed the assessment while the remaining regions have been on progress. Based on assessment finding, grading has been completed and license in Green, Yellow and Red grade provided to all public and private health facilities.

In order to ensure the quality of services provided, pre and post licensing inspection were conducted and certificate of competence was issued for 8,043 health services (different type of hospitals, health center, private clinics, medical diagnostic laboratory and imaging centers. Moreover, post licensing was conducted on 23,259 different level health institutions to ensure their compliance with standards and other legal framework. In addition, inspection of 81.8% of the target planned was accomplished on health related facilities (mass catering establishment like prisons, teaching institutions etc...).

Various measures were taken on the basis of the inspection results: 2 importers and distributors of pharmaceuticals, 10 retail pharmacies, 7 health facilities, 12 food item factories and 1 pharmaceutical factory received warning, suspension or revocation according to the severity of the infringement. Similar measures were taken by regional regulatory bodies, for a total of 17 retail pharmacy and 31 health related facilities.

### **3.3.3. REGISTRATION AND LICENSING OF HEALTH PROFESSIONAL**

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It was planned to ensure competence and ethical practice of health profession through licensing and registration, strengthening federal and regional ethics committee, promotion of scope of practice and launching provision of Continuous Professional Development (CPD) for health professionals. Accordingly, in EFY 2007, license was issued and renewed to 16,414 and 8,458 professionals respectively. Besides, promotion of health professional scope of practice and continuous professional practice was conducted. Furthermore, CPD provider institutions identified to launch provision of CPD. Likewise, establishment and strengthening of ethics committees at federal and limited regional level undertaken. As a result, a total of 37 health professional ethical breach issues were reviewed and decision undertaken.

In EFY 2007, registration and/or licensing of traditional medicine practitioners directive has been launched. As a result, a total of 834 traditional medicine practitioners were registered in Amhara and Oromia Regions.

### **3.3.4. TOBACCO CONTROL**

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In order to implement tobacco control, enforcement of tobacco control directive was developed in consultation with regions. The directive disseminated to reach the wider communities through different means including at FMHACA web site.

## **3.4. GENDER MAINSTREAMING**

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Different strategies have been implemented to enhance the capacity and level of consciousness of women. Based on the experiences that have been achieved on EFY 2006, the core plan for EFY 2007 was designed and implemented through the participation of women to enhance awareness and capacity; increase the involvement of women in the health sector. The major activities planned and implemented in EFY 2007 among others include:

### **3.4.1. HEALTH SECTOR GENDER MAINSTREAMING**

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Gender Mainstreaming recognizes gender as a social construct that has implication both for female and male. It is a means to institutionalize gender equality through different tools.

In EFY 2007, the coalition of different working groups (forums) were created and showed encouraging results in the health sector. Furthermore, the management was giving relentless follow up and support to enhance the role of the women in the forum.

A total of 34 women leaders participated in experience sharing sessions on the following points.

- To decrease the household burden for the women, new electronics devices were introduced and made available through long term payments.
- Economically disadvantage women workers were fully covered for their education; thus helped to improve their status and competence in the field work.
- Strong and integrated link has been created between the forum and the government structure.



- The members of the forum have conducted an awareness creation session on the health service (programs) for 2,650 females 2,722 males in total of 5,372 individuals
- Continuous discussions have been conducted among the forum members to combat rent seeking.
- Beyond creating job opportunity to some forum members by designing income generating strategies, it was also possible to create capital in some set ups. For example it has been possible to accumulate 95,000 birr capital at St. Paul Hospital.

In EFY 2007, different activities were carried out to ensure the benefits of the Women especially on education and training etc. In this regard, seven postgraduate chances have been awarded to females by providing special support.

### **3.4.2. INSTITUTIONALIZATION OF GENDER ISSUES**

In EFY 2007, a manual focusing on gender issue has been prepared to support the different stakeholders involved in the health sector. A total of 871 higher officials (268 females and 503 males) and gender focal persons from various regions, zones and woredas have been sensitized on the manual. In addition, a total of 263, 469 and 75 participants attended the sensitization workshop from Oromia, SNNP and two zones of Amhara Region, respectively.

### **3.4.3. TRAINING ON GENDER AND RELATED ISSUE**

Sexual assault is the social problem that mainly affect females irrespective of time and place. In EFY 2007, a document was prepared on responding to sexual assaults at work places that creates awareness on gender issues and enhance conducive working environment.

A manual was prepared and trainings were organized for a total of 682 participants from FMOH, Federal Hospitals and new graduates to enhance the awareness on gender and related issues.

Besides, budget support was given to awareness creation trainings on harmful traditional practices in Gambella Region.

### **3.4.4. MOBILIZATION ACTIVITIES ON NATIONAL AND INTERNATIONAL FESTIVALS**

In EFY 2007, the international anti-sexual assault day was celebrated by sensitizing and creating awareness on the physical and psychological consequences of the sexual assault on females. On the day, a total of 400 people participated on the event. Furthermore, the same awareness creation sessions arranged for a total of 1,939 participants.

FMOH with other Non-governmental organizations, civic societies & professional associations carried out the following activities in EFY 2007:-

- Report preparation and writing skill training was given for 19 participants from various regions;
- Training was conducted on youth reproductive health issues;
- Training was conducted on good governance and rent seeking principles;
- Awareness creation sessions were conducted on ensuring gender equality;
- Family law awareness creation session was conducted; and
- A total of 551 female workers of the Federal office and representing offices got pre-cancer screening tests.

### **3.4.5. WOMEN EMPOWERMENT**

In EFY 2007, training on the role of female leaders on Leadership, decision making and communication was provided to 85 regional female leaders. In strengthening the female leadership, female workers in the FMOH prompted to higher position in the same fiscal year.

## **CHALLENGES**

- Minimal support and follow up with the structure of regional women and youth;
- Lack of strong information documentation; and
- Absence of best practice documentation.

## **WAY FORWARD**

- Promote and strengthen supportive supervision with regions; and
- Capacitate the woman and youth on information documentation and collection of best practices.



# CHAPTER 4



# HEALTH INFRASTRUCTURE AND RESOURCES

# HEALTH INFRASTRUCTURE AND RESOURCES

This section describes the progress made in EFY 2007 in constructing and equipping HPs and HCs as well as in constructing, rehabilitating and expanding hospitals and strengthening medical equipment management.

## 4.1. HEALTH INFRASTRUCTURE DEVELOPMENT, REHABILITATION AND MAINTENANCE

### 4.1.1. CONSTRUCTION OF HEALTH POSTS

In EFY 2007, a total of 196 new HPs were constructed, making a cumulative number of 16,447 HPs (Figure 48).

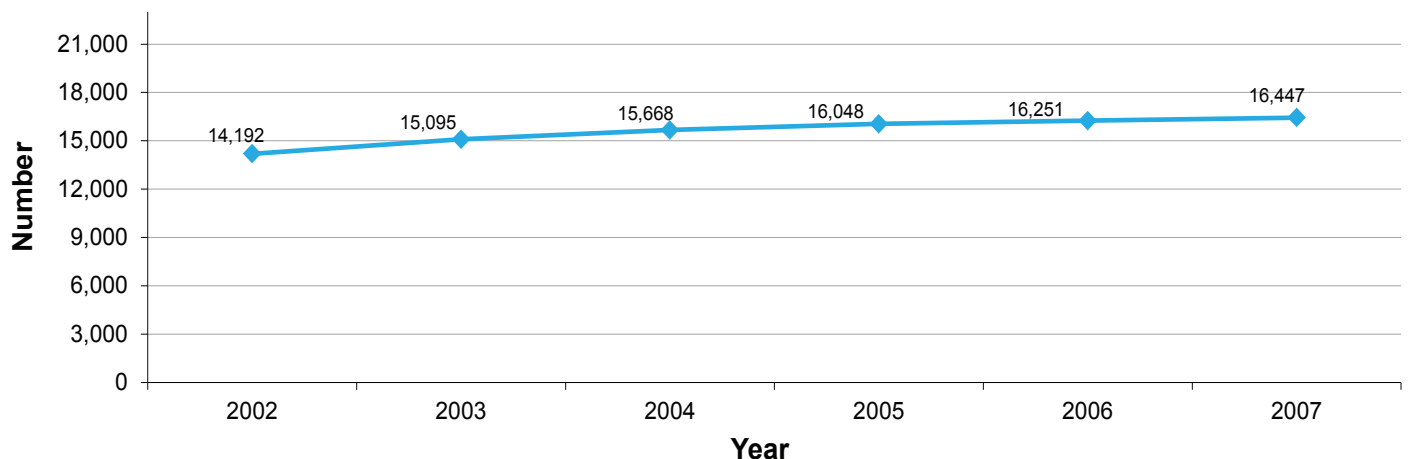


Figure 48: Trend in the Cumulative Number of Available Health Posts (EFY 2002 - 2007)

The highest number of HPs is found in Oromia Region (6,519), accounting for 39.6% of the total, followed by SNNPR (3,842) and Amhara (3,336) Regions (Table 11).

Table 11:

### Cumulative Number of Health Posts by Region

(EFY 2007)

Region	Cumulative Number of HPs Available in EFY 2007
Tigray	712
Afar	396
Amhara	3,336
Oromia	6,519
Somali	1,062
Benishangul Gumuz	399
SNNPR	3,842
Gambella	118
Harari	31
Dire Dawa	32
<b>National</b>	<b>16,447</b>

### 4.1.2. EXPANSION OF HEALTH CENTERS

The number of newly constructed and completed HCs was 251, increasing the cumulative total of available HCs from 3,335 in EFY 2006 to 3,586 in 2007 EFY (Figure 49).

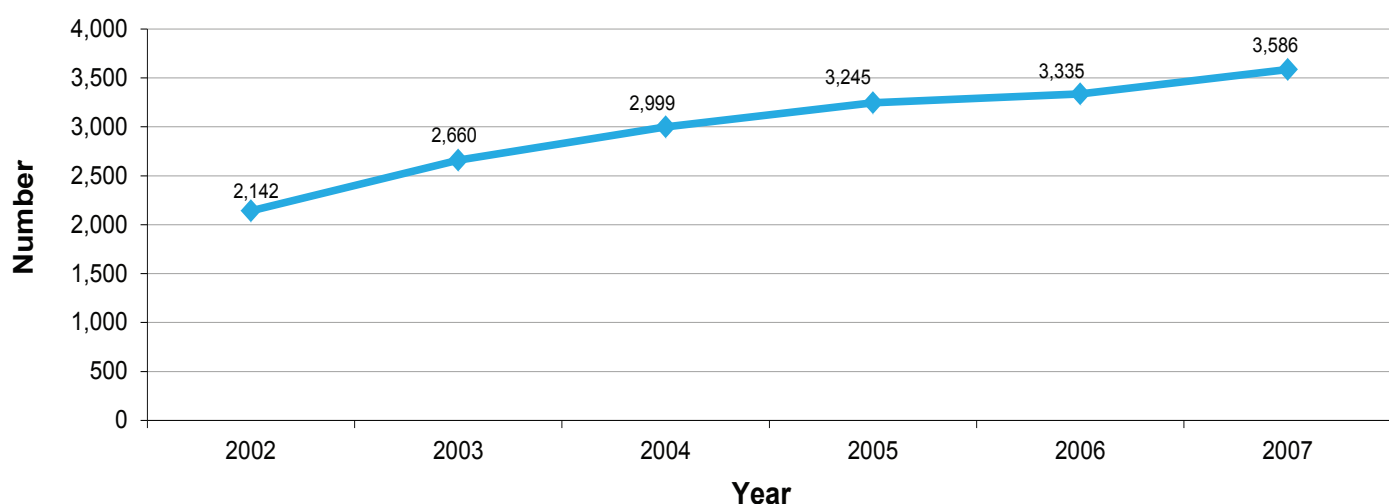


Figure 49: Trend in the Cumulative Number of Available Health Centers (EFY 2002-2007)

Out of the 3,586 HCs that were available, 3,547 (98.1%) were functional. Furthermore, a total of 180 HCs were under construction (Table 12).

The highest number of HCs was found in Oromia Region (1,320), accounting for 36.8% of the total, followed by Amhara (834) and SNNPR (752) Regions.

Table 12:

**Number of Available, Functional and Under Construction Health Centers by Region**

(EFY 2007)

Region	Available	Functional	Under Construction
Tigray	202	202	0
Afar	84	84	12
Amhara	834	834	23
Oromia	1,320	1,320	93
Somali	204	204	0
Benishangul Gumuz	45	37	8
SNNPR	752	726	26
Gambella	31	29	1
Harari	8	8	0
Addis Ababa	15	15	0
Dire Dawa	91	88	17
<b>National</b>	<b>3,586</b>	<b>3,547</b>	<b>180</b>

**4.1.3. CONSTRUCTION, REHABILITATION, AND EXPANSION OF HOSPITALS****4.1.3.1. FEDERAL HOSPITALS****Construction**

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

Phase I: the construction of the new General Hospital, which includes 161 inpatient beds, has reached 105.88% of physical progress and finishing works are in progress.

Phase II: The design and bid process has been completed for the construction of the Research Institute and administration buildings with offices and housing to accommodate approximately: (i) offices for 50 administration staffs; (ii) different training rooms for 50 to 100 students; and (iii) 20 family guest rooms.

**St. Peter 2B+ G+1 Building:** The progress of the construction has reached 45%.

**St. Peter Workshop, Fence and Guard House Construction:** 65% of the construction process has been completed.

**St. Peter Hospital G+6 Apartment Building:** The progress of construction of one block with 36 flats with two bed rooms and 4 flats with three bed rooms has reached more than 80% and finishing works are in progress.

**Alert Hospital Rectification and Triage Expansion:** The construction process is completed.

**Alert Hospital G+2 Directorate Residences:** Financial evaluation has been finalized. More than 30% of the construction is completed.

**Alert Hospital G+6 Apartment Building:** More than 56% of the construction of two blocks with 36 flats with two bed rooms and 4 flats with three bed rooms is completed.

**G+12 MOH Staff Residence Building Design:** Architectural and structural design has been finalized, a bid document has been prepared, and the bid process is underway.

**Adama G+7 Anti-Malaria Center:** The construction progress has reached 23%.

**Blood Banks:** Construction of Gondar blood bank has reached 20%, while 40% of the construction of Arba Minch blood bank is completed.



### 4.1.3.2. REGIONAL HOSPITALS

A total of 234 hospitals were available in EFY 2007 and, out of these, 189 (80.8%) were functional. On the other hand, on-going construction of 147 hospitals was reported from eight regions (Table 13).

Table 13:

**Number of Available, Functional and Under Construction Hospitals by Region**  
(EFY 2007)

Region	Available	Functional	Under Construction
Tigray	15	15	0
Afar	6	6	2
Amhara	43	42	36
Oromia	53	53	63
Somali	11	9	2
Benishangul Gumuz	6	2	4
SNNPR	77	41	36
Gambella	3	1	0
Harari	7	7	0
Addis Ababa	2	2	1
Dire Dawa	11	11	3
<b>National</b>	<b>234</b>	<b>189</b>	<b>147</b>

### CHALLENGES

- Serious shortage and unexpectedly high price of construction materials; and
- Limited capacity of contractors and RHB contract administration.

### WAY FORWARD

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

## 4.2. HUMAN CAPITAL AND LEADERSHIP

This strategic objective entails: (i) leadership development; (ii) human resource planning, development and management including recruitment, retention and performance management; (iii) community capacity development; and (iv) technical assistance management. To ensure adequate availability of skilled and motivated staffs who are committed to work and stay in a well-managed sector.

The strategic initiatives to strengthen human resource development and administration in EFY 2007 included: (i) increase the capacity of medical students intake to 2,400 and improve quality of education; (ii) enrol 135 Integrated Emergency Surgery Officers (IESO); (iii) increase annual enrolment of anaesthesia professionals from 320 to 360 per year, (iv) increase annual enrolment of level IV HEW training from 2,650 to 4,000 (v) Enhance emergency medicine, ambulance service, in service training and level IV biomedical technicians.

The following section describes the performance of the sector in implementing the federal and regional level strategic initiatives to improve human capital and leadership in EFY 2007.

## 4.2.1. TRAINING

### 4.2.1.1. MEDICAL DOCTORS

According to the WHO standard for developing countries, the physician to population ratio is 1 physician to 10,000 population. Compared to EFY 2006 (1:20,970), the ratio increased to 1:17,160 in EFY 2007. In the same fiscal year, New Medical Education Initiative (NMEI) has been rolled out to 13 medical schools, and a total of 3,117 new students were enrolled in 27 public medical schools making the total medical students on training 14,940 (Table 14).

Table 14:

#### Number of Medical Students by Year of Study and University

(EFY 2007)

University	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year	Total
<b>Addis Ababa</b>	290	367	245	320	235	290	1,747
<b>Arba Minch</b>	116	173	99	102	57	56	603
<b>Arsi</b>	121	71	81	121	73	103	570
<b>Bahir Dar</b>	150	169	141	164	77	114	815
<b>Defence</b>	0	0	0	15	22	0-	37
<b>Gondar</b>	301	400	271	259	162	198	1,591
<b>Haromaya</b>	240	340	225	225	188	108	1,326
<b>Hawassa</b>	399	340	265	222	123	178	1,527
<b>Jimma</b>	292	450	310	308	198	188	1,746
<b>Mekelle</b>	251	298	275	172	138	141	1,275
<b>St.Paul</b>	149	176	113	93	62	0	593
<b>Adigrat</b>	86	90	35	0	0	0	211
<b>Wachamo</b>	74	55	36	0	0	0	165
<b>Debre Tabor</b>	54	47	0	0	0	0	101
<b>Axum</b>	33	26	64	38	0	0	161
<b>Wollo</b>	40	46	77	52	0	0	215
<b>Debre Markos</b>	60	50	72	41	0	0	223
<b>Debre Birhan</b>	49	39	55	62	0	0	205
<b>Ambo</b>	47	30	78	67	0	0	222
<b>Wollega</b>	37	25	58	60	0	0	180
<b>Wolayita Sodo</b>	52	34	67	65	0	0	218
<b>Medawolabu</b>	37	17	61	45	0	0	160
<b>Dilla</b>	33	17	48	58	0	0	156
<b>Dire Dawa</b>	27	29	68	53	0	0	177
<b>Adama Hospital</b>	52	47	64	42	0	0	205
<b>Yekatit 12 Hospital</b>	72	75	83	74	0	0	304
<b>Yirgalem Hospital</b>	55	31	66	55	0	0	207
<b>Total</b>	<b>3,117</b>	<b>3,442</b>	<b>2,957</b>	<b>2,713</b>	<b>1,335</b>	<b>1,376</b>	<b>14,940</b>

To strengthen teaching capacity, lecture notes, modules, books, ICT, Therasim simulation software and laboratory aids have been distributed to the medical schools.

To technically support capacity of teacher's, training about problem based learning was provided to 133 teachers from new medical education schools as well as 9 international specialists and 4 experienced local specialists were being deployed in medical schools.

Besides, integrated supportive supervision was provided to 13 new medical schools. Furthermore, new and existing medical schools were networked in 8 clusters to exchange experiences and consultative workshops were carried out to set way forward.

## 4.2.1.2. INTEGRATED EMERGENCY SURGERY AND OBSTETRICS TRAINING

One of the major initiatives designed by the FMOH in EFY 2001 was to improve the provision of emergency obstetric care and surgical services at primary hospital level where a gynaecologist or surgeon are not available. The IESO training was thus started as a three years master's program for health officers in five universities aimed at reducing maternal mortality related to pregnancy and child birth. In 2007 EFY, 74 health professionals completed the training and being deployed in different health facilities. In the same fiscal year, 132 health professionals were enrolled in 11 existing and new training institutions, with a total of 489 professionals being under training (Table 15).

As part of the capacity building, supportive supervision was conducted in 10 universities and 28 hospitals. Assessment was conducted to identify knowledge gap, then training was provided for graduates accordingly. Educational materials, teaching aids and medical equipment were being procured for medical schools.

Table 15:

### Number of IESO Trainees and Number of Graduates

(EFY 2007)

University/ College	Number of Students on Training			Total	Number of Students Graduated			Cumulative Number of Graduates
	Year I	Year II	Year III		1st batch	2nd batch	3rd batch	
<b>Mekelle</b>	22	13	32	67	19	24	19	62
<b>Jimma</b>	24	18	29	71	14	20	23	57
<b>Hawassa</b>	11	19	26	56	10	16	18	44
<b>Haromaya</b>	0	17	30	47	14	10	17	41
<b>Gondar</b>	0	0	32	32	17	17	14	48
<b>Wollo</b>	21	12	15	48	0	0	0	0
<b>Adama</b>	18	22	19	59	0	0	0	0
<b>Dilla</b>	11	8	15	34	0	0	0	0
<b>Arba Minch</b>	11	0	14	25	0	0	0	0
<b>Wolayita Sodo</b>	14	10	15	39	0	0	0	0
<b>St. Paul HMMC</b>	0	0	11	11	0	0	0	0
<b>Total</b>	<b>132</b>	<b>119</b>	<b>227</b>	<b>489</b>	<b>74</b>	<b>87</b>	<b>91</b>	<b>252</b>

## 4.2.1.3. LEVEL "V" ANAESTHESIA TRAINING

Anaesthetists play a critical role in the provision of emergency surgery at primary hospitals and HCs level. In order to increase access to the services of nurse anaesthetists, in EFY 2006 the FMOH trained and deployed 96 Level V nurse anaesthetists and 126 in EFY 2007. Besides, in BSc program 151 anaesthesia trainees were graduated and deployed. Currently, a total of 159 level V nurse anaesthetists are under training in the fiscal year (Table 16), while 705 trainees are attending Bachelor of Science Program in 12 Universities and one HSC (Table 17).

In order to strengthen the learning and teaching process, 1,285 various anaesthesia books, 1,372 different skill lab teaching medical equipment were dispatched to HSCs. In addition, FMOH conducted pre - deployment training, supportive supervision and transfer of budget for health science collages.

Based on the gap identified, a total of 22 anaesthetists were deployed for medical schools. Effective teaching skill, preceptor and technical updating trainings were provided to 138 anaesthesia teachers. Besides, printing of 3,420 anaesthesia learning modules and 500 pocket guides were prepared

Table 16:

**Number of Level V Anaesthesia Trainees**

(EFY 2007)

Region	Health Science College	Number of graduates (EFY 2005 intake)	Number of graduates (EFY 2006 intake)	Number of trainees (EFY2007intake)
Harari	Harari	28	20	17
Amhara	Dessie			
	Teda	47	0	0
	Bahir Dar			
Tigray	D/r Tewolde	21	0	20
	Araya kahisu	0	0	20
SNNPR	Hawassa			
	Hosanna	0	35	22
	Arba Minch			
Oromia	Shashamene			
	Adama HMC	0	60	60
	Nekemte			
Somali	Jigjiga	0	11	20
<b>Total</b>		<b>96</b>	<b>126</b>	<b>159</b>

Table 17:

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

(EFY 2007)

University/College	Number of Students on Training				Number of Students Graduated in EFY 2007
	1 <sup>st</sup> Year	2 <sup>nd</sup> Year	3 <sup>rd</sup> Year	Total	
Addis Ababa	50	30	25	105	54
Gondar	33	30	26	89	33
Jimma	28	30	30	88	28
Dilla	15	15	15	45	17
Wolayita Sodo	12	16	16	44	0
Mekelle	41	25	30	96	19
Debre Tabor	20	15	0	35	0
Dire Dawa	32	31	0	63	0
Hawassa	20	21	0	41	0
Axum	20	15	0	35	0
Arba Minch	22	0	0	22	0
Menilik II HMC	30	0	0	30	0
Arsi	12	0	0	12	0
<b>Total</b>	<b>335</b>	<b>228</b>	<b>142</b>	<b>705</b>	<b>151</b>

#### 4.2.1.4. HEALTH EXTENSION WORKERS

HEWs are the key resources for implementation of HEP in Ethiopia. The aim of HEW upgrading program is to improve the quality of health extension services at community and household level. A total of 8,647 Level III HEW were enrolled to be upgraded to Level IV qualifications. Out of enrolled in last 3 years, a total of 3,667 graduated and deployed back to their respective HPs. The remaining 4,970 are on training and will be graduated at the end of 2015 (Table 18). Level III replacement training has been continuing in line with the upgrading program in all regions. Based on demand of RHBs, a total of 3,644 enrolled in EFY 2007. To support the teaching learning process 5,000 teaching modules were distributed to training centres and 61 HEW trainers and program managers were trained on teaching skill, occupational standard and assessment methods in the same period.

Table 18:

#### Regional Distribution of HEWs Enrolled for the Replacement and Upgrading Program

(EFY 2007)

Region	Number of Training Centres	Number of Level III Replacement HEWs Enrolled in EFY 2007	Number of Level IV Upgrading HEWs Enrolled in EFY 2007
Oromia	4	1,370	1,725
Amhara	5	1,250	1,250
SNNPR	4	0	1,000
Tigray	2	300	350
Somalia	2	300	400
Harari +Dire Dawa	1	0	80
Gambella	1	140	65
Benishangul Gumuz	1	150	100
Afar	1	134	0
<b>Total</b>	<b>21</b>	<b>3,644</b>	<b>4,970</b>

#### 4.2.1.5. EMERGENCY MEDICAL TECHNICIANS / PARAMEDICS TRAINING

This training program is a new category in Human Resources for Health (HRH) pre-service training in Ethiopia. The objective of this training program is to improve pre-hospital emergency care in managing all emergencies, including maternal emergencies. A total of 281 paramedics were enrolled in 6 training centres and will be graduated at end of 2015 (Table 19).

Table 19:

#### Emergency Medical Technicians/Paramedics Training

(EFY 2007)

Region	Number of Training Centers	Number of Enrolled in EFY 2007	Remark
Oromia	2	129	
Amhara	2	40	
Harari	1	80	For Somalia, Harari, Dire Dawa, Benishangul Gumuz, Afar and Gambella.
Tigray	1	32	
<b>Total</b>	<b>6</b>	<b>281</b>	



## 4.2.1.6. HEALTH INFORMATION TECHNICIANS TRAINING

The purpose of the Health Information Technician (HIT) program is to train and deploy HITs in the category of mid-level professionals, who will be responsible for the collection, analysis, maintenance, retrieval, and reporting of health data, in accordance with data quality and regulatory standards of Ethiopia. In 2007 EFY a total of 1,176 students were on training in 19 HSCs (Table 20).

Table 20:

### Training of Health Information Technicians by Region

(EFY 2007)

Region	Number of Health Science College/ TVET	Student Enrolled in EFY 2007
Tigray	2	0
Afar	0	16
Amhara	5	260
Oromia	4	400
Somali	1	50
Benishangul Gumuz	0	10
SNNPR	4	160
Gambella	0	10
Harari	1	6
Addis Ababa	2	249
Dire Dawa	0	15
<b>Total</b>	<b>19</b>	<b>1,176</b>

## 4.2.1.7. BIOMEDICAL TECHNICIAN TRAINING

Biomedical technician level “IV” training program have started in collaboration with Debre Markos University and Human Bridge College. In EFY 2007, a total 200 student enrolled from all regions. In addition, Addis Ababa Tegbar Eid College enrolled 50 students. Therefore, a total of 250 students enrolled in the fiscal year in two colleges (Table 21).

Table 21:

### Enrollment of Biomedical Technician level IV

(EFY 2007)

Region/ Institution	Training Colleges	
	Enrolled in Debre Markos College	Enrolled in Addis Ababa Tegbar Eid College
Tigray	44	0
Afar	10	0
Amhara	32	0
Oromia	46	0
Somali	5	0
Benishangul Gumuz	4	0
Gambella	5	0
SNNPR	31	0
Harari	1	0
Addis Ababa	6	50
Dire Dawa	4	0
Federal Hospitals (Alert, St.Paul, St. Peter, Amanuel)	4	0
Gondar University Hospital	3	0
Federal Prison Police	3	0
Human Bridge College	2	0
<b>Total</b>	<b>200</b>	<b>50</b>

## 4.2.1.8. NURSING SPECIALTY INITIATIVES

Along the traditional training systems, FMOH has introduced a new track of training specialty nursing through pooling of candidates from the nursing/midwifery background and who have had diploma. Current emphasis of the government is on promoting the production of more health personnel, especially of nurses. Moreover, equal emphasis is being given to the relevance of the trained personnel to the health needs and demands of the population in line with the current health priorities as stipulated in its health policy. The aim of the new track is therefore to ensure the optimal use of the right kind of trained personnel that could respond to the country's long-standing requirement in general and in education and training of health personnel in particular.

The new track of training specialty nurse is, as is named, and involves reorientation of its curriculum towards community focused Nursing Specialty Training with the specialty of Neonatal Nursing, emergency and Critical care, Operating theatre, Paediatrics and Surgical Nursing—training approach and aimed at responding to the current human resources gap and current and future demand by the country. Neonatal, emergency and Critical care, Operating theatre Nursing is initiated in nine universities and two health science and medical college.

This approach is different from the regular nursing programs by moving from the hospital based, exclusively patient-oriented pattern to radically different learning methods - 'curriculum- in community oriented learning and in problem based education. The conceptual difference in the new curriculum are that it has incorporated new educational strategies, has competency, learning objective, methodologies and assessment; has integrated Biomedical, , Professional competency development, social and population health sciences and is modular in delivery. Content has given emphasis to essential clinical and professional skills.

The goal of the new nursing education initiative therefore is to educate nurses quantitatively sufficient and professionally competent to provide quality health care services to meet the demand of the nation.

### 4.2.1.8.1. NURSING SPECIALTY ENROLLMENT

In EFY 2007, a total 441 trainees enrolled in different nursing specialty programs (Table 22).

Table 22:

#### Enrollment of Nursing Specialty

(EFY 2007)

Name of institution	ECCN	NN	OTN	Total
Menilik II HMC	20	20	20	60
St Paul HMMC	25	15	31	71
Hawassa University	11	0	0	11
Wolayita Sodo University	22	22	0	44
Haromaya University	13	10	0	23
Arsi University	0	10	7	17
Jimma University	0	40	20	60
Mekelle University	11	12	18	41
Wollo University	18	16	15	49
Debre Tabor University	0	21	0	21
Gondar University	17	12	15	44
<b>Total</b>	<b>137</b>	<b>178</b>	<b>126</b>	<b>441</b>

To make the nursing specialty training practical curriculums were developed for five nursing specialties (Neonatal, Operating theatre, Emergency and critical care, Paediatrics and Surgical nursing). To strengthen the teaching learning process supportive supervision were conducted in 11 institution and different technical supports were provided. Based on the gap identified through supportive supervision training in perioperative nursing care for 21 instructors and preceptors and some skill lab materials and reference books were provided in collaboration with partners.

## 4.2.1.9. FIELD EPIDEMIOLOGY TRAINING

The Ethiopian Field Epidemiology Training Program (EFETP) is a comprehensive two-year competency-based post-graduate training and service program designed to build sustainable public health expertise and capacity. Inaugurated in February 2009, the EFETP has been tailored to the needs and priorities of Ethiopia, and is a partnership between the Federal Ministry of Health, Addis Ababa University School of Public Health, the Ethiopian Public Health Association and the U.S. Centers for Disease Control and Prevention. The program is modelled after the Epidemic Intelligence Service program (aka the “Disease Detectives”) of the U.S. government. Other FETP programs are currently active throughout the world, and these programs work to build local capacity to respond to significant public health challenges.

Field Epidemiology is often referred to as “shoe-leather” epidemiology because the work is done in the field in communities. Residents in the EFETP receive 25% of their training from short modular classroom courses designed to teach principles of epidemiology and public health. The remaining 75% of the training consists of a field residency program, which includes hands-on learning and service. Residents gain competency and experience at field bases within the FMOH and RHBs. The training is closely supervised, is competency-based, and is conducted on the job.

In EFY 2007, Ethiopia expanded the MPH-level FETP to 7 additional universities; 3 started receiving residents in the spring and the remaining will receive residents in the fall. FMOH is driven to meet the GHSA target of 1 epidemiologist to 200,000 people.

In the fiscal, a total of 185 students were under training and 81 students graduated (Table 23).

Table 23:

**Number of Field Epidemiology Trainees in MPH Program by University and Year of Study**  
(EFY 2007)

University/ College	Number of Students on Training			Number of Students Graduated					
	1st Year	2nd Year	Total	1st Batch	2nd Batch	3rd Batch	4th Batch	5th Batch	Total
Mekelle	10	0	10	0	0	0	0	0	0
Jimma	11	0	11	0	0	0	0	0	0
Hawassa	10	0	10	0	0	0	0	0	0
Haromaya	10	10	20	0	0	0	0	0	0
Gondar	10	18	28	0	0	0	0	0	0
St.Paul HMMC	26	42	68	0	0	0	0	0	0
Addis Ababa	15	18	33	13	21	16	15	16	81
Bahir Dar	5	0	5	0	0	0	0	0	0
<b>Total</b>	<b>97</b>	<b>88</b>	<b>185</b>	<b>13</b>	<b>21</b>	<b>16</b>	<b>15</b>	<b>16</b>	<b>81</b>

## 4.2.2. IN-SERVICE TRAINING

### In-service Training Standardization and Institutionalization

MOH has been working to provide need based, standardized and institutionalized In- Service Trainings (IST) to ensure sustainability and ownership of health program trainings, as part of the human capital development, targeted to standardize and institutionalize in-service trainings in the health sector. Standardizing in-service training ensures the quality of the trainings while institutionalizing them ensures the sustainability of in-service trainings in the country.

In line with this, the following key achievements carried out in EFY 2007.

- National IST Directive and Implementation Guideline has developed and distributed to all relevant stockholders.

- Auditorium furniture and essential ICT materials were provided to the 35 IST Centers.
- Capacity building trainings were provided to 183 potential trainers from the IST Centers.
- Capacity building trainings and training material were supported to professional associations.
- Thirty five in-service training packages were reviewed as per the IST courses standardization checklist of the FMOH and 12 training materials namely: BEmONC, IP & PS for health service providers , Human resource for health management , LMG for senior health managers, LMG for woreda health managers, LMG for health facility managers ,Immunization in Practice, Inactivated Polio Vaccine Training, Cervical cancer, Gender training manual for the health sector, Pain management and Leadership in Strategic Information /LSI) were approved.
- The partnership between regional health bureaus and ST centers improved and RHBs have started transferring funds for the conduct of IST courses by the respective IST centers.
- All IST centers have organized and conducted in-service training courses in the fiscal year.
- Thirty five institutions were selected to register as CPD providers.
- A total of 83 FMOH staffs were trained on different topics based on pre assessed training need.

### 4.2.3. NATIONAL LICENSING EXAMINATION

The National Licensing Examination aims at protecting the public through standardized assessment of all health professionals irrespective of where they are trained. It ensures that only competent, effective and safe health care workers are granted a license to practice in the health sector. It also serves as a powerful quality assurance tool by providing a structured and informative feedback on curricula. It has been launched in EFY 2007 for four major health cadres namely: Anaesthesia, Health officers, Midwifery and Medicine. So far, there were two rounds of exams (testing application of knowledge using multiple choice questions) for both public and private training institutions (a total of 3,000 graduates) plus preparations being made to give exams for over 1,800 students at the beginning of 2008 E.C. after taking a pre-deployment training. Table 24 shows candidates who took the exam by category.

Table 24:

#### Graduates who Took the Licenser Exam by Category

(EFY 2007)

Health Professional Category	Total Number of Graduates Examined	Number of Graduates From Private Institution	Remark
Health officers	3,052	2,100 (69%)	The program is rampant in the private institutions
Anesthesia	113	0	The program doesn't exist in Private institutions
Midwifery	868	42 (5%)	A few private institutions
Medicine	795	0	Private colleges and other schools scheduled to take the on January

### 4.2.4. SPECIALTY INITIATIVES IN HOSPITAL BASED SURGERY AND OBSTETRICS AND GYNAECOLOGY (OBGY) TRAINING

To scale up and transform the low rate of specialist physicians, HRD is planning on using the regional and district Hospitals in the country for residency training in surgery and OBGY.

Table 25:

**Enrollment of Speciality Programs**

(EFY 2007)

Institutions	Number of Trainees (Gynaecology/ Obstetrics and Surgery)
Adama Hospital Medical College	20
St. Paul HMMC	43
Wollo University	12
Bahir Dar University	15

**4.2.5. DEPLOYMENT**

The FMOH has been engaged in establishing a human resources database to carry out equitable deployment of health manpower, especially those that are in short supply. Accordingly, 948 general practitioners, 91 anaesthetists, 74 IESOs, and other health professionals have been deployed during EFY 2007 (Table 26).

To ensure the quality of training on Medicine, pharmacy, midwifery, nursing, anaesthesia etc..., implementation guideline and health sector standard policy document were developed and some part of exercise has been started.

Table 26:

**Number of Health Personnel Deployed by Occupation**

(EFY 2007)

Occupation	Number of Health Professionals Deployed
General Practitioner	948
Health Officers	1455
Optometrists	53
Anaesthetists	91
Biomedical Engineering	48
IESOs	74
BSC Nurse	1375
Midwives	548
Clinical Pharmacy	379
Radiology Technology	43
Psychiatry	78
<b>Total</b>	<b>5,092</b>

**CHALLENGES**

- Instructors and preceptors are not specialized for the programs especially in nursing specialization programs;
- High fidelity skill lab materials and books;
- Poor data quality (reliable and timely) for human resource information system;
- Low capacity of human resource management for health;
- A pool system of Human resource administration from civil service in woreda level which did not give a focused emphasis for human resource for health;
- Failure of the lower level administration to absorb the health force needed;
- Critical shortage of qualified teaching staff in the teaching institution;
- Poor motivation and retention strategy particularly for health workers in community service and in teaching facilities;
- Delay in implementation of the standardized health workers motivation and retention package in most of the regions;



- Lack of clarification and inclusiveness of the national health workers motivation and retention package;
- Unclear mandate between FMOH and teaching institutes in human resource development;
- Lack of ownership of Universities on some teaching programs;
- Lack of attention for IST institutionalization and standardization at RHB; and
- Delay in approval of salary and carrier structure for Anesthesia (level V), Master in Pediatric Nursing and Master in Infectious Disease.

## **WAY FORWARD**

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- Focus on critical shortage and scale-up training;
- Improve efficiency and performance of HRM staff at all levels;
- Strengthen coordination with partners, private and other sectors;
- Regular monitoring of health professional education;
- Support teaching institution with teaching aids and staffing;
- Focus on roll out of HRIS at regional, zonal and woreda level;
- Establishing the tele- education program; and
- Strengthen quality assurance mechanism for higher education training centers.

## **4.3. PHARMACEUTICAL SUPPLY AND SERVICES**

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In EFY 2007, PFSA planned to supply and distribute essential pharmaceuticals and health program commodities, build warehouses and modernize the inventory and distribution system, strengthen the production capacity of local pharmaceuticals and medical supplies manufacturers, promote rational drug use, build capacity and good governance, implement integrated pharmaceuticals fund and supply management information system, and strengthen monitoring and evaluation. Performance of the activities is described as follows.

### **4.3.1. PROCUREMENT AND DISTRIBUTION OF PHARMACEUTICALS AND MEDICAL SUPPLIES**

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In EFY 2007, it was planned to procure ETB 7.7 billion worth of pharmaceuticals (RDF and Health Program). Of these, the Agency procured a total amount of ETB 6.6 billion worth of pharmaceuticals (ETB 2.4 billion and ETB 4.2 billion health program). In addition, the Agency has received pharmaceuticals that worth ETB 6.9 billion which was procured by development partners. Overall, the Agency has acquired pharmaceuticals that worth a total amount of ETB 13.5 billion worth of pharmaceuticals.

In line with this, it was planned to distribute a total amount of ETB 12.2 billion worth of pharmaceuticals and it has been distributed pharmaceuticals worth a total amount of ETB 12.6 billion (ETB 2.7 billion RDF and 9.9 billion health program) to health facilities during the budget year which was beyond 100% of the plan.

The inventory turnover rates of Revolving Drug Fund and Health Program pharmaceuticals within EFY 2004 – 2007 were 1.69, 1.45, 1.79 and 1.79 respectively with an average inventory turn-over rate of 1.68. To enhance the pharmaceuticals supply, 350 essential pharmaceuticals were identified and their procurement and stock status followed up closely. In EFY 2007, it has been achieved an overall availability of 89% for these pharmaceuticals. In an effort made to lower the stock difference of essential drugs between the center and branch warehouses to 5 %, flagship plan was developed and implemented. As a result it was achieved to bring the difference to less than 10%.

### **4.3.2. MEDICAL DEVICE SUPPLY, UTILIZATION AND FOLLOW UP ENHANCEMENT**

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In EFY 2007, medical equipments were purchased and distributed for 17 newly built hospitals under Oromia regional health bureau with an estimated cost of ETB 207 million. In addition, for 18 newly built hospitals of Amhara, 28 newly built hospitals under SNNPR and for existing hospitals under Afar Region health bureau

were distributed. Moreover, medical devices were distributed for 139 health centers and 212 health posts. Besides, for 651 health facilities in all regions, except for Benishngul and Harari, new born corner were installed. In addition medical supplies kit for integrated community case management for 1,941 health posts were distributed.

In EFY 2007, for 6 hospitals TB diagnosing electrolyte medical devices and 1000 solar refrigerators were purchased and distributed. Out of these, 835 solar refrigerators were installed and currently fully functional

In EFY 2007, MRI machine, medical device and supplies for kidney transplant were purchased and supplied for St. Paul millennium medical college. In addition, 300 kinds of medical device becomes ready for distribution to 150 health facilities and for the activity 265 health professionals were trained on Medical devices installation and operation. In general during the budget year 1,078 medical devices were installed in 994 health facilities.

### **4.3.3. STRENGTHEN THE PRODUCTION CAPACITY OF LOCAL PHARMACEUTICALS AND MEDICAL SUPPLIES MANUFACTURERS**

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In EFY 2007, it was planned to procure ETB 892,170,770.00 worth of pharmaceuticals and medical supplies from local pharmaceuticals and medical supplies manufacturers. In this regard. contract agreement was signed that worth ETB 820,243,387.07. Out of this total amount, the local manufacturers were able to produce and supply to the Agency ETB 620,729,938.58 worth of pharmaceuticals and medical supplies which is 75.7%.

### **4.3.4. STRENGTHEN AND ENHANCE SYSTEMS FOR ADVANCED PHARMACEUTICALS STORAGE AND BUILD MORE WAREHOUSES**

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PFSA is working hard to make itself more accessible to health facilities within 180 to 300 kilometres radius of geographical area. To realize this, new branches were opened in 2007 EFY at Gambella (Gambella Region) and Shire (Tigray Region) and the construction of warehouses and offices for additional 4 branches namely Asossa (Benishangul Gumuz Region), Kebri Dahar (Somali Region), Semera (Afar Region), and Arba Minch (Southern Nations, Nationalities and Peoples Region) were undertaken.

When the Agency was established, PHARMID had 11 branches although only 7 warehouses, including the central warehouse, were owned by PHARMID. The rest of the branches have been using rented warehouses. The warehouse capacity received from the former PHARMID was 16,760 m<sup>3</sup> and the new 17 warehouses built by PFSA during the past five years increased the total warehouse capacity by 289,150 m<sup>3</sup>. This brings the Agency's own warehouse capacity to 305,910 m<sup>3</sup>. In addition, rented warehouses with a total capacity of 225,710 m<sup>3</sup> are still in use both at Head Office and branches. This brings the current overall warehouse capacity to 531,620 m<sup>3</sup>. In addition to this, all of the 17 newly constructed warehouses have cold rooms and as a result the cold room storage capacity has increased from 50 m<sup>3</sup> to 600 m<sup>3</sup> during the last five years.

The Agency started its operation with 24 Trucks which were transferred from the former PHARMID and 6 Heavy and medium trucks given from Federal Ministry of Health. In the last five years, the Agency received trucks from different development partners and through Global Fund support. This increased the total number of medium and heavy trucks to 151. The number of refrigerated truck increased from 1 to 21 and these trucks are currently operating to support the national cold chain system.

### **4.3.5. IMPROVE PHARMACEUTICALS AND MEDICAL SUPPLIES WAREHOUSE MANAGEMENT SYSTEM**

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In EFY 2007, several trainings and experience sharing were provided; the training was on modern warehouse operation and inventory management for management members of the Agency. In-service training was provided for 1,962 health professionals drawn from different health facilities on Integrated Pharmaceuticals Logistics System (IPLS). Besides, IPLS orientation was also provided for 1,300 participants from regional health bureaus, zonal health departments and woreda health offices. Furthermore, the Agency was provided training on pharmaceuticals supply management for 180 health professionals selected from regions and zones. In addition, 227 health professionals were trained on Supply chain management monitoring and evaluation.

Training was provided for 282 health professionals on laboratory reagents' handling and use. In order to strengthen pharmaceuticals' storage management and information system at health posts, 847 health centre

and warehouse heads were trained. Besides, 106 health professionals were trained on Health Commodity Management Information System (HCMIS).

In order to improve pharmaceuticals supply between health posts and health centers, 22,865 Health Post Monthly Report and resupply format (like 7 435 FLIP books and 22,305 posters) were printed and distributed. In addition for 2,386 health facilities, 10,393 Report & Requisition Forms, 2,134 Internal Facility Report and Resupply Forms were distributed.

To strengthen inventory management and pharmaceuticals supply services at health facilities, supportive supervision was conducted at 1,055 selected health facilities. Furthermore, 71 selected health facility warehouses were equipped with shelves, ladders, pallets and ventilators that worth ETB 6,885,498.00.

#### **4.3.6. PROMOTE RATIONAL MEDICINE USE**

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To promote the rational use of medicines, it has been carried out lots of activities including strengthening clinical pharmacy services, Drug and Therapeutics Committees, training and public education on rational drug use, conducting supportive supervision, developing operating procedures and educational materials.

In EFY 2007, to strengthen the clinical pharmacy services, a total of 46 pharmacists from 38 federal and regional hospitals were trained on clinical pharmacy service. Since 2004, a total of 200 pharmacists from 65 hospitals trained for one month on clinical pharmacy service and deployed. In addition to the training, clinical pharmacy service standard operating procedure manual was developed and distributed to all public hospitals. Moreover, the first national assessment on the implementation status of clinical pharmacy service was conducted by involving all public schools of pharmacy found in the country.

Furthermore, in EFY 2007, to establish and strengthen Drug and Therapeutics Committees (DTC), training of trainer's course was provided for a total of 31 professionals. Immediately then after, the trained TOT professionals were provided the basic DTC training for health professionals drawn from health facilities. In addition, supportive supervision was also provided on 368 health facilities to strengthen DTCs. Likewise, operating procedures manual for the provision of Drug Information Services (DIS) in Ethiopia, and a working manual for the establishment and operation of DTCs are at their final development stage for printing and for distribution.

In order to reach the wider communities, public education radio program on rational medicine use, the FMOH in collaboration with Fana Broadcasting Corporation was broadcasted in Amharic, Oromifa, Afar and Somali Languages. Besides, the FMOH has also provided induction training on the pharmaceutical supply service system of the country for 375 newly graduated pharmacists prior to their deployment.

### **4.4. HEALTH INFORMATION TECHNOLOGY**

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The goal of the Health Information Technology (HIT) initiative in Ethiopia is in order to support and advance the delivery of healthcare services by enabling information access and supporting healthcare operations, management and evidence based decision process using appropriate technology. This initiative covers a wide range of HIT applications, such as telemedicine, tele-education, mobile health (m-Health), electronic HMIS (e-HMIS), Electronic Medical Records (EMR), Geographic Information System (GIS), and HRIS.

As part of the implementation of this initiative, the following main HIT activities were carried out in EFY 2007.

#### **4.4.1. MOBILE HEALTH**

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The FMOH identified mHealth as a tool to strengthen the implementation of the HEP in Ethiopia and help accelerate the achievement of the health-related MDGs. The FMOH with partners has identified five priority areas (referral, data exchange, supply chain management, training and education, and consultation) for mHealth integration within the health system. An initial set of indicators (regarding FP, ANC, delivery, immunization, malnutrition, malaria, TB, front-line stock out, and vital statistics), derived from routine data sources (including family folder, HEW tally sheets and HMIS report), was selected to be tracked through mHealth. In EFY 2004, the mHealth roadmap was finalized to help guide the design and implementation process, while in EFY 2005 an initial pilot was implemented in four woredas located in four regions in two phases (data recording into

a web-based electronic data entry system and collection of data using mobile phone, respectively). On the basis of the past experiences and after their evaluation, the FMOH has moved in EFY 2006 to interactive voice response (IVR) technology/mHealth system that can be accessed for free full-time (24 hour a day and 7 days a week) using any available phone. The system accommodates English, Amharic, Tigrigna, Oromifa, Somali and Afarigna languages. The required hardware was procured and the software was developed.

In 2007 EFY, in order to begin using this technology training of trainees, assigned a free IVR dialing services on 8756 for transferring messages line (IVR), procured and installed central server, Produced and distributed Security code (PIN) for every health post, hired operators, training of trainees was given for 5,310 HIT/HMIS and cascading of the IVR training was done for 16,535 HEWs accordingly focusing mainly on utilization of this technology.

In this regard, a total of 3,221 health posts have started sending their data in to the IVR data base on the selected indicators.

#### **4.4.2. TELE-EDUCATION AND TELEMEDICINE**

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Tele-education and telemedicine network was initiated to provide access to knowledge, expertise and other healthcare resources in a timely, convenient and cost effective manner. The network provides resources across three areas: health service delivery, education, and research.

In EFY 2005, 13 medical universities were planned to start implementation of tele-education in 4 basic science courses. In EFY 2007, continuous supportive supervisions with regard to technical and logistic perspectives were done for those university hospitals (St. Paul's, Adama and Yirgalem) that have started tele-education in EFY 2006 for further strengthening their performances.

Thirty five health professionals and six information technology (IT) staffs were trained on videoconference group teaching and how to use the videoconference system for e-learning. On this basis, four universities (Axum, Debre Birhan, Debre Markos and Wollo) arranged setup room, internet connectivity, and HR for e-Learning systems and they have started tele-education system in 4 basic science courses accordingly.

The operational strategy and roadmap documents for e-learning and telemedicine were developed. Moreover, for the remaining 7 NIME universities trainings were given for 40 university lecturers and supervisors on how to use video conferencing for e-learning and class room management with other logistic preparation was also done in order to start the 4 basic science courses through videoconferencing system.

Telemedicine plays a vital role in using telecommunication and information technologies in order to provide clinical health care at a distance. It helps eliminate distance barriers and can improve access to medical services that would often not be consistently available in distant communities that can potentially save lives in critical care and emergency situations.

In EFY 2007, trainings for more than 440 health professionals were given on how to use tele-dermatology and tele-radiology for medical activities. The tele-consultation instruction booklet, image center and draft reimbursement document has prepared. Digital cameras, image scanners and laptop computer has distributed for the hospitals. Accordingly, 3 teaching hospitals as a hub and 49 hospitals as a spoke have started tele consultation on radiology and dermatology medical services applying mail/internet (store-and-forward) methods.

#### **4.4.3. ELECTRONIC HEALTH MANAGEMENT INFORMATION SYSTEM**

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The e-HMIS is a comprehensive system which includes also PHEM, electronic Mobile Care Solution (eMCS), electronic Integrated Disease Surveillance and Response (e-IDSR), GIS, and is part and parcel of the smartcare-EMR; it addresses the growing need for a timely, complete and accurate reporting across the health system.

In EFY 2007, training was provided to more than 12,500 health information technology professionals from health facilities and 2,700 health facilities are using the revised e-HMIS. In addition, trainings were given to 19 program managers at federal level in order to use the system for improving decision making and enhance the information use for day to day activities.



#### 4.4.4. ELECTRONIC MEDICAL RECORD FOR HIV CARE (EMR-HIV)

In EFY 2007, the FMOH with development partner has developed the HIV Care/ART module of EMR and has been implemented in several sites as part of the full EMR. The intention of the development of the system; primarily to standardize the ART database throughout the country and secondly, to align with the latest follow up, intake, and PEPFAR indicators. For this purpose additional, new data clerk view module is developed with user friendly features for ease of use by the HIV Care/ART data clerks and it is fully integrated with the EMR. Furthermore the Data Merging Function was also developed to merge data from different existing HIV Care/ART database with MS-Access database and excel.

Advance level training was provided for 313 senior IT staff and HIT's for the provision of site level installation and migration of existing data to the new system. Besides, the trained staff has provided on job training for more than 275 ART data clerks. Until the end of the 2007 EFY, 276 health facilities has deployed the system (Table 27).

Table 27:

#### Number of IT/HIT's Trained and Number of Health Facility Started EMR-HIV

(EFY 2007)

Region	Number of IT/ HIT Trained	Number of Health Facility EMR/HIV Software Deployed
Tigray	25	73
Afar	31	20
Amhara	28	56
Oromia	23	45
Somali	31	3
BenishangulGumuz	6	4
SNNPR	19	0
Gambela	1	1
Harari	15	3
Addis Ababa	121	62
Dire Dawa	13	9
<b>Total</b>	<b>313</b>	<b>276</b>

#### 4.4.5. ELECTRONIC MEDICAL RECORD/ MEDICAL RECORD UNIT

Medical Record Unit (MRU)-EMR is the component of Electronic Health Record System/ Smartcare that computerizes the MRU/card rooms of Hospitals and Health centers.

In EFY 2007, software and hardware installations, forming technical working groups, preparation of standard of procedure manuals were done for 6 Addis Ababa and 4 Federal Hospitals. Accordingly, in collaboration with AARHB strengthen the 9 hospitals medical record unit where implemented MRU-EMR system. The Gandhi Memorial hospital has implemented the full scale Smart EMR system. Moreover training was conducted for 1,194 staffs on EMR-MRU and the system is implemented in 386 Health centers in Amhara regional state. In Addis Ababa, 38 staffs are trained and the system is newly implemented in 33 new HC.

So far, EMR of MRU has been implemented in 732 health facilities (97 hospitals and 635 health centers) throughout the country.

#### 4.4.6. FACILITY BASED SERVICE INFORMATION DISSEMINATION SYSTEM

Ethiopia has conducted Service provision Assessment (SPA+) survey, the first in its kind, in 2014. The eSPA+ collected information on the overall availability of different facility-based health services in a country and their readiness to provide standard services. The key services and topics assessed in eSPA+ survey were: infrastructure, resources and systems (water, electricity, latrines, infection control, management systems, storage and stock monitoring for vaccines, contraceptives, and medicines and infection control); child Health (availability of vaccines, medicines, and Vitamin A, availability of curative care services and the availability of equipment and



supplies for outpatient care and adherence to guidelines for sick child care); maternal and new-born health (availability and appropriate assessment of clients for antenatal care, delivery services, new-born care and emergency obstetric care); family planning (availability of contraceptives and supplies, user fees, counselling and client assessment and provision of STI treatment for family planning clients); HIV/AIDS (availability HIV testing services, HIV/AIDS care and support services, antiretroviral treatment, prevention of mother-to-child-transmission and post-exposure prophylaxis); sexually transmitted infections; malaria (availability of malaria diagnostic and treatment services, guidelines, antimalarial and laboratory diagnostic capacity); tuberculosis (availability of TB diagnostic services and availability of first line medicines for treating TB); basic surgery; and NCD (diabetes, cardiovascular diseases and chronic respiratory diseases).

To make use of the information obtained from this survey, the FMOH has developed facility based information dissemination system applying a web base system as well as the data cleansing and migration was done. This developed application software is provides information on selected eSPA+ survey such as location of the facility, child health, maternal and new-born care, family planning, STDI and HIV/AIDS.

The purpose of the web application is to provide up-to-date information of each facility for the user so that they can use it as an input for their planning and decision making process. It also aims to act as a master health facility list from which one can identify the list of health facilities found in Ethiopia. The deployment of the system has two phases: the first, the application is hosted via intranet for FMOH users and second phase to all stakeholders.

#### **4.4.7. HUMAN RESOURCE MANAGEMENT INFORMATION SYSTEM**

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The HRIS-Manage system is under revision to upgrade it to version 2.0. Currently the version 1.5 has been implemented at FMOH and at various levels across the regions, with Amhara, Oromia and SNNPR scaling up to Zone level in EFY 2007. The biometric attendance module has been implemented at the FMOH and at St. Paul Hospital. More than 147,000 personnel data from all 11 regions & FMOH has been imported into the software and deployed in FMOH data centre.

The HRIS-License system has continued to be used by regional regulatory bodies across the nation. There has been active backlog entry in Amhara, Oromia, Tigray, Harari and Afar regional regulatory bodies. The HRIS-License currently hosts over 64,700 professionals license data entered nationally and published online ([www.fmhaca.gov.et/license](http://www.fmhaca.gov.et/license)).

#### **CHALLENGES:**

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- Limited HIT structure and staff;
- Gap in harmonization among several eHealth initiatives and ICT infrastructures;
- Lack of national standard in implementing eHealth systems in health facilities.
- nconsistent use of the system both HRIS-Manage and HRIS-License due to a high staff turnover;
- Absence of responsible IT HR personnel and structure at zonal and woreda levels has resulted in lack of complete data at these structures which in turn makes the HR data updating very slow and incomplete including challenges faced to enter the HR data on excel from lower level health institutions at the zones or at RHB;
- Poor computer literacy/capacity of the delegated HR officers; and
- Low prioritization of institutions on HR management.

#### **WAY FORWARD**

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- Standardize the HIT structure, staff and ownership;
- Harmonize efforts of key stakeholders towards standardization and interoperability;
- Prepare the national standard to implement eHealth systems in health facilities;
- Create structure and hire dedicated HRIS personnel at lower levels; and
- Upgrade and scale up with version 2.0 of the HRIS-Manage system.

## 4.5. RESOURCE MOBILIZATION AND UTILIZATION

Health services in Ethiopia are financed from the federal and regional governments, grants and loans from bilateral and multilateral donors, NGOs, and private contributions. Although health financing has improved significantly over years, it remains a major challenge for the health system. To estimate the flow of resources in the health sector, the Health Care Financing (HCF) reform is being implemented, with a focus on mobilization of additional resources from DPs, retention and utilization of user fee revenues at health facility level, implementation of fee waiver and exemption services, establishment of health facility governing boards, introduction of private wings in the public hospitals, and development of risk sharing and pre-payment schemes.

The following sections describe major activities carried out in EFY 2007.

### 4.5.1. HEALTH CARE FINANCING

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

This section outlines the performance of the major HCF reform projects during EFY 2007.

#### 4.5.1.1. REVENUE RETENTION FOR QUALITY IMPROVEMENT

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

Currently, a total of 3,288 health facilities (169 hospitals and 3,119 HCs) are retaining and utilizing internally generated revenues to improve the quality of health services. Based on reports from health facilities, they have utilized the retained revenues to: (i) purchase drugs; (ii) improve laboratory services (i.e. purchase of microscopes, haematology complete blood count machines, centrifuges, haematology diagnostic products, chemicals and reagents, etc.); (iii) improve medical equipment (i.e. purchase of Doppler ultrasound machines, operating and patient monitoring tables, modern dental equipment, etc.); (iv) improve the infrastructure of health facilities (i.e. safe water supply, water tank installation, generator, laundry, etc.); (v) renovate and expand the constructions (i.e. patient waiting areas, card rooms, triage rooms, pit latrines, etc.); (vi) improve HMIS (i.e. purchase of computers, installation of local network, printing of consultation cards, request formats, prescriptions, and patient referral slips etc.); and (vii) improve staff motivation (i.e. construction of staff residence, provision of transportation and cafeteria services, etc.)

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

Fee waiver scheme is being implemented as a mechanism for financial risk protection to promote equity of access to health services. Citizens who cannot afford to pay for their medical expenses are entitled to the fee waiver scheme, and any authority providing waiver certificate shall cover costs incurred for the service provided. Accordingly, screening for a total of 1,836,117 beneficiaries being made by the respective woredas and the woredas and regional governments (except Tigray, Afar and Somali) allocated a budget of ETB 44,225,098 for fee waiver beneficiaries. Out of the identified beneficiaries 896,506 (48.8%) received the health services. The scheme is implemented in all regions and in total 151 Hospitals and 2,733 HC currently provides the service.

#### 4.5.1.3. STRENGTHEN HEALTH FACILITY GOVERNANCE AND MANAGEMENT

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

Therefore, among the 3,620 health facilities which are under the reform (174 hospitals and 3,446 HCs), 3,258 health facilities (157 hospitals and 3,101 HCs) have formed governing bodies, with most of them being functional in EFY 2007. Besides, to evaluation the performance of the board's as well as CEO's, a checklist was prepared and communicated with regions. As a means of capacity building, all regions hospital board members were trained on hospital service delivery and hospital service monitoring & evaluation.

#### **4.5.1.4. PRIVATE WING AND OUTSOURCING**

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

In EFY 2007, more than 50 public hospitals have opened private wing services nationwide. Follow-up was being held for federal hospitals to start private wing services.

A guideline was prepared and disseminated for all regions (including the federal hospitals) on the provision of private medical services. As a means of strengthening follow-up and support at each level, measurement tool was included on the guideline for the implementation of private medical services.

#### **4.5.2. HEALTH PARTNERSHIP COORDINATION**

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Lack of resources is one of the main challenges in Ethiopia that hinders health care access and quality. Strengthening effective partnership with different stakeholders will also help to mobilize adequate resources for the health sector. Different activities were carried out in EFY 2007, including: (i) public-private partnership (PPP); (ii) bilateral agreements (iii) NGOs coordination; and (iv) diaspora coordination.

##### **4.5.2.1. PUBLIC PRIVATE PARTNERSHIP**

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In EFY 2007, assessment was completed on 17 concerned health facilities, in all regions, public private partnership has been already implemented to identify best practices and for expansion. Based on the comments obtained from professionals, the final document will help as input document for the implementation guideline for the purpose.

For strengthening PPP in Ethiopia, conference was held and based on the conference proceeding report, several panel discussion was conducted. Moreover, countries best experiences were also documented from other countries and that will help further to identify strategic direction for the implementation of PPP. In accordance to enrich the draft implementation guideline, stakeholder's consultation was conducted.

##### **4.5.2.2. BILATERAL AGREEMENT**

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In accordance with the agreement reached with neighbouring countries on addressing common health-related issues, the following activities were carried out in EFY 2007. The joint Ethio-Djibouti Commission Meeting was held at Djibouti and the previous agreement was reviewed and the meeting approved future joint plan of health sector between both countries. Similarly, the Ethio-Kenya bilateral on strengthening health sector previous agreement was evaluated and to carry on with much effort for the future. For strengthening access to health service and the Ebola with its surveillance for the people living at the border area, the joint minute was circulated for the concerned directorate for the implementation.

The bilateral draft agreement was made on health-related sent to the Ministry of Foreign Affairs, and were prepared with Governments of Somalia, Yemen, South African Republic and Nigeria. The response is expected from the Ministry of Finance for further development. Moreover, the bilateral agreement between Ethiopian and Morocco government, after reviewing the agreement received from Morocco government, submitted to MOFA. In the same year, the bilateral agreement was signed with the Government of Uganda and based on the agreement document, the 2nd Ethio-Uganda Ministers and experts joint commission meeting was prepared action plan for implementation.

Based on previous Ethio-Egypt bilateral agreement, the human resource development on health and supply of drugs action plan prepared and submitted for the concerned body of Egypt. Moreover, Ethio-Kenya, Ethio-Egypt and Ethio Sudan joint border principals and commissioners bilateral health sector agreement follow up and implementation report submitted for FMHACA and other concerned directorate for the implementation.

##### **4.5.2.3. NGO COORDINATION**

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In EFY 2007, a supervision, M&E, and control system regarding NGO activities was launched, after approval by Ministry of Civil Service. For six NGO's, who were on the process of phase out, final terminal evaluation was conducted. The five organizations terminal reports were finalized and submitted for the concerned bodies for action. Moreover, a database was prepared for those NGO's working for health sector having the licence and also registered for the license by identifying the region they are implementing and program they are working on.

Inspection has been conducted on three NGOs following the claims that they were not implementing activities as per the plan, and the decision is still pending.

A forum has been established to strengthen and align the plan with the NGO's working on Reproductive health, maternal, new born, child adolescent and nutrition.

#### **4.5.2.4. DIASPORA COORDINATION**

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To encourage the diaspora's and voluntaries to be participated on health sector on knowledge, skill and technology transfer, in EFY 2007 brochures, documentary film and booklet were prepared and the brochures were circulated on national Diaspora's day, while the printing of the booklet and finalizing the documentary film is being completed. Besides identification in the form of profile was prepared where the diaspora to be participated.

In EFY 2007, with AHIA/TC, a total of 30 volunteers were assigned to provide medical service in the country.

#### **4.5.2.5. OTHER ACTIVITIES**

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In EFY 2007, federal hospitals internal resource generation and financial utilization system guideline was being prepared. In addition, for the implementation of the health care financing reform, draft guideline has been completed. Likewise, health care financing reform training was provided for 28 participants drawn from four federals and one university hospitals.

To facilitate the implementation of CASH project implementation by our locals, Filantherapist; detail information (for about 800 commercial organizations) was collected from National bank of Ethiopia and Ministry of Industry on areas of banking, factories, construction companies, hotels, transport industries, import and export wholesalers. Based on their capital, the ministry identified and categorized about the 400 organizations for the purpose. Accordingly, gap analysis has been made on 11 Addis Ababa hospitals for the CASH project implementation which will be covered by our local filantherapist. Discussion was also made with the filantherapist and linkage has been made with the respective hospital managers.

#### **4.5.3. HEALTH INSURANCE**

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The financial barrier is one of the major challenges hampering the access to health care services in Ethiopia. To promote equity and access, the GOE has articulated equitable financial mechanisms into its policy and strategies; currently, the country adopted two equitable financial mechanisms: (i) community based health insurance (CBHI); and (ii) social health insurance (SHI).

##### **4.5.3.1. COMMUNITY-BASED HEALTH INSURANCE**

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Since EFY 2004, CBHI has been implemented in 13 pilot woredas (3 in Amhara, 3 in Tigray, 4 in Oromia and 3 in SNNPR), and in EFY 2007 the scheme expanded by starting the preliminary work in other 185 woredas (15 in Tigray, 64 in Amhara, 59 in Oromia and 47 in SNNPR).

In EFY 2006 CBHI schemes registered a total of 157,553 households, increasing to 1,374,325 in EFY 2007; the number of beneficiaries increased from 687,309 in EFY 2006 to 6,504,146 in EFY 2007. As a result the coverage ratio out of the total population has reached 7%. Within the CBHI implementing Woredas, enrolment ratio stands at 45.9% of eligible population in the first pilot Woredas and 31.8% of eligible population in the expansion Woredas.

Out of the total 6,504,146 beneficiaries registered in the CBHI scheme, 1,177,393 were served (88.73% at HCs and 11.27% at hospitals) in this fiscal year, and a total amount of ETB 62,111,055.49 was reimbursed to health facilities.

Since the start of CBHI scheme, a total number of 2,214,557.00 beneficiaries received medical care and a total amount of ETB 83,344,046.12 was reimbursed to the respective health facilities. On the other hand, the schemes have so far mobilized a total amount of ETB 196,234,617.69 from contributions of which ETB 133,060,963.69 was mobilized in 2007 alone.

Furthermore, CBHI scheme received a total amount of ETB 20,119,050.40 as general subsidy from the FMOH in the current fiscal year which increased from a total subsidy of ETB 5,878,644.00 in the pervious fiscal year.

With regard to communication and mobilization, CBHI TV and Radio spots were produced and transmitted in the national and local Medias for mobilizing the community. In addition, annual magazine, information booklet, Agenda, Calendar and other print media outlets were produced and distributed to the Health Insurance Branches.



### **4.5.3.2. SOCIAL HEALTH INSURANCE**

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As part of the health financing reform, social health insurance is expected to be launched in January 2008 in Ethiopia. The social health insurance strategy is designed to provide health insurance coverage in the formal sector.

The Ethiopian health insurance agency with its branches across the country is engaged on the accomplishment of the preparatory works useful for the launching of the scheme. The preparatory works has been undertaken that include the design of varies manuals and working guideline, the design of registration codes and the establishment of health insurance members database for the government, private and civic organization employees and employers which are prerequisite for the implementation of social health insurance .

The Agency has also conducted continuous awareness and popularization of the social health insurance concept, principle and benefit to the potential members using different Medias. In 2007 alone, 26 awareness raising forums were used to sensitize and introduce the essence of health insurance for potential members in all branches.

In addition, last quarter of 2007 and the first few months of 2008 overall assessment of health facilities is underway to identify eligible facilities throughout the country to ensure facility readiness.

### **CHALLENGES**

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- Absence of defined date for launching of social health insurance;
- In some regions absence of complete information;
- Lack of adequate human resources;
- Lack of integration of Health Insurance Agency and Regional Government;
- Lack of experience and resources on monitoring of health insurance risks and risk mitigation;
- A shift of direction hampers a slowdown of CBHI activity;
- Lack of harmonization; and
- Delay on approval of directives and guidelines.

### **WAY FORWARD**

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- Accelerate the finalization of the preparation phase and define the date to start implementation of SHI;
- Establish frequent communications of Federal and Regional Governments; and
- Accelerate the approval of the directives and guideline.

### **4.5.4. FINANCIAL/EXPENDITURE MANAGEMENT AND CONTROL**

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The management and control system aim to ensure accountability and transparency in the utilization of the funds so as to meet the objectives for which the funds have been provided. To this end, effective internal control mechanism and good governance are the main instruments.

With regard to grants management practice, FMOH has exert maximum effort to strengthen federal regional grant management practice in terms of hiring additional experts (78 for financial management unit and 14 for grant management unit) in EFT 2007. Besides, a total of 46 people received standard training on grant management practice in the health sector scenario.

Concerning an external audit, FMOH has made effort to get its financial management system audited for the year EFY 2007 by Audit Service Corporation with the scope of auditing based on individual grants requirements and internationally accepted financial management rules and regulations. Out of the total of 23 active grants 15 was audited. This practice ensure accounting system that regards the recording and reporting of transactions of the grant funds, reliability of the financial reports for the accounts of the grant funds, authorization and authenticity in the utilization of the grant funds, proper documentation/file management system, safeguarding and proper utilization of assets that are purchased/ donated by the grant funds.

Budget Utilization: In EFY 2007 a total amount of ETB 6.156 billion was mobilized in the year accounted for and out of that 1.663 billion was spilled over from last year. In the same years ETB 3.490 billion was utilized, which was accounted 44.63%. Considering the regional budget utilization, out of the total cash transferred of



ETB 1.37 billion plus ETB 0.837 billion spills over budget from EFY2006, ETB1.363 billion was utilized, which is account for 62% of the total transferred amount. Considering the government budget from the total amount approved ETB 82.2 million for the EFY 2007, ETB 82.04 million was liquidated, which is accounted for 98%.

## **CHALLENGES**

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- Absence of effective communication mechanisms to collect statement of expenditure from regions and health facilities; and
- Elongated time taken to get regional grant management unit on board to be able to practice the real role of grant management.

## **WAY FORWARD**

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- FMOH needs to strengthen networking and partnership with regions and different implementing partners; and
- Introduce frequent supportive supervision and capacity building training for the regional grant management staffs.

### **4.5.4.1. INTEGRATED FINANCIAL MANAGEMENT INFORMATION SYSTEM**

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

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

Meanwhile, the best practices and the lessons learned from the implementation of IFMIS at the FMOH, is very helpful in putting the IFMIS system into action on the organizations that have relationship with FMOH. Activities have already started to bring all efforts together in order to implement the system at the six organizations, namely: Blood Bank, HAPCO, EPHI, PFSA, FMHACA, and Health Insurance.

IFMIS implementation requires basic Information Technology infrastructures, the Local Area Network (LAN), Woreda Net connectivity, IT personnel for support, basic IT skill of the staffs, appropriate assets management and proper reporting procedures. A detailed assessment has been made along with MoFED IFMIS focal personnel at the aforementioned organizations mainly in order to complement the requirements if there are gaps and to follow up the implementation process on those which are already fulfilling the requirements. If approval is obtained from MOFED to implement the system at the said organizations, the site implementation will be taken place ranging from data cleansing, to provision of class-based and on-job training, and supporting till they will own the system.

Expectedly, within this budget year the implementation of the IFMIS will ensue on the six organizations as well as Oromia RHB which have already equipped with the necessary infrastructure required as part of the implementation process.

## CHALLENGES

- Infrastructure related problems at the subordinate organizations, mainly the absence of Woreda Net infrastructure;
- Skilled human Resources to work on the system; and
- Resistance to change to the new system.

## WAY FORWARD

- Based on the assessment obtained, enabling the organizations to fulfil preliminary requirements for the implementation of the system;
- Putting the Woreda Net infrastructure into place for the Six organizations;
- Providing awareness creation for the staff to fully migrate to the new system; and
- Implementing the IFMIS system at the six organizations and one RHB.

### 4.5.5. PUBLIC BUDGET ALLOCATION

This section explains the allocation to the health sector out of the total public budget in EFY 2007. The source of data is MOFED. Besides, it shows only the allocation to the health sector at regional level.

#### 4.5.5.1. PERCENTAGE SHARE OF THE PUBLIC HEALTH BUDGET ALLOCATION FROM THE TOTAL BUDGET

In EFY 2007, the percentage of total budget allocated in the health sector at regional level was 11.1%, which was higher than in EFY 2006 (10.3%) (Figure 50). In EFY 2007, the per capita health allocation was ETB 122.78, increasing from ETB 116.43 in EFY 2006. The regional block grant budget allocated to the health sector ranged from 5.1% in Harari to 15.7% in SNNPR in EFY 2007. Except Somali and SNNP Regions a decrease in the percentage share of health budget from last year was observed in the remaining nine regions.

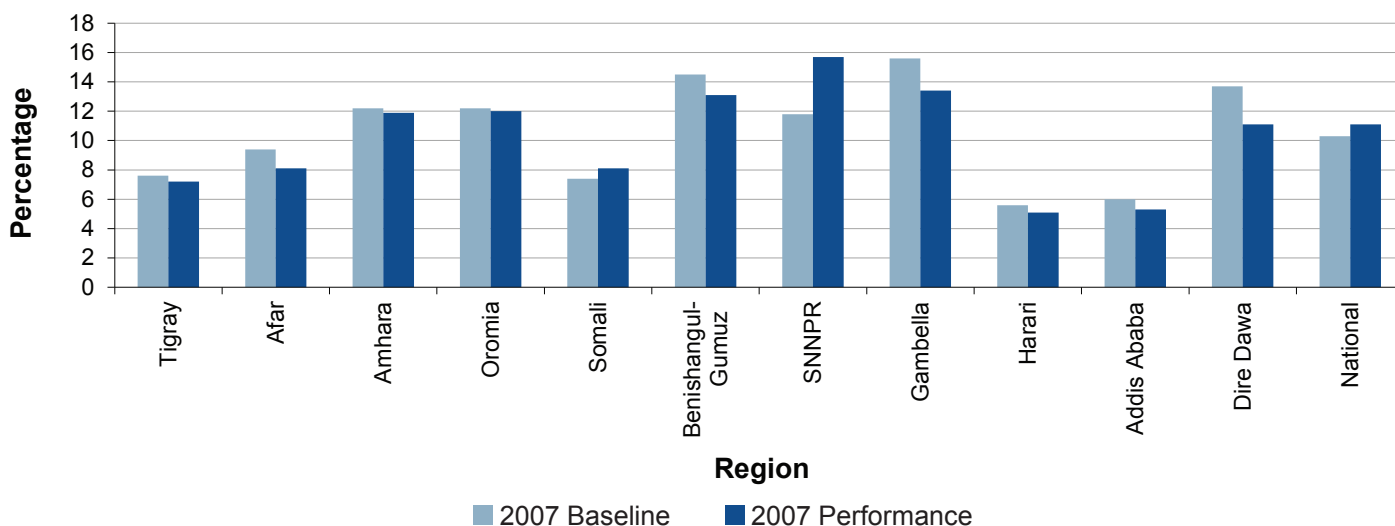


Figure 50: Distribution of the Percentage of Total Budget Allocated in the Health Sector by Region (EFY 2006 and 2007)

As it was observed in the previous years, the per capita allocation is increasing time to time; however, the allocated budget for health in the fiscal year was still below the amount needed to bring quality of health care to the community. Therefore, enhancing implementation of HCF reform and expansion of pre-payment schemes like community and social health insurance, as well as additional funds from different sources are important to increase financial resource for the health sector.

#### 4.5.6. DEVELOPMENT PARTNERS' CONTRIBUTION TO THE HEALTH SECTOR

The contribution from DPs is one of the major sources of funding for the Ethiopian health sector. The following section shows how much was contributed and disbursed by DPs to the health sector.

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

A total amount of USD 445.96 million was committed and a total amount of USD 269.07 million (60.3%) was disbursed using channel 2 modality to the health sector in EFY 2007 that was lower than EFY 2006 commitment and disbursement (USD 558.33 and USD 612.87, respectively). (Table 28)

Table 28:

### Commitment and Disbursement of Funds by Development Partners

(EFY 2007)

S.N.	Source of Funds	Commitment (in USD) in EFY 2007	Disbursement (in USD) in EFY 2007	Percentage Disbursement
<b>1</b>	<b>MDG Performance Fund</b>			
	DFID	121,464,646.46	101,647,000.00	83.7%
	AusAid	0.00	0.00	0.0%
	World Bank	34,000,000.00	34,521,883.44	101.5%
	Netherland Embassy	14,877,143.00	14,862,788.00	99.9%
	Irish Aid	6,709,610.00	13,620,725.80	203.0%
	Spanish Aid	2,683,844.00	1,112,199.24	41.4%
	UNICEF	500,000.00	500,000.00	100.0%
	Italian Cooperation	3,354,804.08	3,544,798.00	105.7%
	UNFPA	1,000,000.00	0.00	0.0%
	GAVI	22,000,000.00	0.00	0.0%
	WHO	0.00	0.00	0.0%
	EU	6,200,000.00	7,565,337.00	122.0%
	<b>Total</b>	<b>212,790,047.54</b>	<b>177,374,731.48</b>	<b>83.4%</b>
<b>2</b>	<b>Technical assistance pool fund</b>			
	DFID	1,007,757.60	0.00	0.0%
	Italian Cooperation	201,288.24	0.00	0.0%
	UNICEF	650,000.00	0.00	0.0%
	USAID			0.0%
	<b>Total</b>	<b>1,859,045.84</b>	<b>0.00</b>	
<b>3</b>	<b>Bilateral Partners</b>			
	CDC	6,669,581.00	4,051,632.00	60.7%
	<b>Total</b>	<b>6,669,581.00</b>	<b>4,051,632.00</b>	<b>60.7%</b>
<b>4</b>	<b>UN Organization</b>			
	UNICEF	1,650,000.00	2,612,054.88	158.3%
	UNFPA	14,595,739.00	1,228,970.95	8.4%
	WHO	21,684,664.74	16,845,691.00	77.7%
	<b>Total</b>	<b>37,930,403.74</b>	<b>20,686,716.83</b>	<b>54.5%</b>
<b>5</b>	<b>Global Fund</b>			
	Malaria	77,945,974.42	36,603,819.28	50.8%
	TB	23,467,531.42	11,943,767.76	50.9%
	HSS	3,680,982.00	1,812,002.00	49.2%
	HIV/AIDS	63,813,214.64	0.00	0.0%
	<b>Total</b>	<b>168,907,702.48</b>	<b>53,359,589.04</b>	<b>31.6%</b>
<b>6</b>	<b>GAVI</b>			
	CSO	2,000,000.00	1,350,000.00	67.5%
	Global Sanitation	1,774,950.00	1,113,450.00	62.7%
	One WASH	6,704,522.00	3,807,684.00	56.8%
	<b>Total</b>	<b>10,479,472.00</b>	<b>6,271,134.00</b>	<b>59.8%</b>
<b>7</b>	<b>Foundations</b>			
	CIFF	7,326,329.00	7,326,329.00	32.0%
	<b>Total</b>	<b>7,326,329.00</b>	<b>7,326,329.00</b>	<b>100.0%</b>
	<b>Grand total</b>	<b>445,962,581.60</b>	<b>269,070,132.35</b>	<b>60.3%</b>

DFID committed the amount of USD 86.20 million and disbursed an amount of USD 101.65 million which was the largest contributor to the health sector followed by Global Fund and World Bank in EFY 2007. (Figure 51)

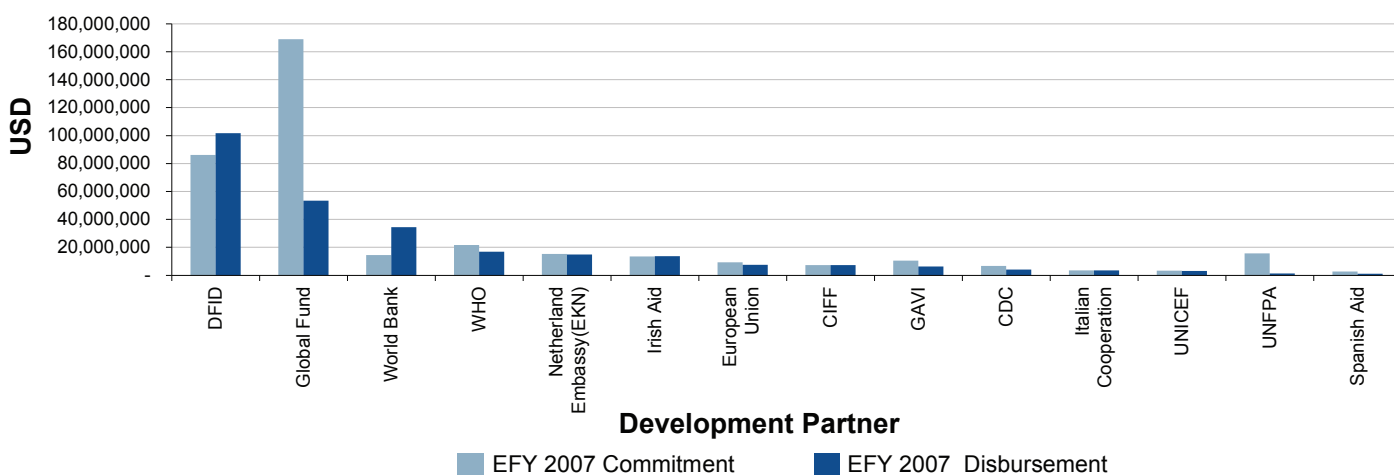


Figure 51: Distribution of Amount Committed and Disbursed by Development Partner (EFY 2007)

As share of disbursement by DP, DFID accounted 37.8% of the total, followed by Global Fund (19.8%), World Bank (12.8%), WHO (6.3%), Netherland Embassy (5.5%), Irish Aid (5.1%), European Union (2.8%), CIFF (2.7%), GAVI (2.3%), CDC (1.5%), Italian Cooperation (1.3%), UNICEF (1.2%), UNFPA (0.5%) and Spanish Aid (0.4%). (Figure 52)

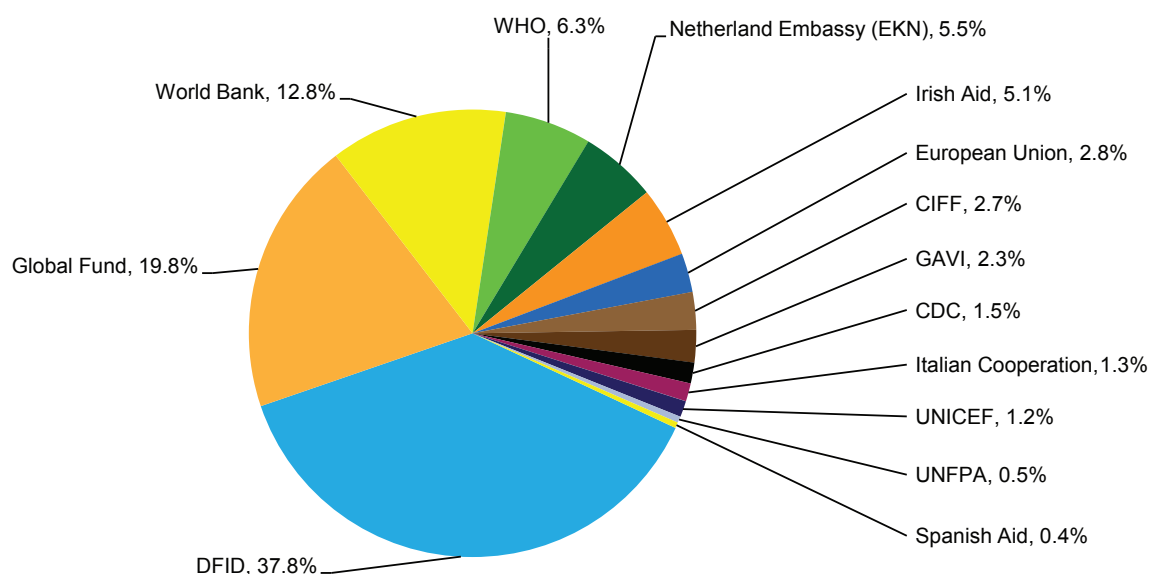


Figure 52: Percentage Distribution of Disbursement by Development Partner (Out of Total Disbursed) (EFY 2007)

As it was documented in the previous years, channel 3 contributors are not accounted for the above financial contribution. It is known that there is a considerable amount of resources provided by US partners through channel 3 modality which is not directly monitored by FMOH.

#### 4.5.6.2. MDG PERFORMANCE FUND

Following the signing of the global IHP compact, the Federal Ministry of Health developed the national Compact which was followed by the development of a Joint Financing Arrangement. The objective of both compacts was to strengthen the harmonization and alignment of the financial and technical resources coming to the sector so as to ensure the effectiveness of aid and make it more result oriented. Mostly the IHP principles are making sure that governments' leadership and ownership of their development agenda. This further includes using the existing government system as far as it fulfils the minimum criteria of transparency and reliability. Using this opportunity the JFA was designed to set out the jointly agreed terms and procedures for

the MDG PF management including planning, financial management, governance framework and decision making, reporting review and evaluation, audit and supply chain management. Therefore, the MDG PF was created based on those rules and regulations and the signed JFA. The MDG PF came into existence in 2009 and has increased both in number of contributors and in volume of their contribution in the last six years. The number contributors increased from 2 to 12 and the value increased from 10 million to over 200 million over those years.

According to the JFA, the MDG PF covers all program areas where there is funding gap. The only exception to this is that it doesn't cover salaries or wages. However, from the past five years' experience the MDG PF is seen to cover mostly the procurement of public goods required to facilitate the health service delivery at the health facilities.

Budget commitment to MDG PF by contributors was 212.8 million USD in EFY 2007. The plan was a worth of USD 251 million taking into consideration the unused balance from EFY 2006 of USD 6 million and USD 22 million balances from procurements and some contingency in-case additional resources come in the middle of the year.

In the same period, a total amount of USD 177.37 million was disbursed to MDG PF. This accounted 71.5% DP's disbursement in the fiscal year which shows DPs pooling resources to the preferred channel that FMOH can manage by applying GOE financial procedures. However, there was 24.4% decrement from EFY 2006 (USD 234.68 million) in the same period.

As it was documented last year, DFID was the major contributor to MDG PF, accounting 57.3% of the total amount disbursed by DPs to MDG PF; followed by World Bank (19.5%), Netherlands Embassy (8.4%), Irish Aid (7.7%), EU (4.3%), Italian Cooperation (2.0%), Spanish Aid (0.6%) and UNICEF (0.3%). However, GAVI, AusAID, WHO and UNFPA were not disbursed to MDG PF in EFY 2007.(Figure 53).

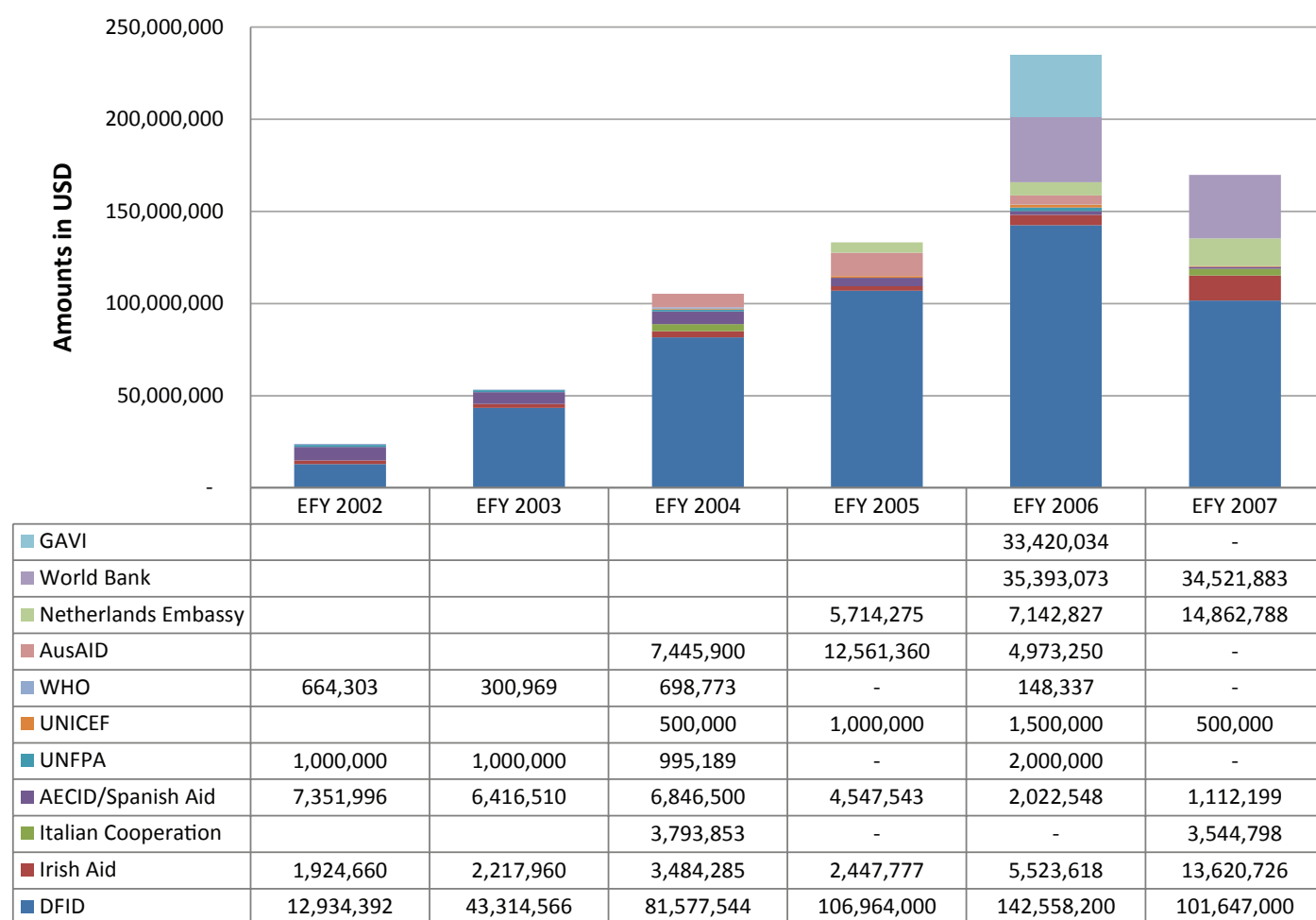


Figure 53: MDG Pooled Fund Disbursement (EFY 2002 - 2007)



#### 4.5.6.2.1. IMPLEMENTATION PROGRESS OF THE MDG PERFORMANCE FUND

As indicated in the Joint Financing Arrangement (JFA), MDG PF was established to finance the gaps which were identified in the comprehensive plan of EFY 2007. Hence, gaps which needed to be financed through MDG PF were identified after the preparation of the comprehensive plan and specific activities were set in line with the eligible expenditure stated on JFA. The major areas of funding of MDG PF in 2007 EFY were indicated in Table 29.

Table 29:

**Areas of Support Funded by MDG Performance Fund**  
(EFY 2007)

Area of Focus	USD		
	Total MDG PF Allocation	Rolled Over From Previous Years*	Total Budget for EFY 2007
<b>Public Health Commodity Procurement</b>	143,620,521.00	191,167,245.00	334,787,766.00
<b>Health System Strengthening</b>	56,759,158.00	58,425,327.00	115,184,485.00
<b>Health Service Delivery</b>	5,237,364.00	2,079,359.00	7,316,723.00
<b>Maternal new-born Health and nutrition</b>	21,044,479.00	3,268,065.00	24,312,544.00
<b>Human Resource Development</b>	6,584,000.00	0.00	0.00
<b>Prevention, Control of Communicable and Non communicable Diseases</b>	4,100,000.00	8,375,422.00	12,475,422.00
<b>Health Extension Program</b>	13,000,000.00	5,169,981.00	18,169,981.00
<b>Miscellaneous</b>	819,321.00	10,828.00	830,149.00
<b>Total</b>	<b>251,164,843.00</b>	<b>268,496,227.00</b>	<b>513,077,070.00</b>

\*Rolled over refers to all the funds which are not liquidated so far. It is not necessarily in cash, it include s all committed and paid.

The rolled over budget of USD 268.5 million represents activities under process or awaiting for documentation: these are reflected in accounts receivable and will be registered as expenditure EFY 2007 when full documentation is received. The budget is included as rolled over to allow for comparison of budget utilization when recorded as expenditure.

In EFY 2007, public health commodity procurements received the higher amount of budget (USD 334,787,766) followed by health system strengthening (USD 115,184,485) and maternal new-born and nutrition program (USD 24,312,544).

#### **4.5.6.2.2. IMPLEMENTATION STATUS OF THE MDG PERFORMANCE FUND**

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MDG PF was used to fill the financial gap in most underfunded priorities of the health sector. Particularly, MDG PF mainly focused on the following areas in EFY 2007 like health extension program, maternal and child health, communicable diseases, health system strengthening through developing public health infrastructure, strengthening human resources, equipping hospitals and health centers (procuring public health commodities) , strengthening blood transfusion service and HMIS. Underfunded activities were identified from the EFY 2007 comprehensive plan and prioritized based on their contribution to the sector priority goals and the possibility of soliciting other sources of funding. The implementation status of MDG PF was reported JCCC on quarterly basis and after comments were received from the JCCC members and contributing partners, final reports were compiled and sent to all contributing DPs.

##### **Health Extension Program**

Health posts were equipped and furnished during the fiscal year by MDG PF. Supply of consumables for health posts, health extension training and supporting the implementation of health extension program especially for emerging regions had been funded from MDG PF.

##### **Maternal and New-born Health**

Access to obstetric care was strengthened through procurement of ambulances and the service was supported through procurements of EmONC drug supplies and equipment, and contraceptives. For strengthening new-born health service, equipment for new-born corner was being processed for procurements. Training of HEW on Implanon insertion was one major activity funded from the MDG PF.

##### **Child Health**

MDG PF has supported child health service for procurements of vaccines syringe, drugs, refrigerators as well as spare parts for cold chain equipment, and its spare parts including training for professionals. The construction of cold room at PFSA ware house is also being supported.

##### **Communicable Diseases**

MDG PF was used for IRS operational cost, support to extra disease burden service in development corridors, survey of national disease burden for NCD, support mental health services (program and drug procurement), and training of health professionals on leprosy.

##### **Health System Strengthening**

The MDG PF supported trainings for midwives, anaesthesia, health extension level III and IV, paramedics, biomedical and pre deployment training. Different health infrastructure for health centers, operation theatre equipment, health centers equipment, construction of regional blood

banks, strengthening the blood bank service were funded under the MDG PF. Procurement of medical equipment for emergency service like operation theatre and intensive care unit were being done. HMIS scale up was one of areas supported by MDG PF to cover the expenses of training and printing of HMIS tools.



# CHAPTER 5



# CONCLUSION

# CONCLUSION

This report provides the progress made in the health sector in line with the planned activities, main achievements and constraints encountered in EFY 2007. Besides, it identifies gaps in achieving universal health coverage, and provides way forward to attain the strategic objectives set in HSDP IV. In EFY 2006, the focus was on “Crossing the finishing line and visioning beyond: Towards equitable and better quality health services in Ethiopia”, and in this year continuum of activities carried out to attain equitable and better quality health services. This also paves the way to the coming HSTP that mainly focuses on quality and equity in line with Sustainable Development Goals (SDGs).

There has been a remarkable improvement in health status in Ethiopia over the past years during HSDP IV. While struggling for development and better health, Ethiopia is an example that low-income countries can achieve better health and improved service coverage if policies, programs and strategies are supported by political will, community involvement, and commitment at all levels with harmonized efforts of all stakeholders. However, despite the progress achieved so far, there is the unfinished Millennium Development Goals (MDG) agenda around mortality reduction, particularly maternal and newborn mortality, and challenges are still to be addressed in improving the health of the population across the life course, in improving quality of care, and in addressing health inequalities. For instance, Ethiopia is highlighted as one example of a country that demonstrated a gradient pattern of contraceptive use across education subgroups and the difference between the richest and poorest quintiles was particularly large. Besides, Ethiopia had the largest level of within-country relative inequality, with coverage in urban areas exceeding that of rural areas.

Central to Ethiopia’s health performance is the country’s strategy to deliver more and better health care to women and children. To this end, the HSDP has been successful in putting in place the HEP which has contributed to improved availability and accessibility of PHC services, and paved the way for the achievement of the MDGs. In this perspective, the implementation of the HDA is underway with the aim to drive behavioural change and expand safe health practices at community level, with a vision of considering the community as a potential producer of health, instead of as a mere consumer of medicines and curative services.

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

An increase in service coverage was observed in past HSDP IV years on maternal health services like antenatal (at least four visits) and postnatal care as well as for SBA. In particular, the steep increase in percentage of deliveries assisted by skilled health personnel observed in EFY 2007 is a major achievement towards safe motherhood, reflecting multiple high impact interventions implemented at both facility and community levels. Similarly, an increase in CAR observed in consecutive years of HSDP IV mainly due to HEWs who play a



central role in such achievement. Besides, Option B+ service have improved time to time and the percentage of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy to prevent Maternal to Child Transmission (MTCT) of HIV has been estimated at 64.9% in EFY 2007.

Child health services also showed progress in EFY 2007. For instance, immunization coverage has improved in the fiscal year and good progress has also been recorded for nutrition. The National Nutrition Programme is using multi-sector partnerships to tackle under nutrition and includes social protection, food security, community nutrition programs, micronutrient supplementation, treatment of severe acute malnutrition and a package of free health services.

With respect to prevention and control of communicable diseases, a general increase in coverage of key MDG-related interventions for disease control has been observed over time in the HSDP IV period. Encouraging results have been achieved in HIV/AIDS control, with combination of relatively low HIV prevalence, sustained prevention efforts and increased ART coverage. Alternatively, malaria prevention and control also showed a progress on early diagnosis and effective treatment, vector control and epidemic prevention and control. There was a distribution of 17.2 million long-lasting insecticide-treated nets in EFY 2007 and the number of laboratory confirmed plus clinical malaria cases decreased by half in EFY 2007 with respect to the previous year. With regards to TB control, there was an increase on TB case detection and cure rates with slight fluctuations in treatment success observed in EFY 2007. Further efforts should be in place to bring higher achievements on case detection and cure rates.

There was contribution from DPs that enabled the health sector to increase the amount of resources mobilized and utilized. Health has moved in recent years from underinvestment and single disease focus, to increased funding, harmonization between FMOH and partners, and a systemic approach. A critical step towards “One Budget” has been the establishment of the MDG PF to facilitate resource pooling in order to finance the priorities under the HSDP.

There were strategies applied to achieve the above successes and meeting MDG goals like implementing multi-sectoral strategies to address crucial health determinants; implementing country-specific strategies to mobilize the community and develop partnership; applying shared guiding principles based on national leadership and partner harmonization that shape strategies, align stakeholder action and steer progress; maximizing health outcomes by developing catalytic strategies, implementing cost-effective and high impact interventions, and using evidence-based, innovative, and context-specific approaches.

Improved health intervention coverage and outcomes at the national level; however, in some cases this was fuelled by more rapid gains in the advantaged subgroups than in the disadvantaged subgroups. In these cases, health policies, programs and practices should be re-oriented to uphold the principle of equity and promote faster improvements among the disadvantaged.

It is for this reason that improving quality and addressing inequalities are the organizing principles around the next Health Sector Transformation Plan (HSTP) 2015/16-2019/20 built in the framework of the vision of the health sector in the next 20 years. The approach to address these challenges is to expand Universal Health Coverage (UHC) through strengthening the primary health care: services must be physically accessible, financially affordable and acceptable to patients if UHC is to be attained. In the context of HSTP, monitoring is much more than tracking individual indicators, and it is high time to address the current limitations of health equity metrics and develop methods for monitoring inequalities in health.

The emerging post-2015 sustainable development agenda cites equity as a central principle of the renewed global development goals and targets. The inclusion of universal health coverage as part of the health-related post-2015 sustainable development agenda puts equity at the forefront of a major global movement. Learning from the oversights of the past, the post-2015 development agenda recognizes the monitoring and reduction of inequalities as a global priority. This means all people should be able to obtain high-quality, essential health interventions, which they should be able to access without experiencing undue financial hardship. From the initial implementation of universal health coverage through to its realization, on-going monitoring of the state of inequality is vital to ensure that disadvantaged populations are identified and prioritized.

Therefore, participants at ARM 2015 are welcomed to observe this report in depth and come up with important recommendations that will further enrich HSTP for equitable and quality health service delivery as the post-2015 sustainable development agenda.



