17th Annual Review Meeting of The Health Sector Development Program

Short Proceeding Report

Federal Ministry of Health

October 30, 2015

INTRODUCTION

During the last 16 years, the Health Sector has maintained the tradition of monitoring and evaluating the programme through Annual Reviews Meetings (ARMs), Joint Review Missions (JRMs), Mid-Term Reviews (MTRs) and Final Evaluations.

HSDP, which was based on the application of the "Sector-wide Development Approach-SWAP", launched in 1998. On the basis of the review system put in place in the Programme Implementation Manual (PIM) adopted at the launch of the programme, the assessment activities carried out during implementation of the HSDP include monitoring of key performance indicators, periodic reviews, joint donor missions, annual review meetings and thematic and evaluation studies.

The Annual Review Meeting (ARM) is an important annual event jointly planned and executed by the Government and its development partners, notably, the stakeholders known as Health Population and Nutrition (HPN) Donors Working Groups.

Accordingly, the 17th Annual Review Meeting was held in the Town of Adama from 28-30 October, 2015. It was attended by representatives from the Federal Ministry of Health, Regional Health Bureaus, other federal and regional government bodies, selected woreda health offices, Hospital CEOs and Directors, HPN Development Partners, NGOs, professional associations, institutions of higher learning, the private sector, local and international guests.

OBJECTIVES OF ARM 2015

In accordance with the TOR of ARM 2015, the objectives of the review meeting were to:-

- take stock of the progress made and problems encountered in the implementation of the EFY 2007 Plan based on the review of the EFY 2007 Performance Report;
- look forward into the activities of the coming year by reviewing and endorsing the Sector's Draft Core Plan for EFY 2008;
- provide the forum for the introduction/endorsement of new Health Sector Transformation Plan (HSTPI), for exchange of views on key components of the plan and for forging common understanding / knowledge about the plan; and
- strengthen the partnership between the government, donors and other stakeholders through joint work in preparing and conducting the Review Meeting;

MAJOR AREAS OF ARM 2015 DELIBERATIONS

The major areas/topics for deliberation during the Review Meeting included the following:

A. Presentation of the Report on EFY 2007 HSDP Performance

B. Presentation of EFY 2008 HSDP Core Plan

F. Brief Statement by the Minister of Health on the launching of HSTP I

G. Presentation of Group Reports

H. Keynote address by the Co-Chairperson of the HPN development partners

I. Signing of Contract Agreement on the Implementation of EFY 2007 Core Plan

J. Reflections on ARM 2015

K. Presentation of the Joint Statement of ARM 2015 Participants

These topics make up the core content of ARM 2015 Work Programme. Additional events that took place at the ARM were the field visit, the exhibition organized at the conference venue, various side events, working lunches, and the ceremony of awarding certificates for distinguished service.

PROCESS AND METHODOLOGY OF THE REVIEW MEETING

The review meeting was conducted using the following methods:

- Presentations: The abovementioned topics were presented at the plenary session. In addition, such agenda items as the opening and closing sessions of the meeting, feedbacks from group discussions, reflections on ARM 2015 and Joint Statement of the participants were presented at the plenary.
- Plenary Discussion: On the basis of the Work Programme, presentations were followed by discussions at the plenary session.
- Group Discussion: On Day Two of the meeting (October 29), ARM 2015 participants had conducted group discussions based on the following themes or topics:-
    - ***Leaving No one Behind****: How can we ensure equity and quality of service provision in Ethiopian health sector?*
    - ***Aspiration to action****: How Woredas can transform?*
    - ***Business is not as usual*** *: Information revolution and its endeavors*
    - ***Demonstrating our heartfelt concern to help those seeking care***

WORK PROGRAM

The Work Programme was prepared for a period of three days (October 28-30, 2015). This programme was supplemented by a one-day field visit conducted before the official opening of the meeting. The proceeding began and concluded according to the content and time frame of the work programme.

REGISTRATION OF PARTICIPANTS

The 17th Annual Review Meeting was attended by 1100 participants representing the Federal Ministry of Health, other federal government ministries and agencies, regional health bureaus and health science colleges, woreda health offices and health extension workers, HPN development partners, universities, professional associations, NGOs, guests invited from abroad, and consultants. In addition, as was done last year, Hospital CEOs and Directors, participants drawn out of local NGOs and other regional stakeholders invited by the hosting RHB have taken part in the meeting and the organizing of the exhibition.

OPENING SESSION

WELCOMING ADDRESS

Ato Shallo Daba, Head of the Oromia Health Bureau welcomed participants to the 17th Annual Review Meeting and expressed his pleasure to be hosting this historic meeting. He further stated that the Ethiopian health sector has achieved tremendous results and the field visit conducted the day before revel the success of health sector programs and projects in the Ormia region.

He concluded his brief statement by inviting H.E. the President the Oromia National Regional State to deliver his welcoming address

Ato Shallo Daba, Head of the Oromia Health Bureau

The 17th annual review meeting was officially opened by H.E. Ato Muktar Kedir president of the Oromia National Regional State at the Gelma Aba Geda Hall in Adama, on Wednesday October 2015. In his opening address he stated that high value is given to the day's 17th Annual Review Meeting of the Health Sector for its uniqueness, expected outcomes, and as it is held at a historical time where Ethiopia's developmental democracy has started transforming the country's growth and transformation plan to a new and crucial chapter.

H.E. Ato Muktar Kedir president of the Oromia National Regional State

He further indicated that being one of the African nations who have met the MDGs in the health sector shows that the country's health sector is on the right track. The health development agenda which has put community mobilization as one of its key pillars is practiced nationwide, however, the level of participation varies from region to region. For instance, in the Oromia region the community widely takes part in health matters which are related to mothers and children and mobilizing funds for the purchase of ambulances. The president further stated that besides the above mentioned activities the community works for the provision of fast paced transport to mother's in labour, promote environmental hygiene and modern lifestyle in the rural setting, and the newly created women's Development Army. The number of mothers who give birth in health institutions has drastically increased to reach 75% today contrary to that of 17% two years ago. He concluded his remark by thanking the Ministry of Health, Oromia Health bureau, All Regional Health bureaus, various organizations and individuals, who collaborated to the success of this meeting.

The minister of Health of the Republic of Ethiopia, H.E. Dr Kestebirhan Admasu in his opening address indicated that the Ethiopian health sector has done remarkably well in meeting most of the Millennium Development Goals (MDGs). Among the notable achievements include, a significant drop in under-five mortality, a 69 percent decrease in maternal mortality, and reducing mortality and morbidity from communicable diseases. Maternal and infant mortality have been reduced by changing misconception and empowering women where currently 61% of women are now giving birth at hospitals.

DR. Kestebirhan Admasu The minister of Health of the Republic of Ethiopia

The country has made tremendous achievements from implementing high impact interventions mainly through its flagship community focused program known as the Health Extension Programme. The Oromia region can be cited as a good example in which the community mobilized fund to purchase 70 ambulances. Dr Kesetebirhan further stated that the 17th annual review meeting is more unique and historic because it marks the conclusion of HSDP that had been implemented in four successive phases and held at the beginning of the Health Sector Transformation Plan (HSTP) that will be launched today. HSTP has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system by giving priority to the following impact level targets:

1. Intensify RMNCAH interventions to end preventable maternal and child deaths by 2030.
2. Sub-national elimination of malaria from its mid and low lands in the eastern part of the country and implement strategies to pave the way for malaria-free Ethiopia by 2030.
3. Combat HIV infection by focusing on the most at risk population groups. The fast-track cities initiative towards 90-90-90 will also be implemented to reach all people living with HIV, put and retain them in treatment, and achieve viral suppression.
4. Strengthen prevention strategies to improve case detection and cure rate of all forms of TB and increase investments to improve access to diagnostic and treatment facilities.
5. Fight Neglected Tropical Diseases (NTDs) through integrated investments reduce the burden of NTDs.
6. Designing and implementing Non communicable diseases and injury prevention strategies by integrating the interventions into existing health infrastructure.
7. Promotion of hygiene and sanitation through the health extension program giving special attention for urban sanitation and using a multi-sectoral approach to address the complex sanitation issues in cities.

The minister indicated that the HSTP has identified four interrelated transformation agendas. These are:

- **Transformation in equity and quality of health care** –During implementation of the HSTP, efforts will be doubled up to ensure equity in health care. This can be achieved by continuous improvement of the service, conducting clinical audits, and improved health system information. The success of HSTP will mainly be measured by the quality of health service and how equitable the health outcomes are
- **Woreda transformation** – Woreda transformation aims at narrowing the gap between the high and low performing woredas. It has three components: Model Kebeles, financial protection through CBHI and high performing PHCUs.
- **The Caring, Respectful, and Compassionate (CRC) health workforce**–This calls for a mechanism to persistently remind health professionals the values, hopes, and aspirations that brought them into healthcare profession. The movement requires nominating Role Model professionals. It also requires a culture change and a change in attitude, manner, and approach of health care delivery.

- **Information revolution** – This is reforming the methods and practice of collecting, analyzing, presenting and disseminating information. It is a radical shift from the traditional way of data utilization to a systematic information management. It includes advancing the data collection, aggregation, reporting and analysis practice; promoting the culture of information use at place of generation; harnessing ICT; improving data visibility and access; and strengthening verification and feedback systems

Dr Kesetebirhan concluded his statement by whishing fruitful deliberations for the remaining days.

CEREMONY OF AWARD FOR DISTINGUISHED SERVICE

The objective of the programme is to publicly honor and recognize individuals and institutions for their extraordinary and distinguished contributions and service to the peoples of Ethiopia in the field of health. The prominent and meritorious individuals selected for this honor this year were:

1. **Kashan Adem:** Since 1987, Dr. Kasahun has served with great distinction in various capacities by generating innovative approaches, inspiring his colleagues and actively engaging in implementing new programs. Dr. Kasahun has also been instrumental to Menlik Hospital's implementation of the Clean and Safe Hospital initiative and has made a significant contribution to make the hospital's environment conducive to rendering quality health care.

2. **Dr. Yilikal Alemu Azene:** After graduated as a medical doctor from Jimma Health Science Institute, he served as practitioner and Medical Director in different health facilities. Dr. Yilikal persistently promoted the caring of those suffering from eye diseases and campaigned for the building of new and modern facilities by mobilizing critical financial and human resources for the establishment of a secondary eye unit with an optical workshop.

3. **Mr. Yemanebirhan Tadese W/Gebreal:** He holds BA degree in management and public administration, BSc degree in pharmacy, and MSc in public health. He served as a pharmacist at the Humera Hospital, and Gonder Kiflehager Health Department. He is curemtly working as Operation Programs vice Director in Pharmaceuticals Fund and Supply Agency, and effectively fulfilling his responsibility.

4. **Dr. Yishak Tesemma** Graduated from Addis Ababa University as a Medical Doctor and has completed his post graduate study specialization. He has served as school teacher and as a health professional at the Debre Markos and Adama hospitals for 14 years. Dr. Yishak also served at the Mizan General Hospital for seven years, followed by four years as the medical director. He also served with passion by providing volunteer services in various clinics to needy and indigent patients.

5. **Dr. Aster Shewamare Gebremedhin:** As a medical practitioner she has served at Zewditu Memorial Hospital since 1987 G.C. and is known as a resourceful professional who generated innovative ideas and implemented successful programs. Dr. Aster also worked as head of HIV/AIDS prevention and control team, playing a key role in facilitating the construction of a modern building to care for the multitude of patients with HIV/AIDS. She was also very instrumental in promoting the cleanliness of the hospital's facilities and promoted a safe environment. Dr. Aster has been an exemplary role model for her colleagues and a compassionate care giver to her patients.

6. **S/r Emebet Tarekegn** is a nurse and holds a bachelor degree in management. S/r Emebet served at the Hossana Hospital and Health Center and at Lideta Health Center in Addis Ababa. She also worked as a head nurse at Amanuel Specialized Psychiatric Hospital for four years. Currently, she is staff member at the Gandhi Memorial Hospital providing outstanding leadership and with high distinction.

7. **Dr. Mohammed Yusuf:** served in Dederi hospital from 1995-1999 as general practitioner and medical director with dedication and commitment. He has also served in the Birsidimo and Chiro Hospitals as medical dire-tor. After having been transferred to the Black Lion Hospital from Chiro Hospital, due to public outcry and request, a special arrangement was made for him to continue his service at Chiro Hospital. Dr. Mohammed is also credited for starting surgery services in Deder Hospital and has played a significant role service expansion at Chiro Hospital. Dr. Mohammed is a compassionate, dedicated and caring professional and has made a tremendous contribution to the development of Ethiopia's health sector.

8. **Mr. Gonfa Ayana Guta**: He graduated with Master's Degree in Chemistry from Karl Marks University, Germany. Since 1982 he has served at the former Ethiopian Main Laboratory and Research Organization and since 1984, he has worked as a head of clinical chemistry laboratory at the National Health Research Institute. Mr. Gonfa has also worked as an associate researcher where he was recognized as committed and hard worker. Since 2012, he has been working as the lead persons for capacity building of regional laboratories.

9. **Professor Yifru Berhan Mitke:** got his medical degree in1997 completed his specialty in 2005.Since then he has served with great distinction in remote health facilities and has also played a significant role in mitigating and fighting disease outbreaks such as typhoid fever in the hospital that he served. After, Professor Yifru was appointed as the Dean of School of Medicine in Hawassa University where he's currently serving. Since 2004, Professor Yifru is a selfless professional who has been providing free clinical services Professor Yifru was also responsible for the development of an MSC curriculum in Integrated Emergency Surgery which won a grant of 12million birr from the Netherland Government. His proposals of an original research on ART and PMTCT, which is in collaboration with several universities, has also generated over 5 million in grant money from organizations such as WHO and UNCICEF.

He has published Pro-fessor Yifru has a number of origin9al scientific re-search published in reputable international and local journals.

10. **Dr. Gerbi Dhugum:** obtained his first and second degrees from Moscow Lengeres University in 1982 and 1984 respectively. Since 1983, Dr. Gerbi has served in various capacities in Negele Borena, ALERT and Ras Desta Hospitals and Kolfe Health Center with dedication and commitment. Also, since 1994 Dr. Gerbi has been serving as dermato-venereologist and lecturer in Jimma University. Overall, Dr. Gerbi has served for the last 30 years in various capacities with dedication and exceptional commitment.

11. **Prof. Abraham Haileam-lak** he did his specialization in pediatrics and his sub specialty in pediatric cardiology. Since 2011, Professor Abraham has been the Dean of Jimma University College of Public Health and Medical Sciences. He is also a consultant to Gorge Washington University in Washington DC and African Global center for Health Transformation on Medical Education Part-nership Initiative. In addition, he is a member of the International Committee for Medical Journal Editors and the World Association for Medical Editors. Prof. Abraham obtained his sub-specialty fellowship from Israel Wolfson Medical Center and from the Ludwig Maximilian University of Germany. His name is closely associated with the opening and upgrading of the bio-medical engineer and dental schools at Jimma University.

12. **Professor Adem Ali Ahmed** his medical education in 1973 at Addis Ababa University. Professor Adem has taught at medical education at Gonder Public Health College, the Black Lion Hospital and also served as a registrar in London Chest Hospital. Professor Adem obtained Assistant Professorship from Addis Ababa University and surgery consultant in Black Lion Hospital. Professor Adem also served in Harare Central Hospitals as a registrar in cardio-thoracic unit in Harare, Zimbabwe. Professor Adem served as leader and member of Ethiopian Medical Association, Ethiopian Surgical Society, Ethiopian Public Health association and Association of Surgeons of East Africa. Professor Adem has also participated several research activities and has published over twenty five articles in national and international scientific journals. Moreover, professor Adem has presented his research findings in over forty inter-national and national conferences. Currently professor Adem is serving as a full professor of surgery in Addis Ababa University Faculty of Medi-cine. He also a recipient of many honors and accolades including from the Surgical Society of Ethiopia and Ethiopian Medical Association for his years of dedicated service and outstanding achievements.

13. **Dr. Amanuel Gessese:** obtained his medical degree did his specialty in Obstetrics and Gynecol-ogy. Dr. Amanuel worked in Bokoji Health Center, as head of the Awuraja Health Department and Assela, Adigrat and Ayder hospitals. Dr. Amanuel has published over thirty articles in various respected national and inter-national journals and has also pre-sented his research findings at reputable national and international conferences. Dr. Amanuel has been awarded several awards and certificates of merit for his immense contributions.

14. **Sister Letebirhan Teklehaymanot:** At sixteen, she joined the struggle to overthrow the 'Derge Regime' in 1978. Despite all the hardships during the struggle she excelled in providing health services in a most resource challenged environment. Since 1982, Sister Letebirhan served as medical officer in the army and was trained as a midwife in Wolikaite Ruba Nursing School and also served at the Kilda Gimele near Wolikaite. Her dedication and professionalism has enabled Sister Letebirhan to deliver over eight thousand children, three thousand during and five thousand after the struggle. In 2014, the Ethiopian Midwifery Association appointed Sister Letebirhan as a good will ambassador to the Tigray Region in recognition of her great contribution to the profes-sion where she served with distinction.

15. **Dr. Amanuel Haile Aberha:** completed his medical degree and specialty in internal medicine in Addis Ababa University. Currently Dr. Amanuel is teaching undergraduate and postgraduate students at Mekele University where he also serves as the Medical Director of Ayder Teaching Hospital. Dr. Amanuel's aspiration is guided by a vision to see the people of Ethiopia leading a healthy and prosperous life. Dr. Amanuel is a member of the Ethiopian Medical Association and Ethiopian Society of Internal Medicine and has received several awards and certificates of appreciation, including from the Ethiopian Red cross Society, Addis Ababa University, and the Tigray Regional Health Bureau.

16. **Addis Ababa University Neuro-surgery Department:** In 2014, because of increasing demand of trauma patients, a meeting was arranged with professionals composed of emergency medicine, neurosurgery, orthopedics and general surgery to discuss on the expansion of a trauma center outside Tikur Anbessa Hospital. With the support of the Ministry of Health, in June of 2015, a fully functional 52 bed trauma center, with its own CT scanner, was established. Permanent neurosurgeons and residents, with additional 67 medical and supporting staffs have so far served over 1457 patients. The Ministry of Health honors, Addis Ababa University Neurosurgery Department for its exemplary contribution in establishing and delivering quality medical services for trauma patients.

17. **Soddo Christian Hospital Private Limited Company:** established in 2005 in Wolaita Zone of Soddo town of the Southern Nation Nationalities and People Re-gional State. Missionaries, Dr. Adolf and his wife Bonijo'e Adolf, and their Ethiopian colleague surgeon Dr. Kelemu Desta and his wife Mekides Chaka are among the visionaries who played a pivotal role in the establishment of the hospital. An American bone specialist, Dr Duane Anderson (Orthopedics) and his wife Jackie Anderson took great part in scaling up the expansion of the hospital. For the last nine years, these orthopedists served by providing voluntary orthopedic services and inspiring and mobilizing volunteer professionals to come to Ethiopia for short and long term services. The hospital is equipped with modern orthopedic devices and ultrasound machines to provide quality services. Moreover, the Soddo Christian Hospital provides trainings for nurses, surgery, eye care professionals anesthesiologists and other health professionals in the country. The Ministry of Health honors Soddo Christian Hospital for its exceptional service and contribution to Ethiopia's health sector.

In addition two individual and institutional awardees; Ato Seleshi Demise popularly known as "Gash Abera Mola" and Ato Zenabizu also known as "Mesfin fromSew Lesew Drama" were officially designated by the ministry as good will Ambassadors for urban sanitation and hygiene.

The highlights of the programme included: The introduction of the individuals through public citation about their lives and achievements and the ceremony of awarding certificates of distinction, the Ministry's Gold medal and trophies. Following the introductory citation, the awardees were invited to the stage one by one amid great applause to receive their awards from H.E. Dr. Kesete-birhan Admassu, Minister of Health and H.E.Ato Muktar Kedir. The awards presented included: The Ministry's highest Certificate of Distinction citing their specific merit, the Ministry's Gold Medal and trophies made of crystal. After receiving their awards, the 17 distinguished persons had made brief remarks to express their thanks and appreciation for the great honor accorded to them.

EXIHIBITION

Following the award ceremony (during coffee break) the mini-exhibition at the conference venue was officially opened by H.E. the President of Oromia and H.E. the Minister of health. A total of 17 exhibitor institutions/departments from the federal Ministry of Health and Regional Health bureau (RHB) of Oromia have taken part in displaying their respective programs and activities. They have also made available pamphlets, and brochure, and other printed materials for distributions.

PRESENTATION / DISCUSSION

PRESENTATION ON THE REPORT OF EFY 2007 HSDP PERFORMANCE

The EFY 2007 Annual Performance Report was presented by Ato Noah Elias, Director of Policy Planning Directorate. After introducing the outline of his presentation, Ato Noah briefly explained the framework of the performance report. He stated that the report was based on a core set of sector-wide indicators, consistent with HSDP, GTP and MDG indicators, standardized definition and procedures for data collection, denominator based on projection from inter census CSA 2013 inter-census population survey estimates, comparison across regions and trend analysis and main data source from woredas, with validation from regions and programs.

Ato Noah went on to present the EFY 2007 performance of the sector along the following Strategic themes:

1. **Health Service Delivery and Quality of Care**

Health Extension Program: The HEP registered better performance where a total of 454,140 development groups and 2,334,559 one-to-five networks were established countrywide.

Maternal and New-born Health Services: National targets for Antenatal Care (+1) Coverage was achieved; however, the achievement which is 67.9% was below the target (87.0%). The coverage ranged between 13.6% in Gambella and 100% in Addis Ababa.

The performance of deliveries assisted by skilled health personnel in EFY 2007 showed a 13% gap between planned (72.0%) and achieved (60.7%). The performance ranged between 18.7% in Somali and 100.0% in Harari and Addis Ababa. Three regions are above their regional targets (Oromia, Harari and Addis Ababa).

PNC coverage in EFY 2007 was higher by 6% more than from planned (84.0%) with coverage of 90.0%. 5 regions above their own baseline and target (Afar, Oromia, SNNP, Harari and Addis Ababa). 4 regions below the target and above their own baseline (Tigray, Amhara, Benishangul Gumuz and Dire Dawa).

Contraceptive acceptance rate in EFY 2007 showed 15.1% gap between planned (85.0%) and achieved (69.9%). CAR ranged between 5.7% in Somali and 97.2% in Amhara. One region is above its own target (Amhara).

Child Health Services: Pentavalent 3 Coverage revealed 3.6% gap between planned (98.0%) and achieved (94.4%). It ranged between 48.7% in Somali and 100% in Oromia, SNNP, Harari and Addis Ababa. 4 regions above and equal to their own target (Oromia, SNNP, Harari and Addis Ababa).

PCV 3 Coverage in 2007 showed 4.1% gap between planned (98.0%) and achieved (93.9%). It ranged between 48.2% in Somali and 100% in Oromia, SNNP, Harari and Addis Ababa. 5 regions achieved their regional targets (Afar, Oromia, SNNP, Harari and Addis Ababa).

Rotavirus vaccine 2 immunization coverage in EFY 2007 Revealed 8.2% gap between planned (97.0%) and achieved (88.8%). It ranges between 30.3% in Somali and 100% in Harari and Addis Ababa. 3 regions achieved their regional targets (Afar, Harari and Addis Ababa)

Measles immunization coverage in EFY 2007 showed 4.7% gap between planned (95.0%) and achieved (90.3%). It ranged between 35.9% in Somali and 100.0% in SNNPR, Harari and Addis Ababa. 4 regions (Oromia, SNNP, Harari and Addis Ababa) above or equal to their regional targets

Full immunization coverage in EFY 2007 showed 8.6% gap between planned (95.0%) and achieved (86.4%). Range between 33.8% in Somali and 100% in Harari and Addis Ababa. 2 regions (Harari and Addis Ababa) are above their own target.

National Nutrition Program: Vitamin A Supplementation in EFY 2007 showed 9.5% gap between planned (99.0%) and achieved (89.5%). Moreover, de-worming showed 23% gap 75.2% between target (98.0%) and achieved (75.2).

Malaria Prevention and Control: The trend in number of ITNs Distributed EFY 2007 Performance has reached 17.2 Million, yearly performance.

The total number of laboratory confirmed cases reached 86%. 2.2 million with a peak in November, lower than in EFY 2006 (2.6 million)

Tuberculosis Prevention and Control: TB case notification rate showed a performance of 151 per 100,000. It ranged between 73 per 100,000 in Somali and 404 per 100,000 in Dire Dawa. The TB case detection rate (EFY 2007) performance was 67.3%; below the target (83.0%). It ranged between 32.6% in Somali and over 100% in Afar, Gambella, Harari, Addis Ababa and Dire Dawa. 5 regions achieved regional targets (Afar, Gambella, Harari, Addis Ababa and Dire Dawa). The TB treatment success rate (EFY 2007) showed 1.9% gap between performance (92.1%) and target (94.0%). It ranged between 66.8% in Gambella and 97.0% in SNNP. Two regions are equal or above their regional target (Somali and SNNP). The TB cure rate in EFY 2007 reached 16.1% gap between performance (77.9%) and target (94.0%). It ranged between 35.9% in Afar and 87.0% in Amhara. No region above its own target. Low performance has been noted for few regions; but Somali region has the least performance in almost all indicators. Afar's performance show drastic changes since 2004; however, data verification is required.

Quality of Health Services: Regional EHRIG Implementation status at national level reached at 83%. Afar and Addis Ababa EHRIG implementation status lower than EFY 2006. The remaining 9 regions have improvement on their EGHRIG implementation.

APTS (Auditable pharmaceutical transaction system) was implemented in 47 hospitals where drug availability increased from 35% to 97%. Expired date rate decrease from 8% to 2%. Furthermore, quality information on drugs has Improved; High patient satisfaction; and introduced accountability and audit in the pharmacy service.

Addis Ababa Emergency Services showed better and Optimized bed utilization; 'To any referral' has been abolished; all emergency referrals have been facilitated; Maximized efficiency of the hospitals; Introduced accountability in the health care system; Enabled quality information on Emergency conditions; and led to the establishment of ICU and Trauma centers.

The new CASH initiative has showed pertinent progress. Engagement at all levels from senior politicians to health professionals; attitude of rejecting the status quo has been enhanced; mass campaigns conducted in all hospitals; CASH audit tool and systematic monitoring was possible; and renovation and beautification of different hospital units.

Increase in number of units of blood collected from 87,685 in EFY 2006 to 127,851 in EFY 2007 (95% from voluntary blood donors).

2. Health Infrastructure and Resources

Health Infrastructure: A total of 196 new health posts were constructed in EFY 2007. The cumulative total number of HPs reached 16,447. The cumulative number of Health Centers made available for service reached 3,586; 251 HCs was constructed in EFY 2007. In terms of strengthening and expanding Hospital Services, the total number of available public hospitals reached 234. Of which 189 were fully functional. There is an ongoing construction of 147 new hospitals reported by 8 regions.

Health Care Financing: Health Care Financing (HCF) reform was implemented at federal, regional, Woreda and facility levels. A total of 1,836,117 beneficiaries being screened and the government allocated a budget of ETB 44,225,098 for fee waiver beneficiaries. 3,288 health facilities (169 hospitals and 3,119 HCs) retaining and utilizing their revenues. More than 50 public hospitals have opened private wing services nationwide.

Community-Based Health Insurance (CBHI) was implemented in 185 Woredas. A total of 1,374,325 households have been registered. 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); and a total amount of ETB 62,111,055.49 was reimbursed to health facilities.

Development Partners' Contribution: In terms of disbursements, total committed in EFY 2007 was USD 445.96 million. The total disbursed was USD 269.07 million (60.3%) through channel 2; US partners dedicated substantial resources through Channel 3. A higher proportions of the disbursement was made by DFID, 37.8%, followed by others including a significant proportion made by Global Fund, 19.8%, World Bank, 12.8%, WHO, 6.3%, Netherland Embassy (EKN), 5.5%, Irish Aid, 5.1%. The MDG Pooled Fund Disbursement showed decrement and a total amount disbursed was USD 177.34 million compared to USD 234.68 million (EFY 2006).

Ato Noah also presented the EFY 2008 HSTP woreda based health sector annual core plan.

EFY 2008 Core Plan

The health policy envisioned Ethiopia's Path towards Universal Health Coverage; second Growth and Transformation Plan (GTP-II); and with emphasis on Equity and Quality. The core principles of HSTP are equity and quality health care; information revolution; Woreda transformation; caring, respectful and compassionate health workforce (CRC).

Flagship projects for 2008 are: Saving Lives through safe surgery (SALT); Sekota declaration; Information revolution; Community scorecard; and CRC

In terms of budget, the total amount required is of 63.6 Billion ETB. Commitment made by the Ethiopian government is 25.8 Billion as compared to 14.9 Billion secured from aid. The resource gap is 26.2 Billion of the total budget required. Lower budget commitments were noticed for Benishangul

Gumuz and Dire Dawa regions. Further analysis showed Non-communicable disease, Malaria and Adolescent health has the least.

Finally, the presentation concluded that Ethiopia would be a good example that low-income countries can achieve better health and improved service coverage if policies, programs and strategies are supported by political will. Thus, there has been a remarkable improvement in health status nationwide over the past years during HSDP IV. There are 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. Community involvement and commitment at all levels with harmonized efforts of all stakeholders.

Plans are made to improve 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.

QUESTIONS AND DISCUSSION SESSION

- **Collaboration with teaching institutions**
  - What is the plan to involve academic institutions (universities and health science collages) to scientifically explain, validate or justify the performance report?
  - The support of health science collages is low. What will be the plan to support these institutions from FMOH?
- **Data quality**
  - Credibility of the information system is questionable.
  - There is high variability between populations based survey and HMIS data, particularly in areas of skilled delivery, ANC and PNC. How do you justify it? Especially, in the case of Afar.
  - Is there any benchmarking for data quality?
  - Is there a data quality assurance system before dissemination?
- **Resource requirement and gap**
  - What is reason for high variability on the cost for EFY 2008 plan across regions?
- **Core plan**
  - Some of the indicators do not have baseline data and stated as "NA". what is the reason?
  - Why TB treatment success rate (TSR) targeted only 2% increment from previous year (i.e. 92% to 94%)?
  - The transformation agendas are not well articulated in the EFY 2008 core plan. Who will be the lead organizations for each transformation agenda?

- With regards to health waste management, the plan document only describes to strengthen the available waste management system. What is the plan on establishment of treatment plants for both pharmaceutical and health facility waste?
- The plan needs situational analysis which includes SWOT analysis.

❖ **Inequality**

- How do we overcome the huge variability across regions to achieve the existing inequity in health service delivery and outcome?
- What is the strategy to achieve universal coverage of health insurance? Why the implementation delayed after launch?
- What is the strategy to contain the continuous increment of health cost, particularly in the private sector?

❖ **Traditional medical practice**

- Even tough, traditional medical practice have been contributing a lot in keeping the Ethiopians health for long period of time compared to the modern medicine, there has been nothing said in the performance and plan about it.
- MOH should promote involvement of traditional healers in research undertaking and ensuring their right to contribute more in the health system. What is the plan?

❖ **Best practice**

- Oromia achieved the highest in maternal and child health indicators while the progress of Tigray is low. What are the success factors?

❖ **Climate change resilience**

- What is the plan to integrate climate change with health? Explain about the multi-sectoral coordination in this regard?

❖ **Health Development Army**

- What is the level of implementation of health development army?
- Have you identified the bottleneck of the implementation of HDA in terms of attitude, inputs and good governance?

❖ **Service quality**

- How do we overcome the huge variability across regions to achieve the existing quality gap in health service delivery?
- How do the FMOH see the implication of availability of modern/branded medical equipment on the quality of health service delivery?
- The regulatory aspect is not addressed in the performance report and plan.
- The budget allocated for regulatory activities is limited. Therefore, how can the regulatory system address the necessary quality related initiatives?
- Even though emergency service shows a remarkable improvement, there is limited activity with regard to pre-hospital care service. Besides, utilization of ambulances for emergency services is not satisfactory still the focus is related to maternal health services. So, what is the plan and direction on these aspects?
- What are the initiatives to address linkage between community, PHCU and ambulatory services?

❖ **Caring, Respectful and Compassionate (CRC)**

- CRC transformation agenda is one of the difficult agenda that needs paradigm shift on attitudinal change. The current CRC agenda doesn't apply "the whole person care theory" and lacks leadership and communication as component of human resource development. Here, medical students loss their compassion during their stay in medical schools. This is mainly due to the philosophy of medical reductionism which sees human being as "things". Therefore, working on the curriculum and involving Ministry of Education, teaching institutions to lead this effort is mandatory.
- As recommendation, the HSTP I should lay a foundation on" the whole person care theory" to bring the success in the coming 15 years of time.
- Health Extension Workers now showing fatigue on their career. What is the strategy to maintain their level of strength to keep the momentum on Health Extension Program?

H.E. Dr. Keseteberhan Admasu, Ato Shalo Daba and Ato Noah Elias responded to the questions and comments as follows.

Response from Ato Shalo Daba

It is appropriate to raise concerns and questions on sharp performance increment especially in areas of maternal health in this forum. If there are political leaders who keep on asking why the performance is lagging behind and conduct a regular follow up, there will be inproved outcomes and better performance. Hence, the performance documented in Oromia Region (from 17% to 71%) is directly linked to high political commitment including the involvement of Regional State Presidential Office, health professionals and the community itself to bring high performance in many indicators.

The following strategies were applied in addition to the political commitment:

- Respective administrative leaders organized discussion sessions with more than 8 million women to identify real challenges, and come-up with agreed upon solutions on improving maternal health.
- Regional health bureau heads, program managers, zonal department heads and respective program experts paid a visit to Tigray Regional State and shared best experiences on the improvement of health service delivery.
- Listing of all pregnant mothers with their Expected Date of Delivery and follow them for antenatal care (ANC), delivery at health facilities and prenatal care (PNC) services.
- Conducting regular pregnant mother's conference twice a month.
- Involvement of communities in mother-support activities such as transporting labouring mothers to health facilities using traditional ambulance, contributing money and variety of food items (42,000 quintal of cereals) to make homelike environment in the health facilities.
- Availing waiting room (Home like environment) for pregnant mothers including kitchen for cooking food (880 waiting rooms constructed by the community).

- Health professionals assigned to kebeles. They are technically supporting and follow regularly by involving the community. Besides, the health professional performance appraisal is based on the change in health condition of the community.

Furthermore, health partners participated in assessment of maternal health service delivery, joint planning and supplying delivery kits and provided couching. Ato Shalo emphasizes the point that reports coming from regions are reliable and credible. The data quality on maternal health has improved due to:

a. Daily monitoring system;
b. Triangulation with administrative data that is collected command post; and
c. FMOH verification using RDQA and inspection.

Response by Ato Noah Elias

In relation to the question and comments raised about research, data quality and cost for EFY 2008 Ato Noah responded as follows.

- Working with academic institutions and doing different researches is important. So, the FMOH will foresee collaboration with academic institutions for better researches and development (R&D).
- With regard to data quality, FMOH is conducting data verification assessment integrated with supported by regular supervision.
- Concerning data quality in the Afar Region report, the 6 month data verification and HMIS report showed big discrepancy due to outliers. On the other hand, sero-status assessment on vaccines in one woreda showed the discrepancy.

- Similarly, on the data quality in TB indicators, there are problems on report completeness and calculation of eligibility.
- If higher officials regularly monitor performance, data quality and credibility issues can be improved.
- The information from routine data source (HMIS) and information reported from population based surveys such as DHS may have some discrepancy due to different methodology implemented. Caution should be exercised in interpreting differences between DHS and HMIS estimates that may be related to different causes, including:
    a. different data sources;
    b. different timeframe of indicators;
    c. different definition of indicators; and
    d. different type of errors. For example, the variation of 2014 mini-DHS result and the HMIS result on the same year shows less than 10% difference which is an acceptable range. In conclusion, the concern should be reaching out and providing the service to the mothers (4out of 10) who DONOT get the service in health institutions than focusing barley on data quality.

- Regarding budget requirement, planning at all levels is conducted with the help of available concrete and reliable evidence. Planning is becoming more participatory which involves all relevant stakeholders at all levels. Woreda level plan is prepared by a team from woreda health office, Directors of PHCU's, NGOs, and administrative leaders. Regions are also involved in the reconciliation process. In EFY 2008, the annual plan, target setting and costing was conducted using "One Health Tool" for the first time. This might cause errors on cost estimation at some regions. However, we will check and take necessary corrections for the final version.
- Concerning regulatory performance report, since the presentation is brief, it doesn't include all components of the health service it is possible to find the complete report on the main annual performance report document.

H.E. Dr. Kesetebirhan Admasu response

Finally, H.E. Dr. Kestebirhan responded on the following four transformation agendas.

- **Quality and equity in health care**
  - Traditional medicine is included in the 5 years plan. We will design interventions to modernize traditional medicine. The focus will be ensuring patient safety and control mechanism.
  - Climate resilience adaptive strategic plan is developed. Public health emergency risk profile map will be prepared every year at woreda level.
  - Multi- sectoral coordination is one of the key areas in HSTP I. Its important to integrate health issues/policy among the different sectors of the country.
  - To improve pre-hospital service, paramedics have been deployed and preparatory works are being done to organize ambulances for paramedic's service.
  - Quality and equity summit will be organized every year.
  - Health service quality strategy will be developed.
- **Information revolution**
  - Information is vital for all stakholders. False report is a sign of professional malpractice and is unethical. Therefore, it is mandatory to take major action to avert this serious problem once and for all. It needs a paradigm shift on attitudinal change by all people working on the health sector to give value for data. The focus here is to make all health institutions collect, analyze and use all available information.
  - To address issues related to data quality, community based information system using family folder is a key. Currently, the HEP using around 18 million family folders at household level to document every health related data. It is a good opportunity to improve data quality at the point of service delivery and individual level using the existing system. Digitizing the system will further enhance the data quality and then information use.
  - With the growing expansion of academic institutions, there is a possibility of having demographic surveillance sites and documenting health conditions in respective

areas. This can complement the improvement of data quality, triangulation and analysis.

- With regard to Afar data quality, a team will be organized to assess and do in-depth analysis in health facilities. Afar also has good opportunity that improves the data quality since the region has more than 200 HITs which is more than other big regions.
- Non-governmental organizations such as L10K and IFHP have conducted data quality assessment. Their finding is in correlation with the routine information system report.

❖ **Worda transformation**

- Special emphasis is given to the four regions requiring special support. As woredas are the engines of the transformation agenda, without implementing woreda transformation, it would be difficult to bring development stability at national level.
- Due to various reasons partners are working on emergency management in regions requiring special support rather than focusing on development. Therefore, focus will be given to involve partners in development.
- The woreda transformation has only three focus areas. These are universal health insurance coverage, creating model kebeles and scaling up high performing primary health care units. These will tackle the prevailing inequality.
- Health extension workers have been working for the last ten years with the existing HEP program. The focus from administrative bodies was in training HEWs, constructing health facilities and supplying available materials. In HSTP we have to create a momentum to motivate HEWs. We have started 2nd generation health extension program (level 4 upgrading program). Currently around 5,000 HEW are upgraded to level 4 and around 8,000 are on training. The up grading will have significant improvement on their salary scale. During the implementation of HSTPI the plan is to train all HEW to level 4 and create conducive work environments.
- In regions requiring special support there are experts at regional health bureaus. The Woreda health office lacks technically competent staff thus; attention will be given to change the capacity of woredas. Incubation centers will be established to provide long and short term training and capacity building at woreda level.

❖ **Caring, Respectful and compassionate health professionals (CRC)**

- The CRC is a generational movement which will be implemented continuously for better outcomes. Foundation will be established in the HSTP 1. The CRC program will start from the primary and secondary schools. Health professionals will be volunteers in pre-service training to maintain their compassion. Projects will be designed to provide opportunities for health professional to visit health facilities.
- The curriculum for health professionals will be revised to comprehensively address the CRC program.
- Inter-sectorial collaboration will be strengthened particularly with Ministry of education.
- Senior professionals will be involved to work as Ambassadors as role models.

H.E. Dr. Keseteberhan concluded by stating that detailed and robust information will be found on the disseminated documents. Moreover, the group discussion sessions will give opportunity for the participants to circulate and exchange ideas that will be applicable to better implement HSTP I.

Moreover, brief presentations on Saving life through surgery (SALT), Community Based Health Insurance (CBHI) scale up strategy, and Master facility list were presnted and feedbacks and brief questions were forwarded.

BRIEF STATEMENT ON THE LAUNCHING OF HSTP I

Day one deliberations concluded by officially launching HSTP I which has the ultimate purpose of improving the health status of the peoples of Ethiopia in an equitable manner. The HSTP is cascaded to all levels and will be translated into annual operational plans using the Woreda-based health sector annual plan. Its implementation will be consistently monitored using the agreed monitoring framework in a coordinated manner. After the plenary session was concluded Dr. Keste conducted a press conference with more than 20 media representatives from regional, federal and international agencies to officially launch HSTPI.

GROUP DISCUSSION

The objective of the group discussion arrangement in ARM 2015 was to ensure an in-depth and more focused exchange of views on HSTP 1 transformation agendas. The deliverable of the discussion will come up with concrete next steps that will be implemented by stakeholders within the framework of the next five year strategic plan.

Accordingly, the participants of ARM 2015 were divided into five groups around the following transformation agenda items.

Agenda 1: Quality and Equity in Health Care

Agenda 2: Woreda transformation

Agenda 3: Information Revolution

Agenda 4: Caring, Respectful and Compassionate health professionals

selection of participants in to respective agenda was based on based on the nature of their work, their expertise, and exposure in order to ensure proactive discussion and realistic recommendations.

FMOH made prior arrangements and assigned heads of directorates and experts within the FMOH to chair and facilitate the group discussions respectively. Development partners were also requested to propose professionals as group co-chairs. Each Group was informed to select its rapporteurs. The

Group chair persons were also advised to prepare short discussion papers (based on a short guideline provided by the organizers of ARM indicating standardized content structure) to guide the discussion process. In order to ensure a structured and uniform approach to the discussion and to the presentation of the report, groups were advised to focus on i) brief description of the agenda, ii) problems or major challenges and iii) way forward and recommendations. A ten minutes documentary film was presented before the beginning of each group discussion based on the agenda items.

GROUP DISCUSSION: QUALITY AND EQUITY IN HEALTH CARE

The group was chaired by Dr. Ephrem Lemango and Co-chaired by Ato Kassa Mohammed.

The group discussion was focusing on the quality and equity in Health Care in particular on the definition of equity and quality; and dimensions of equity and quality on areas of standards, leadership, policy and model of care. Besides, the group tried to understand of equity and quality in line with the institute of medicine 10 equity rules.

Challenges:

- Lack of awareness by the beneficiary;
- Health knowledge & Information gap;
- Limited leadership commitment towards using resources to improve quality;
- Supply chain management defect;
- Inadequate attitude and commitments of providers; and
- Limited community engagement & involvement.

Proposed Solutions and way forward:

- Merit based appointment of leaders;
- Succession plan via mentoring and coaching of leaders (retaining leadership skill);
- Pre service training & on the job training on leadership;
- Motivate good performing leaders;
- Strengthen information system;
- Patient & population engagement;
- Setting regulations & standards;
- Apply different and adaptive health delivery "Model of care";
- Enhance organizational capacity;
- Avail adequate resources (HR, equipment, and supplies); and
- Setting accountability.

GROUP DISCUSSION: WOREDA TRANSFORMATION

The Group was chaired by Dr. Zufan Abera, Director HEPHC (FMOH) and Co-chaired by Benyam Fekadu (JSI)

The group discussion was focus on the Woreda Transformation. Group discussion on woreda transformation started with a welcome address from Dr. Zufan Abera followed by a short video showing the objectives and focus areas of the woreda transformation.

A presentation on the woreda transformation concept note was made by Dr. Zufan, the presentation included the following issues;

- Why we need woreda transformation
- Woreda transformation objectives
- Focus areas (model kebeles, Community Based Health Insurance (CBHI), high performing PHCUs)
- Implementation strategies
- Woreda transformation outcome measures
- Roles and responsibilities of national and sub-national structures of the MOH

Challenges:

- CBHI structure is outside of the health sector that does not reach to kebele level;
- The existing accountability mechanism is not effective;
- In adequate availability of water and electricity;
- Woreda leadership has competing priorities and high workload which is a risk for woreda transformation;
- Inadequate data accuracy and lack of objective model family and kebele verification criterion;
- Different salary for health professionals and Woreda health office heads across the nation;
- In adequate management and leadership capacity; and
- There are de-motivated HEW.

Proposed Solutions and way forward

- Woreda administration should play a leading role in the woreda transformation;
- Woreda administration should address health, education and agriculture sectors in a coordinated manner;
- The woreda transformation should address both urban and rural centers according to their context;
- Woreda transformation movement should be guided by well designed strategy, directives, implementation manual, and procedures;
- Revisit the organizational structure, process and staffing at Woreda level;
- Improve data quality assurance and verification system for model families and kebeles
- Career development and growth for HEWs should be addressed;

- Establish effective accountability mechanism to address low performance and sustain high performance; and
- Potential linkage of CBHI with private health care providers needs to be assessed.

GROUP DISCUSSION: INFORMATION REVOLUTION

The Group was chaired by Dr. Yibeltal Assefa and Co-chaired by Ato Amsalu Shifferaw. The group discussion was focus on the following points.

- What and Why information revolution?
- Changing the culture information use
- Who can bring Information revolution? (Community, decision makers and high level management, health professionals, researchers, data collectors, analysts, media, multisectorial organizations and other Stakeholders)
- Strategies for the implementation of information revolution (short term and long term)

Challenges:

- There are gaps on information use and quality;
- No data triangulation and verification;
- Poor data quality (Less reliable, timeliness, completeness and less detailed);
- No data security and legal frameworks;
- Poor standardization of data, recording and reporting formats, procedures in most of the health information systems (with exception of HMIS);
- No /little information use at lower level : Gaps on data analysis synthesis and interpretation;
- Lack of community and health care providers awareness on health information use; and
- Human resource: shortages in professionals for data analysis and interpretation.

Proposed Solutions and way forward

- Paper based system should be transformed to electronic systems (for better data validation and integration);
- Change information use culture;
- Create knowledge management system;
- Institutionalize information revolution (health institutions, community, and universities);
- Appropriate governance and leadership for information revolution;
- Build information revolution incubation centers;
- Enhance human resource and infrastructure capacity;
- Standardization (data, recording and reporting formats, data exchange tools, working procedures);
- Five to ten (5-10) percent of the budget should be allocated to information revolution;
- Establishing independent data verification unit
- partnership and collaboration
- Improve information accessibility

GROUP DISCUSSION: CARING, RESPECTFUL AND COMPASSIONATE HEALTH PROFESSIONALS

The Group was chaired by Dr. Andualem Beyene and Co-chaired by Ato. Asegid Samuel.

The group discussion was focusing on the following points.

- What is CRC all about?
- Actions leading towards CRC
- The role of teaching institutes
- The role of Hospitals, Health Centres and Healthcare professional at all levels
- Health and health system literacy
- The role of professional associations
- The role of media and communications
- Expectations from the outcome of the movement

Challenges:

- Overburdened health professionals due to low professional to population ratio;
- Payment system variations;
- Limited availability of resources;
- False saturation of healthcare professionals: Negative morale for themselves and the work; and
- Inadequate recruitment to enroll health students in teaching institutions.

Proposed Solutions and way forward

- Institutionalize standard package including motivational incentives at all levels;
- Public conference for community awareness and engagement;
- Link CRC with quality improvement approaches;
- Create a mechanism to avoid unjustified fear in relation to ethical and CRC issues;
- Community empowerment and patient involvement;
- Introduce servant leadership approach;
- Strengthen collaboration with professional associations on healthcare professionals right;
- Conduct quick assessment on the level of CRC;
- Strengthen health development army;
- Advocacy works on medico-legal issue;
- Create team-work sprit;
- Integrate CRC with individual work plan and performance measures;
- Set monitoring system through performance evaluation metrics;
- Create CRC movement ambassadors; and
- Strengthen continues professional development for competency development.

CLOSING SESSION

SIGNING OF AGREEMENT BY FMOH & RHBS ON EFY 2008 CORE PLAN & AREAS OF FOCUS

Towards the closing session of the 17th ARM, the FMOH and the RHBs signed a joint agreement confirming their pledge to implement the EFY 2008 Core Plan. After the signature of the agreement copies of the signed document has been formally handed over to the director of Policy and planning Directorate for follow up and custody of the document

KEYNOTE ADDRESS BY HPN DEVELOPMENT PARTNERS

Mr. Faustin Yao, HPN CO-Chair and UNFPA Ethiopia representative gave the key note address on behalf of CO-Chair Esteban Lopez from Spanish Cooperation and all the Health, Population and Nutrition Partners and congratulated the ministry of Health for successfully conducting the 17th Annual Review Meeting for the Health Sector Development Programme. He indicated that the meeting comes at a very strategic time as the global community at the UN General Assembly adopted the Sustainable Development Goals which are going to shape our development programmes for the next 15 years. Mr. Yao congratulated the ministry for the achievements realized during the year under review and acknowledge the tremendous achievements in increasing the skilled birth attendance, the increase in the human resources for health, contribution of the community to the health sector which was highlighted on the first day, the model kabeles, the infrastructure development especially the construction of the health centres which brings health services close to people and the community health insurance system which ensures equity in access to health services. He further noted that major progress has been made in increasing access to clean water and sanitation, reducing malaria, tuberculosis, polio and the spread of HIV/AIDS.

Mr. Yao pointed out the role of the development partners through the Joint Consultative Forum, the Joint Core Coordinating Committee, the consultative forums on the HSTP, the Joint Assessment of the National Strategies (JANS), revision of the joint financial arrangement and the MDG pool fund, and other modalities of assistance has also been instrumental to drive the performance improvement in the health sector.

Mr. Yao, however, recognized the following challenges that require additional attentions:

- The need to meet the Abuja target of 15% allocation of the national budget in order to meet the goals of the HSTP
- There is still a high maternal and newborn mortality and hence the need to focus more in this area

- The need to collaborate more with other line ministries to address chronic shortages of water and electricity in the health facilities.
- Closing the gap of regional disparities and ensuring equitable health services for all including in the pastoralist communities and addressing the health needs of disabled, adolescents and the youth
- Improving quality of health care in the health system
- Improve data tracking, management, quality and evidence based programming among others.

Mr. Yao concluded by congratulating the ministry for successfully launching HSTP and expressed the commitment of HPN in the implantation of the transformation agenda.

JOINT STATEMENT OF ARM 2015 PARTICIPANTS

This is one of the last agenda items of the review meeting. The Joint Statement was read by Ato Noah Elias, Director of the Policy and Plan Directorate. The statement is called "joint" because it reflects the views of all the participants. The content of the Statement had included:

- Expression of thanks and appreciation to the hosting region
- Description of the agenda items, the number and composition the participants as well as the conduct of the field trips
- Assessment of the major achievements shortcomings as
- Description of the major areas of focus in EFY 2008.
- Joint pledge of commitment to work together to implement the Core Plan of EFY 2008.

REFLECTIONS ON ARM 2015

This year also representatives of some institutions have delivered their short reflections on the overall proceeding and outcomes of the 17th ARM of HSTP. The participants who made their reflections were:

- Ato Shallo Daba The head of Oromia RHB
- Dr.Alemayehu Mekonen, Executive Director of Ethiopian Public Health Association
- Ato Mezeber Ketema, ECO of Alert Hospital
- W/t Sintayeh Werku- , HEW from Ambo,Oromia Regional State
- Dr Dessalengi Tigabu, Gonder University

Field Visit Summary

I. Field Visit: Bishoftu

The field visit to Bishoftu Hospital was led by H.E. Dr Kesetebirhan Admasu and about 100 people participated in the visit. A welcoming ceremony was ready when the team reached at Bishoftu General Hospital. Bishoftu General Hospital is one of the oldest hospitals in the surrounding, established 1941. The hospital is located at the heart of Bishoftu City, a beautiful city surrounded by numerous lakes and attractions. The city is also famous for its attractions including the annually celebration of "Erecha" – a cultural Oromo festival. The reception was opened by a cultural welcoming addressed by a renowned "Aba Geda".

Following the implementation of various reforms the hospitals was able to achieve several goals as presented by the hospital Medical Director. The hospital of has about a total of 271 staffs, 63% of which are healthcare providers. Installation of cash payment service nearby the service delivery points; launching of emergency services; and establishment of one stop shopping were among the main achievements. Other indicators mentioned in reference to access and related service improvement includes the following. The daily patient load has rose to about 600 OPD cases /day which is equivalent to an annual load of 218,000 in 2007; private wing service has reached about 8-10%; BOR has shown an increment by more than 10 percent in 2007, from 74.3% to 85.4%; maternal delivery has increased to about 1020; and MMR has decreased drastically and only three deaths were recorded in 2007; the hospital raised funding mainly from two sources: 12.7 million (61%) government treasury and 8.1 million (39%) from internal revenue; and the hospital outsourced several services for private companies.

The hospital conducted several activities using its funding, mainly from internal revenue. The main activities include construction of new building and renovation; installation of automatic generator; establishment of three new operation theaters; purchasing physiotherapy machines; and making available bus service for stuffs. Other achievements include daily dose dispensing practice for inpatient; central medication box, located in one ward; and mini-media for information delivery. Shortage of specialist, absence of adult ICU; and shortage of equipment maintenance and reagent were among the challenges mentioned.

The second session of the field was a stopover in selected service points, led by HE Dr Kesete. The service points visited included MNCH services and NICU; delivery and postpartum service; laboratory; admission and referrals; and pediatrics ward. During the visit pertinent questions were asked by HE Dr Kesete. Cause of maternal death in the hospital; availability of blood bank and future plans; established quality assurance mechanisms and clinical audit; and postpartum counseling availability of maternal family planning methods, particularly Postpartum IUD performance were among the questions forwarded by Dr Kesete. In response to one of the questions asked by Dr Kesete, the hospital staff replied that they were able to score a record of saving a life of a neonate with 900 gm birth weight.

HE Dr Kesete also commented and forwarded the following feedback during the visit. Training of the NICU stuff; working on regular HIV viral load testing; availing child playing field and toys; initialization of adult ICU service; and appropriate utilization of available hospital land space to alleviate inadequate space challenges were among the main comments. In the end HE Dr Kesete also commented on handing out materials and equipment to the hospital to support the initiation of the Adult ICU service. Furthermore, the Minister also promised to respond to all sorts of requests made by the hospital if the hospital achieves 50% score in Postpartum IUD service provision.

II. Field Visit: Gimbichu

Field Visit to Gimbichu Woreda, Chafe Donsa Health Center, Germame Health Post, and Weberi Mensur HP were conducted. The programs visited in this Woreda include health Insurance; ODF kebele-HHS; High Performing PHCU/Worde health Office. 150 people participated in the field visit. Gimbichu Woreda is located in east Shewa zone of Oromia Region 84 km southeast of Addis Ababa. The Woreda has 35 Kebeles, of which 33 are rural and 2 are urban. The Woreda has an estimated population of 108, 255; of which56172 are men and 52 083 are women. Out of the total population 8792 is urban and 99,556 are rural population. Under one year population=3,486; under five years population=17,786; pregnant women =3,756; Number of HHS=22,553; Total number of Kebeles 35(rural 33 and urban 2). There are four health centers,33 health posts ,seven private clinics and 02 rural drug shops.

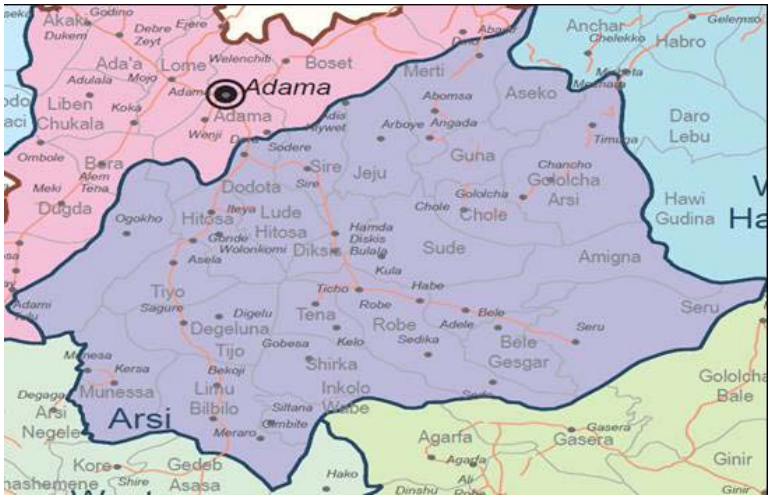
Major achievements and best practice or success stories observed include Health Insurance; and an Outstanding CBHI. Gimbichu Woreda is among the four pioneer Woredas to host pilot community based insurance scheme in Oromia Region. Gimbichu CBHI scheme has registered remarkable results, and is indeed considered among the high performing Woredas in the country in terms of membership enrollment, service provision and financial sustainability. The amount of contribution is set per HH regardless of the size the core family, accordingly the contribution is Birr 180 per year per household for the core family: For each noncore family member, the scheme member has to pay an additional birr per annum. Ten the registration fee is ten which is paid only once.

As of June 30, 2007EFY Gimbichu CBHI scheme has a membership of 11,814 HHS out of the 20,298 eligible HHS, Out of the total registered members 10,609 HHs are paying members ,while 1205 HHs are needy members whose contribution are covered by subsidies played by the regional government and the woreda administration. The enrollment ratio stands at 58%. Out of 33 rural kebeles 8 are declared open defectation free. Out of these the participants has visited two model ODF Kebeles. HPs and HCs are all home delivery free. Number of skill delivery coverage has increased from 4.5 % in 2004 EFY to 71% by the end of EFY

2007. This Ambulance was procured by community contribution.

III. Field Visit: Sire

Field Visitin Sire Woreda, Sire HC & Gasala Chacha Health post in Arsi Zone. Arsi is one of the zones of the Oromia Region in Ethiopia. Arsi is bordered on the south by Bale, on the southwest by the West Arsi Zone, on the northwest by East Shewa, on the north by the Afar Region and on the east by West Hararghe. The administrative center of this zone is in Asella. Sire is one of the woredas in Arsi zone Oromia Region covering 449 square km and located 47 km away from Adama town.The woreda is divided in to 18 kebeles (17 rural and 1 urban). Based on the 2007 national census reported a total population for this woreda is 100,363. There are four health centers and 17 health post in the woreda making the primary health service coverage 100%.



Sire PHCU is one of the model health centers in Arsi zone. Currently the catchment population for the PHCU is 36687 and there are 5 kebeles. A total of 45 field visit participants departed from Adama early in the morning and arrived at Gasala Chaca to see the best performances of the kebele interms of Open Defecation Free activities and CHIS implementation. Then continued to Sire health centre and Sire Woreda health office.

The success story of Open defecation free kebelles and CHIS implementation was visited in Sire Health center and one of the satellite health posts, Gasala Chaca to see how the primary health care unit (PHCU) is delivering preventive, promotive and basic curative services to the community and the woreda health office support and effort. The community received the guests warmly with Arsi traditional dance and food.

Sire Woreda declared 17 ODF kebeles (100%) in 2007 EFY from 12% in 2004 EFY. Ato Mekuria Dinku, Administrator of Sire Woreda, while addressing the participants in his welcoming speech has recognized and appreciated the Community Led Total Sanitation and hygiene' (CLTSH) approach, the enabling health policy, administrative bodies commitment and support at all level, and the community participation and ownership, and the health professionals unlimited effort in realizing an Open Defecation Free (ODF) environment in the woreda. He also added "Sire Woreda played a key role in the promotion of sanitation in the zone by introducing the 'Community Led Total Sanitation and hygiene (CLTSH) approach and making the woreda Open Defecation Free (ODF) community , which served as a learning centre for the other kebeles (communities) within the zone as well as the Region."Mr Mekuria has also applauded the support from sector government offices at different

levels and Sire Woreda community in the implementation of ODF, Skilled delivery, Health care financing and other community development programs in Sire district.

Major Activities performed in declaring ODF Kebeles include training provided for School WASH Club established by teachers & student; students were highly involved in during triggering; training provided for women's development group regarding ODF; mapping of villages (house hold with latrine and without latrine) with community; planning with community leaders for follow up; and ODF committee established incorporating religious leaders, hews and HDA leaders. Support was provided to the households to construct latrine with local materials; continuous PHCU staffs follow up was conducted; demonstration were carried out using simple hand washing device during panel discussion (tip tap); and communal latrine construction through community participation were some of the events during the post-triggering

The major achievements and best practice observed in the Woreda were the following. Sire Woreda has piloted the Community Led Total Sanitation and hygiene (CLTSH) approach in selected two kebelles as of 2004. The piloting was successful and CLTSH enabled achieve notable successes in sanitation and hygiene behavior changes. Communities were able to design and construct their own latrines and established follow up and monitoring mechanisms

In Gasala Chaca kebelle all the 1049 households have latrine. Out of it 989 households have standardized latrine facilities. In addition 60 households constructed shower facility. The kebelle also have 25 public latrines. CHIS if fully implemented in Gasala Chaca kebelle. Health care financing is strong in the woreda (4 Health centres provided with generator from the community).

In conclusion, as observed in the field visit Sire Woreda has done tremendous activities to graduate "Open defecation free" kebeles and improve service provision at all level. Above all the community and Woreda administration ownership and participation in planning, Execution, monitoring and evaluation of health programs was extraordinary and should be scaled up to other sites of the region and the country.

Field Visit: Dera

Field visit to Dera health center and Dodola alem health post in odota Woreda. Dera Health center and Dodota health post are found Arsi Zonea in Dodota Woreda. The Woreda is situated 25 kms away from Adama town and has about 100,000 population, two health centers, fifteen Kebeles and twelve health posts. About 23 participants from different regions and organizations had visited the area. The visit covered activities at house hold, health post and health centers. After the participants reach the area, both at the health post and health center, there was a very colorful welcome ceremony by the Zonal, Woreda, staff and community. After the welcome speech and a brief explanation at the health facility, the participants departed to the health post and community. During the trip to the health post, participants were able to watch the public latrines constructed for the community which were signs of the efforts being done to achieve 100% ODF(currently it is 75%).

At house hold level the implementation of the 16 components of the health extension package were observed and checked. At the health post level detail explanation were given by the health extension workers regarding the achievements of all health programs and consequently, questions and comments were directed by participants, where the health extension workers briefly explain based on the feedback. At the health center level, all the services points were visited and appropriate explanation were given by the respected staff.

After completing the visit the participants had got chance to observe different and color full traditional food items prepared from local grains. During the show the participants were invited to test from these different food items which were very delicious and nutrious. Finally, the participants were gathered in a hall and reflect what they had observed, particularly about best practices learnt, the strengths and areas to be improved for the future.

Major achievements at HC level include ODF-75%; ITN distribution; Health coverage 100%; and Long acting contraceptive about 74%. Best Practices

At Health Center level best practices include linkage of Health center and health post; Pharmacy which is supported with IPLS; best in budget management using IBEX software; patient waiting area which has TV; triage room; HCF where they have collected more than 714,000 birr; delivery room with waiting area floor; equipped with bed with bed net and also a kitchen for preparing food.

IV. Field Visit: Dole

Dole health centers and Daka Hara kalo's health post. Number of **participants was**53. Arsi Negele, located at a distance of 231km far from Addis Ababa and **25** km from the zonal town shashe mene, is one of the Woredas of West Arsi zone in Oromia region. The projected population based on the 2007 national census is expected to be 264,209.Regarding the public health infrastructure, there are 9 health centers and 43 health posts in the Woreda.

During the stay in Arsi Negele Woreda, the first level of care, taking the case of one primary health care unit, Dole PHCU, was visited. The PHCU consists of Dole health center and six health posts (HPs). The PHCU focuses on delivering preventive and promotive health services at community level. Alongside, high impact curative interventions and basic curative interventions are delivered at health post and health centers, respectively. The health center serves for 22,184 people while Daka hara kal'o health post serves for 5,107.The PHCU is ensuring community participation through the health development army. There are 605 women development army networks (1-5) and 114 women development teams. The women development army has contributed a lot for big performance increment in priority areas. All surviving infants in the catchment population have got all immunization services. Regarding maternal health care services, there was progressive increment. Generally, community based achievements and success in service provisions have been mainly attributable to the following strategies executed in the primary health care unit. These strategies are: WDAs contributed in identifying all pregnant mothers and refers them to the health post for further investigation. HEWs depict their EDD and follow them for ANC, Delivery at health facilities and PNC services. Conduct regular pregnant mothers Conference twice a month – to create

awareness on advantages of attending ANC, skilled Delivery, and PNC, danger signs, advantages of Breast feeding and supplementary foods.

WDAs involved in identifying all reproductive age groups who are eligible for Family planning services and follow them to get the services. Identify number of under one year children and enforce their families to immunize them as per EPI schedule involve communities in mother support activities such as transporting laboring mother to health facility using traditional ambulance, contribute money and variety of food items to make homelike environment in the health facilities. Availing waiting room (Home like environment) for pregnant mothers including kitchen for cooking food.

All Kebeles in Dole PHCU are home delivery free. All births expected to be happened in the catchment population in 2007 was attended by a skilled health professional. All surviving infants received all the antigens supposed to take. All the six Kebeles in Dole PHCU are open defecation free. Waiting room for pregnant mothers has been built in the health center with financial support from the community. Each health development team has owned a traditional ambulance. Good health data management system has observed in the PHCU

The community awareness has improved through health development army. When one visit a house and say "Good morning/Good afternoon", the dwellers respond "no one should die with communicable disease"

V. Fiel Visit –Batu Hospital

Batu Hospital is located in East Shewa Woreda Batu Town at 160 Km distance from Addis Ababa and Adama 110 KM. The Federal Ministry of Health of Ethiopia (FMoH) has been leading a sector-wide reform effort aimed at significantly improving the quality and accessibility of services at all levels of the countries health system. As part of this reform, health facilities throughout the country have been streamlining their operational processes and building their capacities with a view to make their services more efficient and effective. Recognizing the importance of strengthening management capacities, the FMoH has given priority to building the management capabilities of hospitals, including through pioneering Ethiopian Hospital Management Initiative (EHMI). Launched in 2006, EHMI has introduced a comprehensive blueprint of standards for the optimal management of hospitals and made considerable progress. The ongoing Ethiopian hospital reform implementation guidelines focus on selected management functions.

Hospital cleanliness is an important determinant of quality of care and patient satisfaction. Health care provided in health facilities should be safe, effective, patient-centered, timely, efficient and equitable. Health facilities should ensure that patients are the corner-stone in the whole health care

delivery process. This would entail for health facilities to be responsive to the values, beliefs and culture of patients in all aspects as well as creating a healing health care environment.

Cleanliness in hospitals is about more than just keeping the place clean. It makes a statement to patients and visitors about the attitudes of staff, managers and the board in terms of attention to detail on the level of care and the way the hospital is organized and run. It is not possible to have a good hospital without being clean and tidy. Excellence in patient care is dependent on getting the basics right, making sure that the food is good, making sure that the patients are cared for appropriately and that the surroundings are clean, tidy, comfortable and safe.

It is also said that cleanliness is everybody's responsibility .The advantages of a clean hospital include clean, comfortable and safe environment for patients, attendants, visitors, staff and members of the general public; increased patient confidence in local health care settings in relation to environmental hygiene and the organizations commitment to reduce the incidence of hospital acquired infections.

Major achievements and best practice or success stories observed:

- Staff discussion was made and Assessment was conducted on how to make the hospital clean and safe according to CASH principles
- Weekly based regular campaign program was arranged to clean Hospital compound
- A 1:5 network was established and provided work site to be cleaned,
- Plant trees in the hospital compound,
- Keep grasses of the compound in the way it is attractive to the staffs, patients and visitors
- A water source was made available in the compound for the effective implementation of green and clean hospital program
- Mobilize resource from CSI in the process of creating water source,
- dry waste removal, inclinator were constructed
- create animal free compound through strengthening security and constricting fence around the hospital,
- working on environmental management
- prepared close washing areas
- segregation of Highly infectious and none infectious waste

Adoption strategies

- The hospital compound sites were provided for adoption to senior management members and GP.
- Adopters organized in to 1:5 network according to their service area and participate weekly, every time on their site.