Proceedings of the experience sharing visit by Tanzanian and Lesotho delegates

International Institute for Primary Health Care

Addis Ababa, Ethiopia
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Contents

Annexes

Acronyms

BEmONC:	Basic emergency obstetric and newborn care
CEmONC:	Comprehensive emergency obstetric and newborn care
CHW:	Community health worker
DLIs	Disbursement Linked Indicators
EU:	European Union
FP:	Family planning
FMoE/MoE:	Federal Ministry of Education
FMoH/MoH:	Federal Ministry of Health
FMHACA:	Food, Medicine and Healthcare Administration and Control Authority
GOE:	Government of Ethiopia
HC:	Health center
HEP:	Health extension program
HEW:	Health extension worker
HH:	Household
HMIS:	Health management information system
HP:	Health post
HRH:	Human resources for health
HSDP:	Health sector development program
HSTP:	Health sector transformation plan
IEC:	Information, education and communication
IIfPHC:	International Institute for Primary Health Care in Ethiopia
JFA:	Joint Financing Arrangement
JHU:	Johns Hopkins University
JCCC:	Joint core-coordinating committee
JCM:	Joint consultative meeting
JSM:	Joint steering meeting
M&E:	Monitoring and evaluation
MCH:	Mother and child health
MNCH:	Maternal, newborn and child health
MDG:	Millennium development goal
MoFED:	Ministry of Finance and Economic Development
NGO:	Non-governmental organization
PHC:	Primary health care
PFSA:	Pharmaceuticals Fund and Supply Agency
SDG:	Sustainable development goal
SDGPF:	Sustainable development goal performance fund
SRH:	Sexual and reproductive health
RHB:	Regional Health Bureau
WB:	World Bank
WDA:	Women development army
WDT:	Women development team
ZHD:	Zonal health department

Summary report

The experience sharing visit for Tanzanian and Lesotho delegates took place between August 15 and 19, 2016 at the International Institute for Primary Health Care in Ethiopia (IIfPHC) in Addis Ababa, Ethiopia. The opening remark was convened by Professor Mengesha Admassu, the Executive Director of IIfPHC. Following that, training participants introduced themselves and the institutions they represented. Before commencing the training session, participants were given an overview on Ethiopia's demographic and socio-economic profile as well as its unique culture and heritage by the Communication Officer of IIfPHC, Mrs Ludina Abebe.

Professor Mengesha, then, briefed the background on the establishment of IIfPHC, which is detailed in Section II. Following the introduction of the Institute and its vision, mission and main objectives, Professor Mengesha made a motivational presentation on "attitude and development".

The third session focused on the "Health system in Ethiopia: policy and planning" that was presented by Mr Melaku. The presenter outlined the Ethiopian health policy and the current policy priority areas. He discussed about the 20 year plan, which is used as a long-term health sector transformation roadmap. From the plan, a five year plan, named 'Health Sector Transformation Plan' (2015 -2020) has been developed.

The next session was on "Resource mapping exercise: rationale and importance", presented by Mr Medeksa. The presenter explained why resource mapping is important and how the resource data is collected and used in Ethiopia. Mr Medeksa's presentation is available in Section IV.

The following presenter, Dr Lisanu Taddesse, gave details on "Maternal, newborn and child health in Ethiopia". He elaborated the services given at health center and health post levels by health extension workers. Dr Lisanu talked about the women development army and how the community is involved in the health service delivery. His presentation is summarized in Section V.

Dr Zufan Abera and Mr Taeme G/Mariam briefed on the "Health extension program in Ethiopia". HEP is a defined package of basic and essential promotive, preventive and basic curative health services targeting households. Mr Taeme explained on the HEP implementation strategies and on how the packages have been implemented. The presenter elaborated the achievements gained under HEP, the key challenges and the future direction of the program. The presentation is included in Section VI.

Then, Mr Abebaw Derso presented on the "Health system in Ethiopia". The presenter outlined the historical background of the Ethiopian health service since 1947. He elaborated on the current structure and function of the health system. More details are available under Section VII.

The next presenter, Dr Henry Perry introduced IIfPHC and his involvement in the formation of the Institute. In his presentation, Dr Perry reviewed the historical background of PHC from the global perspective, the details of which is covered in Section VIII.

Later, Dr Alemayehu Mekonnen discussed about "Primary health care in Ethiopia". He defined the concept of PHC referencing the Alma-Ata conference of 1978. Dr Alemayehu elaborated: how the PHC evolved in the country; the priority areas under HSTP; the principles, strategies and components of the PHC program. In addition, he presented on the achievements, success factors, limitations and challenges of the program. His presentation is detailed in Section IX.

Mr Assegid Samuel presented on "Human resources for health in Ethiopia" afterwards. He elaborated the vision, goal and the main objectives of the national human resources for health (HRH) strategy. Mr Assegid also explained on: the identified issues for improvement; quality assurance issues; and health workforce financing. The summary of the presentation is discussed in Section X.

The next presentation was on "Harmonization and alignment on budget" that was presented by Ms Abebayehu Haile. She discussed about the sustainable development goal performance fund, which is a pooled funding mechanism of international development health partners. Ms Abebayehu talked about the principles of harmonization: "one plan; one budget; one report". The involvement of the partners in the planning and monitoring phases were also explained. See Section XI for details.

Then, training participants made a field visit in Debre-Berhan town to see how the PHC is implemented at the grass roots level. The team visited Debre-berhan health science college; keyit health center and Bakelo kebele health post. The details of the field experience are incorporated in Section XII.

Following the field visit, Dr Perry continued his presentation on "Primary health care, community health and community health workers: part 2". He focused his discussions on the conceptual models of PHC. Refer Section XIII for details.

Each of the sessions was followed by general discussions with questions and answers. The Q&A are incorporated under each section.

The final session was a de-briefing on the overall training program, including the field experience. The suggestions forwarded by the Tanzanian training participants are included under Section XIV. That was followed by a closing remark by Dr Perry. He thanked all for the helpful comments and promised that IIfPHC will keep in contact with all the participants to provide more information. Dr Perry also made some suggestions how the course could be improved in the future.

The proceedings of the experience sharing visit has been written and complied by IIfPHC's resource center officer, Mrs Emebet Zerfu.

Tanzania and Lesotho training participants

Section I
Opening remark

1.1 **Introduction of the program**

Professor Mengesha Admassu
Executive Director
IIfPHC

Professor Mengesha Admassu welcomed training participants from Tanzania and Lesotho and thanked all for coming to share Ethiopia's experience in the implementation of the primary health care. He introduced the five-day program and kindly requested participants to introduce themselves. Participants, then, introduced themselves and the institutions they represented. (see Annex I for the schedule of the experience sharing visit [I.a] and list of participants [I.b; I.c])

1.2 **Overview of Ethiopia**

Mrs Luidina Abebe
Communication officer
IIfPHC

Before starting the training sessions, an introductory briefing was given on Ethiopia's demographic and social economic profiles; geography, climate as well as its unique culture and heritage. (see Annex II for power point presentation).

Section II

2.1 **Introduction of the International Institute for Primary Health Care in Ethiopia**

Professor Mengesha Admassu presented on "International Institute for Primary Health Care in Ethiopia (IIfPHC)". (See Annex III) He gave background information on the MDGs and how Africa and other developing countries have been striving to improve the health status of their citizens. Professor Mengesha stated that MDG 4 (under-five mortality care), MDG 5 (maternal mortality rate) and MDG 6 (control of HIV, tuberculosis, malaria, and other communicable diseases) have been achieved in Ethiopia before the 2015 deadline.

Professor Mengesha emphasized that the MDG results were possible mainly through the community-based services offered by community health workers. He explained the health extension program (HEP) as the main strategy for achieving universal coverage of primary health care (PHC) to citizens. The 16 health extension program training packages on basic promotive, preventive and curative health services that target households were elaborated. Discussing on how the program is implemented, Professor Mengesha stated that the HEP training is given to health extension workers (HEWs). The HEWs, in turn, train women development army (WDA). The WDA form women development teams (WDT) consisting of 30 households residing in the same neighborhood. The WDT have 1-to-5 linkage, with a total of 6 teams. Team members trust each other and meet regularly to discuss about the health issues.

In addition, Professor Mengesha explained that the involvement of HEWs, WDA and WDT resulted in full community participation and ownership. He highlighted the achievements of the HEP which included: increased access to basic health services; improved contraceptive prevalence rate; increased immunization coverage and increased latrine coverage. Prof Mengesha also discussed the impact level achievements.

Explaining the key drivers for the improvement in the health status of citizens, Professor Mengesha mentioned the political commitment and the alignment of policies and strategies with the national plans. Also, the emphasis on expansion of PHC played a key role. In relation to monitoring and evaluation (M&E) of HEP, he explained that there is integrated supportive supervision by the health centers and woreda health offices. There are also regular review meeting at all levels.

On the future direction of the HEP, Professor Mengesha stated that the current HEP has been revised. The second generation HEP will focus on: upgrading HEWs to level IV community health nurses; renovation, expansion and provision of equipment and supplies to health posts; and enhancement of community engagement to shift basic services at the community level.

2.1.1 **The formation of IIfPHC**

Briefing on how IIfHPC has been established, Professor Mengesha stated that the FMoH hosted high level health officials from African countries to share the experience of the health sector in Ethiopia and on how the country has achieved such remarkable MDG results. IIfPHC has been established and officially launched in February 2016 to build capacity on technical, managerial and program issues and to conduct PHC systems implementation research. Professor Mengesha also explained the vision, mission and main objectives of the Institute.

With regards to the trainings offered by IIfPHC, Professor Mengesha gave details on the different types of trainings available. The training for African policy makers will focus on the understanding of the magnitude of the health problems as well as the development of positive attitude and political commitment towards the implementation of PHC at grass root level. Training for health programmers will aim to share experience and knowledge as well as to develop skills to implement PHC at community level. In addition, the local training for health officers aims to strengthen HSTP implementation and leadership capacity.

Professor Mengesha stated that all trainings aim to develop critical thinking and analysis skills of participants. The trainings are organised in collaboration with the FMoH and Johns Hopkins Bloomberg School of Public Health. After the completion of a training program, certificates will be awarded to trainees.

2.2 **Attitude towards development**

Professor Mengesha wished to share some life principles for training participants and made a presentation on "Attitude is everything". (See Annex IV). He stated that for the smooth running of his former organisation (Gondar University), he used to share these principles to staff, academic community and students.

Using a picture of an iceberg, Professor Mengesha asked how much could training participants see of the iceberg. He explained that only 10% of any iceberg is visible for us; while 90% is not. Professor Mengesha stated that this phenomenon could be adapted to people. He said that people usually try to conclude by observing only 10%, which accounts to knowledge and skills (behaviour). The other 90% is attitude. Prof Mengesha clarified that attitude includes: values, standards, judgments, motives, ethics, and beliefs. Attitude impacts behaviour. What makes our life 100% is attitude plus behaviour. A 'can do' attitude is essential for life. By having this principle, Prof Mengesha stated that we can do more. He finalized his presentation by reading some quotations on attitude.

2.3 **General discussions**

The following questions and answers were discussed among participants and Professor Mengesha:

Q: In the government health structure, who supervises who and how is it organised?
A: Ethiopia has nine regional states. There is Federal Ministry of Health, Regional Health Bureaus; Zonal Administrations (Zones may not be present in some regions) followed by

Woreda health offices at woreda/district level. Specialized hospitals are found at federal and regional levels and general hospitals at regional or zonal levels. There are also primary hospitals above the health centers and health posts. A primary hospital, health center and health posts constitute primary health care units.

At a health post, there are two HEWs and they are government employees. There are HDA and WDA in a rural setting (These are people and are not institutions). One of the HEW visits households while the other remains at the health post (HP) to provide service on the 16 packages. At a health center (HC), there are paramedics, nurses, sanitarians, laboratory technicians and so on. The HC is led by a health officer. There is no theatre and therefore there is no need to keep a GP. At a primary hospital level, there are GPs.

Q: Who supervises who at different levels?
A: The health officer supervises the nurses; the senior nurse supervises the juniors. At a health post (HP), HEWs supervise WDA. The woreda administration offices also supervise the overall activities. In the political system, the woredas have power. In PHC, inter-collaboration is important among different offices.

Q: At village level, how is the women development group established and what is their relationship with HEWs? How are they nominated?
A: HEWs train the 16 packages for 30 HH to introduce the services in a village. Out of the 30, those who performed best will be HDAs. They are volunteers and are not paid. Managing 30 HHs is very difficult. Hence, a WDA organises 5 HHs (using 1 to 5 linkage). The five will nominate a person as a leader. The 6 women will meet and discuss as to what has happened in their vicinity and on various health issues.

Q: What is the motivation?
A: Certificates are given for HDA and WDT. Otherwise there is no motivation or incentive. If someone is kind to you, you give back, which is African culture.

Q: How do you go about HEWs? There were community health agents and traditional birth attendants who worked as volunteers.
A: CHAs and traditional birth attendants were volunteers; but they were not accepted by the community. If they are not accepted, then it is a failure. For instance, if by chance there is a problem with a new born, the traditional birth attendant may be considered as the main cause for the problem; or she may even be considered to have 'evil eye'.

Q: There are about 102million people in Ethiopia and 38,000 HEWs. How do you engage HEWs since they are limited to certain households? How do you make sure that they reach all people in the country?
A: HEWs should be selected from their villages. They know the culture and the local language and provide the health package services. They are all female because women are caring by nature. The selection criterion is that they have to complete grade 10 and are above 18 years of age.

Section III
3.1 **Health system in Ethiopia: policy and planning**

Mr Melaku
Policy and planning directorate
FMoH

Mr Melaku's presentation focused on the "Health system in Ethiopia: policy and planning". He explained the ten components of the health policy which include: democratization and decentralization of the health service system; development of equitable acceptable standard of health service delivery; and development of promotive and preventive health care, to mention some. (see Annex V for details)

Mr Melaku also clarified the priorities of the health policy such as: Information Education and Communication (IEC) of health; emphasis to control communicable, epidemics and other diseases related to malnutrition and poor living conditions. Development of environmental health and rehabilitation of health infrastructure; applied health research; and expansion of middle level health workers are also other priority areas.

Mr Melaku talked about the Health Sector Development Program (HSDP) as a strategic plan for the implementation of the health policies and strategies in Ethiopia. HSDP had been implemented in the last 20 years (1996-2015), in five rounds. Mr Melaku stated that focus areas were identified in each round and stakeholders were implementing the plans. Following the completion of the HSDP, the country has adapted a 20 year plan entitled: "Envisioning Ethiopia's path towards universal health care through strengthening primary health care". It is a long-term health sector transformation roadmap. The highest level of health and quality to citizens is aimed to be the final outcome.

Mr Melaku explained that the HSTP is a five year plan (2015 -2020) that emanated from the 20 year plan. HSTP is developed following the assessment of the HSDP implementation, consultative workshops and research. He also explained the four strategic themes which are the sector's pillars of excellence. The annual plan of the HSTP is produced in line with the country's growth and transformation plan.

Mr Melaku further elaborated the four transformation agendas of HSTP; the health service delivery arrangements and the health infrastructure. He covered various topics including service delivery, health workforce, pharmaceuticals and the health management information system (HMIS). Other topics covered included leadership and governance as well as healthcare financing. (see Annex V)

2.2 **General discussions**

Q: You have talked about the health system in the urban and rural areas. I would like to know the challenges you face between the urban and rural population. In Lesotho, we have migration problems. Is it difficult to engage the community workers?

A: Since 83% of the population is a rural community in Ethiopia, the priority agenda of MoH has been to work for this community. The rural population may not have access to some services and the health system is trying to narrow the gaps. For instance, in Somali region, mobile heath care services are provided. Also, free services are given on immunization, maternal care and so on. To address the health service delivery gaps at urban and rural setting, the MOH constructed HP, HC and hospitals in every region, even in remote areas like Gambella.

If we are going to have HEWs at urban settings, they will be attached with health centers since there are no health posts. The urban needs are more complex. A think-tank group has been established to address the critical issues. Model health centers that could work with HEWs in urban settings are underway. The challenges in the implementation will guide us to come up with the best solutions. Ethiopia's experience is mainly from the rural settings. The urban primary health care is at its infant stage.

Q: Regulatory system is there. Is there a policy and regulation based on the performance of HEWs?

A: The regulatory body provides license to health professionals so that they provide safe and quality health care services. The professionals will be deployed in health facilities after having their license.

Q: You mentioned about integrated supervision. Who undertakes it?

A: It is planned that supervisions need to be conducted every six months. The checklist to be used will be developed by technical working group at each level. For instance, for MoH, the technical working group will be composed of members from MCH, resource mobilization and other units. Every directorate will be involved and priority areas for supervision will be selected by the Council.

Q You stated that all health partners including NGOs, are reporting to HMIS. It was not clear how they are doing that.

A: HMIS has been used since 2008. Before its introduction, the health system was not good in collecting data. All those working in the health programs were collecting data independently. Parallel reporting has now decreased because of the system. Since 2008, better data reporting is available. Still, there are some issues that need more work in this area.

Q: You indicated that the HRH task sharing policy has been implemented? Do you have implementation plan in place?

What are the training needs after shifting roles and responsibilities between health cadres; have you done any review of the training curriculum?

How do you provide continuing professional development for existing staff on task sharing practices?

How do you implement regular supportive supervision and mentoring on task sharing practices? Do you have supportive supervision tool and checklist?

The above four questions from a participant were clarified by Dr Lisanu Tadesse before he presented his session on maternal, newborn and child health (MNCH).

A: MoH is considering task shifting so that the health system would be community led. When the health extension program started in 2003, the main task was implementation. Access was a major challenge to PHC services since a vehicle was needed to reach the rural population. The HEP started by implementing the curative aspects. Gradually, the implementation plan focused on how to go about the training, supply chain and HR to link the health facilities to community service.

A: The HR directorate at MoE standardizes curriculums at national level. Any training uses that curriculum. The HEWs are trained at level 3 (package training) for task shifting.

A: The continuous professional development is a mixed approach. The integrated refresher trainings for HEWs focus on maternal and newborn as well as preventive approaches. Training will also be provided when new initiatives role out. MoH provides comprehensive training for HEWs upon the introduction of new interventions. For community based new care activity, there are review meetings that take place every 6 months where experience is shared. The professional licensing is still on its infancy and a lot needs to be done.

A: Regarding supportive supervision, an example was given from the community-based new born and child health. The woreda takes a lead in monitoring, supervision, accountability and in grading the services provided. MoH trains the HC staff on how to supervise the HP. The staffs are assigned to mentor and supervise the HP. Different woredas have supportive supervision check-lists. The woredas consider accountability such as skill-based attendance; no dropout rate, etc. Some woredas have comprehensive supervision including nutrition, maternal and child care. There is a need to be comprehensive at woreda level.

Section IV
Resource mapping exercise: rationale and importance

Mr Medeksa
FMoH

Mr Medeksa started his session by explaining why resource mapping is necessary for the health sector. The government is facing increased resource constraints coupled with a lack of visibility into health spending. A number of challenges such as resource constraints, the need for transparency and accountability, and 'value for money', could be addressed using resource mapping tools. A planning tool helps to reduce duplication of efforts and improve coordination and resource allocation. A resource mobilization tool assists to derive detailed gap analysis against costed plans. Similarly, a harmonization tool aids to minimize multiple financial and programmatic data requests.

Mr Medeksa elaborated the uses of resource mapping data in Ethiopia. These include: assisting the district-based planning process; harmonising efforts of partners and identifying the funding gaps for efficient allocation. Mr Medeka elaborated what information the annual resource mapping exercise captures. These encompass information on: the actors; activities/projects; geographic areas where the activities/projects are implemented and financing (project's budget with categories and funding channels) on all health programs.

In relation to how the data is collected for resource mapping, Mr Medeksa stated that a simple Excel based tool is completed by multiple stakeholders. The data is then aggregated into a master data set. The resource mapping exercise takes about four months to complete. The outputs of the data are used by all directorates of the MOH for planning purposes. Finally, Mr Medeksa presented samples for participants so that they would understand the process clearly. (see Annex VI for details)

3.2 **General discussions**

Q: The system is working very well within the government. I would like to know how the same system is working for the private sector?
A: Resource mapping is mainly on public resources or public health sector. The targets of the private sector are considered in the planning process. But, the private sector is not included during budgeting.

Q: You mentioned that when you allocate resources, government takes equity into account. How do you do the allocation?
A: Equity issues are taken into consideration during planning and resource allocation. After identifying what the sector needs and carrying out a situational analysis, a fiscal year budgeting is made. Prioritizations are made based on the strategic plan. Key problems are identified based on epidemiological data. For instance, usually non-communicable diseases do not have enough funding and available resources. MoH has a pooled fund and it allocates resources for such poorly funded areas.
Q: I would like to know if the regions are allowed to identify their needs. Are they also allowed to retain their revenues?

A: In the system, regions have autonomy and allocate resources by their own. The Ministry of Finance and Economic Development allocates resources at federal level. HC and primary hospitals are allowed to retain their revenues, which is used for quality improvement.

Q: In health care financing strategy, is the process carried out at a district level?
A: Resource mapping was introduced to harmonise partners that work in the health sector. They are obliged to inform their resources to the MoH. While mapping at national level, partners are requested in which region they are operating and they provide the information at district level.

Section V
Maternal, newborn and child health in Ethiopia

Dr Lisanu Taddesse
Newborn and child health technical assistant
MCH directorate
FMoH

Dr Lisanu introduced himself and gave a briefing on maternal, newborn and child health (MNCH) profile in Ethiopia. He said that 3.1 million births are expected annually. Maternal mortality rate was 353/00,000 live births in 2015, based on the UN estimate. According to HMIS (June 2015), skilled delivery reached 60.7% and postnatal care about 90%. Dr Lisanu discussed the causes of newborn and child mortality, malnutrition contributing about 45% of deaths in children under-five. Thus, key newborn and child survival interventions are under implementation.

Dr Lisanu informed participants that contraceptive prevalence rate is around 42% because of task shifting to HEWs. He stated that there is significant variation in family planning acceptance among the communities and regions. There are activities to expand access to family planning (FP) through availability scale up and training HEWs and health service providers.

Then, Dr Lisanu highlighted the HEP's philosophy, goal and main strategy. The program aimed to reduce morbidity and mortality of mothers and children using HEWs. The provision of quality and respectful maternity care focus on: early initiation of ANC coverage; building skilled and quality task force; and availability of BEmONC and CEmONC at health facilities. Dr Lisanu mentioned that a new initiative on postnatal care is underway to keep mothers from 24-48 hours in the health facilities if they live in faraway places. Obstetric fistula and pelvic organ pro-lapse are carried out during the immunization campaigns. Then, screened productive women are sent to hospitals.

On community-based child health EPI and nutrition interventions, Dr Lisanu explained the activities that are given at HP and HH level by HEWs and WDA, respectively. The services are provided at low cost and involve the community in service provision.

Dr Lisanu elaborated the building blocks to strengthen the health system. These include: producing health professionals; scaling up the health infrastructure; using HMIS country-wide; improving quality, financing the health care, as well as leadership and management (one plan, one budget and one report).

Dr Lisanu mentioned the factors that decreased maternal and child mortality that include: national focus, leadership and non-health factors such as education and water supply and sanitation infrastructure.

Discussing the challenges for the HSTP implementation, Dr Lisanu raised issues such as negligence in the areas of SRH and the presence of harmful traditional practices. He stated that still about 1million women deliver at home. There are community disparities in FP. Also, the issues of high turnover and data quality and reliability need to be addressed.

Finally, Dr Lisanu presented the HSTP's major RMNCH plan and indicators. (See Annex VII for details).

3.2 **General discussions**

Q: How do you attract pregnant mothers to deliver in a health facility? You mentioned about compassionate care. Who is funding that? Federal or regional government? Or is it a loan from government? Do you have a system?

A: We use social mobilisation approach. The political body takes the leadership and commitment to mobilize the communities. The slogan is 'no mother should die while giving birth.' Initiatives like WDA with the 1 to 5 team encourage pregnant women to visit health facilities. We do not encourage traditional attendants to attend birth. Traditional birth attendants are made accountable if something happens to the mother or child. Rather, the traditional birth attendants are encouraged to bring expecting mothers to HCs.

Review meetings and panel discussions are held to find out financing modalities to improve delivery nearby homes of mothers. Maternity home is constructed by the community to help expecting mothers.

Respectful and compassionate health/maternity care is a new campaign. A mother could use a mattress; floor; or delivery bed. Previously, it was the physician's choice. Allowing ceremonies (eg. coffee ceremony) after delivery is getting common among the rural community.

The health officers are professional cadres. They are clinical officers and can attend birth. The officers also manage the HC at woreda level.

Q: What is the plan to provide quality service?

A: Quality service has been a challenge. It comes from the provider side (skills, competencies), availability of standards, norms and guidance. In addition, the continuing professional development plan at hospital level is a challenge. The service provision and the perceived quality by the community is another challenge. These parameters are the drivers for quality.

In HSTP structure, the quality directorate provides standards and roles out the activities. The directorate is partnering with IHI and quality strategy is designed. Implementation plans are set for the quality of service. For example, MoH provides award for quality service. Last year, a 5million Birr award was made for quality under the 'clean and safe hospital' initiative.

Q: Who is responsible for speedy production of HR?

A: The Ministry of Education under the federal government is responsible. Health officers, medical doctors, nurses are under the MoE. The MoE helps in improving quality, attachment, training, and skills development in university facilities to make graduates competent. The HEWs are trained by regional colleges and universities. The training is

funded by the regions. The approach uses cost-sharing mechanism whereby the graduates pay after completion of their courses.

Q: How do you manage the reporting to capture all the activities at HP?
A: There is a family folder at a HP and each care seeking activity is documented. HEWs take the data from that folder and report to a HC. The HC, in turn, reports to the woreda. Data quality issue is under discussion currently.

Q: There is task shifting from the facilities to the community including HIV testing, malaria testing, etc. How are they regulated? Who regulates the HEWs? How is the quality assurance?

A: The Ministry of Education has a quality assurance directorate. The directorate is responsible for quality in the medical field. For the HEWs, the quality is regulated by HP and HC. There is also regional higher education quality assurance. Service provision and customer care training is given and certificate is awarded for those who meet the requirements. WDA are used for disseminating message, encouraging discussion, up-taking of important health characters like hygiene, sanitation, environmental health and health seeking behaviour.

Q: Who is monitoring the transportation of samples from HP to hospitals?
A: HEWs service is not laboratory dependent. The HEW program only performs malaria test at HP level. HIV test is given on-site at HP and HC. Hospitals are equipped with organ tests. Samples are transported to check the viral load.

Section VI
Health extension program in Ethiopia

Dr Zufan Abera
Director of Health extension and primary health service directorate
FMoH

Mr Taeme G/Mariam
Program officer/expert
FMoH

Mr Taeme gave a briefing on HEP in Ethiopia. He stated that the primary health service coverage in the country is 100%. Mr Taeme mentioned about the health policy directions and the health tier system. A rural PHCU provides essential health care from 15,000 to 25,000 people and a majority of health problems are managed at this level.

Mr Taeme explained that HEP is an institutionalised community approach for 'Universal Health Coverage'. HEP is a defined package of basic and essential promotive, preventive and basic curative health services targeting households. It has been introduced since 2004. Mr Taeme stated that HEP's philosophy is transferring basic knowledge and skills to individual HHs so that they could produce their own health, as they produce their agricultural products. The implementation strategies to materialize successful HEP require: the training and deployment of HEWs; construction of HPs; provision of medicines and supplies; full community participation; leadership as well as M&E. Mr Taeme elaborated on each of the strategies. (See Annex VIII for details)

Mr Taeme further discussed that the HEP packages are implemented through activities that are based at: family/HH level; community based/outreach services; health post based services (such as immunisation, FP); and in youth centers and schools.

Mr Taeme stated the involvement of HDA, working hand in hand with HEWs has helped to realise full community participation and ownership.

HEP activities (source: MoH)

As to what has been achieved since the implementation of HEP at service level, Mr Taeme explained that there has been: increased access to basic health services; improvement in contraceptive prevalence rate; increased institutional delivery, as well as improvement in hygiene and environmental sanitation. At impact level, MDG has been achieved; fertility rate has decreased. Also life expectancy of citizens has increased from 44 to 64.
In regards to leadership and M&E of HEP, Mr Taeme stated that close supervision and support is conducted by health centers and woreda health offices. There are also regular review meetings. Thus, there is an integrated supportive supervision at all levels.

Mr Taeme gave details on the future direction of the HEP. The MoH is planning a second generation program which includes: upgrading HEWs to level IV community health nurses (additional one year training); revision of the health extension packages based on needs of the community; and renovation and expansion of health posts. There is also a plan for engaging the community; shifting basic services at community level and institutionalizing the HDA platform.

At last, Mr Taeme stated that one of the key challenges of HEP is regional inequalities, especially in pastoralist areas and regions. In urban settings, there is poor housing condition and complex socio-economic setting. The MoH is re-designing the approach to urban areas by adopting the approaches that have been successful in Cuba and Brazil. Categorisation based on income and health risk as well as family health team approach have already been piloted in Addis Ababa and have been found to be promising.

6.2 **General discussions**

Dr Zufan and Mr Taeme responded queries raised by the trainees.

Q: What is the age of HEWs?
A: The lower limit is 18 years of age. Another criterion is completion of grade 10 and above. There is also a pass mark to join the training. HEWs are selected from the specific woreda and kebele. In our case, most of them are young.

Q: Who is responsible for upgrading the HEWs training? Who manages the process? Are there similar upgrading opportunities for others, like midwives?
A: The Ministry of Education, in collaboration with MoH, UN bodies and training institutions, develop the curriculum. HEWs need to be upgraded to community nurses; but the name is not yet decided. HEWs provide public health service and they are not supposed to go to hospital. The training modality for HEWs is that it is a one-year training, including theoretical and practical sessions. It is a 64 credit hours course.

For WDA, the training is more practical and it is designed based on their educational background. In the second generation program, separate competency training is designed (promotive and preventive aspects). It is a two-month training; 2 days a week.

Q: Why only female?
A: HEWs are supposed to give house to house services for about 50% of their time. Usually, HEWs meet mothers since husbands are engaged in farming. It is more cultural for women to talk about their feelings and problems to women than men. Intimacy

could easily be developed between women. The other reason could be creating more jobs for women – motivating and empowering women to be role models for others.

Q: Could you clarify on the selection of HEWs, WDA and women development teams?
A: The governance system is highly decentralised. The district health office selects candidates from those who have applied to be HEWs. One criterion of recruitment is acceptance by the WDA. About 90% of the women involved should accept her to be their leader. She must be a model in implementing the health packages; very committed for change and good at communication. The organisation of WDTs depends geographical proximity and residing in the same neighbourhood. Social bond is there among neighbors and they meet regularly, for example during coffee ceremony. These women select their leader who could be a model.

1-5 team (source: MoH)

Q: Where do HEWs get lab service?
A: They only test malaria using their kits. They refer clients to a health center.

Section VII
7.1 **Health system in Ethiopia**

Mr Abebaw Derso
Clinton Health Access Initiative

Mr Abebaw Derso introduced himself and stated that he used to work for MoH. He then, outlined the purpose and learning objectives of the health system training module units. Mr Abebaw informed participants about MoH's vision and mission. He clarified the healthcare system and the tier system. In the structure, the primary hospital is important since they provide emergency surgeries; and preventive and promotive services. The general hospitals provide secondary care, which is more of curative service. The specialized hospitals at national level are teaching hospitals, well equipped with highly educated personnel. In terms of referral system, there are horizontal, diagonal, vertical systems.

Then, Mr Abebaw briefed on the healthcare policy of Ethiopia. The policy is designed following the critical examination of the nature, magnitude and root causes of the prevailing health problems of the country as well as the awareness of newly emerging problems. He also elaborated the general policy directions.

Mr Abebaw explained the historical background of the Ethiopian health service. The first initiative was the issuance of the "Public Health Proclamation of 1947", which laid a cornerstone for the establishment of MoH in 1948. The different periods that he specified include: the reconstruction period (1941-53); basic health services period (1953-74); primary health care (1974-1991) and the sector wide approach period (since 1991).

Mr Abebaw gave details on the current structure and function of the health system, which consists of the FMoH, Regional Health Bureaus (RHBs), Zonal health departments (ZHDs) and woreda health offices. There are also autonomous agencies such as Ethiopian Public Health Institute, FMHACA, PFSA, etc with their own branches. The agencies report to FMoH and MoFED. The mandates of the FMoH, RHBs, ZHDs and woreda health offices were discussed in detail. The mandate of the woreda health office is to manage and coordinate the operation of the PHC services at woreda level.

Mr Abebaw concluded his presentation by discussing the HSTP transformation agenda, which consists of: transformation in equity and quality of health care; information revolution; woreda transformation; and caring, respectful and compassionate health workforce. (see Annex IX)

7.2 **General discussions**

Q: How is the traditional medicine contained? Do people have access?
A: About 80% of people use traditional medicine in the country. Earlier, traditional medicine was not recognised by the government; but recently, it is accepted. The issue is how to integrate it in the system. There is an association with regional counterparts that are entitled to bring traditional medicine for research. The government is trying to understand the situation to make it more practical. Currently, we do not know how it is going to be scientific. The problem is that people who know about traditional medicines do not want to transfer the knowledge. They share the secret to the child they love when they are about to die. The government is trying to contact those who are willing to share their knowledge. The policy also supports them.

Q: In Ethiopia, how successful is the healthcare financing in the health system?
A: Ethiopia piloted and assessed the community based insurance in 13 woredas and it has been found to be successful.

Q: How do you know that the policies are implemented at the grassroots level?
A: MoH provides capacity building trainings and integrated support system. There are also monitoring reports. Review meetings are held at regional and national levels to evaluate performance.

Q: Concerning quality of care for all, do you have standards? National or international? How is the medical system; is it one regulatory body or separate professions (doctors, nurses, etc)?
A: Ethiopia has national standards which is a hybrid of international standards to fit our system. Without standards, we cannot regulate. The standards are cascaded in the health system. The regulatory body (FMHACA) monitors against the standards. Professions are regulated by professionals in the country.

Section VIII

8.1 **Primary health care, community health and community health workers**

Henry Perry, MD, PhD, MPH
Health systems program
Department of International Health
Johns Hopkins Bloomberg School of Public Health

Dr Perry introduced IIfPHC and explained his involvement in the establishment of IIfPHC through a request from Dr Kestebirhan Admasu, Minister of Health of Ethiopia to the Johns Hopkins University (JHU) three years back. Dr Perry explained that IIfPHC has a number of goals; part of it being to see how Ethiopia is implementing PHC. JHU sees how PHC works worldwide and help to stegthen a country's PHC progam.

Dr Perry reviewed about the historical background of PHC from the global perspective. He also elaborated the three kinds of public health: disease oriented; service oriented and community oriented. Community-oriented public health works with communities to improve their health. Dr Perry stated that how we work with the community is one of the challenges of public health. Ethiopia is becoming a model on how to work with the communities.

Dr Perry talked about John Grant, the father of PHC, who went to China in 1920s to improve the health of the population. At that time, there were high levels of mortality and sanitation problems in China and John Grant worked with the local community. They trained farmer scholars' to record vital events, vaccinate against smallpox, and administer simple treatment. This was the first example of the community health care program, which became the extension of the 'bare foot doctors' in the 1930s. Dr Perry discussed the development of public health in the 1940s and 1950s through the involvement of Professor John Gordon of Harvard school of public health. Prof Gordon realised that routine home visitation made a very powerful surveillance and health systems. Dr Perry also talked about Carl Taylor (1950-60s), Halfdan Mahler, Director General of WHO (1973-88) and James Grant, executive director of UNICEF (1980-95), who were considered as towering figurers in the development and evaluation of primary health care.

Dr Perry briefed about the Christian Medical Commission as well as the development of the WHO's PHC approach in the 1970s in India. They trained illiterate and low-caste women on how they could become health workers. Dr Perry also explained about the declaration of the Alma Ata, 1978 in the International Conference on PHC and the challenges that arouse to Alma Ata vision. (see Annex X for more details)

Section IX
9.1 **Primary Health Care in Ethiopia**

Dr Alemayehu Mekonnen, MD, MPH
Associate professor, Addis Ababa University
Ethiopian Public Health Association

Dr Alemayehu explained the definition of PHC adopting the Alma-Ata Conference of 1978. He stated that PHC has 14 components of PHC, of which eight are in the list of Alma-Ata. Six components were added later. PHC, in addition to the health sector, involves related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education and housing. Dr Alemahyehu stated PHC requires community and individual self-reliance and participation as well as making full use of local, national and other available resources. PHC should also be sustained by referral systems.

Then, Dr Alemayehu discussed about the evolution of PHC in Ethiopia. The sector wide approach was accepted as a strategy during the Derg Regime starting 1974. In 1991, PHC was officially launched. The country has already implemented 4 HSDPs between 1995 and 2015, with the aim to ensure full access to quality health service. Dr Alemayehu explained the priority areas of PHC under HSDP.

Dr Alemayehu explained about PHC under HSTP, which was ratified in 2015. In the coming 20 years, the MoH will follow the strategies specified in the HSTP document. The HSTP aims to improve: equity and quality of health services; information revolution; transforming the health workforce (caring, respectful and compassionate human resource for health (HRH).

The ultimate goal of PHC is better health care for all. Dr Alemayehu explained the WHO's key elements to achieve the goal, which include: universal coverage reforms; service delivery; public policy reforms and leadership reforms. He also explained the principles in PHC, strategies and components of PHC; and the organisation of primary health care in Ethiopia. In the discussion, Dr Alemayehu elaborated the management structures (RHBs; Zonal health departments; woreda health offices); as well as the monitoring and accountability mechanisms.

In financing PHC in Ethiopia, Dr Alemayehu explained that the country ratified a proclamation on financing 30 year ago. It included waiving of fees and free services. Currently, three strategies are adapted to generate finance: budget allocation from the Ministry of Finance; fees retention and utilisation as well as introduction of CBHI (community-based health insurance) schemes. In the long run, everybody will be covered by CBHI.

The Achievements, success factors, limitations and challenges of the PHC program were also discussed. Dr Alemayehu further discussed what would be required to replicate a successful PHC system and program implementation at policy, programmatic and organisational levels. (See Annex XI).

9.2 **General discussions**

Q: In the Ethiopian healthcare system, you have primary hospital. How many primary hospitals are there in one woreda? How many HC? How big is the responsibility of the primary hospital?

A: By putting health posts and health centers, one cannot say that PHC is addressed. That is why primary hospitals were introduced recently. Five HPs, a HC and a primary hospital, together form a PHCU. At a primary hospital, there must be a GP (performing surgery). A district may have several HCs. The primary hospital is a catchment for 4 health centers and 20 health posts. They serve up to 100,000 people.

Q: Do we have government commitment?

A: Commitment is important at every level - at Kebele and woreda levels. By working in the government health sector, we have to convince ourselves that we are all working for the community.

Q: You emphasised on respectful and compassionate HR. Where is the problem? Is it in school – that we are not telling them to be respectful. In Tanzania, we are shifting tasks. Have you recognised the problem in Ethiopia?

A: Regarding compassionate care, the MoE is trying to address the curriculum. Also choosing the right candidates and giving incentives are considered.
On task shifting, for instance, through time the HSDP started to address the pastoral communities. It has its own challenges because of its topography.

Q: How is the annual budget allocation planned?

A: There is budget and also additional amount is retained from the service. The woreda health office does the annual planning and it should indicate the sources, classifying the retention and new budget request from the government. The budget, then, will be endorsed by the government

Section X

10.1 **Human Resources for Health in Ethiopia**

Mr Assegid Samuel
HR development team leader
MoH

Mr Assegid gave a background on the health sector policy and the HSTP. He explained about the vision and goal of the national human resources for health (HRH) strategy. Mr Assegid stated that the main objectives of HRH strategy are: HRH policy, planning and partnership; quality, quantity and equitable deployment and distribution of the health workforce among all regions; leadership, governance and HR management as well as attraction and retention of health professionals. The issues that were identified for HRH improvement include: -improving education and training of health workers; improving skill mix and geographic distribution; improving quality of pre-service education and in-service training; as well as leadership and governance capacity of health workforce. Mr Assegid elaborated each of the strategic issues. Discussing the pre-service training, he mentioned task shifting (sharing) which was implemented based on the tailored needs of the country. The training programs include training for HEWs; health officers; accelerated midwifery; emergency surgical officers and Ethiopian field epidemiology training programs.

Mr Assegid stated that MoH is investing on quality and discussed about quality assurance and regulation of the health education. Towards this end, the Higher Education Relevance and Quality Agency has developed standards. In-service trainings and continuing professional development implementation guidelines have been developed to update health professional knowledge, skills and attitude.

Further, Mr Assegid explained on the health workforce financing through the government, bilateral and multilateral donors and individuals out of pocket and how the funding is spent. He also explained the motivation and retention schemes including higher salary scale; cost sharing for pre-service education; government scholarships; private wing practices as well as financial and non-financial incentives.

Through implementing the HRH stratetgy, Mr Asseged stated that Ethiopia has achieved significant improvements in the health indicators. (see Annex XII)

10.2 **General discussions**

Q: The government is going to optimise utilisation of funds. At the same time, you mentioned government sponsorship is available. Is that for specific people?
A: MoH is trying to use different mechanisms to retain health workers. Trainings are provided for all cadres. Those who perform well are offered to enrol into advanced training programs. There are criteria for government sponsored training programs.

Q: Regarding motivation and retention, when you say that health staffs are paid 2 step higher, did you mean a step or a grade. Were they motivated by the salary and was

there an evaluation? This could lead to a dissatisfaction for other workers. People still leave to other developed countries and there is exodus of health professionals.

A: Salary is not the only means to retain workers. The health sector pays higher, for instance, than the construction sector. For example, a graduate in accounting gets a salary two-steps lower than a graduate health officer. Salary increment is made every 2 years based on performance.
To retain the health workforce, career structures have been developed. For example, MDs to specialisation; HEWs to nurses. Previously, best students were enrolled into the medical schools and trained for 6 years. There are requests from paramedicals and nurses to be trained as GPs. They are admitted in any medical university and are trained for 4 years. There is also opportunity for other health workers to be medical doctors. This is another form of retention.
There is a brain drain in Ethiopia. Many health professionals go abroad. More than 3,000 medical doctors have left the country.

Q: How do you manage the training plan? At federal or regional level? How do you ensure that people are trained equitably?
A: Training programs are planned and nationally coordinated through MoE and MoH. The regional bureaus manage the training programs. The MoH coordinates the activities nationally.

Q: In strengthening HR, there was strong quality assurance. I didn't know the regulation.
A: The regulation is part of the quality assurance. Those who pass the national licensing exams are given licences and are deployed.

Q: Under strategic issues, there is equitable geographic distribution of HR. How can you achieve this? What do you do to make sure that the imbalances are improved? In Tanzania, this is difficult. There are, for instance, discrepancies between doctors and nurses.
A: Geographic imbalance is a problem in Ethiopia as well. We cannot assign every professional in a specific area. The licensing unit has standardized the number of staff in each facility. We are working to meet these standards.

Q: In task shifting, apart from HEWs, you have included Ethiopian field epidemiology training program? How is this different for Ethiopia? Why a shift? Are these cadres regulated in terms of their health obligation? Also, when they practice, are they regulated?
A: Field epidemiology (Masters level), midwifery and emergency surgical officers are the result of task shifting. They are regulated based on the national regulation system. It is not unique for Ethiopia; but it is tailored to the country's needs. There are international standards; but the regulations need to focus on Ethiopia's problems. For instance, if a GP is not available, tasks are shared among professionals. There are regulatory bodies at the Zonal and woreda levels. They are responsible for monitoring by using the national guidelines and standards.

Section XI

11.1 **Harmonisation and alignment on budget**

Ms Abebayehu Haile W/Aregay
Grant management unit coordinator
MDG pooled fund
MoH

Ms Abebayehu gave an outline of her presentation and stated that she will focus on the MDG pooled fund, and harmonisation and alignment. She mentioned that the sustainable development goal (SDG) performance fund is a pooled funding mechanism, which considers international health partnership in support of HSTP.

Ms Abebeayehu stated that the major focus of harmonization is "one plan; one budget; one report". The MDG performance fund is a non-earmarked partner funding. MoH manages the fund and carry overall responsibility and accountability. Before planning, consultations are made with the donors. The joint financing arrangement sets out the overarching governance and reporting requirements for the fund. The development partners will ask separate reports according to the plan. They conduct joint review meetings. Currently, there are 11 development partners contributing to the pooled fund account.

Ms Abebayehu explained the responsibilities of the development partners and that of MoH. Different forums are conducted at MoH with partners and the grant management unit on how the activities are implemented and on how to go forward.

Another modality of funding is a loan from World Bank (PforR). It provides US$120 million (US$100 million credit and US$20 million grant) during the five year period of HSTP. The monies are disbursed against achievement of eight indicators. The main focus of PforR is on institutional capacity building. (see Annex XIII)

11.2 **General discussion**

Q: Does World Bank has two mechanisms? Or is it a pooled funding?
A: The money from World Bank is a credit, not a grant. It is an earmarked fund. The financing modality for Ethiopia is different. The planning is carried out aligned with the MDG plan and also aligned with the pool fund.

Section XII
Field visit at Debre-Berhan

12.1 **The Visit of Debre Berhan Health Science College**

Mr Abenet Dagnew
MSc in clinical, tropical, infectious diseases prevention
and tropical disease

The visiting team at Debre Berhan training center

Mr Abenet, the instructor of the college, gave a brief description about the HEW training program. The center provides level 3 and level 4 courses. Each course is a one-year program. Mr Abenet explained that the training is 30% theory and 70% practice. He stated that the program has three learning processes: theoretical, cooperative training and internship. After completing the theoretical and cooperative trainings, the HEWs' internship is arranged at the health posts.

Mr Abenet gave a quick tour around the center. The team visited the classrooms and the demonstration room. Mr Abenet explained the importance of the antenatal, delivery and midwifery stations in the demonstration room. HEWs also learn about the different equipments such as EPI equipment, antenatal care equipment, delivery and essential new born care equipment in the room.

The demonstration room

It is mostly a time for HEWs to practice independently with some supervision. HEWs are not engaged in delivery; however, if there are complications, they need to be engaged. Although it is not a skilled delivery, they could provide better service than the traditional birth attendants.

12.1.1 **General discussions**

Q: How many students are there in a class?
A: From 40 to 50 in the theory class and from 20 to 25 in the demonstration room

Q: How is the class conducted?
A: The training is module-based. Over-head projector and the traditional black board are used. Check-lists are used to assess the skills of HEWs in the areas of antenatal care, normal childbirth management; helping a newborn breath/resuscitation/; and postpartum assessment and care. The students also prepare reports.

12.2 **Visit of the Keyit health center**

Mr Tamiru Mengistu
Head of Keyit health center

Keyit health center

Following the visit of the training college, the trainees visited a rural health center named Keyit health center. Mr Tamiru Mengistu, the head of the center, explained that they offer preventive and curative services for about 40,866 residents in the area. He stated that although the center is expected to have a GP according to the MOH structure, it has two health officers (trained at degree level), instead. The officers provide OPD treatment for communicable and non-communicable diseases.

In addition, the center is staffed with six nurses (trained at BSc level), three midwives, two lab technicians, two pharmacists, two health extension workers and admin staff. The visiting team met the 6 HEWs who have been on their internship.

HEWs on internship

The team visited the health extension package model house. A rural household have a single room shared by parents, children and cattle. Mothers cook in the same room using firewood. The model is used to show clients coming to the center on how they could partition a room into a living room, bed room and a store. The model encourages households to have a kitchen separate to the house and use energy saving stoves as well as construct their own pit latrines.

Health extension package model house

Trainees visiting the model house

Mr Tamiru showed the facilities in the center including the MCH unit, with examination, operation and delivery rooms. The team also visited the temporary maternity waiting rooms where expecting mothers relax and sleep. These women are coming to the center ten days earlier to avoid risks. While they are staying at the center, mothers eat free of charge. The community generously donates quintals of cereals (barley, wheat, etc) for the expecting mothers.

Quintals of cereals

12.2.1 **General discussions**

Q: What kind of structure is there for the HC?
A: There are six health posts under the health center and each post has two HEWs. The center makes referrals to Debre Berhan primary hospital in case of complications. An ambulance serves two health centers.

Q: How many patients are treated every day?
A: On average, 100 patients are seen and 3 delivery services are given per day. Mortality rate is also registered.

12.3 **Visit of Bakelo kebele health post**

Mr Tamiru accompanied the visiting team to show a health post that is under the Keyit Health Center.

On the way to a rural health post

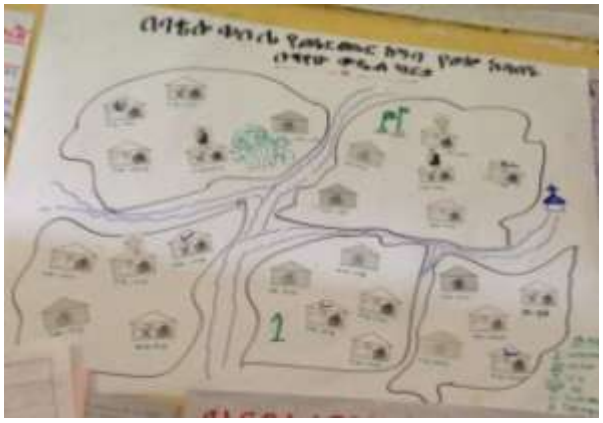
visiting Bakelo health post

The team met the two HEWs working in the health post. One of them stated that 1,273 HHs (5,723 residents) benefit from the heath care services. She explained the types of services given at the health facility as well as at a household level through home visits. Each HEW work alternatively; one stays at the health post while the other makes home visits.

While they provide outreach services, the HEWs register pregnant mothers and advise them to come to the health post for follow-up. The HEWs educate families and children on personal hygiene and environmental sanitation as part of the effort to prevent and control diseases. They also provide post-natal advice to mothers in their homes. The HEW explained that they use their kits to treat children under 5 in the villages. Their training include diagnose and prescription of drugs. Hence, they provide medicines such as as ORS, tetracycline and anti-pain drugs following their eamination and identification of the problems. The HEWs also discuss health related issues with each family and register everything in the family folder.

A HEW explaining about a family folder (source: Dr Henry Perry)

Then, the HEWs showed the visiting team the two rooms and the types of services offered in each room. They use charts and tables to record events such as list of pregnant mothers names, address, LMP, EDD, and date of birth of the newborns. The HEWs explained how they use model map to indicate what is happening at each HH using symbols.



Model map of women development army leader

The health post uses charts and records types of treatments offered

Section XIII

13.1 Primary health care, community health and community health workers: part 2

Henry Perry, MD, PhD, MPH
Health systems program
Department of International Health
Johns Hopkins Bloomberg School of Public Health

Dr Henry continued his presentation on PHC and focused on the conceptual models of PHC. He elaborated five different PHC frameworks: alma Ata; community-oriented PHC; Community-based PHC; census-based, impact-oriented approach as well as care groups/participatory women's groups. (see Annex X for details)

Dr Perry explained that community-based PHC provide services outside the health facility. He stated that the health post in Debre Berhan is a community-based PHC facility and HEWs spend 50% of their time in the community. Another example that Dr Perry mentioned was from BRAC's health program, the largest NGO in the world. BRAC's programs are community based and women provide essential services to the community at affordable prices. The community-based workers use an integrated approach.

The last session of Dr Perry focused on the re-emergence of community health workers. He talked about the failure of large-scale CHW programs in the 1980s and the reasons for the renewed interest in CHWs.

Dr Perry concluded his presentation by stating that community-based programs have been considered important in many countries for many years. That attitude is currently changing. After Alma-ata, there were community programs; but they were not planned and monitored well, which resulted in failures. They lost political momentum. In India and South Africa, they are building community health worker programs as part of the health system. They are going to be important in the longer term.

Section XIV
Debriefing session and conclusion

14.1 **Debriefing**

Professor Mengesha invited training participants from Tanzania to comment on the overall training program. (Participants from Lesotho were not present since they left after the field visit.) He clarified that participants should forward their comments without any limitations so that IIfPHC could improve its services in the future.

The participants' comments follow:

1. "Generally, I think, it was a wonderful experience for me. Together with what we have learnt, I have learned a lot at the actual situation. We ask them [HC and HP staff]; we get explanation from them."

2. "The experience was very powerful. You thought us the concepts and we have something that we could take back home; especially, the community aspect that you were able to implement. You have been successful to see the linkage.

3. "The most important thing and the one that I appreciated was the field visit. It was very comprehensive. I really appreciate the work undertaken at the health post. Your organisation is at an early stage in organizing trainings. We share the vision of your Institute. I would like to stress that good communication is important in order to address the issues."

4. "Thank you for taking your time to lend your experience. We did not know where to go if the Institute was not established. Thank you for committing your time as a director and teaching us on how we could improve. There are issues that I would like to address on the program. Our aim was how to share your experience around HR. You train health workers, community nurses and also use task sharing. Tanzania will compare with the Ethiopian health care system to improve the health service delivery."

   "We saw compassionate service and shared tasks at the health center and the health post. When compared to that of yours, our indicators were low. We need to re-visit our programs to reach the same level. You have produced a lot of doctors, health officers, medical surgeons; regardless of the need of the country. The trained professionals could serve anywhere. How best and where they should be working need to be checked in Tanzania. We also have similar programs; but you are moving fast and showing the results."

   "On the organization of the training program, there were challenges. We wanted more field work. The rural experience is very important. In addition, trainees need to be informed to prepare themselves to come with all the requirements in the future."

5. "Thank you so much. I would like to add two things as an addition to what has been said. First, on the knowledge part that was given through presentation, I would like to suggest that the presentations should be simple. Repetitions should be avoided so that presenters are comfortable. Second, the field visit is very important. I suggest that it comes a bit earlier. People learn through observation; then the presentations could be better understood. It will give the opportunity to ask more."

6. "The task sharing that I have observed is like community based task sharing. You are well placed if you are talking about task sharing at a community level. Basically, the initiative is put in the community itself. We have seen high community involvement. The way you have put the health system at primary level is unique. In Tanzania, we have it; but it is bits and pieces. The primary level care could be learned by others. You did wonderful and this should be shared with all in the future. It is very good achievement towards the aim - providing medical services for all. We may use different approaches. Task shifting to the community and HEWs is necessary. But for us, the understanding was that tasks will be assigned for certain professionals."

   "The advice that I would like to make is the need to have consistency of information, which I found confusing to a certain extent. Repetition to a certain extent may be good to clarify information. But in this case, it was too much."

7. "I would like to ask if the government is working closely with the health professional bodies and associations. It would be important to involve these bodies into the heath care provisions."

   "Details on the task sharing are missing. If the government has a guideline or plan, what is the implementation? What are the challenges? The HEW program and community based approach is similar to Tanzania. Regarding the field visit, find more places that are nearby, if possible."

8. "I was worried that we could not get what we wanted. But, we have achieved it. We were debating among ourselves on different issues. You are doing a great job. If you are going to offer the course, your selling point is the community. Congratulations on this program. A very good example for many countries."

   "Two things need to be considered: why we came here? and what is offered? A broad picture of what is happening has been offered. Why we came here –since most us are practitioners, we make things happen. For the future, it would be more fruitful if we have interactive sessions instead of power point listening. The lectures need to be minimized and more interactions should be encouraged. We should have done exercises using a framework; or on an implementation plan to take something home to show to our colleagues."

   "Generally, I could say that it has been a productive experience; it has created discussions among us. It was a fantastic experience. HEWs work was extensive. However, you need to tailor your experience to the audience; more communication may be needed before we come here. But not listening to lectures. Thanks."

9. "Thank you for what we have seen from Monday up to this point. I would like to comment that Africans have various factors influencing success of PHC. The socio-economic set up is important in the implementation of PHC. On the HR component, it is better that you use HR professors. They should be able to answer many questions. Many professionals are here".

10. "Thank you. Much has been mentioned; but let me make few additions. As institutions, the HC and HP are well run; back in Tanzania, it needs lots of improvement. We have different trainings. What we learnt is that you have HEWs, nurses, etc. with defined tasks and experiences. If possible, ensure that they are practitioners."

    "Our expectation was to learn about task sharing at different levels. But, we are happy that the experience was community based. The real community participation was excellent. What the community is doing in terms of cost sharing and providing food is good. An expectant mother being screened and taken care of by HEW is also very good. This ensures that there are no health problems from the beginning. This is a learning that we take home."

    "We welcome you to Tanzania where you can learn from our experience and with regards to the institution."

11. "I was impressed. At the HC, 80% was preventive and 20% curative aspect of health care. The fact that the community contributes to the cost of the HC with what they have – money, food so that the expecting mothers are brought 10 days before delivery to avoid problems. This is very good. I was also impressed at the HP, seeing the two HEWs. The mapping of the HH was most impressive. At the HP, the family folder and recording system is also good."

    "As to the areas of improvement, I envy Ethiopia very much for establishing this institute. It really should be international. It now looks national. Facilities are poor. We had no internet connection and we couldn't see the materials you send us. Internet communication is important and needs to be introduced. The toilet's hand was broken. To be international, this is a minimum. The transport service we used for the field trip was not comfortable. When we come back, I encourage going far for the field visit to have a touch of the feeling; but of course, with better transport."

12. "We were told about the site visit when we were here. We would have been informed earlier. Also, we would have come with tabs or flash disks or computer if we were informed in advance. For the Inistutute to be international, you need to learn from other international institutes including how they produce their products."

13. "I really appreciate the site visit and the gross motivation of the HEWs who are supported by massive community mobilisation. My interest was task sharing. In the future, with my fellow Africans, we may be able to see how you have done the planning, implementation and evaluation. You have good health system."

"I do appreciate the program and the field visit. I learnt a lot. In the future, the lecture should include task sharing and task shifting."
"Lastly, we do appreciate for hosting this event. You were referring to other African countries. We have a lot to share as well. I invite you to come and see Tanzania."

14. "I enjoyed the three days that I attended. I have documented the best practices. I found that the display at HC and HP was a good practice. I was impressed by the documentation. The family information is also well documented. A pregnant woman's information is there. The community involvement in supporting the mothers is also a good practice."

    "My suggestion is that at least, 3/4th of the training program should be field visit and 1/4th class presentation. Also, the field visit could be far from the main road. The HEW training center needs to be more spacious and with more light for them to learn the new skills. We welcome you to Tanzania for experience sharing, even at a community level."

15. "The Institute should be flexible. Countries may come with their own experience and they should reflect and share their experience. Common understanding is important. The facilitation of the training should be based on needs. Give trainees exactly what they need. In this training, that was lacking."

16. "It would have been a good opportunity for us to see what Lesotho is doing; what their challenges were. We were able to enrich these issues in the course of the discussion. We would have discussed Tanzania's experience and input. You should push in that area in the future."

14.2 **Conclusion**

After receiving the comments from all the participants, Dr Perry thanked all for the helpful comments. He stated that it takes all effort to improve the courses moving forward. Dr Perry said that the Institute looks forward to keep in contact with all the participants and provide information.

With regards to the field experience, Dr Perry stated that it was obviously powerful and enabled to show the reality for trainees. In the future, he suggested using more time to see WDA. Also, the Institute has a plan to introduce participants to other aspects of PHC beyond what Ethiopia is doing to expose them to new ideas and what is happening in other countries. The Institute will also take group works on participants' own countries. Dr Perry mentioned that he would be eager to hear about what kind of things participants would like to learn about PHC.

Following that, Professor Mengesha thanked the training participants and appreciated the comments given. He stated that it was an important opportunity for IIfPHC to listen to the constructive comments to improve services in the future.

This concluded the training program.

Annex I

I.a Schedule of the experience sharing visit for Tanzanian and Lesotho delegates

Ethiopian Public Health Institute, Addis Ababa, Ethiopia

15 – 19 August 2016

Date	Time	Activity	Presenter
August 15, 2016 (Monday)	8:30 – 9:00	Registration	Organizers
	9:00 – 9:15	Opening Remark	Prof. Mengesha Admassu
	9:15 – 10:00	Overview of Ethiopia	Ludina Hailu
	10:00 – 10:30	**Tea break**	**Organizers**
	10:30 –11:00	Introduction of International Institute for Primary Health Care	Prof. Mengesha
	11:00 –12:00	Attitude towards development	Prof. Mengesha
	12:00 – 12:30	Discussions	Participants
	12:30 – 2:00	**Lunch**	
	2:00 – 3:00	Policy and Planning	Ato Melaku
	3:00 – 3:15	Discussions	Participants
	3:15 – 3:45	**Tea break**	**Organizers**
	3:45 – 4:45	Resource Mobilization	Dr. Lissanu
	4:45 – 5:00	Discussions	Participants
August 16, 2016 (Tuesday)	8:30 – 9:45	Maternal and Child Health (MNCH)	Dr. Lissanu
	9:45 – 10:00	Discussions	Participants
	10:00–10:30	**Tea break**	**Organizers**
	10:30 – 11:30	Health Extension Program	Dr.Zufan
	11:30 – 12:30	Discussions	Participants
	12:30 – 2:00	**Lunch**	
	2:00 – 3:00	Health System	Ato Abebaw Dereso
	3:00 – 3:15	Discussions	Participants
	3:15 – 3:45	**Tea break**	**Organizers**
	3:45 – 4:45	Grant Management	Ms.Abebayehu
	4:45 – 5:00	Discussions	Participants
August 17, 2016 (Wednesday)	8:30 – 9:45	Human Resource Management	Ato Assigid
	9:45 – 10:00	Discussions	Participants
	10:00–10:30	**Tea break**	**Organizers**
	10:30 – 11:30	PHC	Dr.Alemayehu
	11:30 – 12:30	Discussions	Participants
	12:30 – 2:00	**Lunch**	
	Afternoon	Free	Free
August 18, 2016 (Thursday)		Visit PHCU at Debrebirhan	Organizers
August 19, 2016 (Friday)		Debriefing	Participants

I.b List of participants from Lesotho

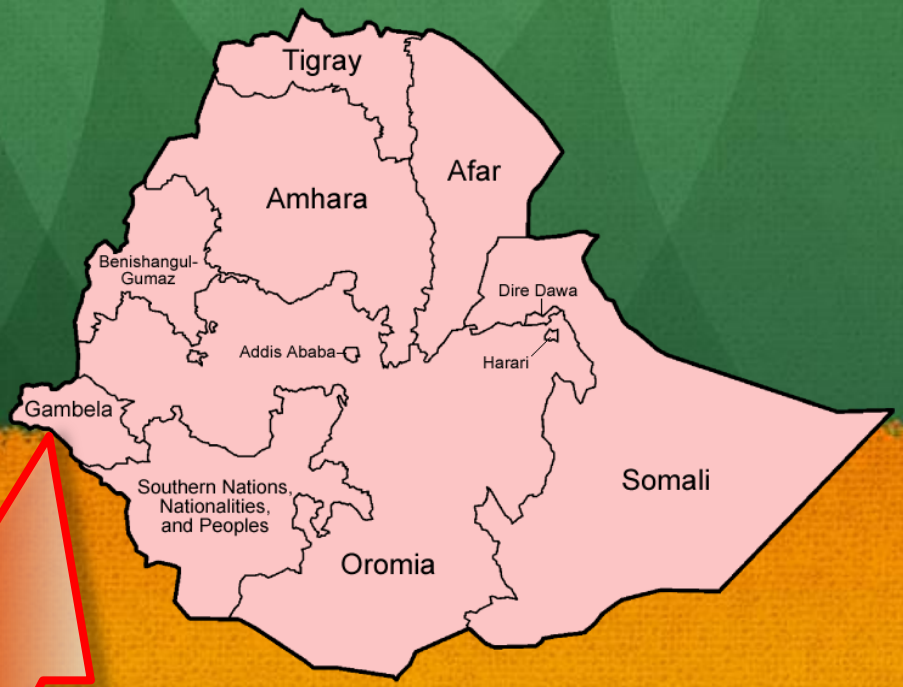
Full Name	Sex	Title	Organizational Affiliation	Department	Position	E-Mail Address
Hon Liteboho Kompi	F	MD	Ministry of Health		DEP Minster Health	kompi182@gmail.com
Ms Palesa Mokete	F	MS	Ministry of Health		Deputy Principal Secretary	parisha2002@yahoo.com
Makhoase Ranyali	F	MD	Ministry of Health	District Health Management Team	District Health Manager	makhoaser@yahoo.com
Thabelo Ramatlapeng	F	MD	Ministry of Health	Primary Health Care	Director	tramattapeng@gmail.com
Mahlape Tiiti	F	MD	Ministry of Health	District Health Management Team	Medical Doctor	mahlapetiiti@gmail.com
Shoeshoe Lemphane	F	MRS	Ministry of Health	Nursing Directorate	Head Public Health Nursing Services	slemphane.lemphane4@gmail.com
Anna Masheane	F	Mrs	Ministry of Health	Disease Control	TB/HIV	
Mamojaki Maine	F	MRS	Christiane Health Association of Lesotho	Nursing Education	Deputy Principal	

I.b List of participants from Tanzania

Full Name	Sex	Title	Organizational Affiliation	Department	Position	E-Mail Address
Otilia f. Gowelle	F	MD	Ministry of Health	Human Resources Training and Professional Development	Director	ogowele@moh.go.tz
Michael o. John	M	Mr	Ministry of Health	Administration and Human Resource Management	Director	mjohn@moh.go.tz
Gozibert Mutahyabarwa		MD	Ministry of Health	Continuing Education	Assistant Director	gozimata@yahoo.com.uk
Mabula Ndimila Masunga		MD	Ministry of Health	Allied Health Science Training	Coordinator Training	mmabndi@yahoo.co.uk
Ndementria Vermand			Ministry of Health	Nursing Director	Assistant Director	
Charles G. Masambu		MD	Ministry of Health	Diagnostic Services	Assistant Director	cmassambu@hotmail.com
Martin Mapunda,	M		Ministry of Health	HRP Section	Health Administrator	masma8@hotmail.com
Hussein Mavunde	M		Ministry of Health	HRH Section	Statistician	mavundeh@yahoo.com
Beatus Leon		MD	I-Tech	Health system strengthening	Director	

Vamsi Vasireddy	M	MD	CDC	Human Resource	Health Advisor	yjz9@cdc.gov
Angela Makota	F		CDC	Health System	Human & Institutional Capacity Founding : Branch chief	hqx8@cdc.gov
Billy Haonga		MD	MNH	MAT	President	bhaonga@gmail.com
Paul Magessa Mashauri		MD	TANA	School of Nurse	President	gesa080@yahoo.com
Lena Mfalila	F		Ministry of Health	TNMC Registrar		lmfalila@moh.go.tz, lenamfalila@gmail.com
Gustav Moya	M		Ministry of Health	Nursing and Midwifery services	Director	gusmoyo@gmail.com
Eliaremisa Ayo	F		Alha-Tanzania	TNI Program Manager	Representative	ayo@aiha.co.tz

Annex II



ETHIOPIA

AN ANTIQUE COUNTRY

OUTLINE

I. **Introduction**
    1. Country Profile
    2. Geography and Climate
    3. Demographic Profile
    4. Government and Administration
    5. Socio-economic status

II. **Diversity within a nation**
    I. Diversity in religion
    II. Ethnic Diversity

III. **Conservancy of a distinctive culture**
    I. Alphabet
    II. Calendar
    III. Food
    IV. Habitat

IV. **Wonders of Ethiopia**

V. **Health System of Ethiopia**

Country Profile

- The oldest independent and second most populous country in Africa.
- It has a unique cultural heritage with a diverse population mix of ethnicity and religion.
- It served as a symbol of African independence throughout the colonial period
- Founding member of the United Nations and the African base for many international organizations.

Geography and Climate

- Located in the North Eastern part of Africa, also known as the Horn of Africa.
- It borders six countries - Eritrea, Djibouti, Somalia, Kenya, South Sudan and the Sudan.
- Highest 4,620m above sea (mount Ras Dashen)
- Lowest below sea level 148m (Dallol)
- Three microclimatic zones:
  - the "Kolla" , or hot lowlands up to 1500m
  - the "Wayna Degas" 1,500-2,400 meters
  - the "Dega" or cool zone on land of elevation above 2,400 meters

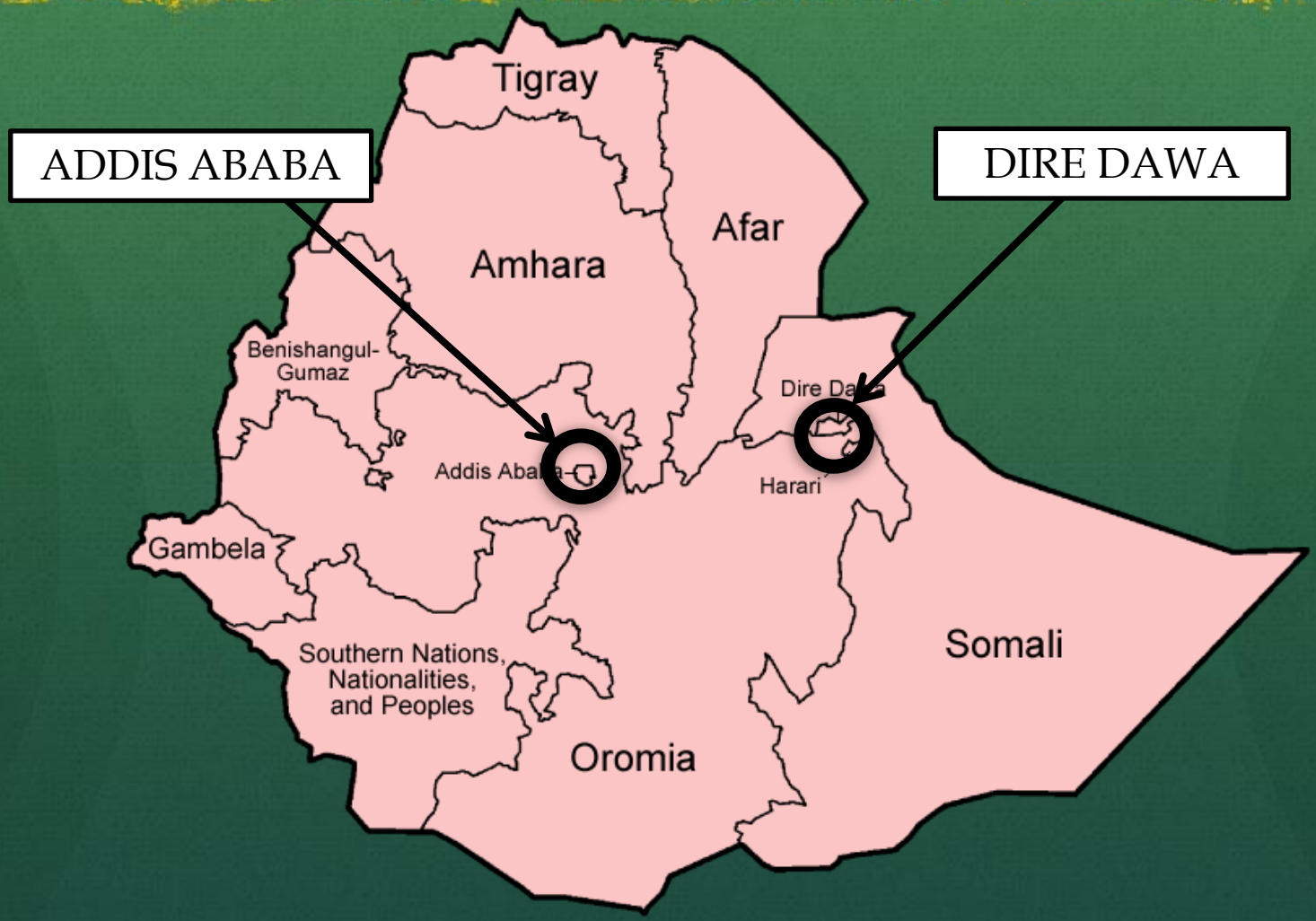
Demographic Profile

- Total population of 102 million (CSA, 2016)
- Variety of nations, nationalities with more than 80 different spoken languages.
- The average size of a household is 4.7.
- Predominately young population with the age of under 15 years close to 45%
- Over 65 years accounts for only 3%
- Women of reproductive age constitute 23.4% of the population.
- The average fertility 4.1 births per woman (EDHS 2014).

Government and administration

- Ethiopia is a federal parliamentary republic, with the Prime Minister serving as head of government.
- Composed of nine administrative regional state
- Two city administration
  - Woredas (districts) and Kebeles (sub-districts).
    - A Woreda/District is the basic decentralized administrative unit and has an administrative council composed of elected members.

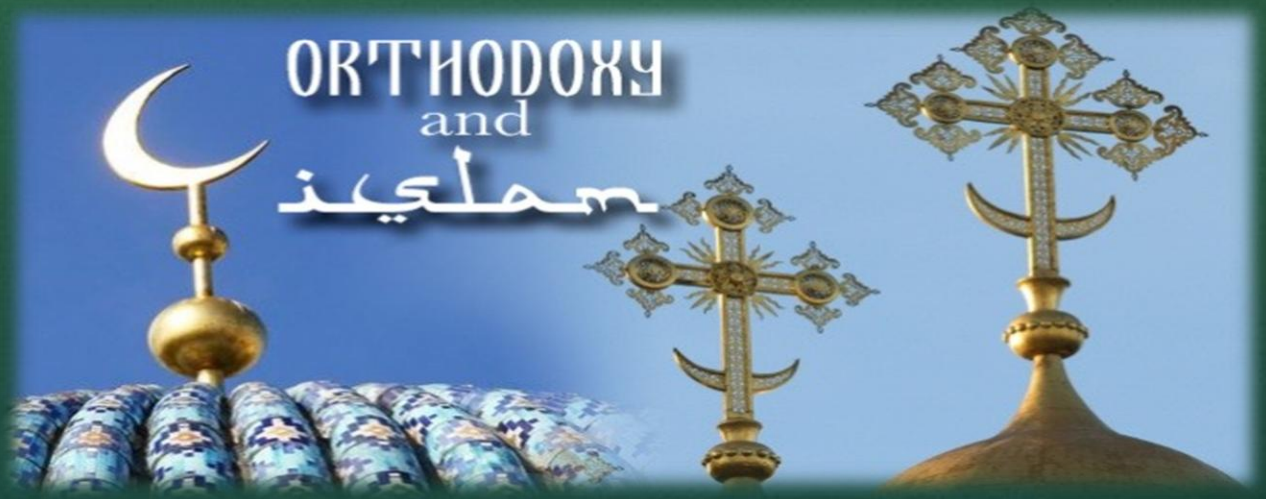
Two Chartered State



Socio-economic status

- OVER THE LAST DECADE (2003/4 -2013/14), HAS A GDP OF 10.9% ANNUAL AVERAGE GROWTH RATE.
- THERE IS AN ECONOMIC TRANSFORMATION FROM AN AGRICULTURAL TO INDUSTRIAL LED ECONOMY.
- THE HEALTH SECTOR IS PLAYING ITS PART AS A MEANS OF ECONOMIC GROWTH WHILE BENEFITING FROM THE ECONOMIC GROWTH.
- THE ECONOMIC REFORM IN ETHIOPIA : EMPOWERING WOMEN TO PARTICIPATE IN THE ECONOMIC DEVELOPMENT
- ETHIOPIA HAS SPENT UP TO 40% OF ITS CAPITAL BUDGET FOR BETTER HEALTHCARE ACCESS

Diversity Within a Nation



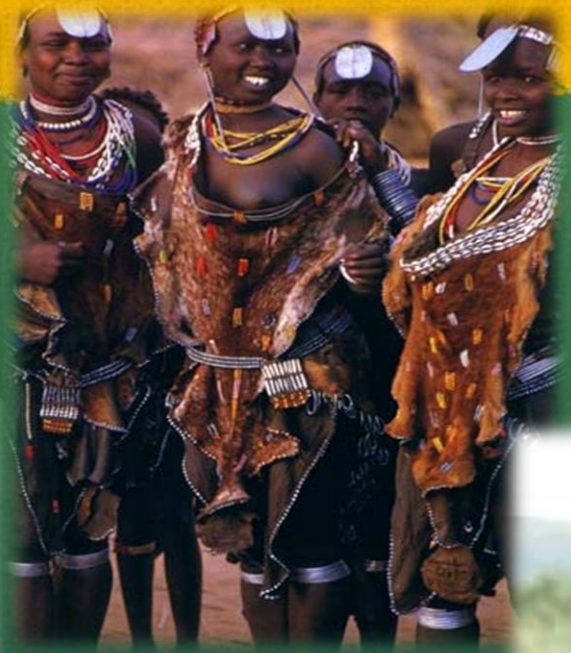
Diversity in Religion

Orthodox Church ceremony on the day of Jesus baptism

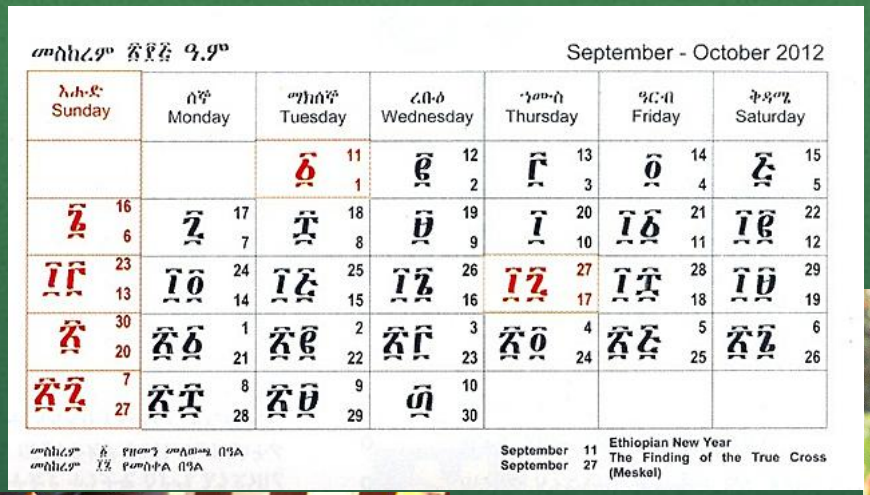
Diversity in Religion cont'd

Ethnic Diversity

Beauty in diversity



A Distinctive Culture



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September - October 2012

እሑድ Sunday	ሰኞ Monday	ማክሰኞ Tuesday	ረቡዕ Wednesday	ኃሙስ Thursday	ዓርብ Friday	ቅዳሜ Saturday
		፩ 11 1	፪ 12 2	፫ 13 3	፬ 14 4	፭ 15 5
፮ 16 6	፯ 17 7	፰ 18 8	፱ 19 9	፲ 20 10	፲፩ 21 11	፲፪ 22 12
፲፫ 23 13	፲፬ 24 14	፲፭ 25 15	፲፮ 26 16	፲፯ 27 17	፲፰ 28 18	፲፱ 29 19
፳ 30 20	፳፩ 1 21	፳፪ 2 22	፳፫ 3 23	፳፬ 4 24	፳፭ 5 25	፳፮ 6 26
፳፯ 7 27	፳፰ 8 28	፳፱ 9 29	፴ 10 30			

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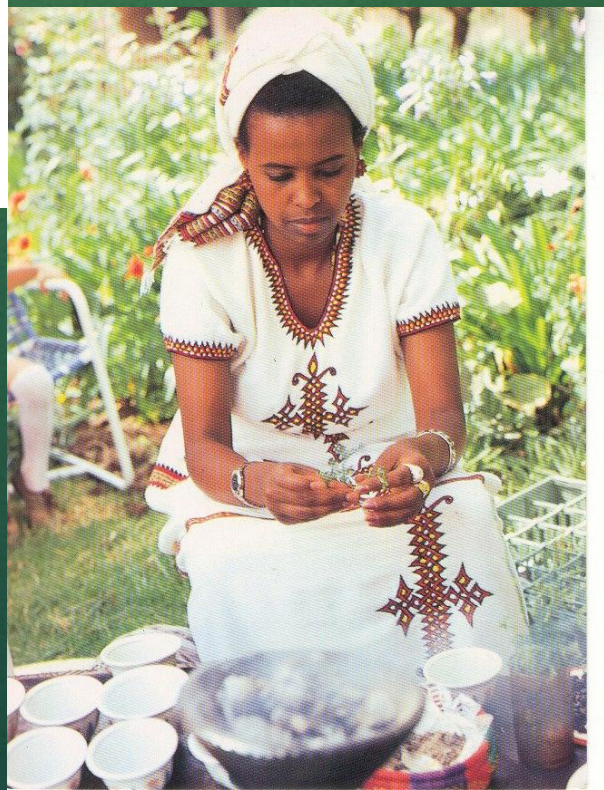
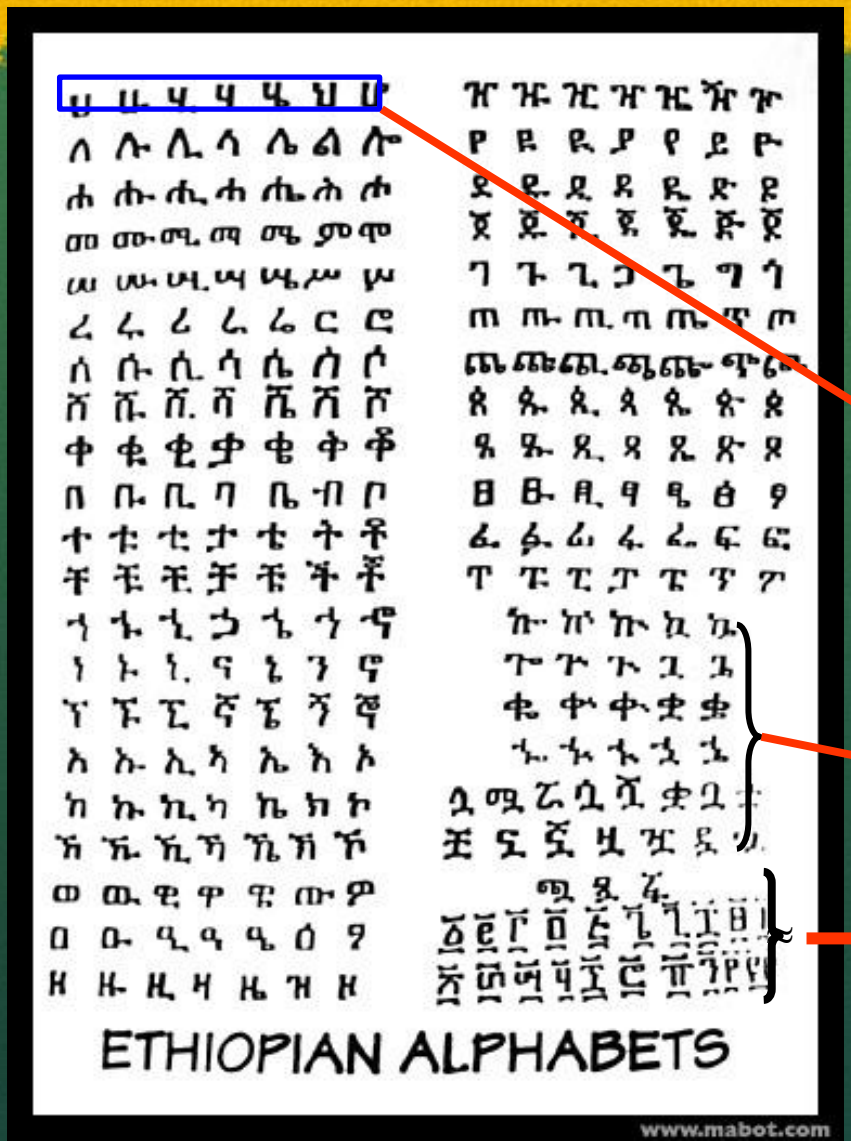
September 11 Ethiopian New Year
September 27 The Finding of the True Cross (Meskel)



Ethiopia: Alphabets and Numbers



Sets of similar characters generally represent the same consonant with different vowels after it.

Example:
Ha, Hu, Hi, Haa, Hee, Hea, Ho

34x7=238 basic
&
38 special alphabets

Numerals

Ethiopian Calendar

7 years and 8 months behind the Gregorian

Ethiopian New Years

መስከረም ጽዮን ዓ.ም — September - October 2012

እሑድ Sunday	ሰኞ Monday	ማክሰኞ Tuesday	ረቡዕ Wednesday	ኃሙስ Thursday	ዓርብ Friday	ቅዳሜ Saturday
		፩ 11 1	፪ 12 2	፫ 13 3	፬ 14 4	፭ 15 5
፮ 16 6	፯ 17 7	፰ 18 8	፱ 19 9	፲ 20 10	፲፩ 21 11	፲፪ 22 12
፲፫ 23 13	፲፬ 24 14	፲፭ 25 15	፲፮ 26 16	፲፯ 27 17	፲፰ 28 18	፲፱ 29 19
፳ 30 20	፳፩ 1 21	፳፪ 2 22	፳፫ 3 23	፳፬ 4 24	፳፭ 5 25	፳፮ 6 26
፳፯ 7 27	፳፰ 8 28	፳፱ 9 29	፴ 10 30			

መስከረም ፩ የዘመን መለወጫ በዓል — September 11 Ethiopian New Year
መስከረም ፳፯ የመስቀል በዓል — September 27 The Finding of the True Cross (Meskel)

Enjera, Staple food in Ethiopia

Eragrostis tef, Graminae

Typical dishes for a get together

Enjera

Spicy and chilly stew

Raw Beef

Chicken stew

Kocho:

Bread of enset

Fried Meat

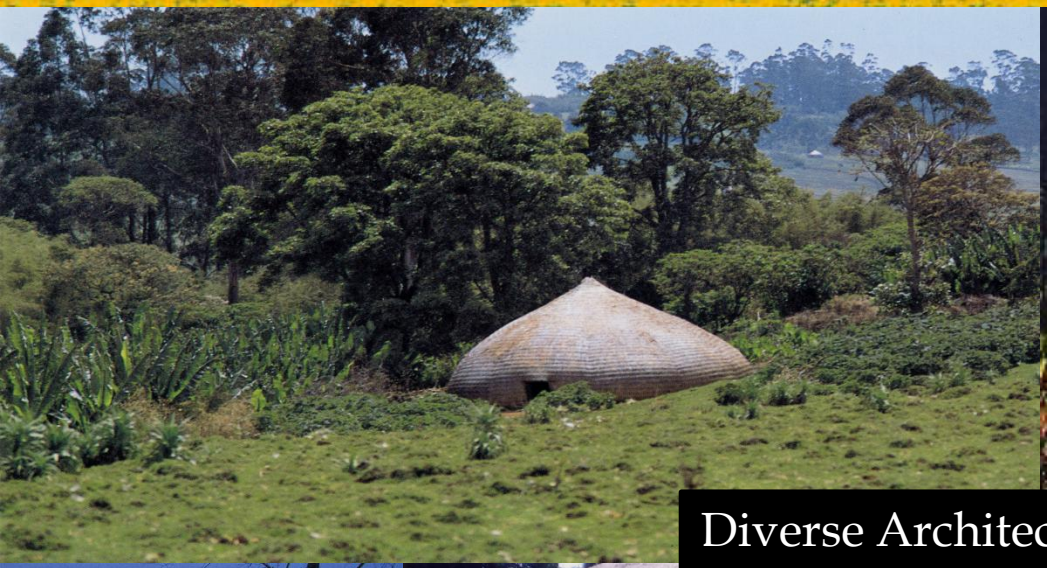
Cheese

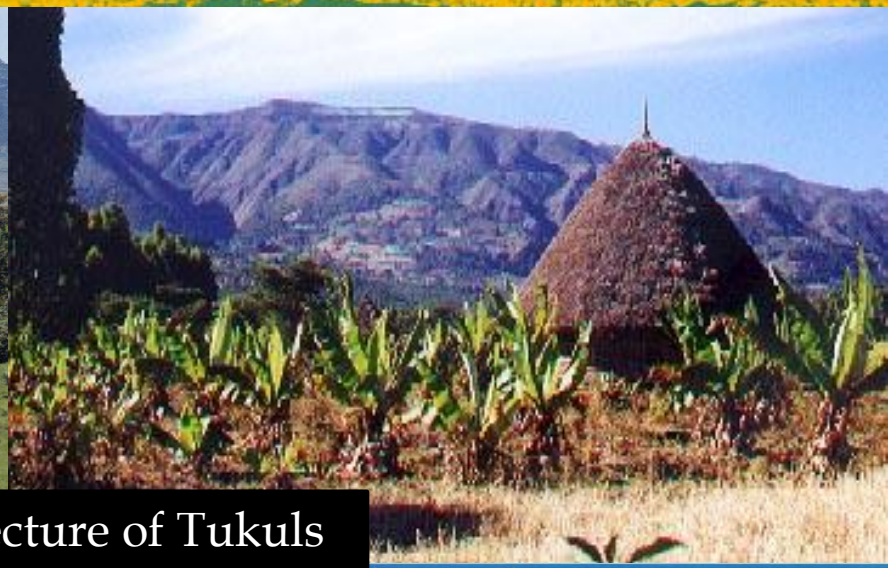
Cabbage

Mild stew

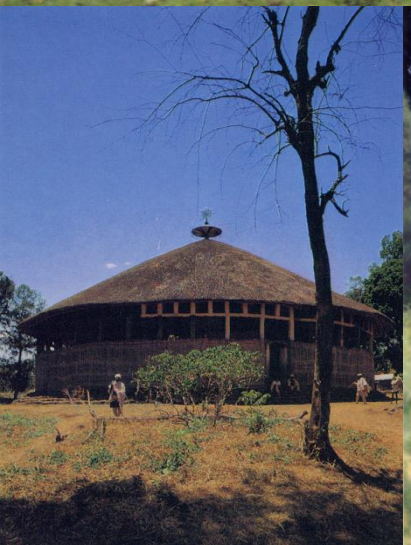
Sharing a common tray

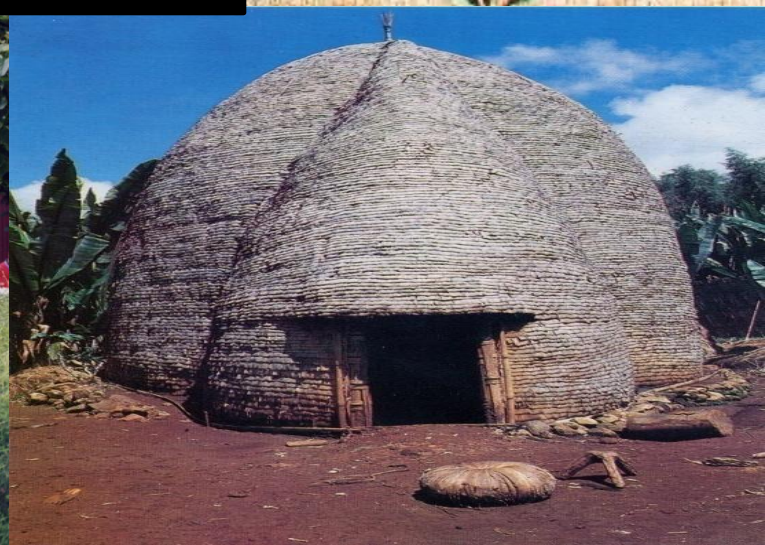
Tukul – Traditional hut in rural Ethiopia





Diverse Architecture of Tukuls

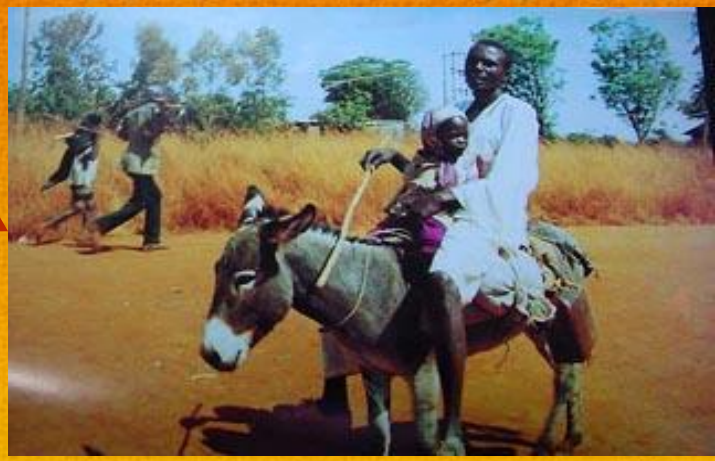




THE MULE

HORSES

DONKEYS



Used for transportation in rural areas

Traditional means of Transportation

Great Wonders of Ethiopia

Natural Wonder 1

Mt Ras Dashen : 4,620m

Natural Wonder 2

Ertale - Home of Active Volcano

Natural Wonder 3

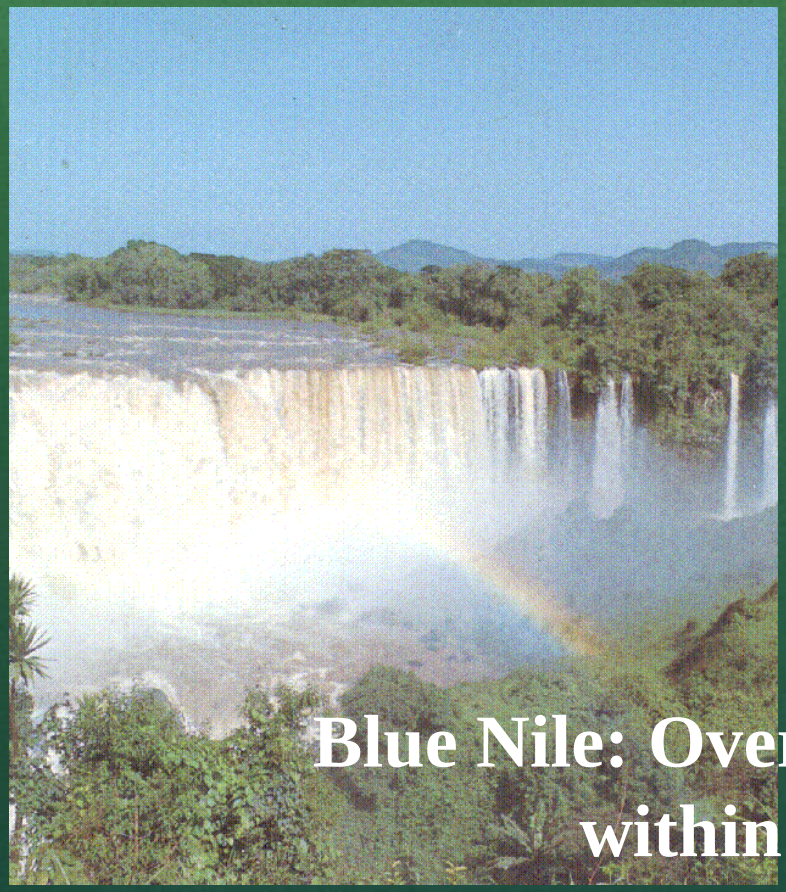
A deadly work of art : Dallol

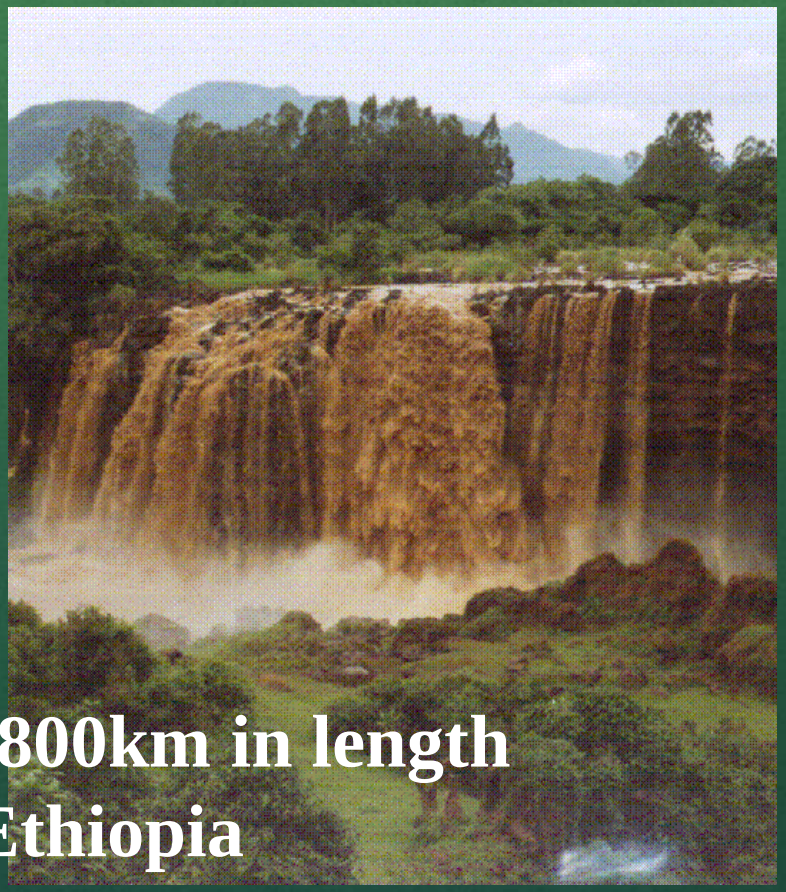
•Natural Wonder 4

Lake Tana – At the source of Blue Nile

- Natural Wonder 5

Blue Nile Falls

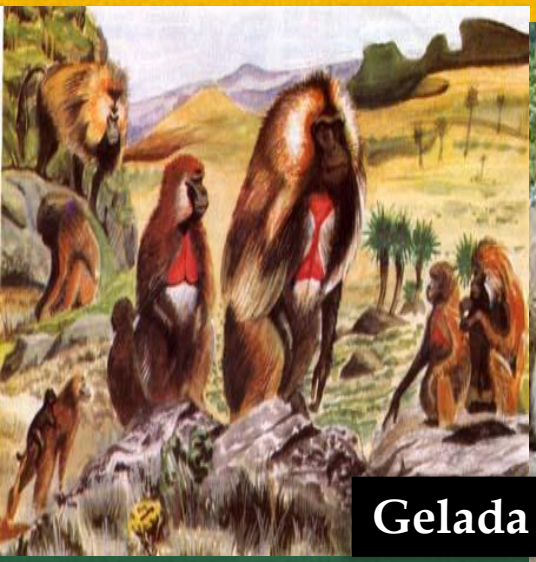




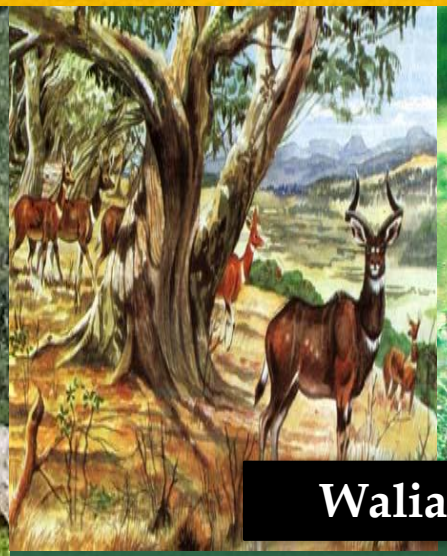
Blue Nile: Over 800km in length within Ethiopia

•Natural Wonder 6

Endemic and rare animals



Gelada Baboon



Walia Ibex

Red Fox

Obelisk of Axum

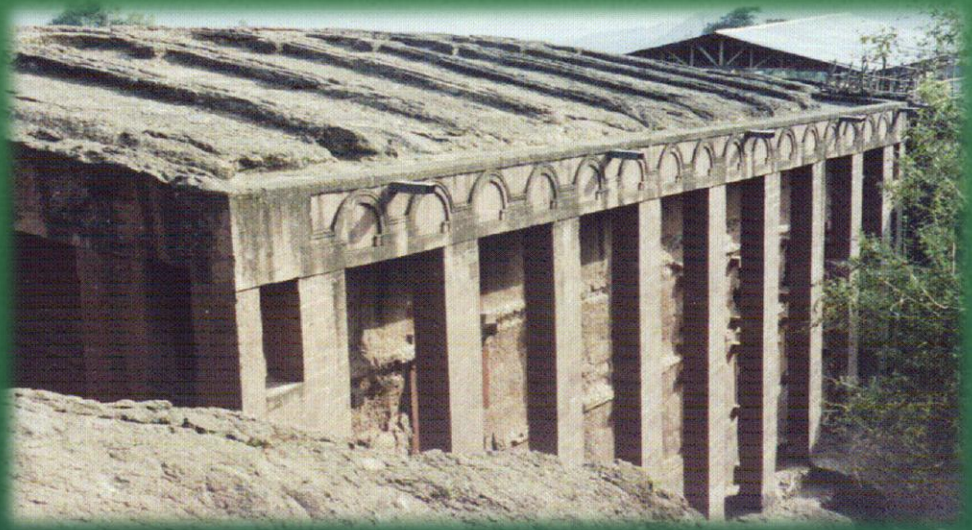
27m tall

Carved and erected around the beginning of the 4th century

4th Century

Historical Wonder 2

Rock-Hewn churches of Lalibella



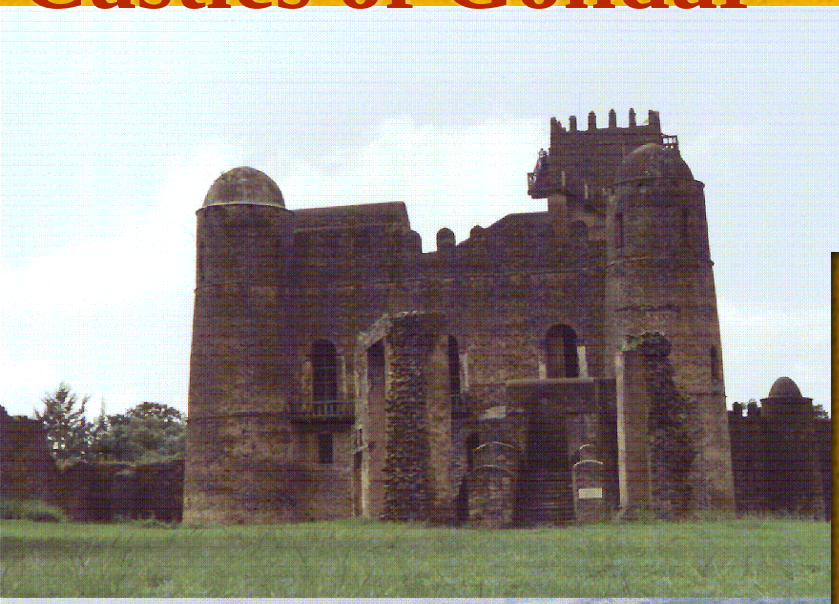
Constructed during the reign of King Lalibella: 1167 to 1207

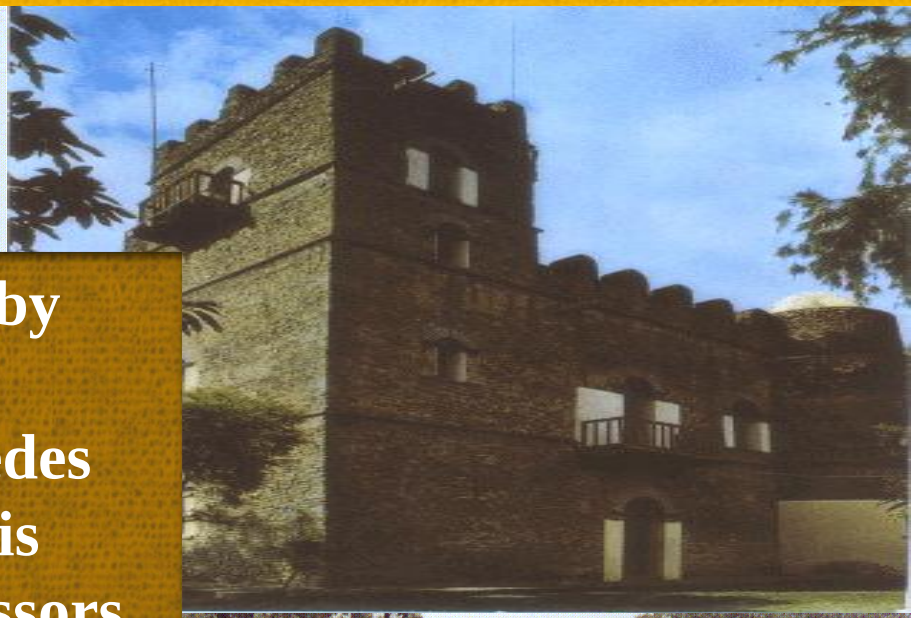
4th Century

12th Century

Historical Wonder 3

Castles of Gondar





Built by King Fasiledes and his successors in 17th

4th Century

12th Century

17th Century

Historical Wonder 3

Kagnew Battalion

BBC Sign in | News | Sport | Weather | iPlayer | TV | Radio

NEWS

Home | UK | World | Business | Election 2015 | Tech | Science | Health | Education | Ent

Magazine

An Ethiopian hero of the Korean War

By Alex Last
BBC World Service

25 September 2012 | Magazine

Sixty years ago, Ethiopia was at war. Not in Africa, but thousands of miles away in Korea. This is the story of one

4th Century

12th Century

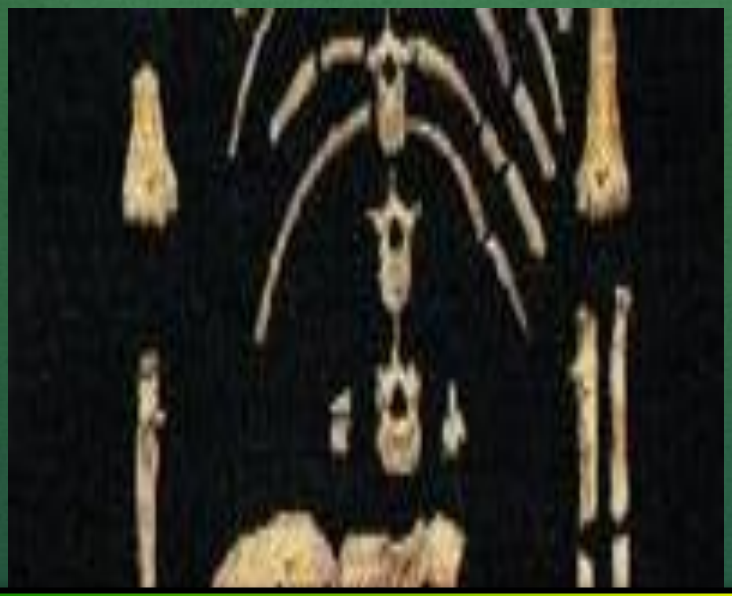
17th Century

Lieutenant Haile Giorgis, right, poses with fellow members of the Kagnew Battalion, which won all 235 of the battles it waged during the Korean War.
Courtesy of Haile Giorgis

1951

Historical Wonder 6

Ethiopia: Home of Lucy



- Lucy - the oldest human fossil
- Found in Afar, Ethiopia in 1974
- This female skeleton is the oldest hominid fossil. (Australopithecus

4th Century

12th Century

17th Century

Lieutenant Haile Giorgis, right, poses with fellow members of the Kagnew Battalion, which won all 235 of the battles it waged during the Korean War.
Courtesy of Haile Giorgis

1951

1974

Historical Wonder 7

Who is SELAM ?

- The Oldest Child fossil ever found
- The almost complete skeleton belongs to a baby girl of the species *Australopithecus afarensis*
- A probable human ancestor that was among the first to walk on two legs — who died at the

4th Century

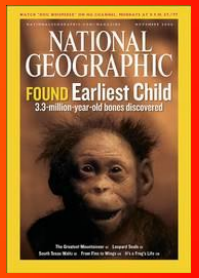
12th Century

17th Century

Lieutenant Haile Giorgis, right, poses with fellow members of the Kagnew Battalion, which won all 235 of the battle it waged during the Korean War.
/ Courtesy of Haile Giorgis

1951

1974

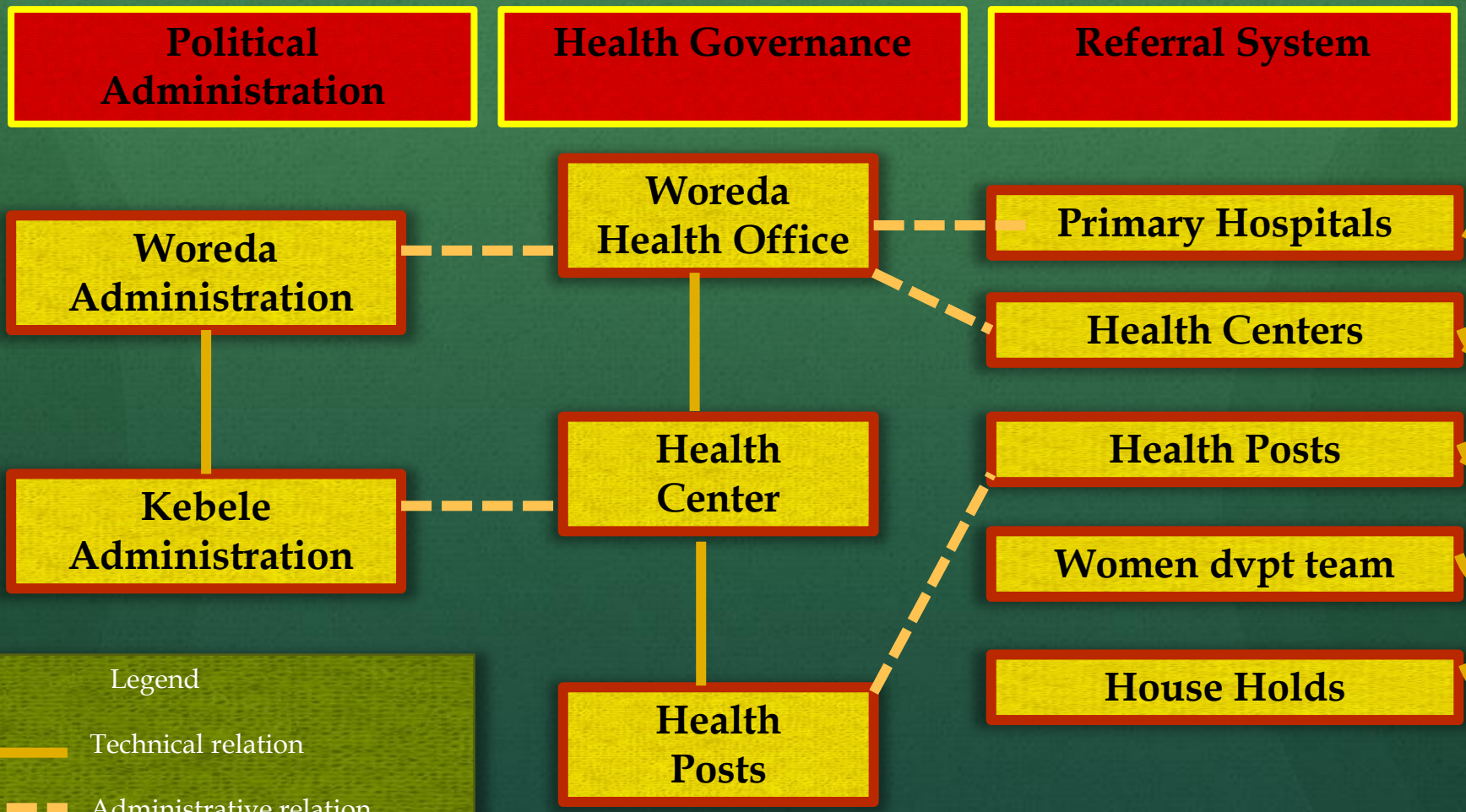


2000

Health System

- ✓ In the past two decades, the Government of Ethiopia has invested heavily in health system strengthening
  - ✓ guided by its pro-poor policies and strategies
  - ✓ significant gains in improving the health status of Ethiopians, as a result.
- ✓ Ethiopia has done remarkably well in meeting most of the MDG targets.

Administration, Governance and referral system



Some Achievements in the Health Sector

- **There was an increase in average life expectancy at birth from 45 in 1990 to 64 in 2014.**
- **An improvement in contraceptive prevalence rate from 3% to 42% has led to a drop in total fertility rate from 7.7 in the 1990s to 4.1 in 2014.**
- **Mortality and morbidity due to HIV/AIDS, Tuberculosis and malaria has reduced markedly.**
- **Women receiving ARV to reduce MTCT IS 65%**

Thank you

“Health for all”
through Primary health care approach!

Annex III

International Institute for Primary Health Care in Ethiopia(IIfPHC-E)

FEDERAL MINISTRY OF HEALTH
(FMOH)

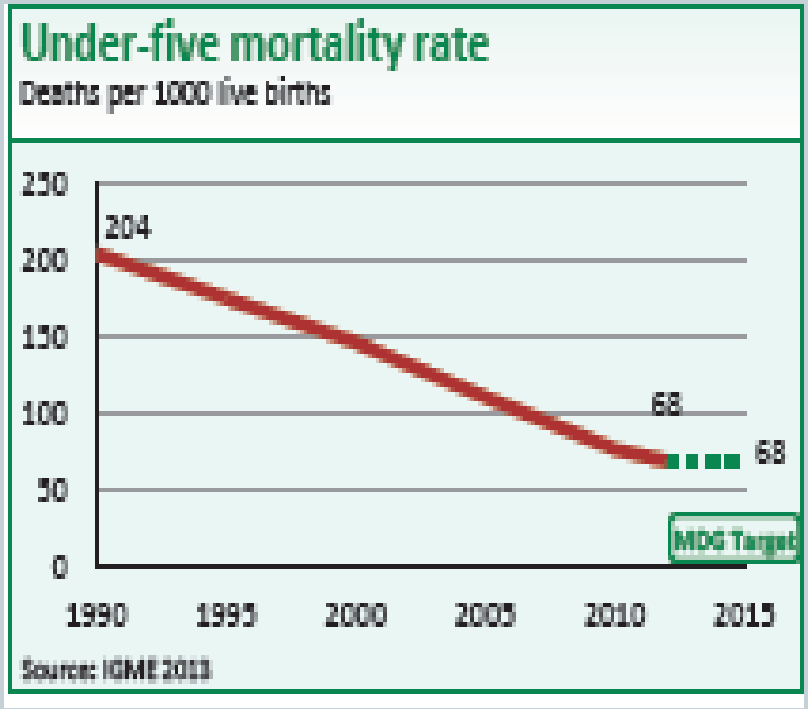
Outline

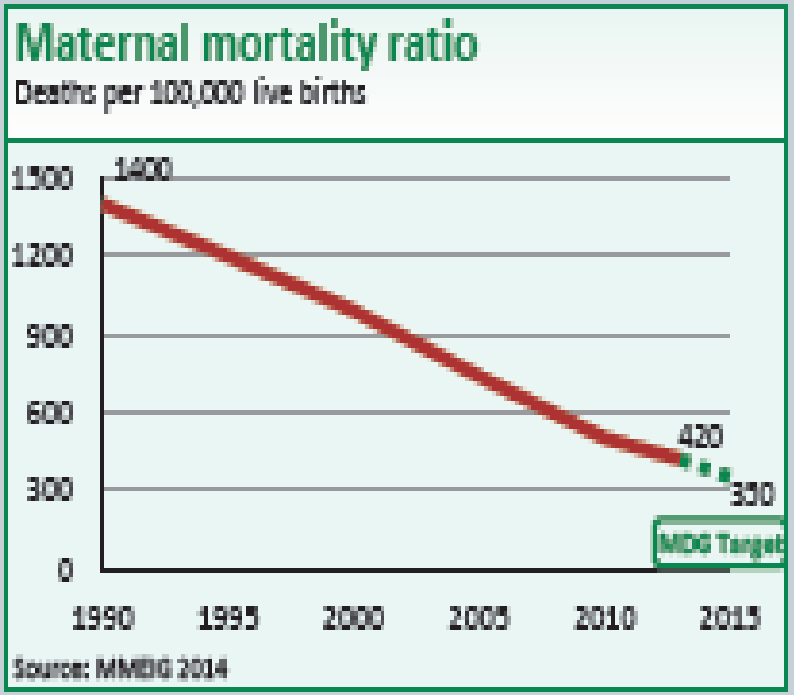
- Background and the MDGs
- The Primary Health Care approach
- The Health Extension Program
- Health Development Army
- International Institute for Primary Health Care
  - Vision and mission
  - Objectives
  - Approach
  - One year plan

Background and MDGs

- **Africa and other developing regions of the world have been striving to improve the health of their populations**
- **In sub-Saharan Africa, only Ethiopia, Rwanda and Eritrea met the MDGs for mothers and children by 2015.**
- **Only 5 of the 44 sub-Saharan countries have already achieved MDG-5; and only 14 of the 44 achieved MDG-4.**

MDG-4 and MDG-5 in Ethiopia





MDG-6 in Ethiopia

- **Ethiopia achieved MDG 6 – control of HIV, tuberculosis, malaria, and other important diseases – well ahead of the 2015 deadline.**
- **The prevalence of HIV has declined in the adult population and the incidence has declined by 90%;**
- **Malaria deaths have dropped by 50%.**

Primary Health Care in Ethiopia

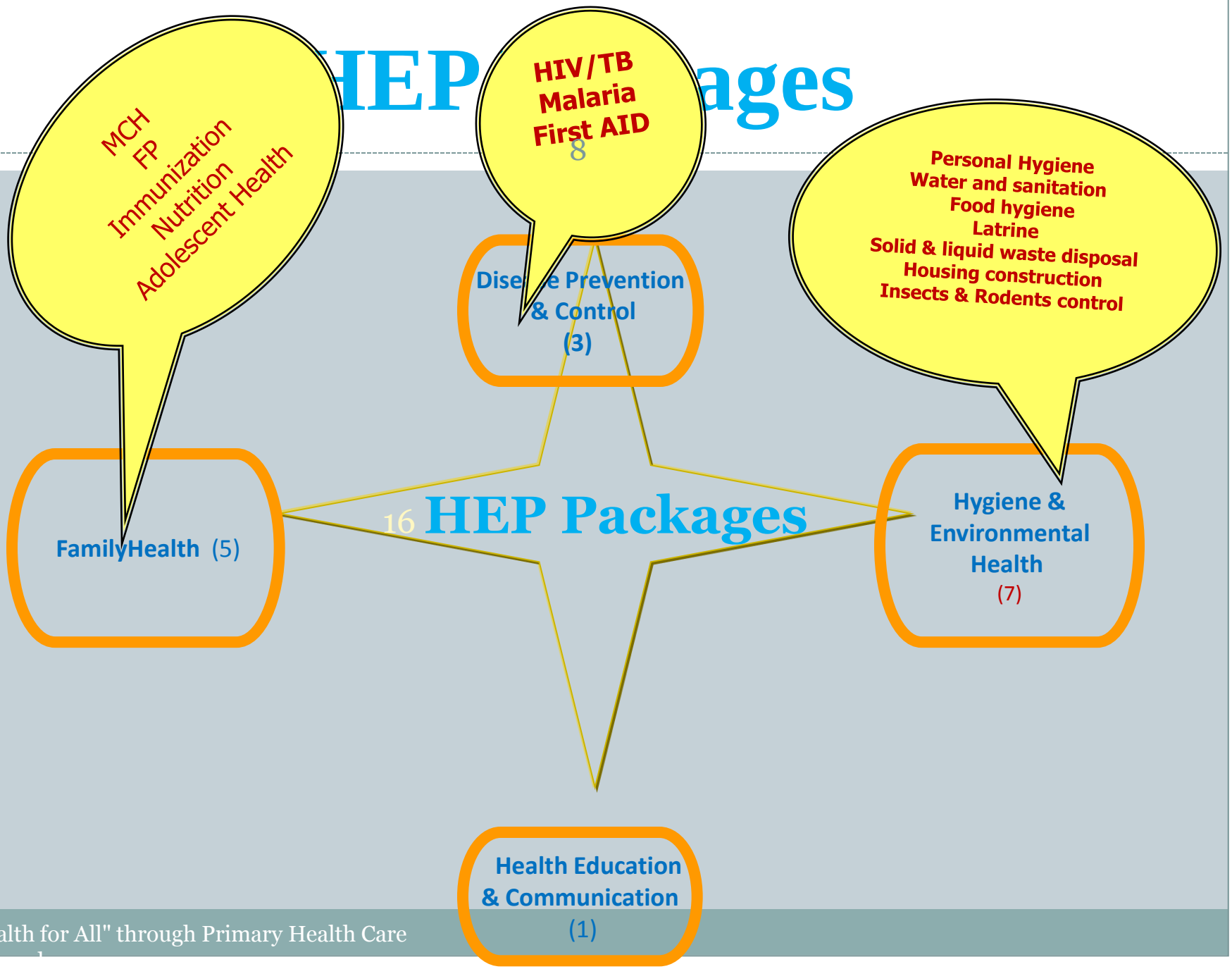
- **The significant progress in Ethiopia can be attributed to the strong community-based services provided by community health workers.**

- **Ethiopia has become a leader throughout the world in accelerating the achievement of 'Health for All' through the primary health care approach.**

Health Extension Program

- **The Health Extension Program (HEP) is the main strategy for achieving universal coverage of PHC to the Ethiopian population.**

- **The HEP is a defined package of basic and essential promotive, preventive and basic curative health services targeting households.**


HEP ages
MCH
FP
Immunization
Nutrition
Adolescent Health
HIV/TB
Malaria
First AID
Personal Hygiene
Water and sanitation
Food hygiene
Latrine
Solid & liquid waste disposal
Housing construction
Insects & Rodents control
Dise e Prevention
& Control
(3)
FamilyHealth (5)
16 HEP Packages
Hygiene &
Environmental
Health
(7)
Health Education
& Communication
(1)

HEP….

- **Through the Health Extension Program (HEP), major advances have been made in the expansion and coverage of community-based services**

- **Engaging the community more broadly also has been an important part of the program.**

Health development Army (HDAs)
Introduction of Health development Army

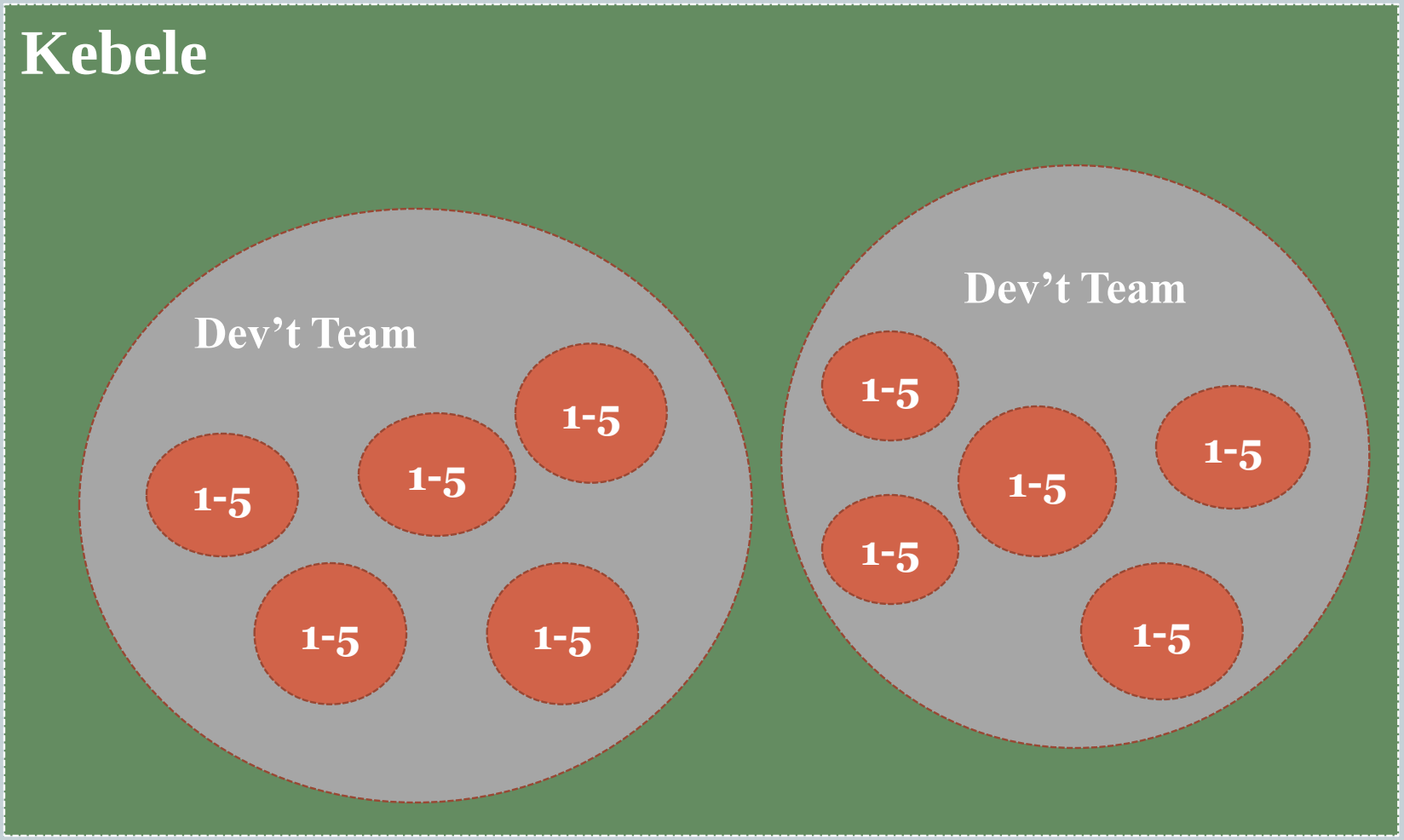
The Health Development Army approach:- Realizing full community participation:

HDA refers to an organized movement of the community through participatory learning and action meetings for health.

HDA..cont

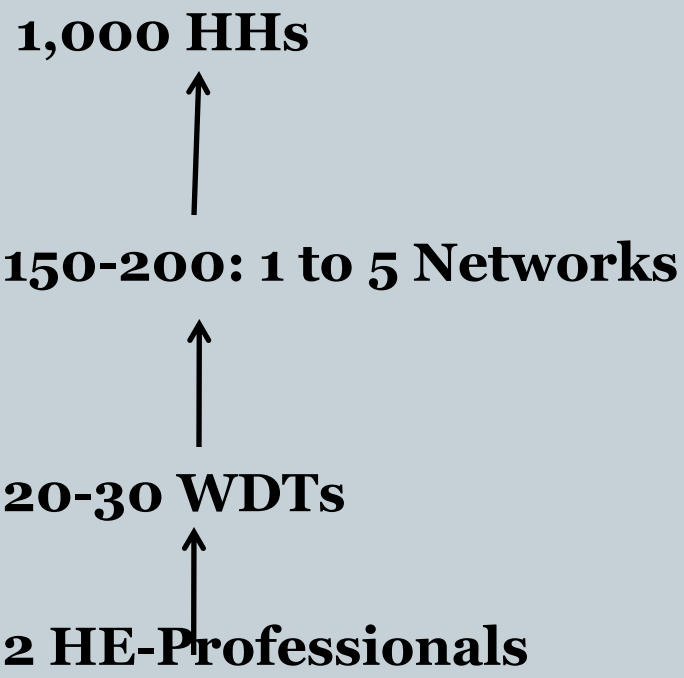
- **HDA Requires the establishment of Women Development Teams (WDT) that comprise of up to 30 households residing in the same neighborhood.**
- **WDT is further divided into smaller groups of six members, commonly referred as one-to-five linkage.**
- **Leaders of the health development teams and the one-to-five networks are selected by the team members.**
- **Selection criteria of leaders, mainly: being a model family and trust by the members in mobilizing the community.**

HDA structure..cont'



HDA…cont

The formation of HDAs facilitated by Health Extension Professionals and the kebele administration.



What are HEP achievements?

- **In terms of service since the implementation of the program;**
  - **Increase access to basic health services**
  - **Improvements in contraceptive prevalence rate**
  - **Increase institutional Delivery**
  - **Increase immunization coverage**
  - **Increase latrine coverage**

What has been achieved?

Impact level:

- **MDG achieved**
- **Fertility rate decreases**
- **HIV incidence rate decrease**
- **Reductions in Morbidity and Mortality related to major communicable diseases has been achieved.**
- **life expectancy increased, (from 44-64)**

What are the Key drivers to improve health status?

- **Political commitment:- deployment of more than 38,000 salaried HEWs**
- **Strong country leadership**
- **Policies and strategies aligned with national plans**
- **More emphasis (focus) on expansion of primary health care**
- **Improved coordination, partnership and contribution from development partners**

Mobilization and engagement of community in health issues

M & E of HEP

- **Close supervision and support by the health centers and woreda health offices**
- **Regular review meeting at all level integrated with other programs**
- **Integrated supportive supervision at all levels**
- **Operational researches**

Future direction…. The second generation rural HEP

Includes:

- **Upgrading HEWs to level IV Community Health Nurses**
- **Renovation and expansion of health posts,**
- **Equipping and supplying health posts with the necessary equipments and supplies,**
- **Enhance Community engagement and shifting basic services to the community level and institutionalizing the HDA platform**
- **Share our experience to other countries**

Visits from other countries

- **Ethiopia has been hosting ministers of health and other health officials from countries throughout Africa and beyond:**
  - to learn firsthand how Ethiopia achieved these remarkable results.
- **During the past three years alone, ministerial-level health officials from around 20 African countries have come to Ethiopia for this purpose:**
  - This has become very demanding for the FMOH.
- **The FMOH has also tried to provide ongoing follow-up support for these countries to put what they have learned into practices.**

International Institute for Primary Health care(IIfPHC)

- **There was no international institute that is closely linked to a successful national program and grounded in exposure to fieldwork.**

- **An investment in the establishment of this Institute will produce major benefits internationally by:**
  - helping other countries design and implement primary health care programs at scale

IIfPHC…

- **The International Institute for PHC in Ethiopia will play a key role in developing a well-structured, proactive, flexible, problem-solving, and resilient PHC system:**
  - **by serving as a valuable resource for building capacity on technical, managerial, and programmatic matters, and**
  - **By carrying out PHC systems implementation research.**

IIfPHC…Vision and mission

- **The vision of the Institute is to contribute** to the revitalization of the global movement of 'Health for All' through primary health care.

- **The mission of the Institute will be to provide** training on primary health care and to conduct PHC research.

Objectives

- **Provide short-term capacity-building trainings on identified needs for national and international trainees: *designing and strengthening PHC and CH programs*;**
- **Provide short-term trainings in line with the "transformation agenda' of the Government's Health Sector Transformation Plan (HSTP) and woreda/district transformation;**
- **Carryout need-based health systems implementation research on PHC and community-based health programs;**

Objectives

- **Serve as a resource center for the FMOH, its Regional Health Bureaus and other institutions in Ethiopia and beyond;**
- **Organize fora to communicate research findings, policy changes, and other updates;**
- **Launch and Issue an international Journal on PHC; and,**
- **Host visits from other countries in Africa and beyond.**

Who will be trained?

	Who are they?	How many?	How long?
Policy makers (lawyers, economic advisors & parliamentarians)	International & national	25	3 days (2 days class & 1 day field visit)
Health Programmers (regional, Provincial, bureau heads)	International & national	25	2 weeks (10 days class and 2 days field visit)
PHC implementers (professionals at woreda and health centre levels)	International & national	25	6 weeks (5 weeks class & 1 week field visit)
Health officers	Only national	25	2 weeks

What is the purpose of the training?

	Purpose
Policy makers	**Understanding the magnitude of the health problem and developed a political commitment for PHC implementations**
Health Programmers	**Sharing of Ethiopian best practices on how to implement PHC at the community level.**
PHC implementers	**Sharing of Ethiopian best practices and hands on training on PHC implementations and lessons from case studies**
Health officers	**Strengthening HSTP implementation & leadership capacity**

Overall approach

- It is a collaborative endeavor led by the Ministry of Health of Ethiopia and supported technically by the Johns Hopkins Bloomberg School of Public Health.
- At the end of the course, a certificate in primary health care will be issued to trainees by the Ministry of Health of Ethiopia and the Johns Hopkins University jointly.
- There will be a governance board from its key stakeholders
- The establishment is funded initially by the Gates Foundation
- A one year plan is developed based on its objectives

One year plan

Activities	Status
Launching	Done
Providing trainings	Partly done
Recruiting full-time staff	Partly done
Developing a five –years strategy plan	Not yet
Marketing and resource mobilization	Not yet
Establishing advisory group	On the process
Establish a resource center	Not yet
Establishing an international journal of PHC	Not yet
Hosting visits requested by countries	Started

What are useful to know for our visitors ?

Activities	Responsible	Potential Sponsers
Visa on arrival for some of the delegates	Delegates	GOV/NGO
International transport	Delegates	GOV/NGO
Accommodations	Delegates	GOV/NGO
Local transport*	Delegates	Each Delegates
Tuition fee*	Delegates	Each Delegates
Health Break services*	Delegates	Each Delegates
*** Once the delegates pay for the package (150 USD/ day/person) ahead of time, the IIfPHC will take the responsibility**		

Thank you

“Health for all” through Primary health care approach!

page 109

Annex V

Federal Democratic Republic of Ethiopia

Ministry of Health

Health System of Ethiopia: policy and planning

Aug 2016

General Directions of the Policy

1. Democratization and decentralization of the health service system
2. Dvt equitable and acceptable standard of health service delivery
3. Dvt of promotive and preventive components of health care
4. Promoting and strengthening of intersectoral collaboration
5. Working with neighboring countries, regional and international organizations

General Directions of the Policy

6. Strengthening Self reliance in health development
7. Capacity building [HR, infrastructure, research, information]
8. Provision of health care for those who cannot afford
9. Promotion of the participation of the private sector and NGOs in health care

Priorities of Health Policy

1. IEC of health
2. Emphasis shall be given to
   - The control of communicable disease, epidemics and diseases related to malnutrition and poor living conditions
   - Promotion of occupational health and safety
   - Development of environmental health
   - Rehabilitation of heath infrastructure
   - Development of appropriate health service management system
3. Appropriate support to curative and rehabilitative components
4. Due attention to traditional medicine

Priorities of Health Policy

5. Applied health research addressing the major health problems be emphasized

6. Emphasis on expansion of number of frontline and middle level health workers

7. Special attention shall be given to health needs of

   - Women and children
   - Those in the forefront of productivity
   - Those most neglected regions and segments of the population and rural population
   - Victims of man-made and natural disasters

Health Sector Development Program

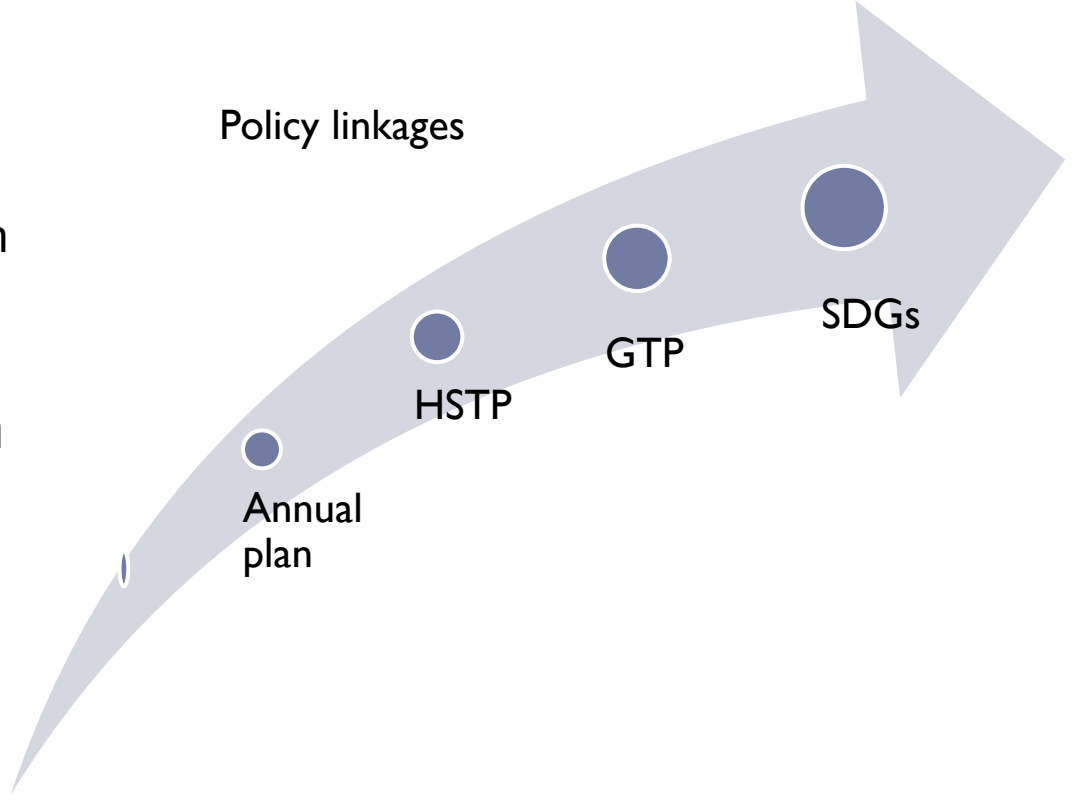
- main vehicle for the implementation of policy and strategies,
- 20 years plan (1996 – 2015) of four rounds
- In each round, focus areas were identified and appropriate interventions designed and implemented

The Health Sector envisioning plan

- Ethiopia has developed its next 20 years strategy called '***Envisioning Ethiopia's Path towards Universal Health Care through strengthening Primary Health Care***'.
- It is long-term health sector transformation roadmap
- It focuses on providing and regulating a comprehensive package of **promotive**, **preventive**, **curative** and **rehabilitative** health services of the highest possible **quality** in an **equitable manner**.
- To have the highest possible level of health and quality of life for all its citizens.

Health Sector Transformation Plan (HSTP)

- First phase of the 20-years plan; *July 2015 – June 2020*
- The development of HSTP considers
  - In-depth situational assessment
  - Performance evaluation of HSDPs
  - Country's global commitment
  - Goals of the national long term vision
  - Growth and transformational plan
- All relevant stakeholder engaged in development
  - Consultative workshops
  - Web-based consultations



Health Sector Transformation Plan (HSTP)

- The strategic planning started with setting organizational mission, vision and core values
- Strategic themes are selected to focus effort on the strategies that will lead to success.
  - Excellence in health service delivery
  - Excellence in quality improvement and assurance
  - Excellence in leadership and governance
  - Excellence in health system capacity

sector's Pillar of excellence

List of strategic objectives

Perspective	Strategic Objectives (SO)
Community	C1: Improve Health Status C2: Enhance Community Ownership
Financial Stewardship	F1: Improve Efficiency and Effectiveness
Internal Process	P1: Improve Equitable Access to Quality Health Services P2: Improve Health Emergency Risk Management P3: Enhance Good Governance P4: Improve Regulatory System P5: Improve Supply Chain and Logistic Management P6: Improve Community Participation & Engagement P7: Improve Resource Mobilization P8: Improve Research and Evidence for Decision-Making
Learning and Growth	CB1: Enhance Use of Technology & Innovation CB2: Improve Development & Management of HRH CB3: Improve Health Infrastructure CB4: Enhance Policy and Procedures

Four transformation agendas of HSTP

1. Transformation in equity and quality of health care
   - Equal access to essential health services,
   - Equal utilization of equal need, and
   - Equal quality of care for all

2. Information revolution
   - 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;
   - Strengthening verification and feedback systems.

Four transformation agendas of HSTP

3. Woreda transformation
   - Model Kebeles,
   - Achievement of UHC with Financial protection through CBHI
   - High performing PHCUs.

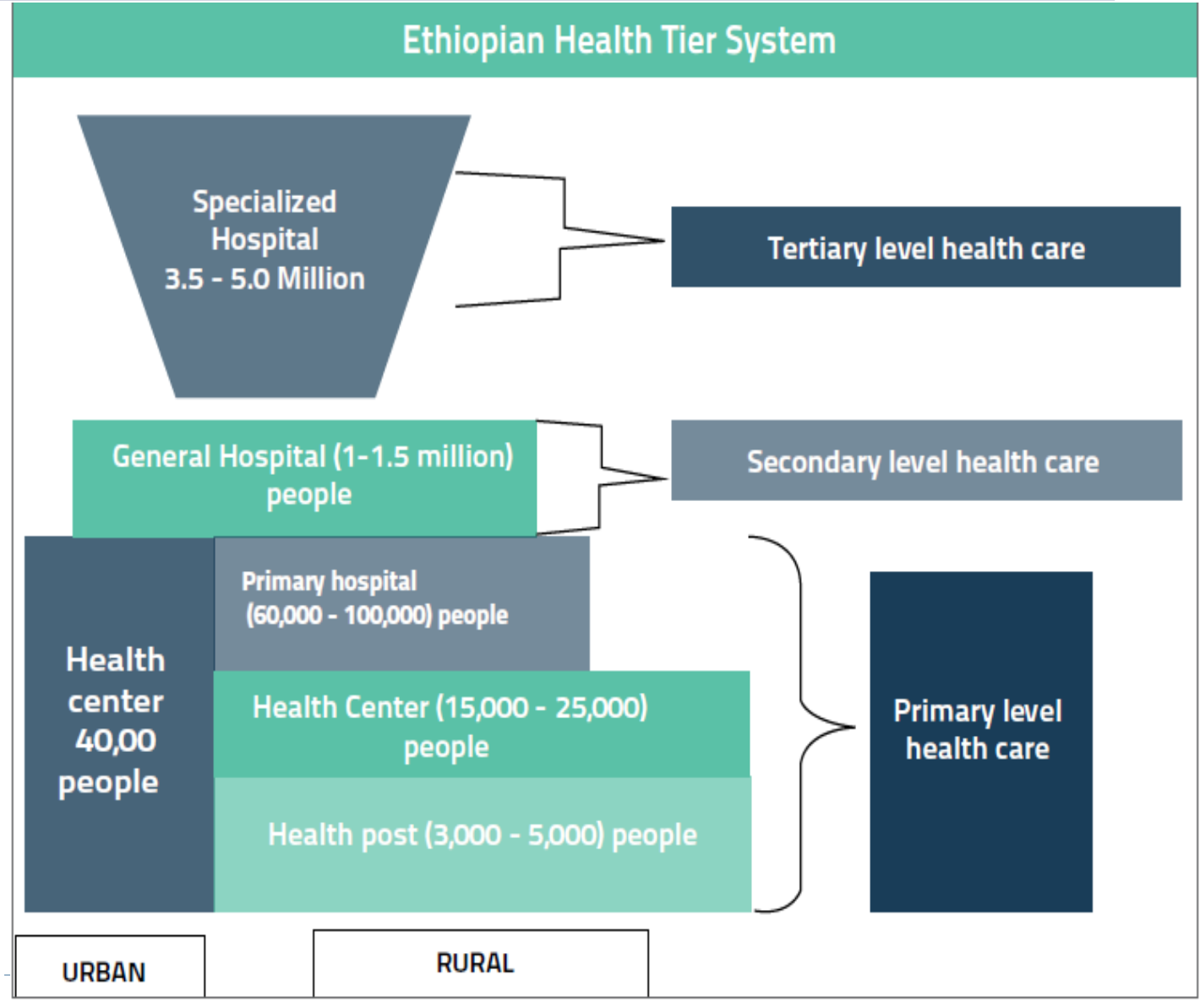
4. The Caring, Respectful and Compassionate health workforce
   - Development of CRC health professionals requires a multi-pronged approach from reforming the recruitment of students to health science students, to improving the curriculum of the various disciplines , and effective management of the health professionals that are already practicing.

Health Service Delivery Arrangment

- PHCU – 1 HC + 5HP
  Serves 25,000
  Ave. 20 staffs ; 5 beds

- Primary Hos – serves 100,000
  - Ave 53 staffs: 25-50 beds
  - Preventive & Curative serives plus emergency sergical services & blood transfusi

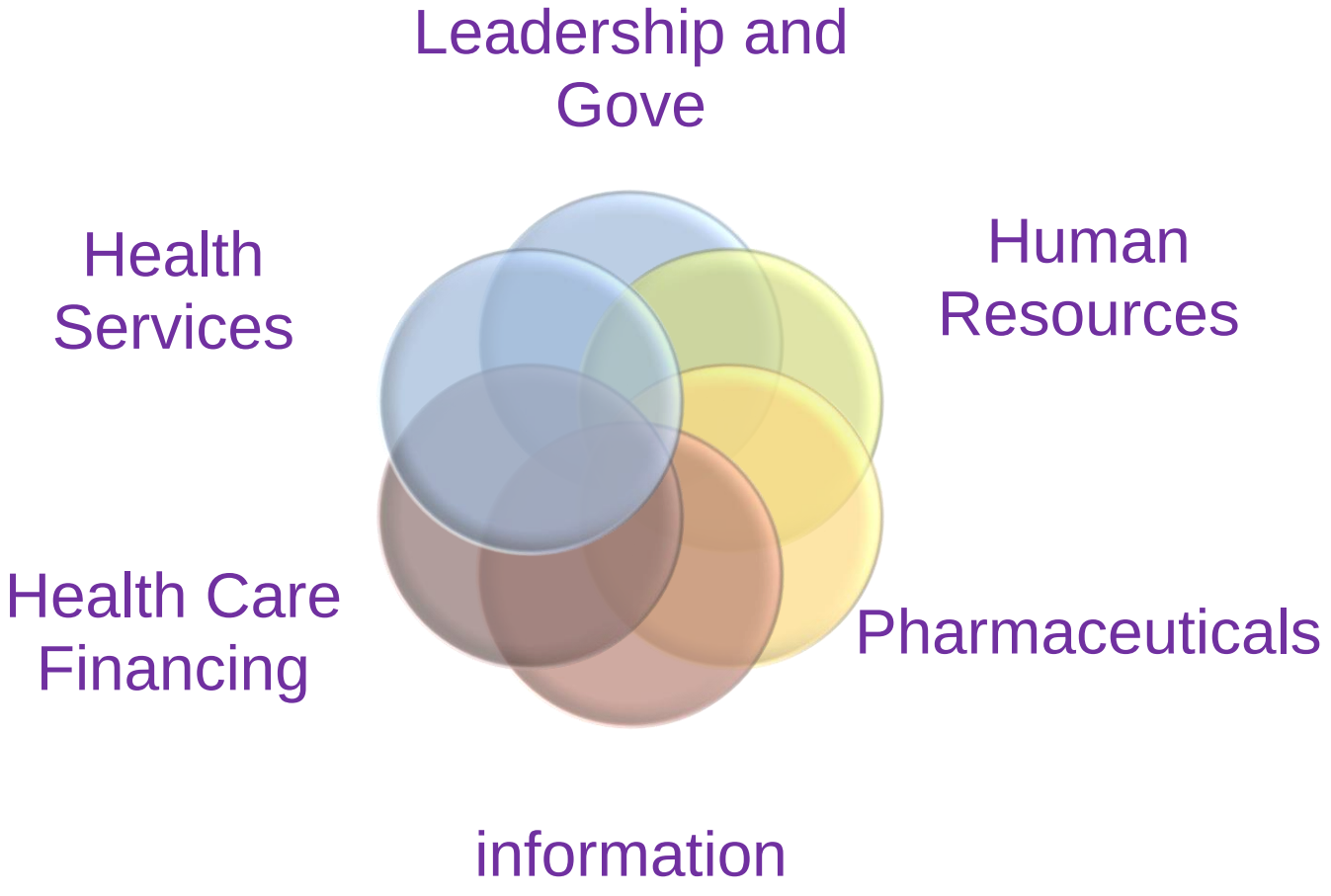
- General Hos - serves 1,250,000
  - Ave 234 staffs



Health infrastrucure

- The health facilities expansion enabled the sector to enhance and improve access to services to almost 100%. Currently we have
  - 234 Hospitals
  - 3,586 Health center
  - 16,447 health post
- However, health facilities are working to provide some of the priority services such as deliveries, in a manner that attracts mothers and patients

Building blocks of Health system



Service delivery

- The minimum level of service standards are set for each level of health facilities
  - Definition of roles of primary and other levels of care in delivering the packages;
- Integrated packages of services (i.e., FP/HIV, HIV/TB etc.);
- Development of referral system
- Continuity of care; service delivery is organized to provide the individual and community with continuity of care across the network of services, natural course of health conditions, levels of care
- Integration of disease control activities.

Service delivery

- HEP is backbone of the health service delivery system:
- Health Extension Workers (HEW) provide integrated promotive, preventive and basic curative services at community level
- HEP has 16 Package categorized into 4 major components
  - Promotion of hygiene and environmental sanitation
  - Prevention and control of major communicable diseases (HIV/AIDS, STI, TB, Malaria
  - Promoting and providing family health services
  - Health education and communication

Health workforce

- To have adequate number and mix of motivated and skilled human resources at all level of the health system.
  - Production of key categories of health workers (HW) in short supply;
    - Accelerated training of health officers
    - Training of HEW in technical and vocational colleges
  - Inter-sectoral collaboration;
  - Public-private partnership; (private health science college and medical schools)
  - Quality assurance ; Competency tests to ensure students are graduating with essential competencies and in-service training
  - Geographic distribution of HWs;
  - Regulatory system

Health workforce

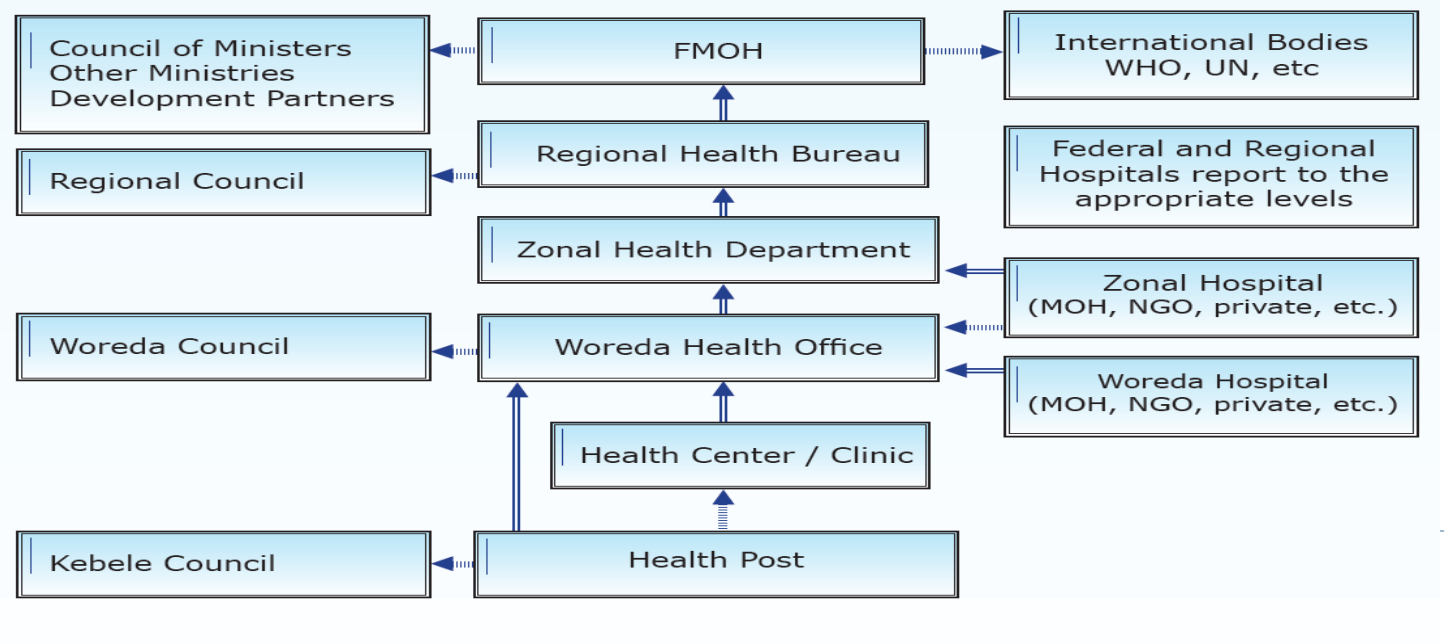
- Strengthening health workforce in Ethiopia
  - **Production**: over 14,000 medical students on training, 2 midwives in each Health centre etc.;
  - **Skill mix and task shifting**: production of 500 integrated emergency surgery officers on training to address the needs for CEmONC and BEmONC
  - **Women's empowerment**: Over 38,000 Health Extension Workers trained and in place (in rural and urban areas)
  - **Retention and motivation**: i.e., upgrading program for HEWs etc.
- 1:17,160 medical doctors
- 1: 4500 Nurse all type
- 1: 2,200 HEW

Pharmaceuticals

- PFSA :- purchase, supply and distribute essential pharmaceuticals and health program commodities to the facility level
- Community's access to the essential medicines that are of good quality
- Promote rational drug prescription and use (DTC and clinical pharmacy service)
- .24 warehouses (overall capacity 531,620 m3) and distribution capacity increased to 12.1 billon ETB in 2015
- IPLS implemented since 2010
- Need-based procurement - National list of essential drugs & pharmaceutical forecasting planning system
- strengthen the production capacity of local pharmaceuticals manufacturers,

Information

- **HMIS reform** based on four principles
  - **integration** of data collection and reporting (**single channel**);
  - standardization of indicators, data collection instruments and analysis procedures; and
  - simplification to decrease data burden and focus on use of information
  - institutionalization



information

- Routine data collected from health facilities
  - HMIS :- from every health facilities (monthly, quarterly and annually)
    - e-HMIS In 2700 HF
  - CHIS :- from the community (monthly, quarterly and annually)
    - Implemented in 78% rural health post
- Non routine data
  - Survey :- DHS in every 5 years , SPA was done, SARA(in every years)
  - Censuses and different researched
- Data quality :- RDQA, LQAS
- ISS conducted in every 6 months
- Mentoring , program based evaluations

Health Care Financing

- Health services are financed by the federal and regional governments, bilateral and multilateral donors, NGOs, and private contributions.
- HCF reform is being implemented
  - retention and utilization of user fee revenues at health facility level to improve quality of health service
- Implementation of fee waiver to increase access for the poor.
- Private wings in the public hospitals: to reduce attrition & absenteesim
- CBHI has been implemented in 13 pilot woredas and now 202 woredas
- social health insurance is expected to be launched soon

Leadership and governance

- Harmonization and alligment aims putting in place: "**One Plan-One-Budget-One Report**" at all levels
- **One plan** – HSDP, HSTP (strategic plan framework for coordinating health sector action
- **WBHS planning** – ensures vertical (from district to national) and horizonal (accros programs) alignments in the health intervention priorities (Top down/ Bottom up)
- HMIS as Integrated and harmonized reporting system ("One Report/ M&E").
- Decentralized health care system is implemented
  - Regions and lower administrative units are given responsibilities, authorities, power and resources for effective governance.
  - Facility governance bodies has been introduced

Leadership and governance

- Different structure are in place to promote and monitor strategies impln
  - FMoH-RHB Joint steeting committee
    - promote and monitor the implementation of the HSTP, and other various reforms.
  - FMOH-HPN Joint Consultative Forum and
    - promote dialogue and regular exchange of information;
    - enhance the spirit of partnership between the Government, development partners and other stakeholders; and
    - facilitate the implementation, monitoring and evaluation of HSTP.
  - Joint Core Coordinating Committee
    - focus on technical and operational issues (review, monitor and evaluate activities of HSTP and co-coordinate operational research and thematic studies.
  - Annual review meeting

Thank you

Annex VI

Resource Mapping Exercise:

Rationale & Importance

FDRE Ministry of Health

August 2016

Why Resource Mapping? Governments are facing *increased resource constraints* coupled with a *lack of visibility* into health spending

Multiple challenges…

- Increasing resource constraints
- Increasing attention on greater 'value for money' and 'efficiency and effectiveness'
- Need for more transparency and accountability from all stakeholders

…can be addressed with a resource mapping tool

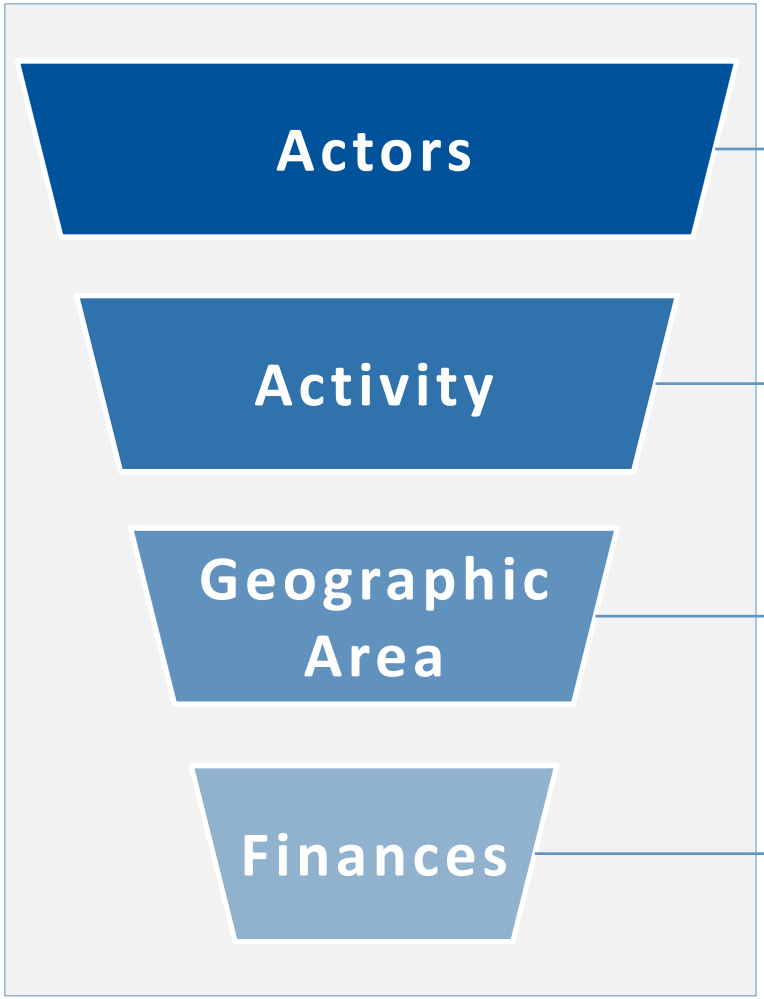
- A planning tool to reduce duplication and improve coordination and resource allocation;
- A resource mobilization tool to derive detailed gap analyses against costed national plans
- A harmonization tool to minimize multiple financial and programmatic data requests;
- A means to increase transparency and accountability across stakeholders in the health sector

Governments are being asked to do more with less, but do not have all the necessary information to do so!

In Ethiopia MoH has three primary uses for resource mapping data

- **Assisting the district-based planning process**
  - All activity information will be distributed to each district so to assist integration and planning with implementing partner activities
- **Partner Harmonization**
  - The Resource Mobilization Directorate uses the data to identify concurrent activities between MoH and IPs to better harmonize efforts
- **Allocation efficiency and Gap Analyses**
  - MoH uses the data to analyze if the current priorities are receiving sufficient funding and where funding gaps are

The annual resource mapping exercise captures 4 levels of information about all health programs



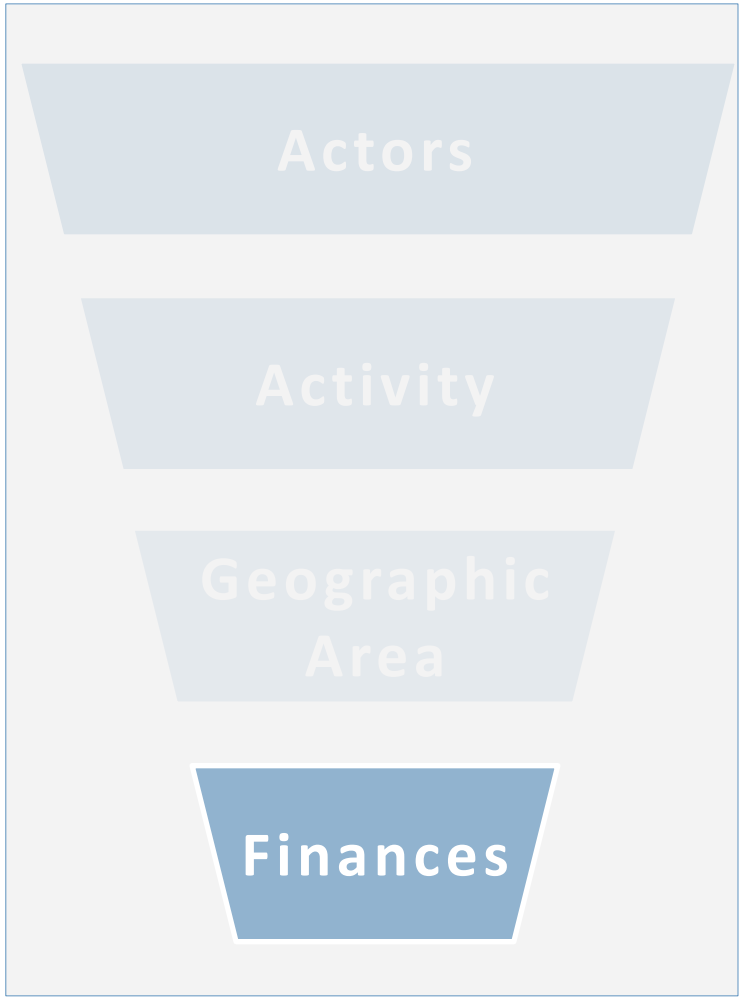
- Who is the financer?
- Who is the implementer?

- What is the project? What are the activities?
- Which Sectoral Strategic plan objective does it contribute to? Which initiatives?

- Which regions and districts does this project operate in?

- What is the project's budget?
- How do those costs breakdown into different categories (e.g., trainings)?

Finances are also broken down into Funding Channels



Donor funds can flow through one of 3 Channels:

- **1A (MoFEC, un-earmarked)**

Funding goes into the government's account and is disbursed though government procedures. the disbursement and accounting functions remain with MOFEC, BOFEDs, and WoFED offices. Health sector support

- **1B (MoFEC, earmarked)**

Funding goes into the government channel and the money is earmarked for specific use. GAVI Vaccine

- **2A (MoH, unearmarked)**

Funding flows directly into accounts managed by health sector units and without earmarks. Eg MDG pool fund

- **2B (MoH, earmarked)**

Funding flows directly into accounts managed by health sector units and the money is earmarked for specific use. Eg CIFF nutrition

- **3 (non-governmental)**

Funding does not enter government accounts and is expended out of government procedures.

How is the data collected? Resource mapping collects data in a basic excel based tool, allowing for simple and standardized data input by multiple stakeholders

Resource Mapping Tool Snapshot

- The tool is a **basic spreadsheet** that is easy for data to be inputted by **multiple stakeholders** and then aggregated into a master data set
- All categories are **pre-defined and standardized** so to collect a standardized data set that is comparable across development partners, and government
- Web-based platform is possible, but should be considered on a case-by-case basis

How long does Resource Mapping take? The resource mapping exercise typically takes approximately four months to complete

Completion of the whole process is expected to take 11-16 Weeks (4 Months)

Resource Mapping Activity	1-2 Weeks	2 Weeks	4 Weeks	4-6 Weeks	Continuously
	• Agreement from all stakeholders on level of detail of data to collect	• Setting-up of Excel tool and testing • Train entities on data entry	• Data gathering	• Data cleaning, quality checks and validation • Analysis	• Dissemination • Continuous use and identification of entry points

Guiding Principles

- Process is completed hand in hand with MOH counterparts
- Final data set validated with all those having made submissions prior to dissemination
- Followed up with support to institutionalize data collection, analysis and application
- Extra time may be necessary, particularly during the first round, in order to provide varying levels of support during data entry phase

How can Resource Mapping inform in-country decision-making? Outputs of resource mapping can inform decision making continuously throughout the year

Resource Mapping Analyses	Multiple opportunities throughout the year to inform decision making

• Funding, programs, activities and strategies by:
  • Funding source/ implementing agency
  • Cost category
  • Activity
  • Geographic location
• Investments measured against:
  • Epidemiological data
  • International benchmarks
  • Strategic plan resource projection
	• Annual government budget and planning negotiations
	• Mid year budget review (if revisions are necessary)
	• Partner budget negotiations (i.e. Country Operational Plan)
	• Proposal development (i.e. GFATM Concept Note development)
	• Development of donor and gov't business cases
	• Development of health sector wide or disease specific strategic plans
	• Partner investment planning

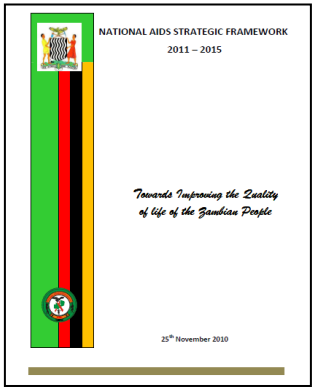
How does Resource Mapping fit within the broader financial system? This annual process can help quantify available resources and inform gap analyses

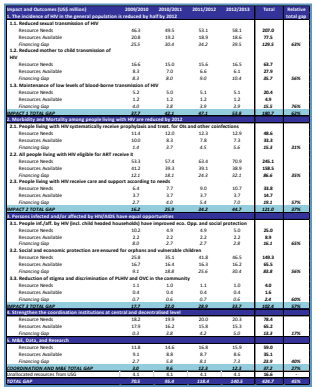
1

How much will the HIV response plan cost to execute?

Projected need

i.e. costed plans



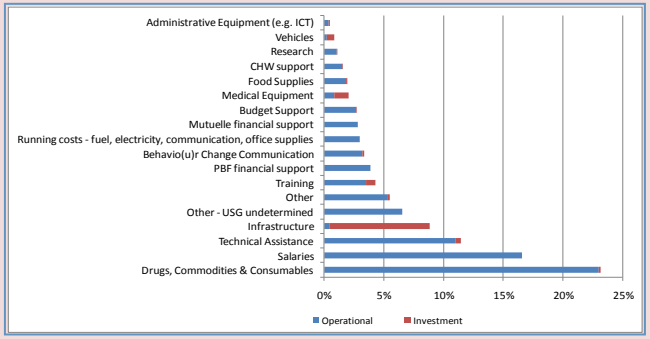


2

What resources are available to fund this plan?

Projected available funding

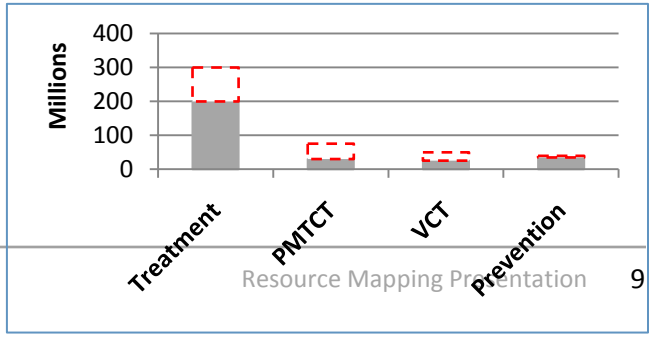
i.e. resource mapping



3

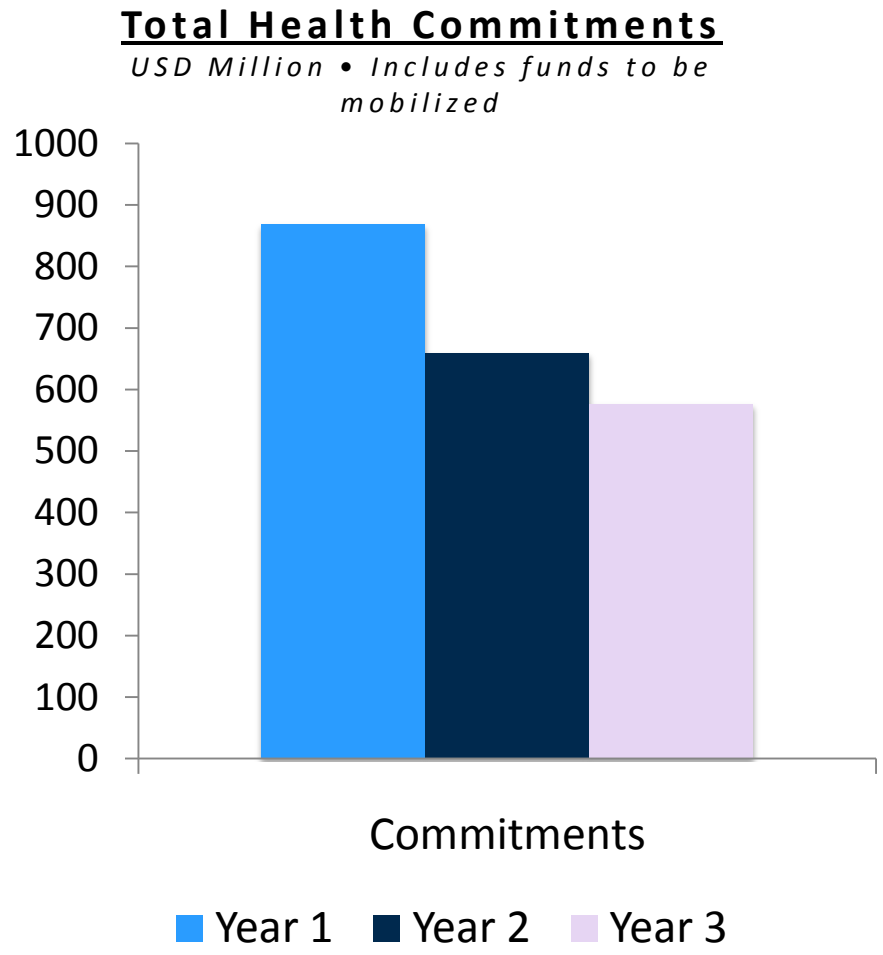
What is the gap between the $$ needed and the $$ available?

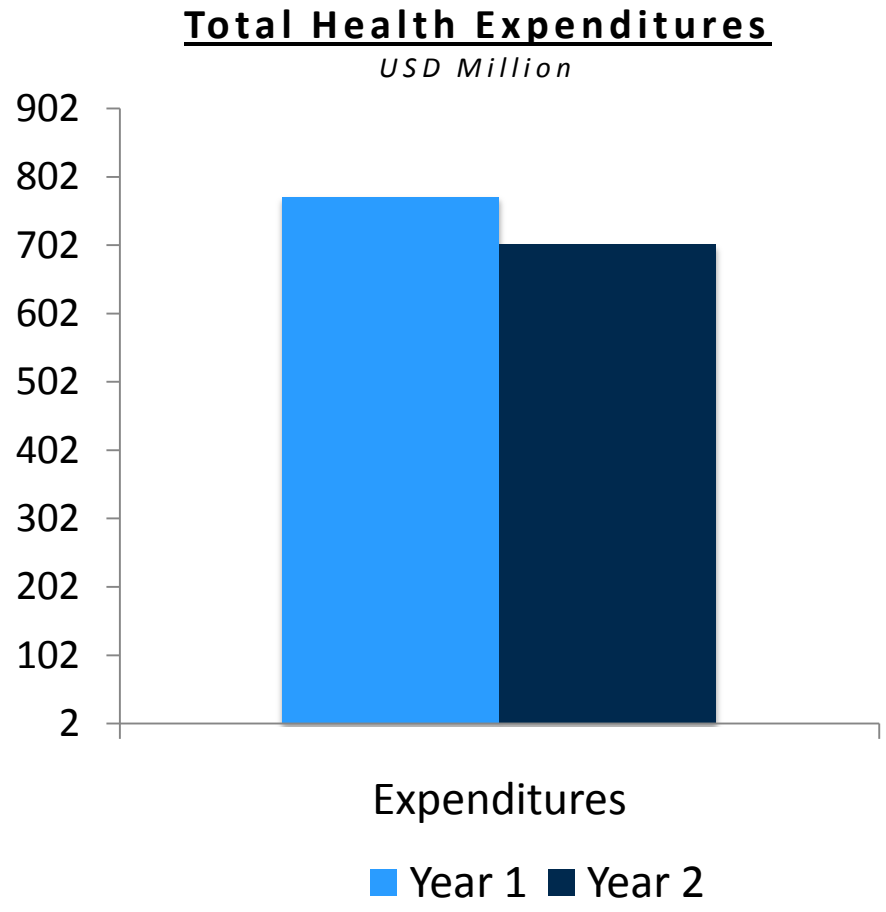
Demand – Supply = Gaps



Sample findings to understand the process

The exercise captures donors' expenditure for the current year and commitments for the next year

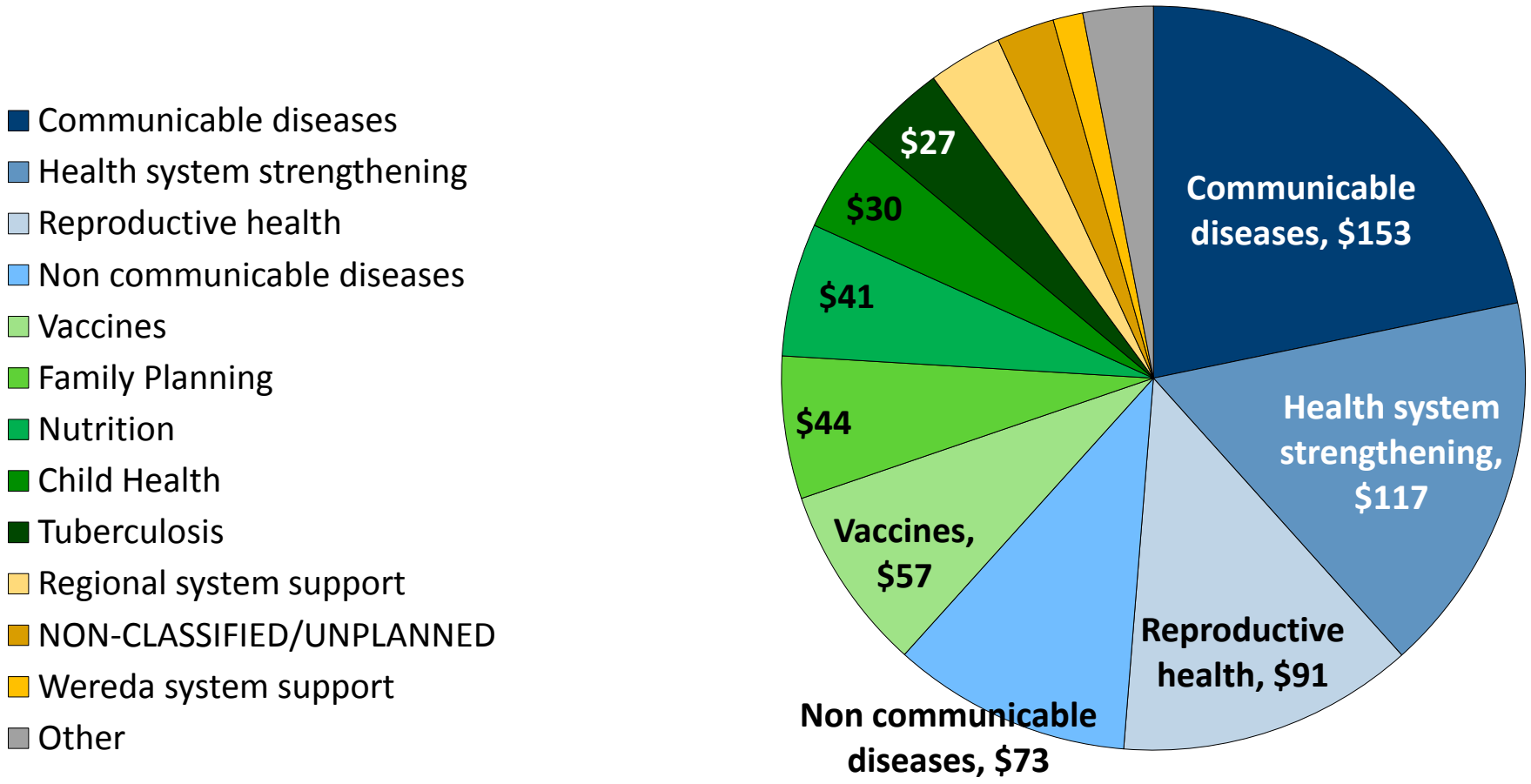




The resource mapping exercise shows the priority areas funded by donors

Year 1 Total Expenditure

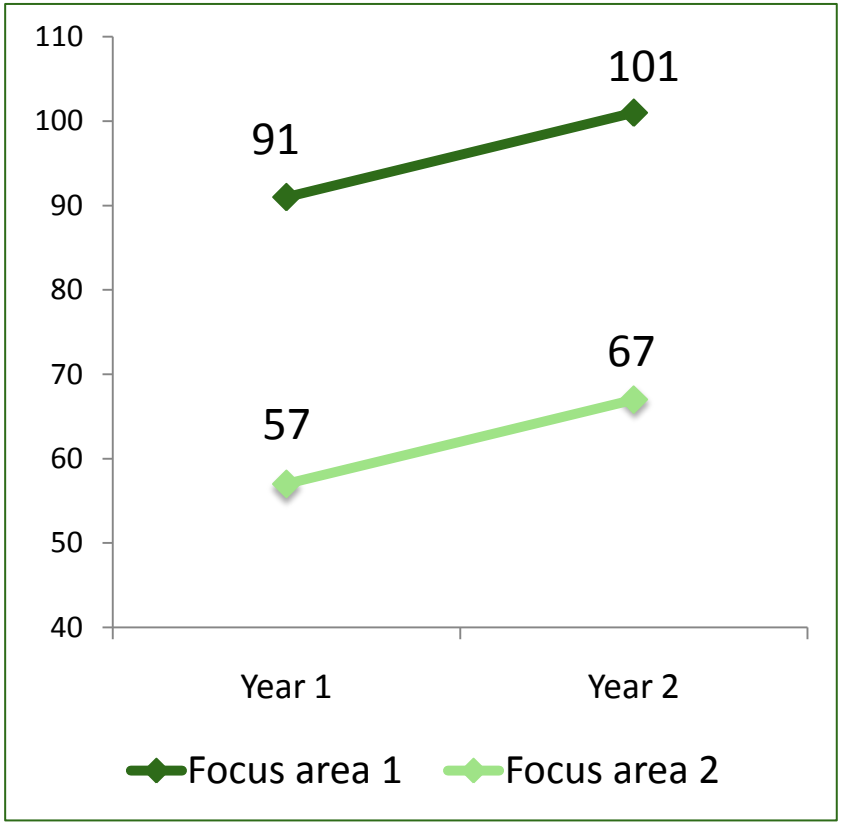
USD Million



The resource mapping exercise can capture whether donors' priorities change across time.

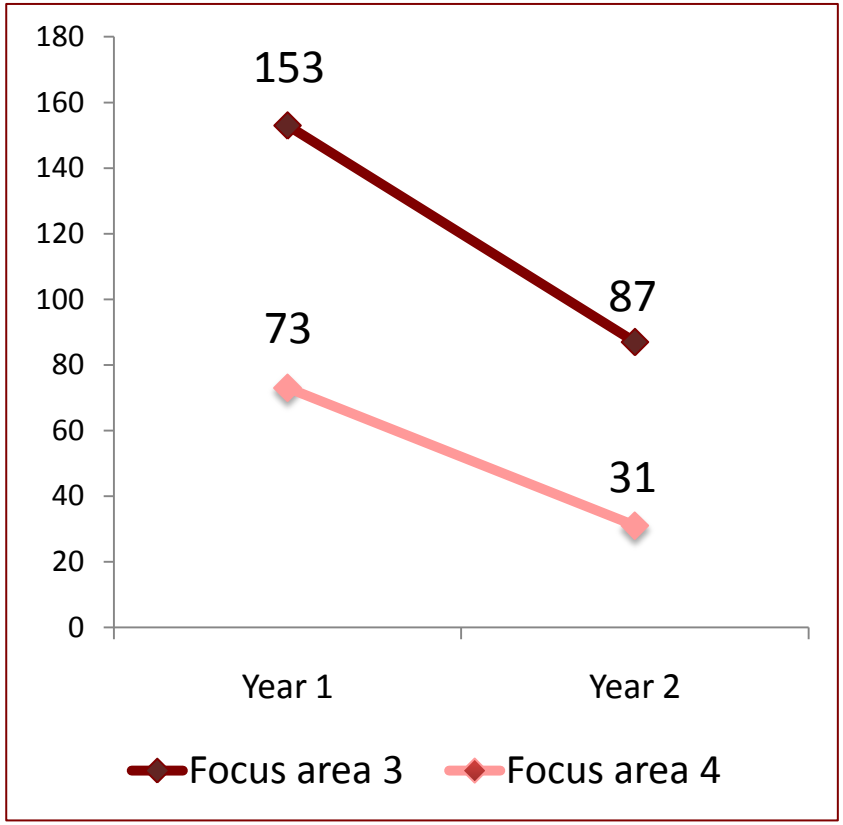
Trend in focus area 1 and focus area 2

USD Million • Includes funds to be mobilized

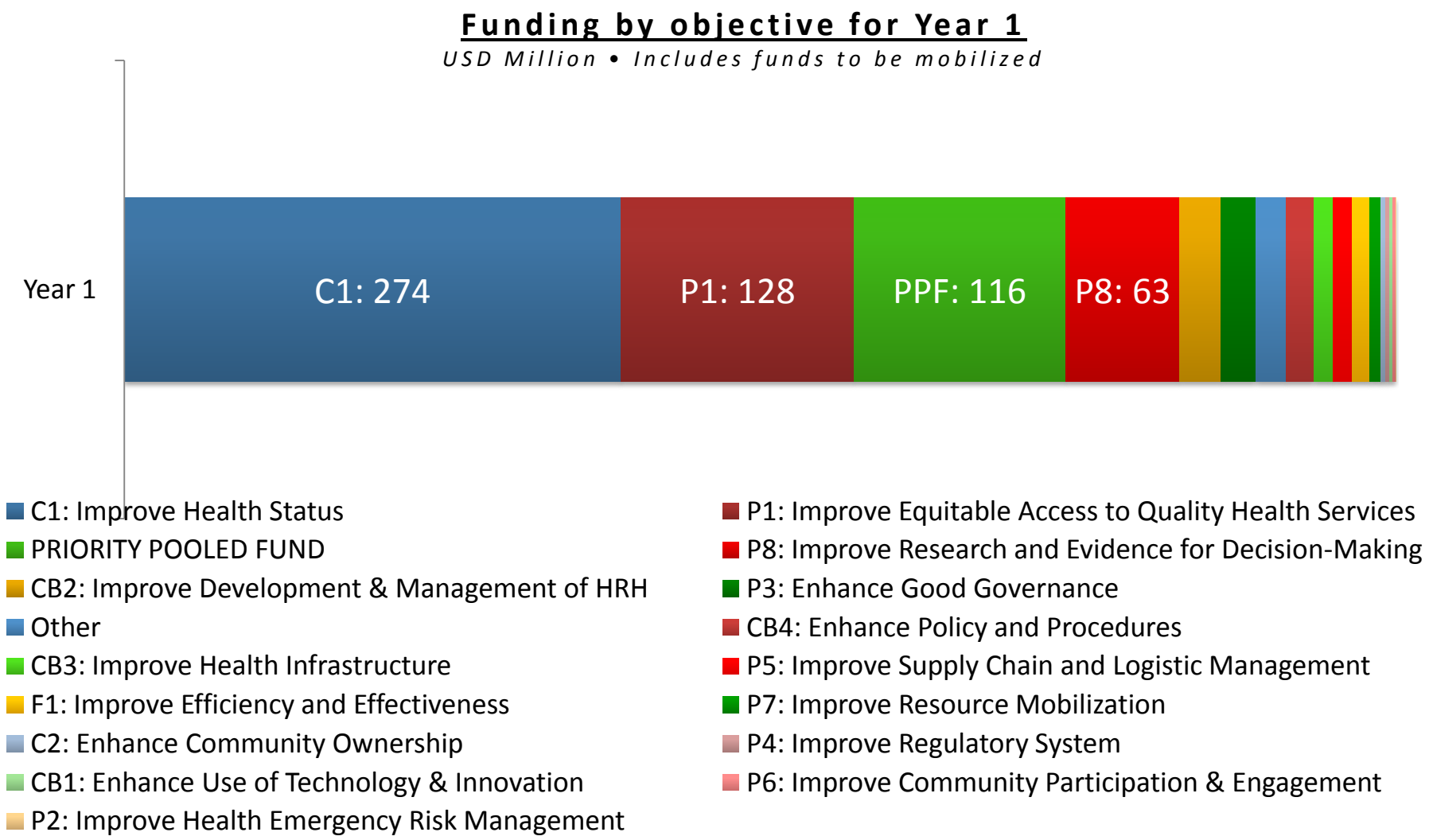


Trend in focus area 3 and focus area 4

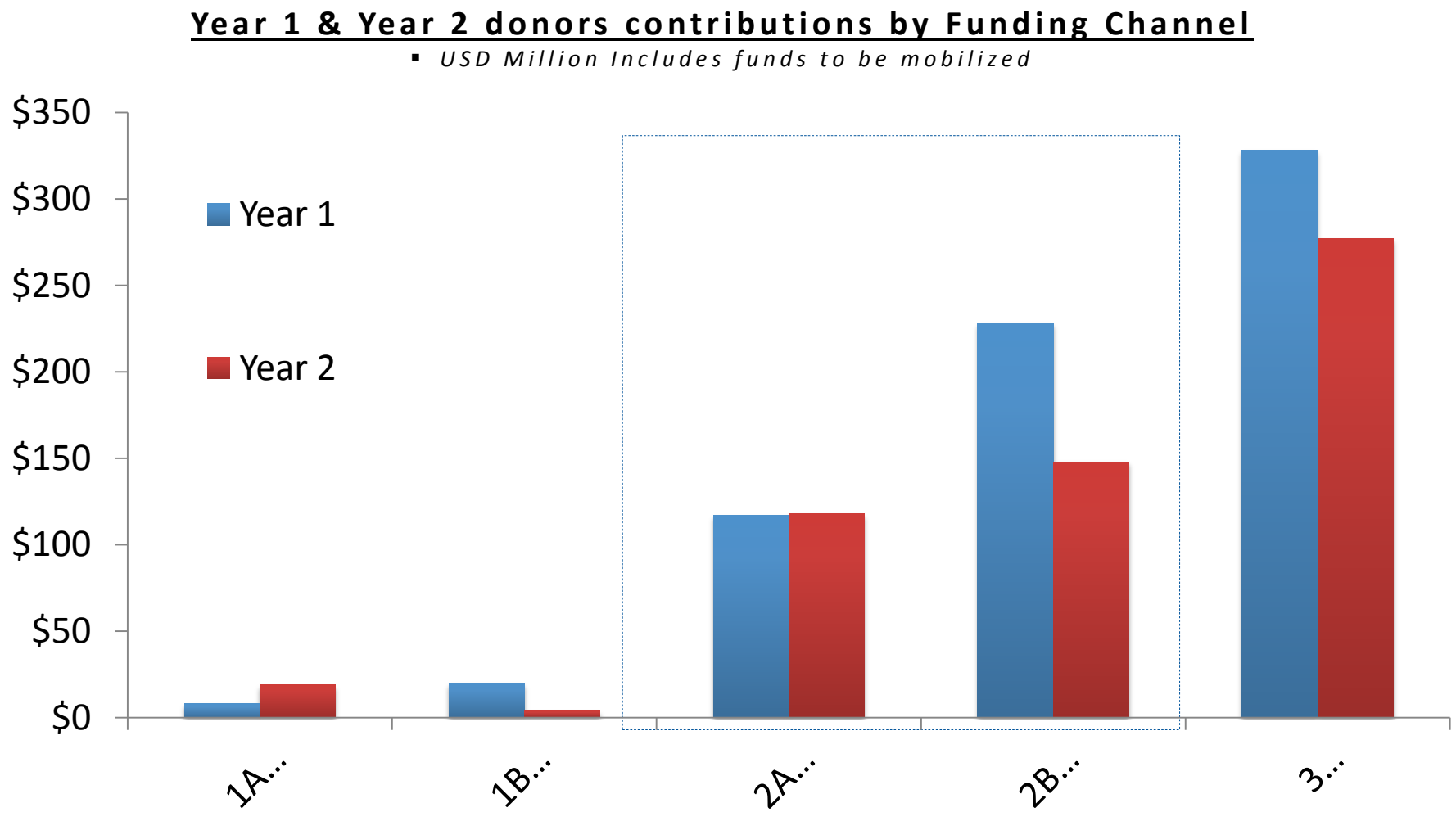
USD Million • Includes funds to be mobilized



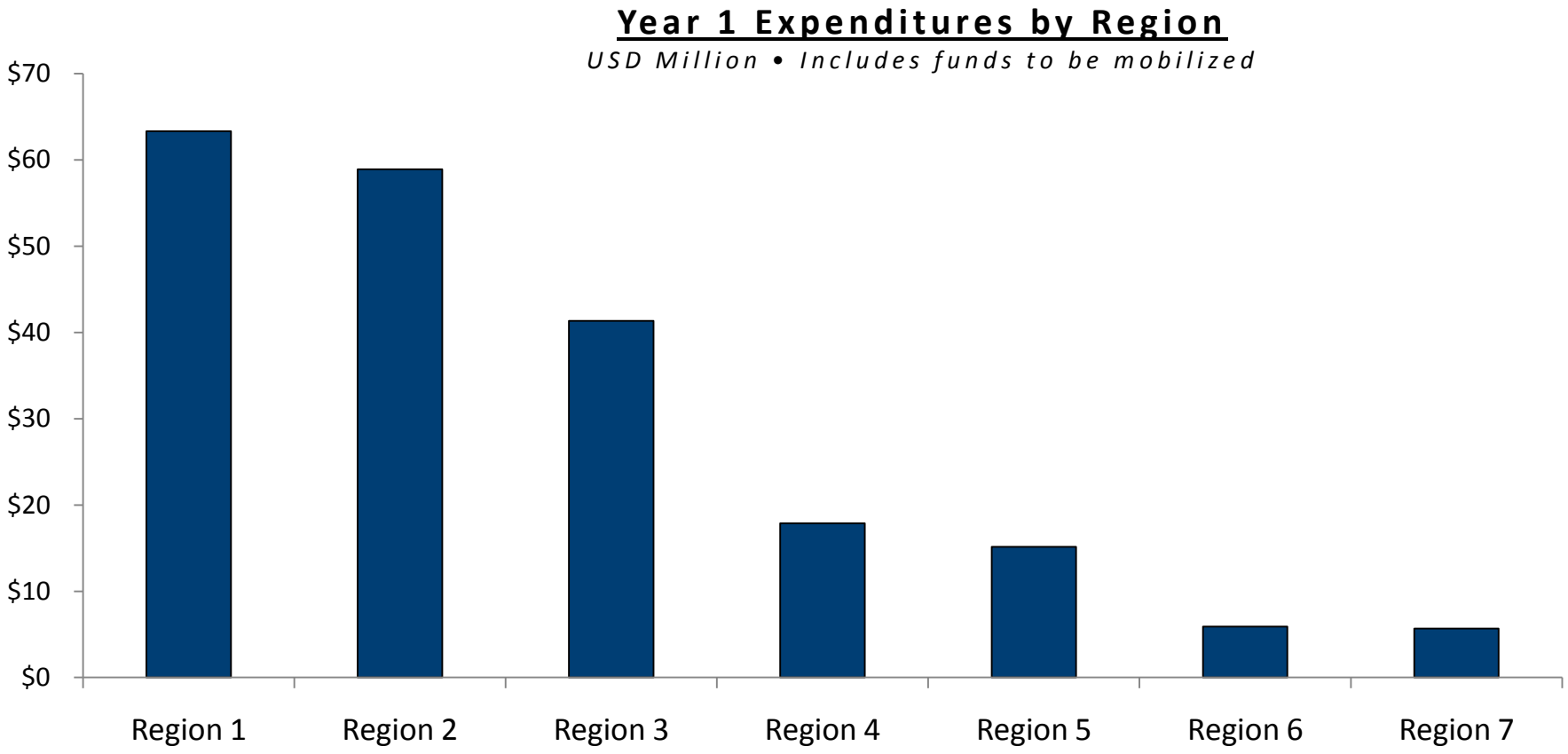
The Resource mapping exercise can show donors' alignment with National Plan objectives



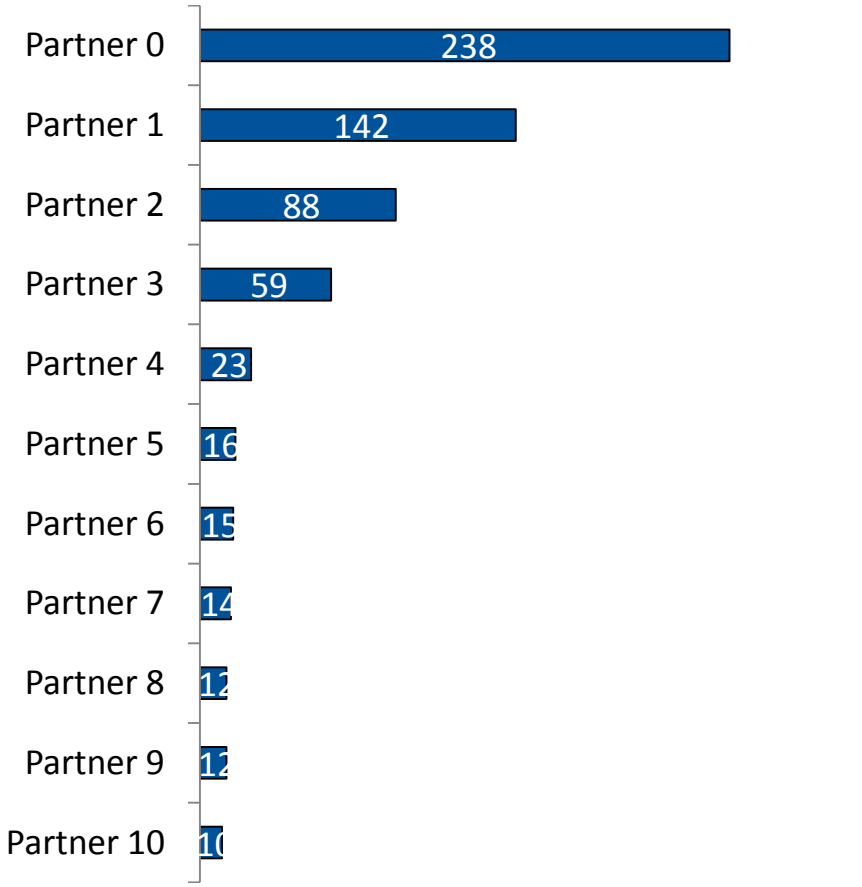
The Resource mapping exercise shows which are the preferred channels of funding by donors

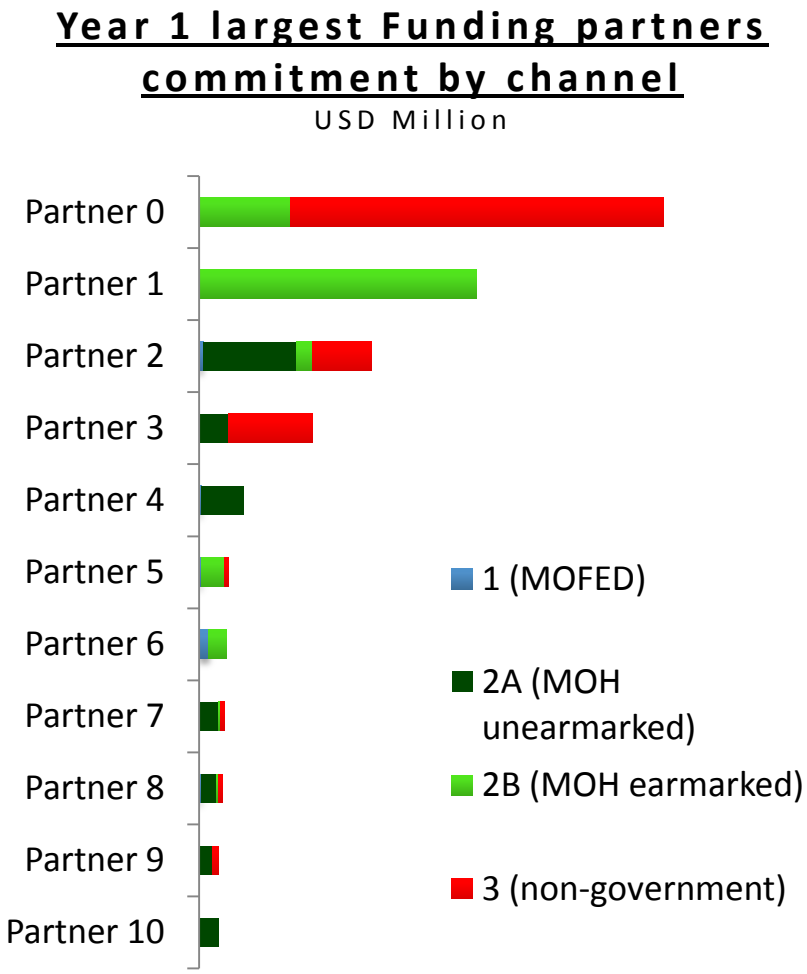


The resource mapping exercise captures the geographical distribution of donors' funding

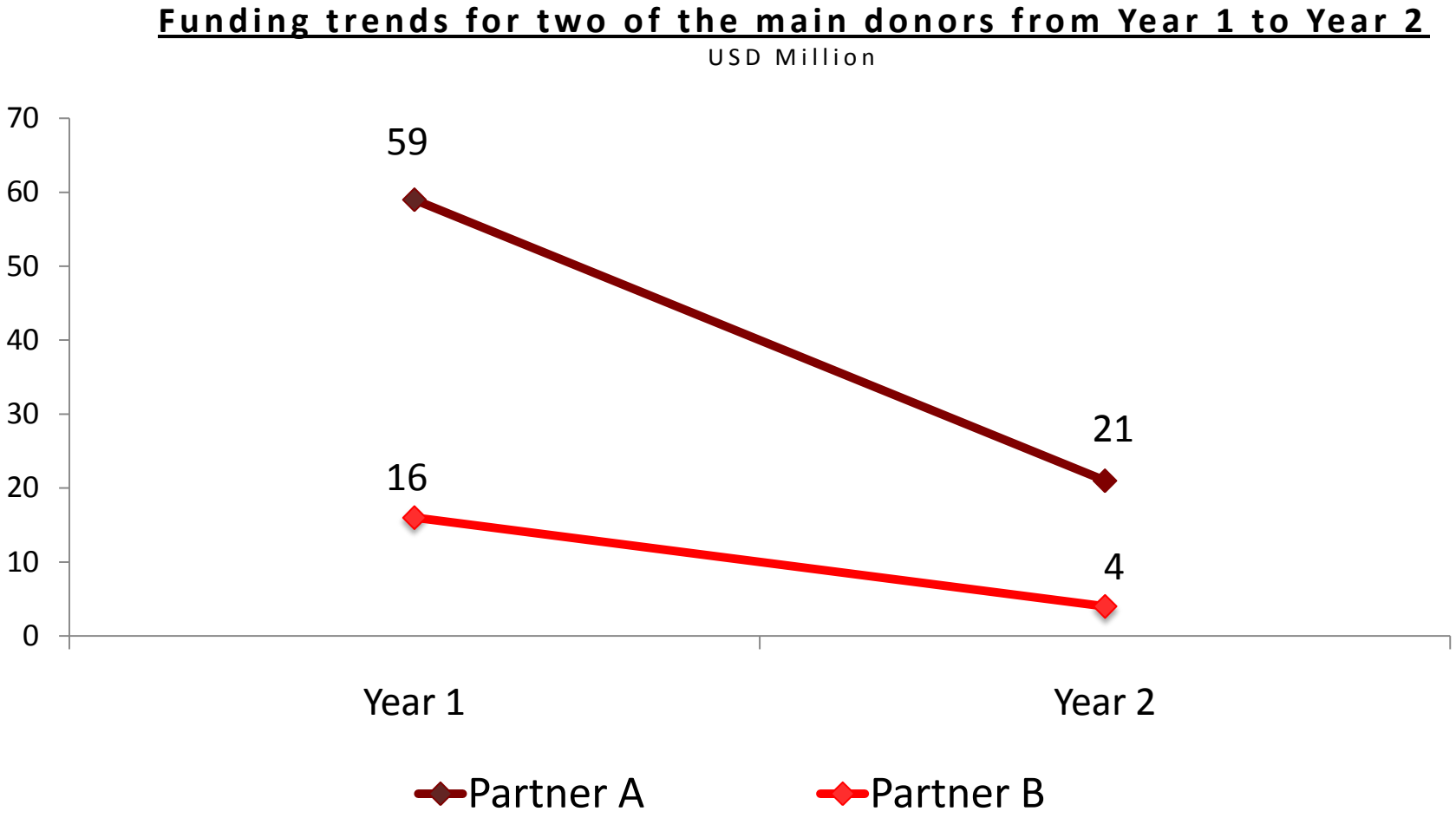


The Resource mapping exercise identifies who are the main funding partners and which funding channels they prefer





The exercise can detect donors who decide to cut their contributions to the health sector across time



All Directorates of the MoH can make significant use of this data for its planning purposes

- Resource Mapping can answer questions around how much is being spent by donors on various programs and where those programs are operating

- Program-specific or region-specific reports can be accessed

- Team Leaders can use the data to assist the annual planning process or answer the following questions:

Are donors spending money in a harmonized manner?
Are we planning activities to maximize patient outcomes?
Which critical areas are under-funded and need to be advocated for?

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Thank YOU!!

Annex VII

Federal Democratic Republic of Ethiopia
Ministry of Health

Maternal, Newborn and Child Health in Ethiopia

MCH directorate

Presentation to Tanzania and Lesotho delegates

August 16, 2016

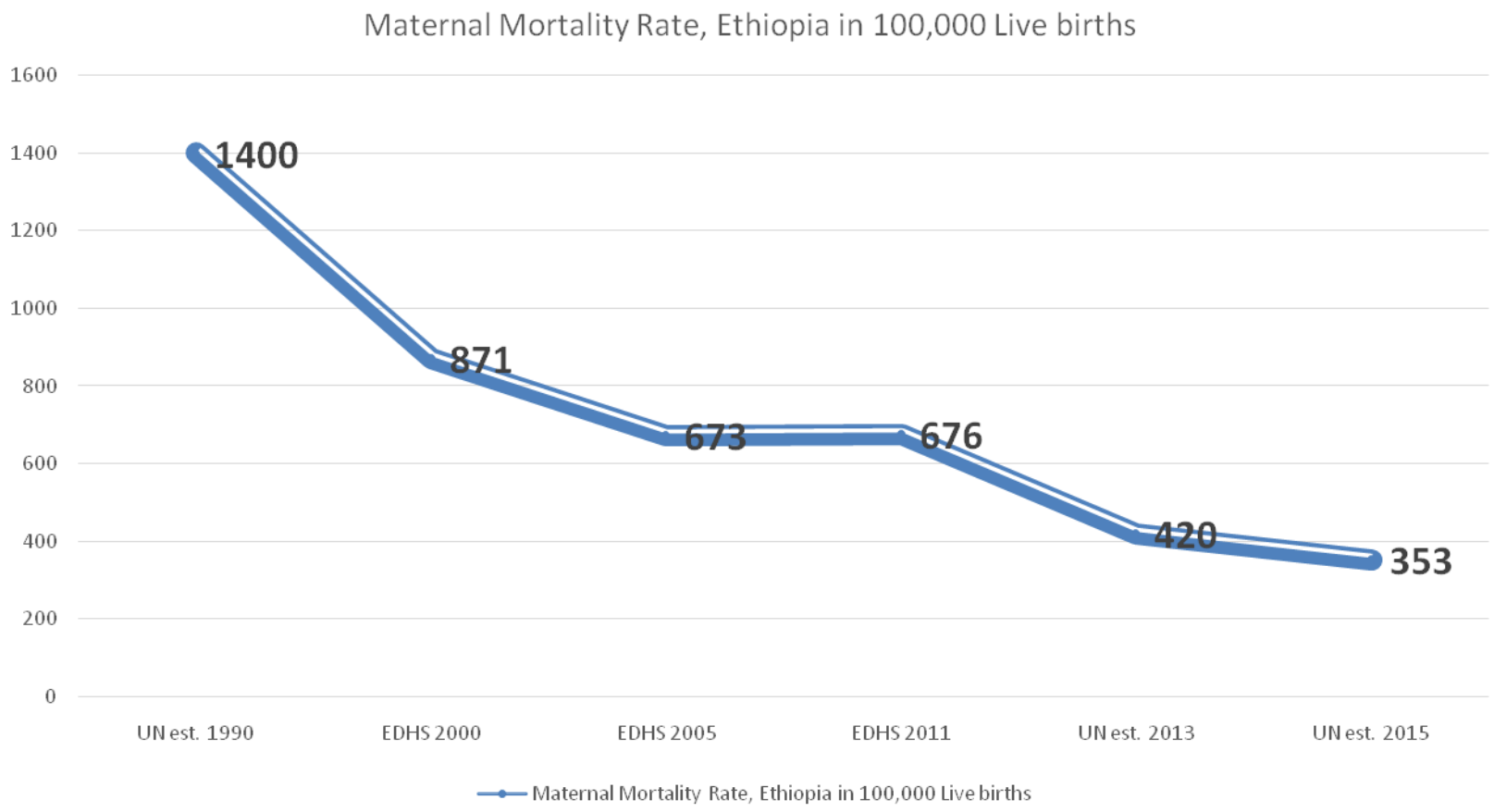
Content

- MCH Profile in Ethiopia
- Past to the Present
- What did Ethiopia do to decrease Maternal and child mortality
  - Health Extension Program and Health Development Army
  - Quality and Respectful Maternity Care
  - Expanding access to Family Planning
  - Elimination of MTCT
  - Child health, EPI and Nutrition Initiatives at community level
  - Success factors
- Health Sector Transformation Plan
  - Major RMNCH targets

MCH Profile

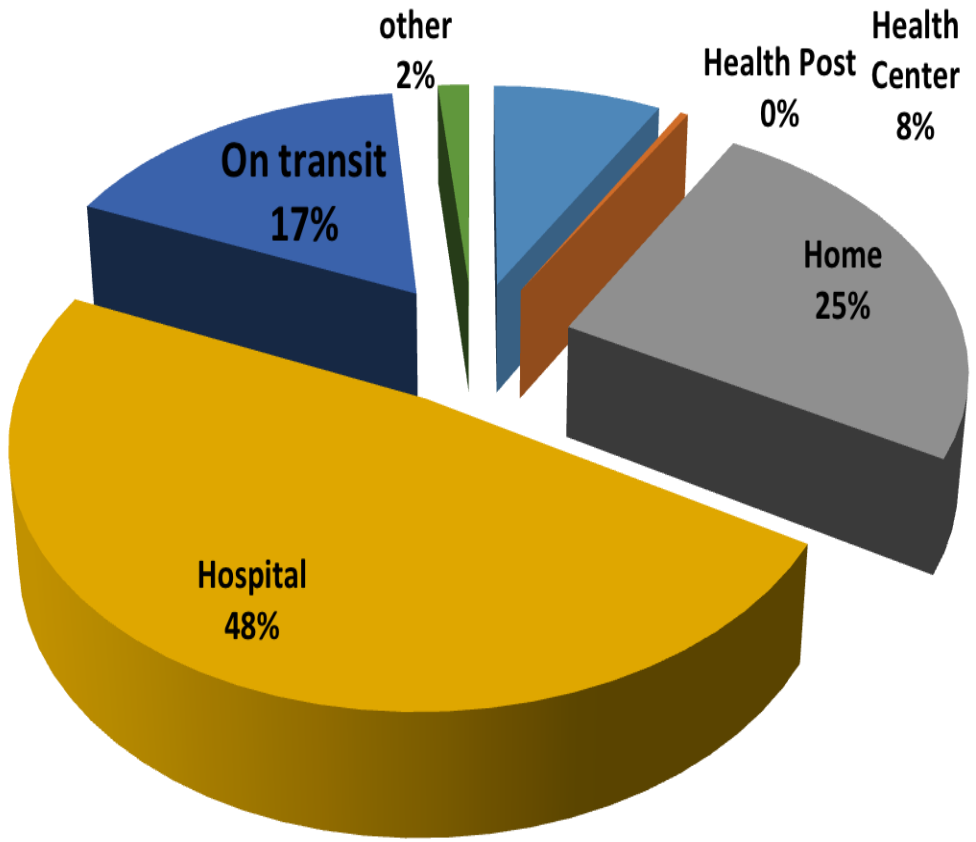
- Annually 3.1 million Births are expected in Ethiopia
- Maternal Mortality Rate in 2015; *353/100,000 live births, UN estimate*
- *According to our HMIS; until June, 2015*
  - ANC 4+ is about 68%
  - Skilled Delivery reached 60.7%
  - Postnatal care is 90%
- Contraceptive Prevalence Rate is 42%, TFR is 4.2
- Women receiving ARV to reduce MTCT IS 65%
- Under 5 child mortality: 59/1000 live births, 44% are neonatal deaths

MMR: Past to the PRESENT (~75% decrement)

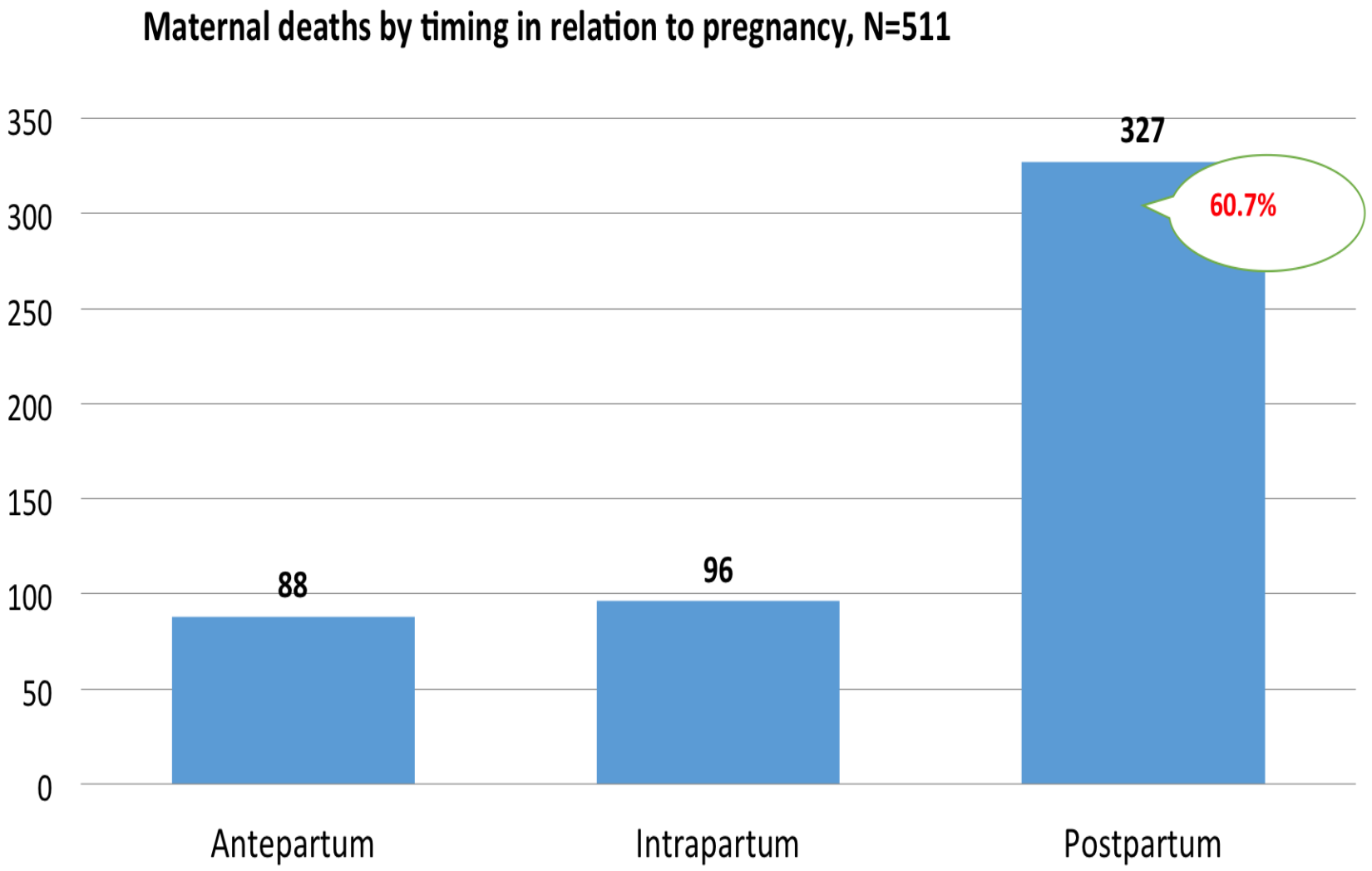


Findings of MDSR data analysis, 2016

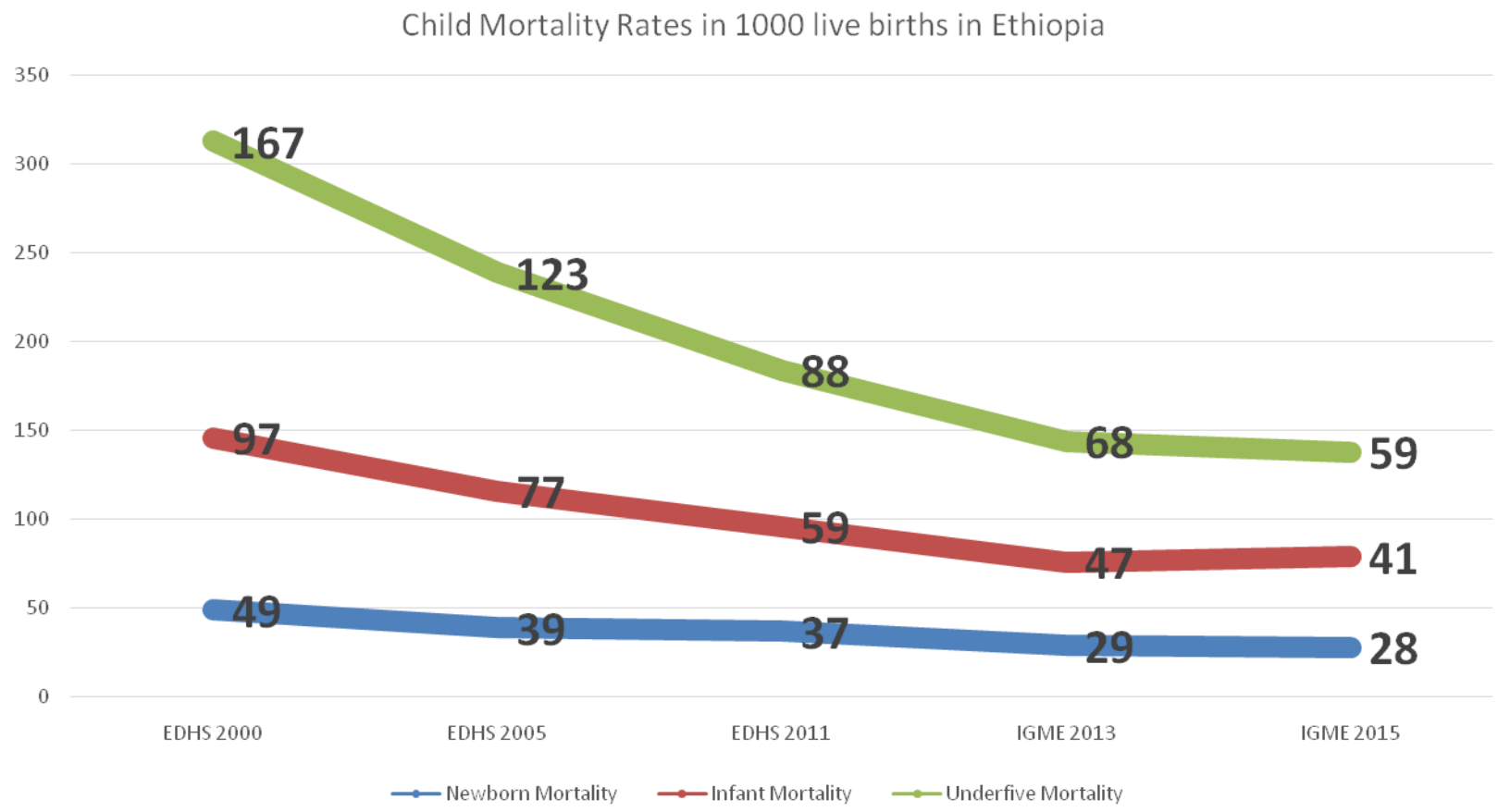
Maternal deaths by Places of death. N=532



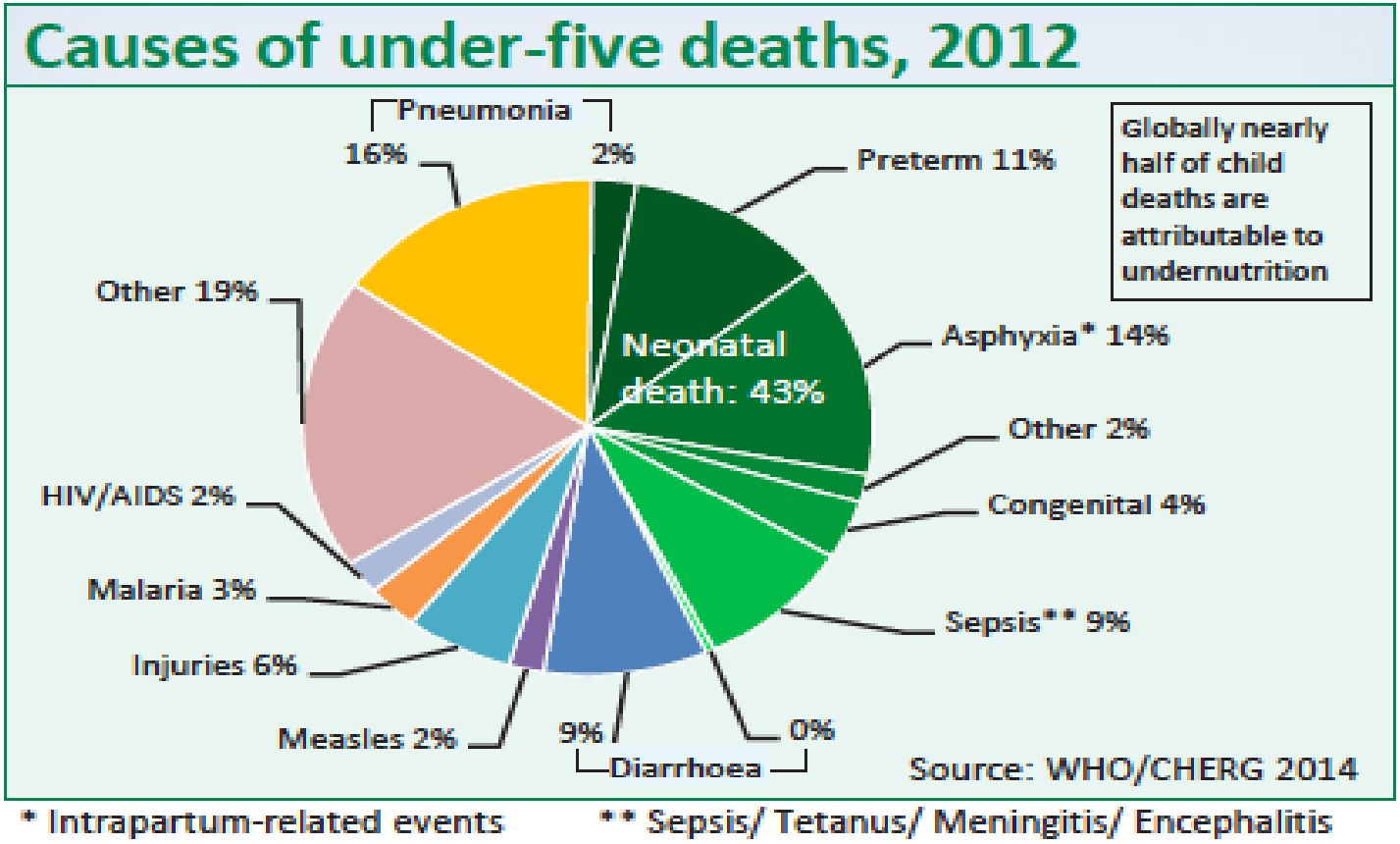
Findings of MDSR data analysis, 2016



Under-five Mortality (71% decrement since 1990)



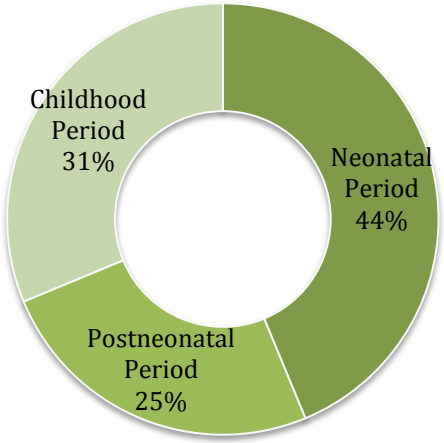
Causes of Newborn and Child Mortality



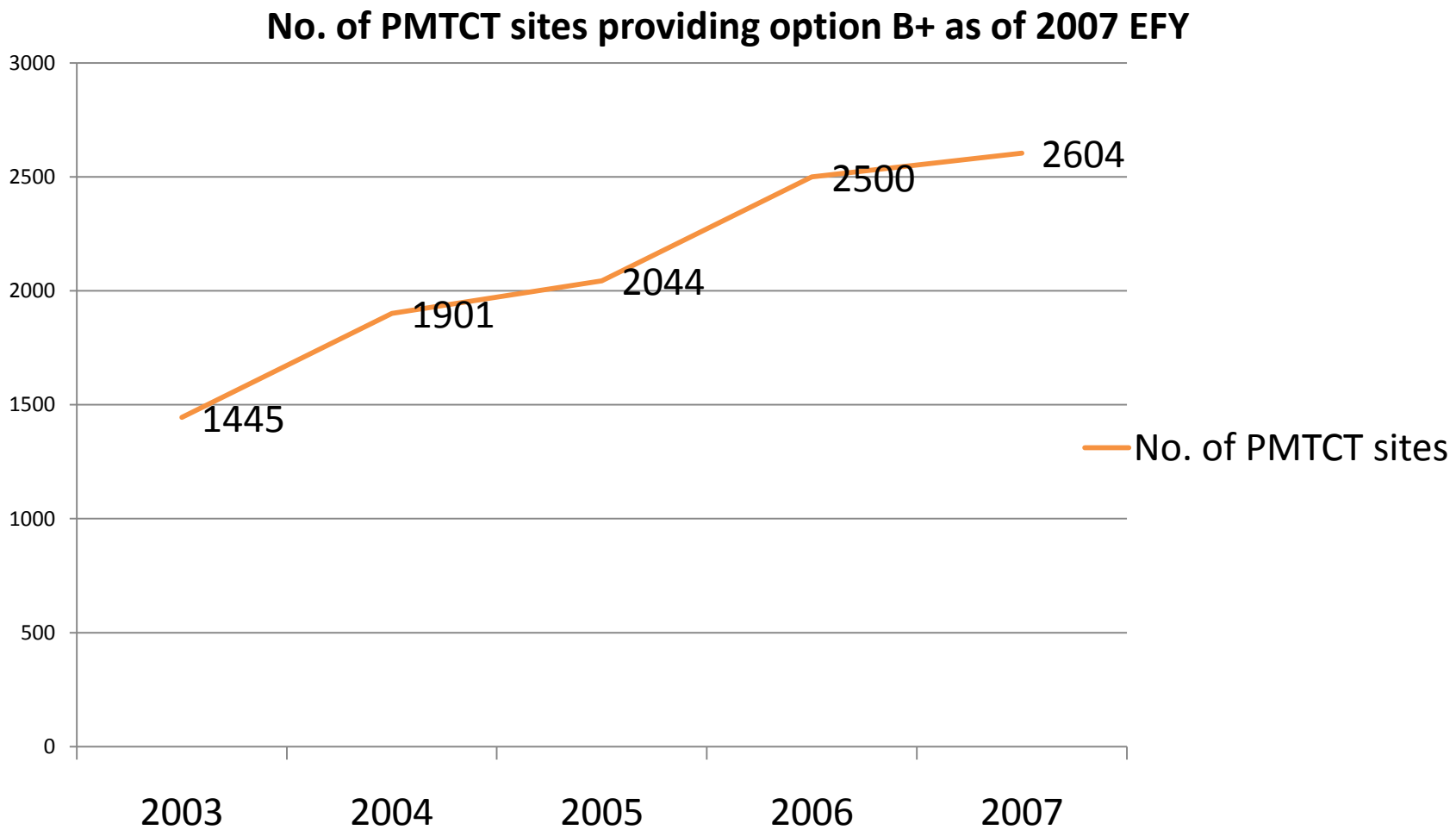
Malnutrition is a major contributor to child mortality in Ethiopia being an underlying cause for nearly 45% of under-five deaths

Newborn and Child Health In Ethiopia

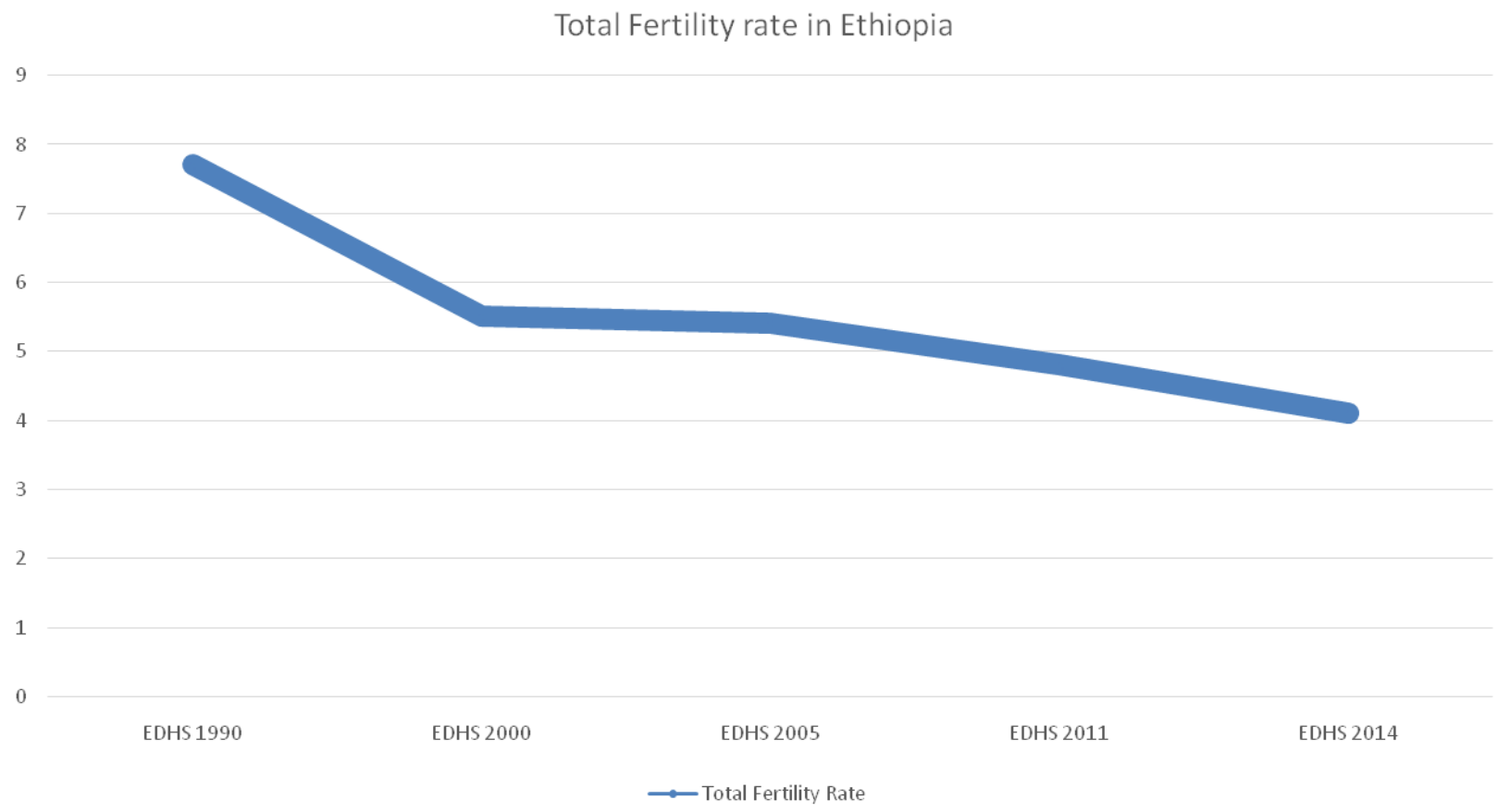
- **When are children dying?**
  - Key Newborn and Child Survival interventions on implementation
  - Emphasis given to regional variation
  - Barriers to service utilization



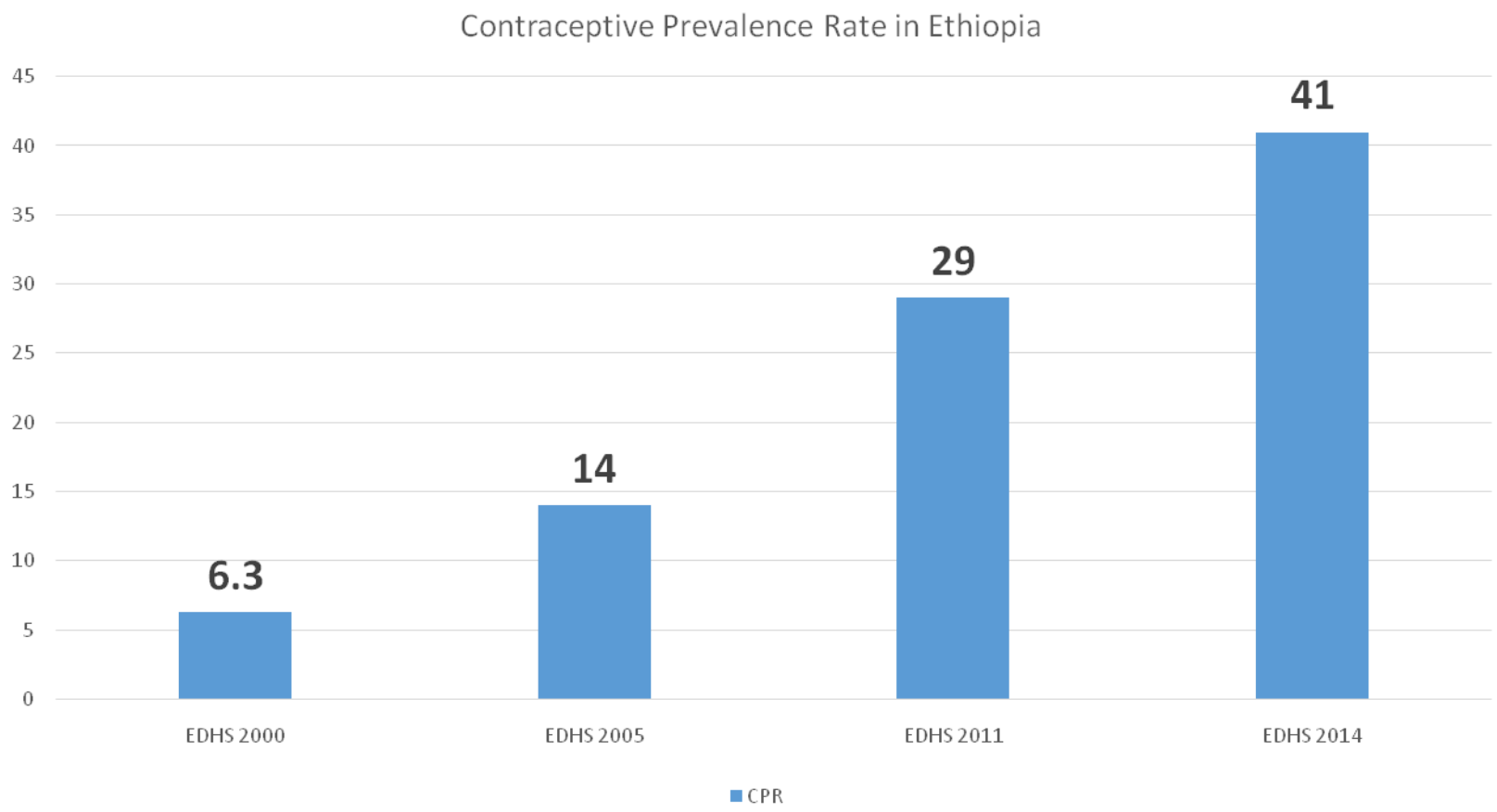
Option B+ implementation



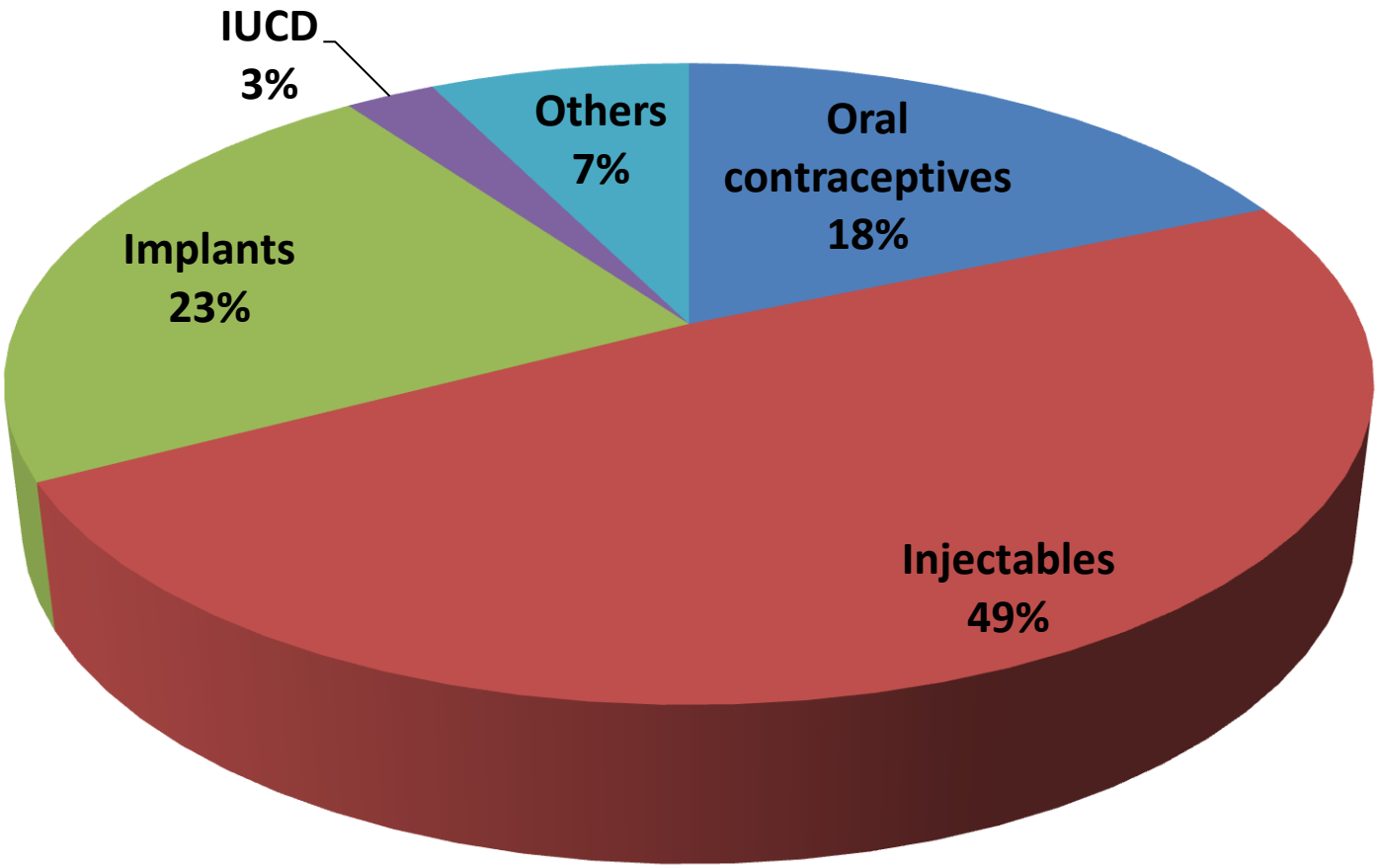
Family Planning, Close up;Total Fertility Rate



FP: Contraceptive Prevalence rate

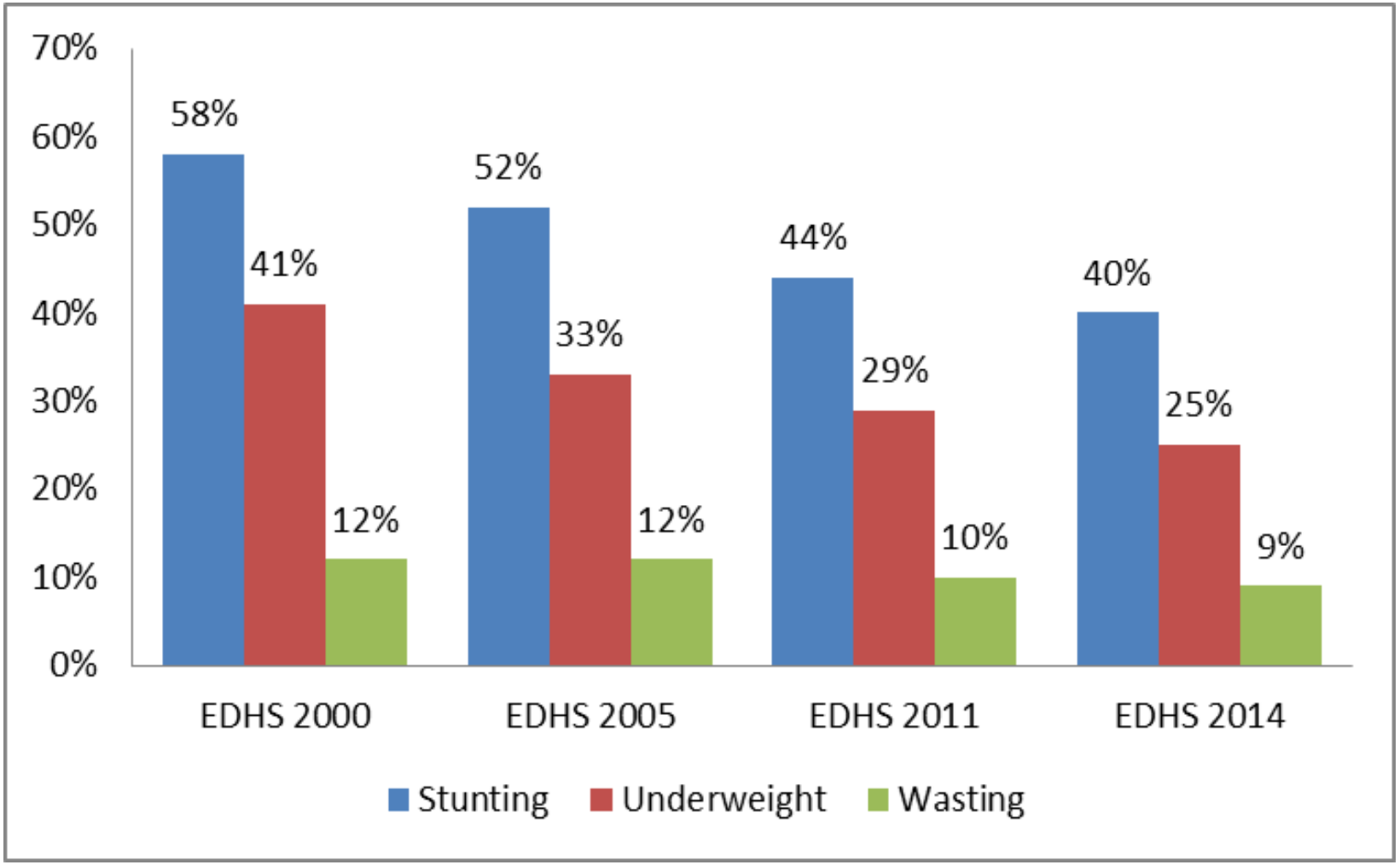


Method Mix (New and repeat acceptors by method)

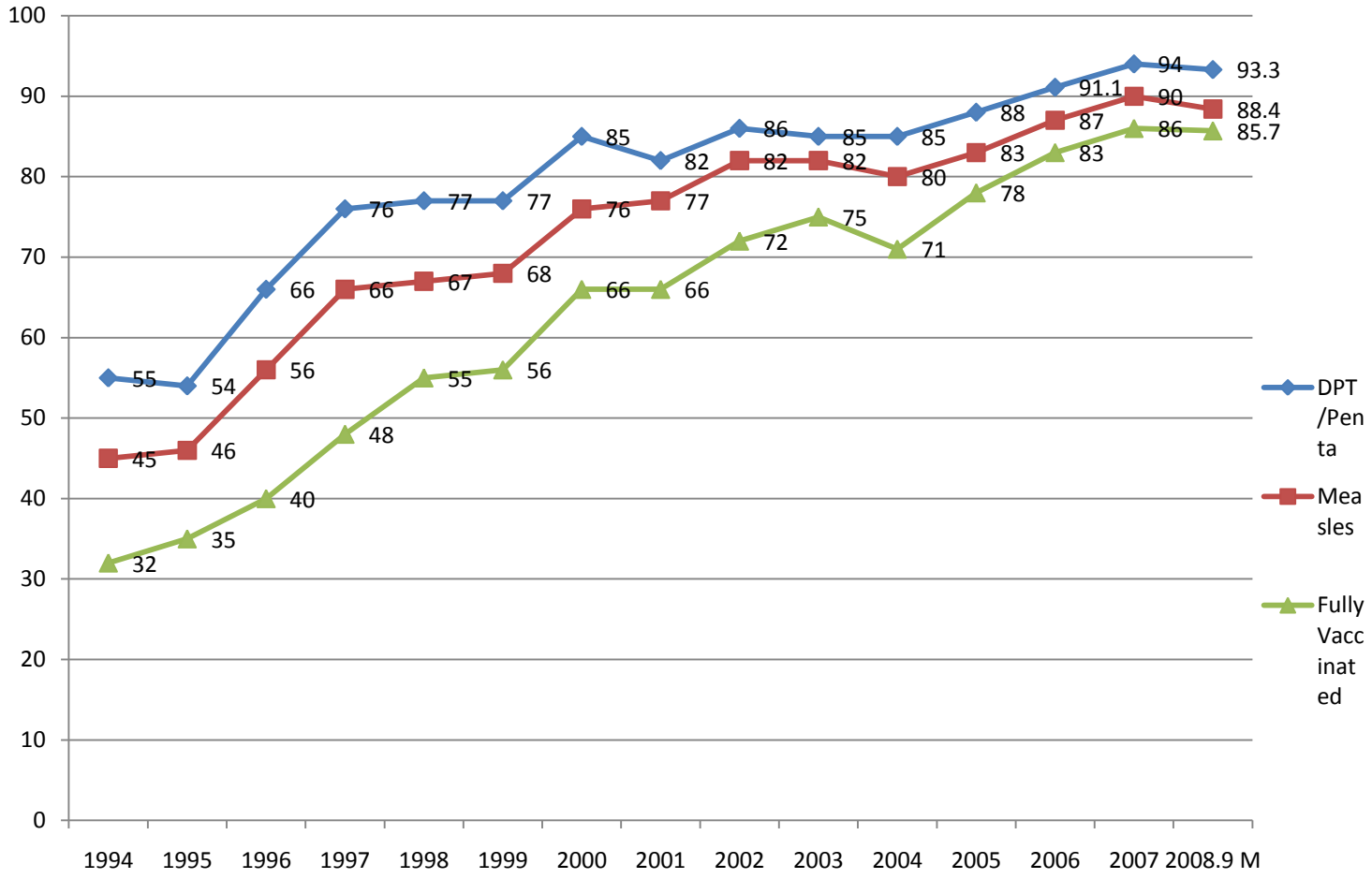


HMIS, Ethiopia, 6 months data

Nutrition – close up



EPI Trend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What did Ethiopia do to decrease Maternal and child mortality

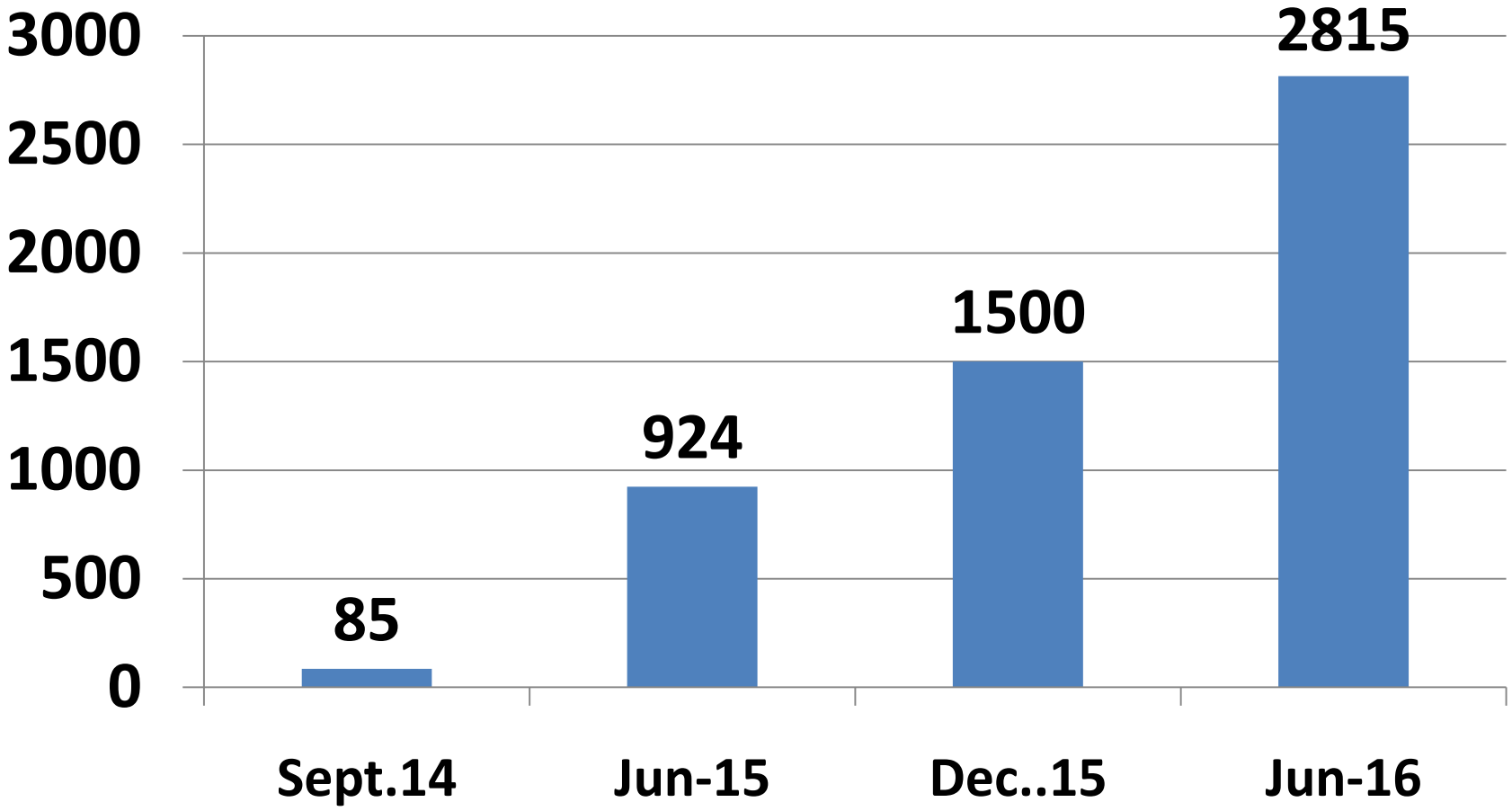
Health Extension Program

- Philosophy
  - If the right knowledge and skill is transferred to households, they can produce and maintain their own health
  - Communities are active stakeholders rather than passive service receivers
- Goal
  - Creating a healthy society and reducing morbidity and mortality of mothers and children
- Main Strategy
  - The introduction of the female **HEALTH EXTENSION WORKERS (38,000)**

Quality and Respectful Maternity Care

- Early initiation of ANC
- Building skilled and quality task force
- BEmONC and CEmONC availability at health facility level
- Increase deliveries attended by skilled health personnel
- Maternal death surveillance and response
- Post natal care 24-48 hours stay in the health facility
- Obstetric Fistula and Pelvic Organ Prolapse Reduction

Expansion (MBPC) Register 2014 to 2016



Expanding access to Family Planning

- Increasing all FP services availability and commodity security
- Implant service and availability scale up by training Health Extension workers
  - 24,000 + trained so far
- Training of health service providers in health centers and hospitals
  - Midwives, nurses, health officers and medical doctors in-service training
- IUCD service availability scale up at health center and health post level
- Postpartum Family Planning
- IUCD insertion by HEWs (learning phase)

Community based child health EPI and Nutrition interventions

Rationale

- Provided at Health post and house hold level by HEWs
- Easily accessible
- Provided with low cost
- Facilitates early identification and service utilization for sick children and mothers
- Involves the community in service provision (community centered)– improves community empowerment & ownership

On Building the blocks: health system strengthening

- Human Resource: speedy production of health professionals at scale
- Health Infrastructure: scale x5 in 10 year period; central purchasing
- Health Information: HIMS country-wide; moving toward electronic
- Health Service Delivery: improving quality and referral linkages
- Health Financing: facility retains revenue; community-based health insurance
- Leadership and management: One plan, one budget and one report but decentralized planning, budgeting and implementation

Success Factors

- National Prioritization of and Commitment to Women's and Children's Health
- National focus on sectoral Alignment and Coordination of all partners
- Outcomes monitored using evidence: Score Card
- Political prioritization of essential health interventions
- Focus on addressing Health Workforce Shortages:

Success Factors

- Legal and financial entitlements, especially for underserved populations
- National Focus and Leadership to Address Malnutrition
- Non – Health
  - Education
  - Infrastructure, water supply and sanitation

Challenges/Opportunities

- Lack of open discussion about SRH
- Harmful Traditional practices (FGM, early marriage)
- Health service provision not ready for AYH
- One million women delivered at home
- Inter community disparities
- Significant cascade loss in PMTCT
- Third delay contributes for 37% of maternal death
- Quality of service especially in components of skilled delivery

Challenges/Opportunities

- Low utilization (iCCM/CBNC)
- Cultural norms (Understanding newborn as a full human being)
- Highly implementing partner dependant
- High turnover (attrition and rotation)
- High drop out rate in immunization
- Missed opportunities for EPI
- Data quality and reliability
- Challenge in coordination and leading of nutrition, EPI and child health activities

Health Sector Transformation Plan

Major RMNCH Indicators

- CPR of 55% by 2020; Our Costed Implementation Plan
- MMR of 199/100,000 live births
- Under five mortality to 29/1,000 live births
- Skilled delivery attendance to 90%
- Obstetric Fistula to <1600, Capacity detection and Management POP
- MTCT to less 2%, Syphilis
- Addressing unmet need particularly of adolescent and youth
- Choice based increment of service availability for LAC methods

Thank you!

Annex VIII

Primary Health Care: Ethiopia's Experience

Presented to:
Delegates from the Republic of Tanzania

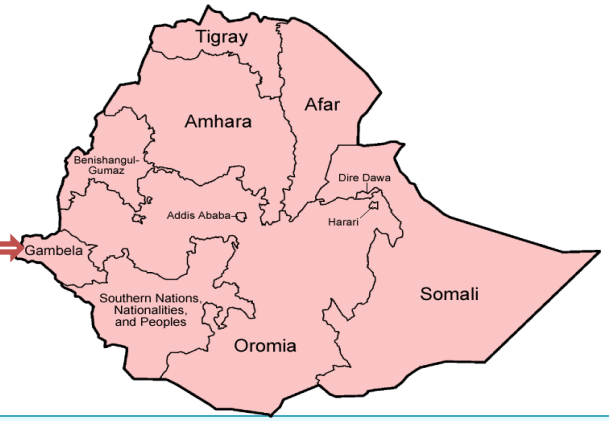
August, 2016

Addis Ababa

Outline

- Country Background
- Ethiopian Health Policy... brief
- Primary Health Care in Ethiopia
  - Ethiopian Health Extension Program
    - Implementation Strategies of HEP
    - Approaches of Implementing the HEP Packages
    - Health Development Army
    - Achievements
    - Challenges

Country Background



Total Pop. ~ 90 + million
1.1 million sq km
Rural Population ~ 83%
9 regional states and 2 City Administrations
It is a diverse country with multi-ethnic
Primary health service coverage = 100%

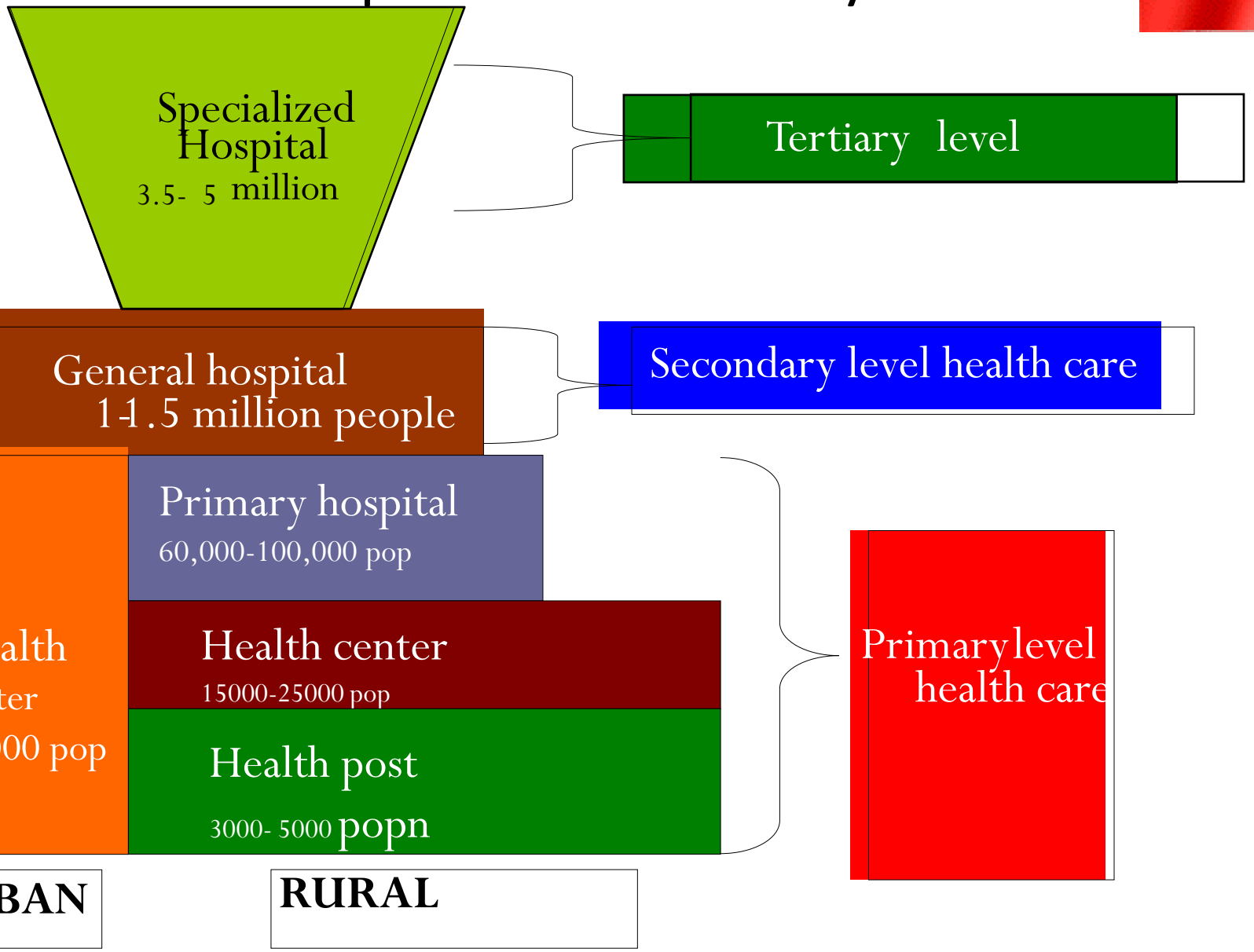
Hospitals = 234
health centers= 3586
health posts= 16,447

Ethiopian Health Policy

General Directions:

- **Democratization** and **decentralization** of the health system;
- Focus to **preventive** and **promotive** components of the health service;
- Ensuring **accessibility** of health care by all;
- Promoting **inter-sectoral collaboration**, involvement of the NGOs and the private sector;
- enhancing **national self- reliance** by mobilizing and efficiently utilizing internal and external resources.

Ethiopian Health Tier System



Primary Health Care

- The primary care level health services include:
  - Health posts (HPs) = staffed with two HEWs, and is responsible for a population of 3-5,000 people.
  - Health Centers (HCs) = Rural HCs serve populations up to 15,000- 25,000 persons; urban HCs serve up to 40,000 people.

5HPs+1HC= PHCU

Primary hospitals= provides inpatient and ambulatory services to an average population of 100,000.

Serve as first referral point to PHCUs

Primary Health Care…cont

- The PHCU provides services to a population of about 25,000 people.
- The closest to the people.
- Essential health care (EHC) is provided.
- A majority of prevailing health problems can be managed at this level.

ETHIOPIAN HEALTH EXTENSION PROGRAM:

An Institutionalized Community Approach for Universal Health Coverage

Health Extension Program (HEP)

Defining HEP:

- Introduced since 2004/5
- The **H**ealth **E**xtension **P**rogram is a ***flagship*** strategy adopted to achieve **universal coverage** of primary health care to the Ethiopian population.
- **The HEP** is a defined package of **basic** and **essential** promotive, preventive and basic curative health services targeting households.
- The HEP packages are designed based on the major health problems and disease burdens in the country.

HEP, Cont'….Philosophy of HEP

Transfer basic knowledge, skill, Ownership & Responsibility

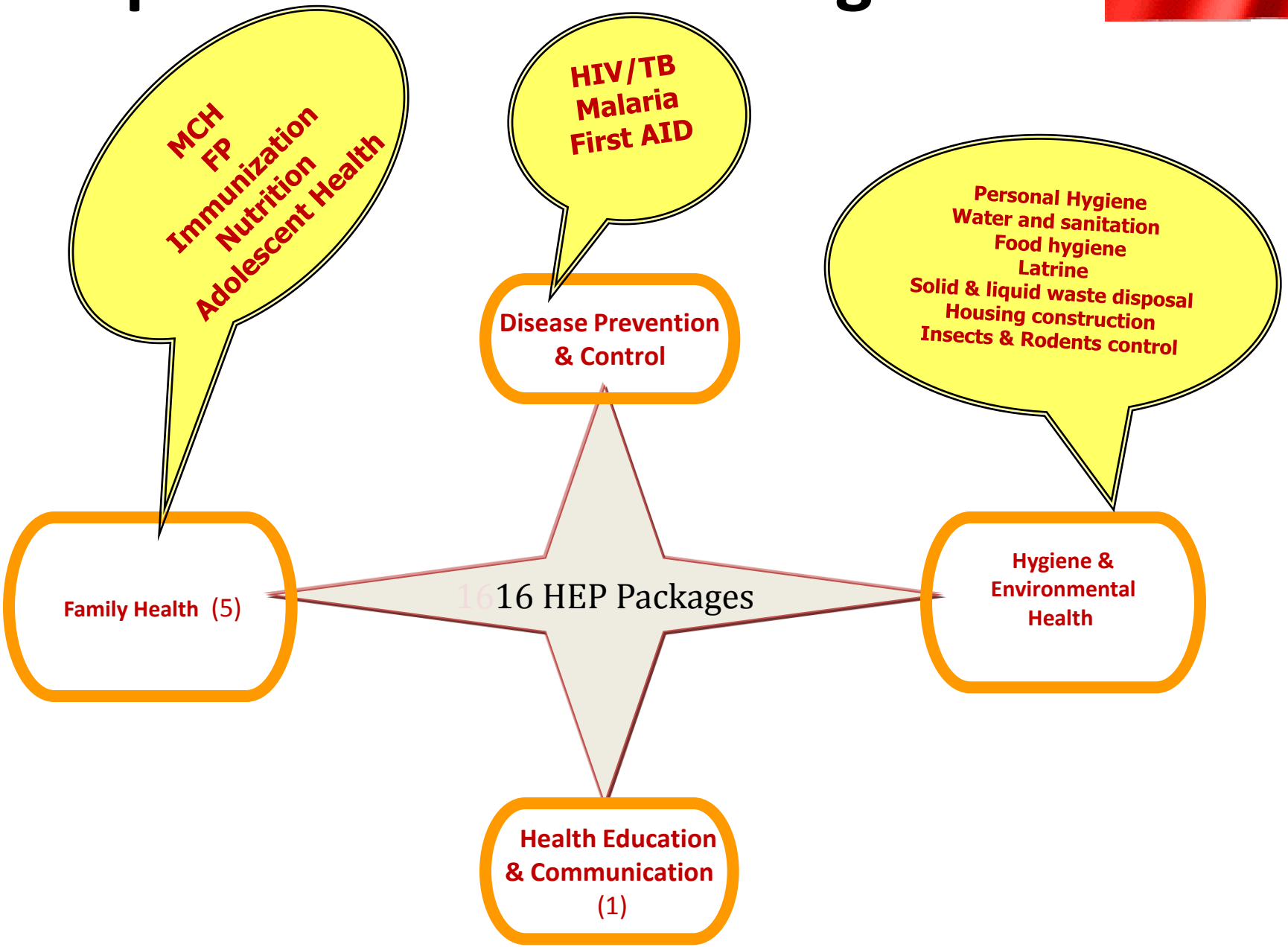
Individual Households

Indrias Getachew, Ethiopia, 2010

The underlined convection is that

Produce their own health the way they produce their agricultural products

Components of HEP Packages



Implementation strategies of HEP

Imple.. strategy Cont...

a). Human Resource (Health Extension Workers):

Rural Areas

- Recruitment criteria
  - Female, age >18 yrs
  - Completed 10th grade and above
  - Speak local language and Resident of the village
- Training of HEWs
  - One-year course training at TVET centres or Health Science colleges (Course work + Field work)
- Deployment : 2 HEWs/5000 people, currently > 38,000 HEWs
- Salaried

Urban

- 10 + 3 (Diploma) complete
- Three months training on UHE packages

Imple.. strategy Cont...

b). Construction of HPs/Health Infrastructure:

- The operational center of the HEP is the Health Post.
- Health Posts are located at Kebele/village level to serve a population of nearly 5000 people.
- ~ **16,447** HPs are constructed in the country through community participation.


Health Post

Imple.. strategy Cont...

c).Procurement of Contraceptives, Medicine and Supplies

- HPs require to be equipped with materials and supplies required to deliver the different packages of essential services.
- Medicines and supplies are **procured** and **distributed** to the HPs by the FMOH, RHBs and District Health Offices-through HCs.

Approaches of Implementing the HEP Packages

- Family based activities
- Community based/outreach/ activities
- Health post based services
- Activities conducted in youth centers and schools

Approaches…

1. At Households Level and Home visits

- HEWs are required to **spend 50%** of their time visiting households.
- HEWs are expected to **teach by example** (e.g by helping mothers care for newborns, food demonstration, construction of latrines and disposal of pits etc).

2.Community Based Health Packages

- HEWs identify and train Women Development Army(WDAs) leaders
- HEWs utilize Women and Youth Associations, Schools and;
- Traditional Associations such as ***idir***, ***mehaber, ekub***…

Aproach……

3. Health post

At HP HEWs provide;

- Antenatal care, delivery, post natal care, immunization, growth monitoring, nutritional advice, family planning etc.
- ICCM- Tx of Pneumonia , diarrhea uncomplicated malaria, malnutrition
- firs Aid
- Referral services
- Health Education

Realizing full community participation: The Health Development Army approach

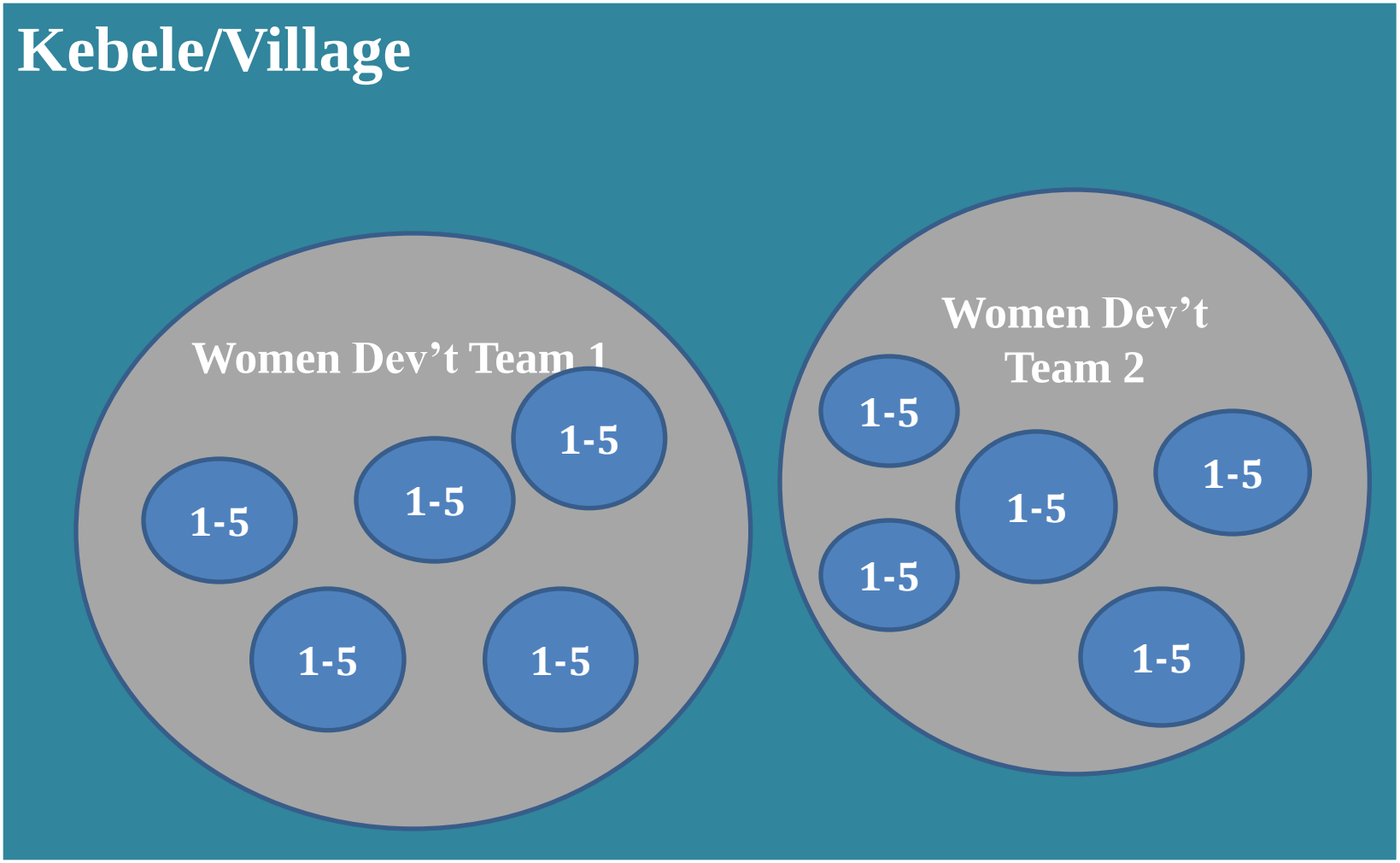
HDA refers to an organized movement of the community through participatory learning and action meetings for health.

HDA..cont'

- HDA Requires Women Development Teams (WDT) that comprise of up to 30 households/women residing in the same neighborhood.
- Women development Team is further divided into smaller groups of **six members**, commonly referred as one-to-five linkage.
- Leaders of the health development teams and the one-to-five networks are selected by the team members.
- Selection **criteria** of leaders, mainly:
  - ✓ being a model family in implementing the 16 HEP packages; and
  - ✓ trust by the members in mobilizing the community.

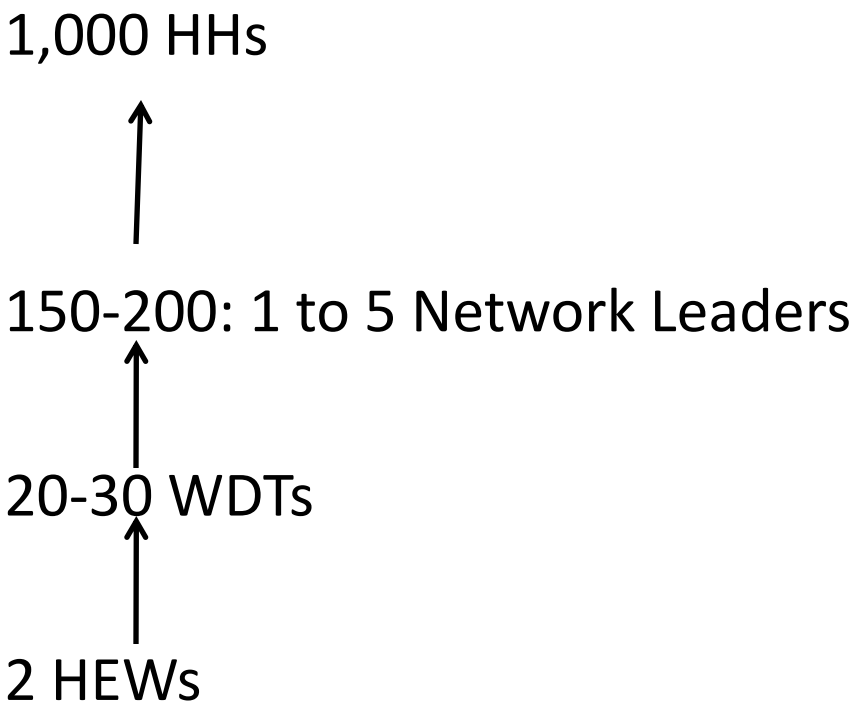
.

Women Development Teams

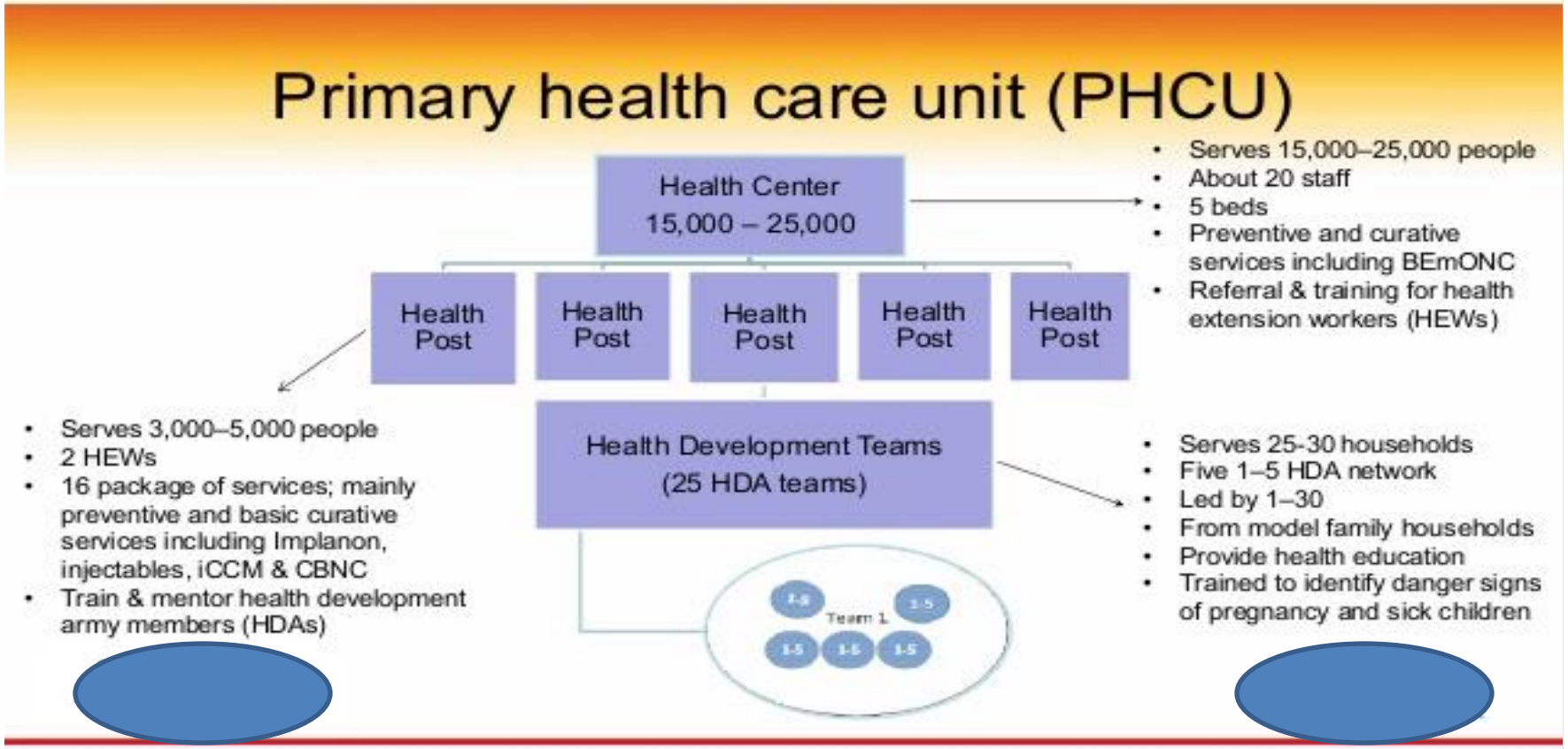


WDT…cont

The formation of WDTs is facilitated by Health Extension workers and the kebele/Village administration.



Linkage with the PHCU



Working Relation of HEWs and HDA Cont…

- The one-to-five network leaders receive training by HEWs.
- The training is both theory and more practice
- Regular supervision & performance review

HDA Cont….Working Relation of HEWs

HDAs leaders demonstrate key health actions for their neigbours

Achievements: What has been achieved so far?

In terms of service since the implementation of the program

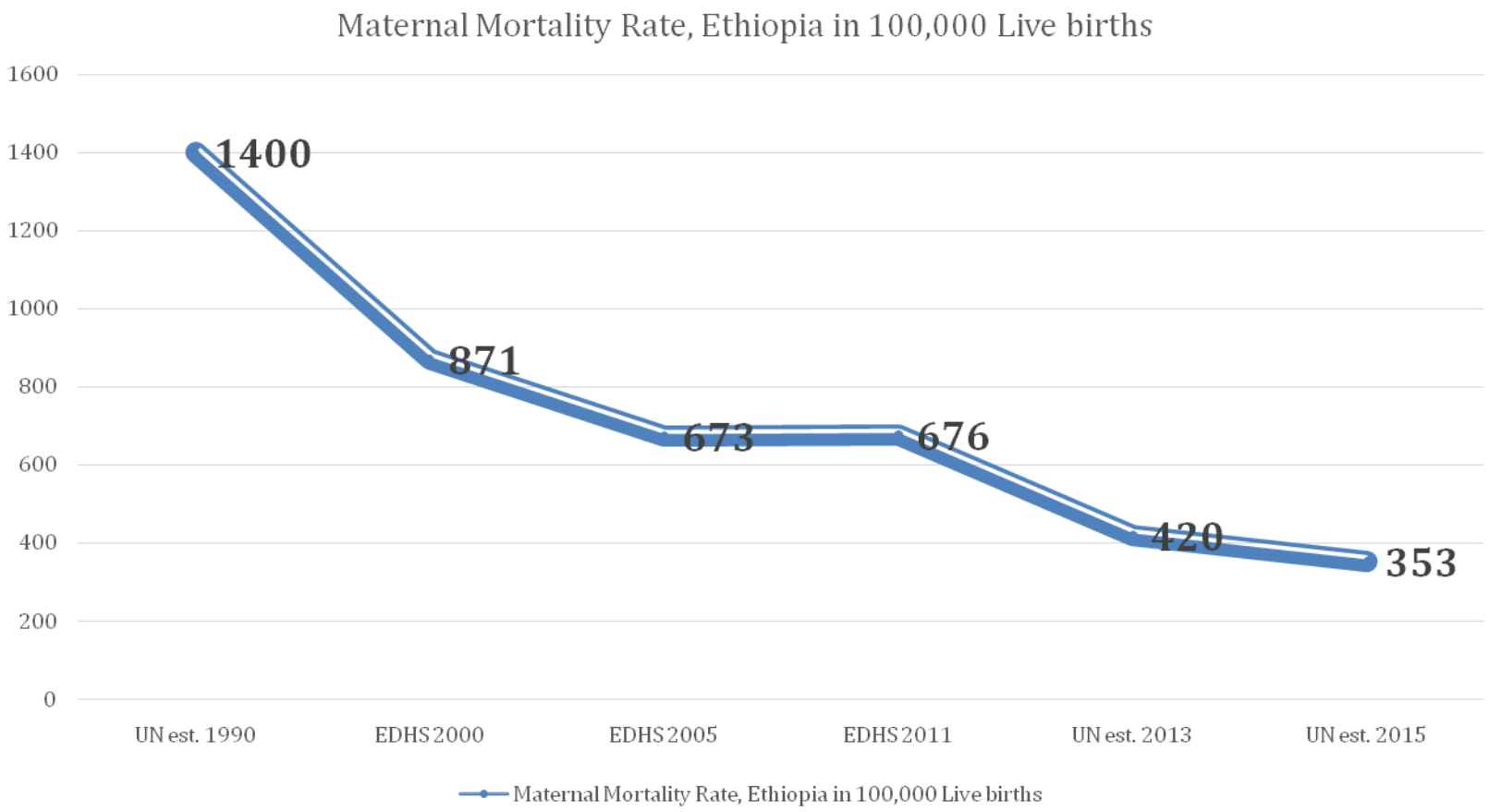
- ♣ Increase access to basic health services
- ♣ Improvements in contraceptive prevalence rate
- ♣ Increase institutional Delivery
- ♣ Increase immunization coverage
- ♣ Increase latrine coverage

Achievements: What has been achieved…

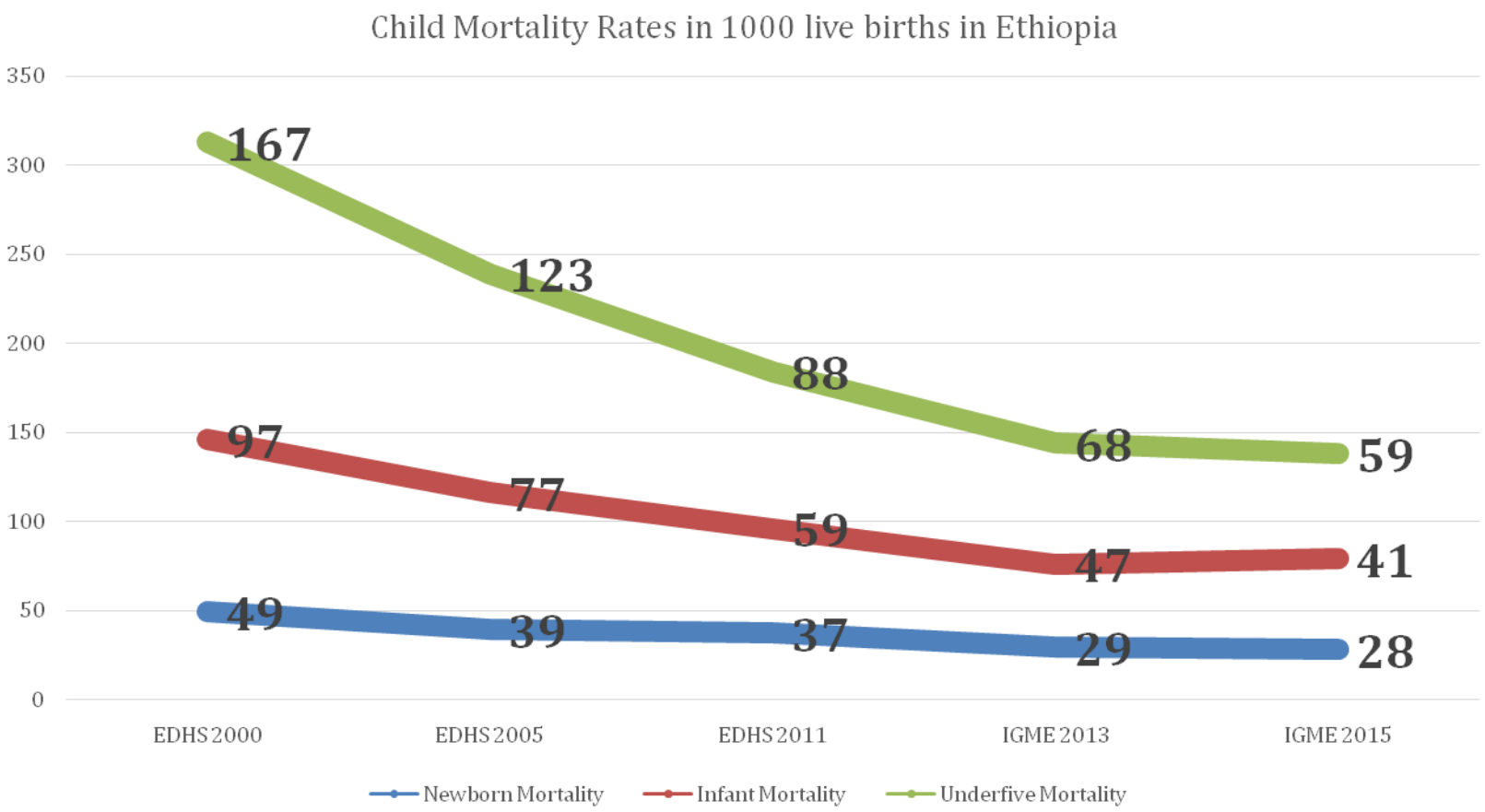
Impact level

- MDG achieved
- Fertility rate decreases
- HIV incidence rate decrease
- Reductions in Morbidity and Mortality related to major communicable diseases has been achieved.
- life expectancy increased, (from 44-64)

MMR: Past to the PRESENT (~75% decrement)



Under-five Mortality (71% decrement since 1990)

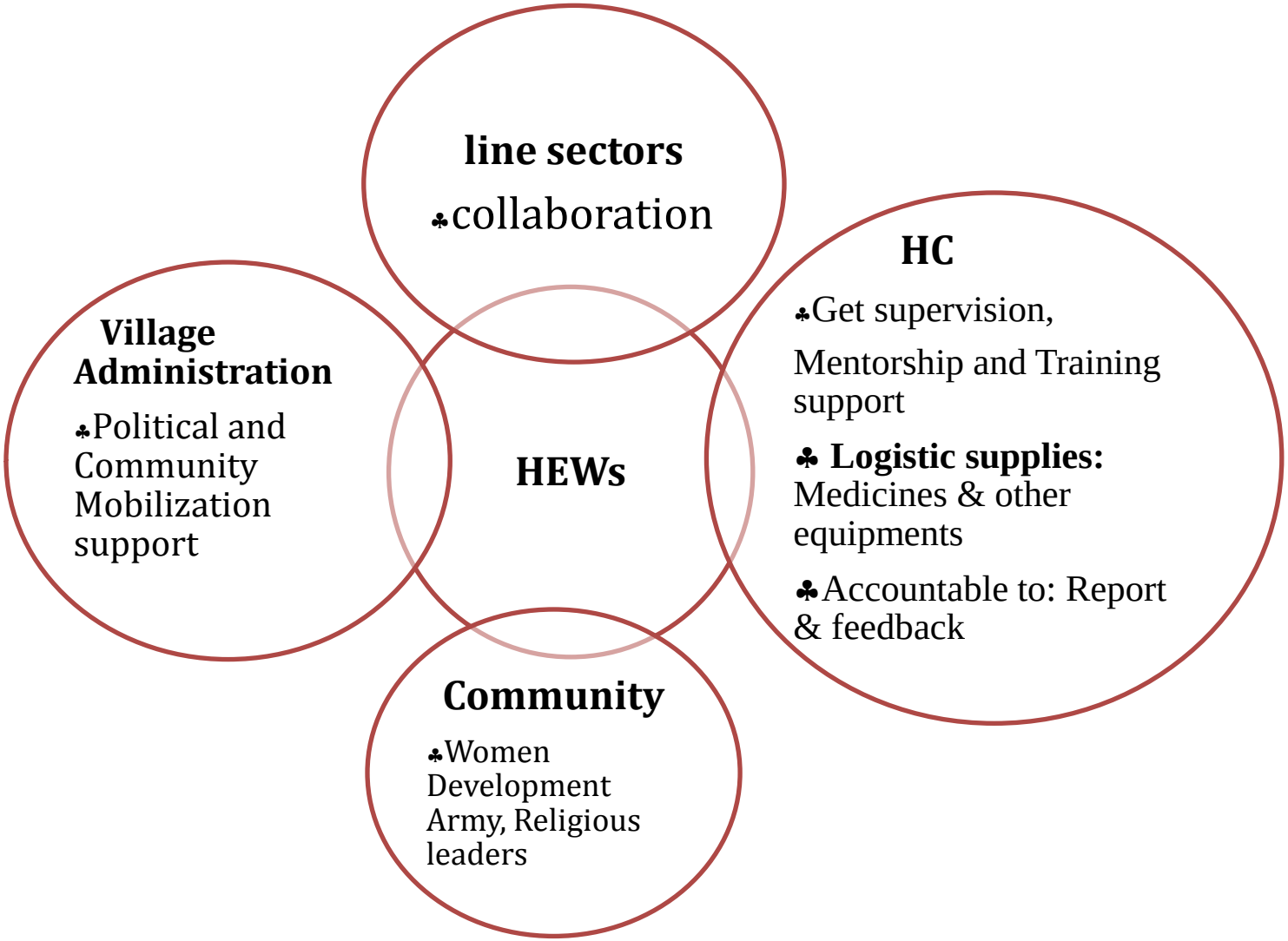


Leadership and M & E of HEP

- Close supervision and support by the health centers and woreda/district health offices
- Regular review meeting
- Integrated supportive supervision at all levels
- Operational researches

M & E cont...

Who Supports the HEWs?



Key drivers for successful HEP

- **Strong Political commitment:-** deployment of more than 38,000 salaried HEWs
  - Strong country leadership: HEP is priority
  - Policies and strategies aligned with national plans
  - More emphasis (focus) on expansion of primary health care
- **Strong Health Centre to Health Posts Linkage**
- **Excellent Community engagement & ownership**
- **Improved coordination, partnership and contribution from development partners**

Future direction…. The second generation rural HEP

Includes:

- Upgrading HEWs to level IV Community Health Nurses: additional one year training
- Revision of the Health Extension Packages
- Renovation and expansion of health posts,
- Equipping and supplying health posts with the necessary equipments and supplies,
- Enhance Community engagement and shifting basic services to the community level and institutionalizing the HDA platform.
- Share our experience to other countries

Key Challenges

Regional Inequity ….Pastoralist Areas

Photo: AMREF Canada

- Lower ratio of HEWs / population
- MOH needs to invest more resources in the 4 emerging regions
- Find innovative ways of adapting the HEP model so that it will work in a context of pastoralist / nomadic populations

Context of urban to implement HEP

- Complex life style
- poor Housing condition
- Complex socio-economic setting

Redesigning PHC

✓ Categorization based on income and health risk

✓Family health team approach

Thank You
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Annex IX

FMOH/EPHI
INTERNATIONAL INSTITUTE FOR PRIMARY HEALTH CARE
HEALTH SYSTEM TRAINING MODULE

Abebaw Derso
Clinton Health Access Initiative

16th August, 2016

Presentation Outline

- Overview of the Health System Module Units
- Learning Objectives of the Health System Module
- The FMOH's Vision and Mission
- Ethiopia's Health Policy and System Overall
- Case Study

Purpose of the Module

- This module is prepared for parliamentarians/policy makers, health programmers, and primary health practitioners who need to work to promote health for all through strengthening primary health care.
- The module will serve as a practical guide to promote, implement, and scale up primary health care.
- It enhances the theoretical knowledge and skills acquired in different setting within the health system

Core Learning Objectives

After the completion of each module, you will be able to:

1. Describe the main features of the Ethiopian healthcare system and compare it with yours.
2. Analyze the achievements and challenges of Ethiopian healthcare system and develop an action plan to strengthen your healthcare system.

Vision and Mission

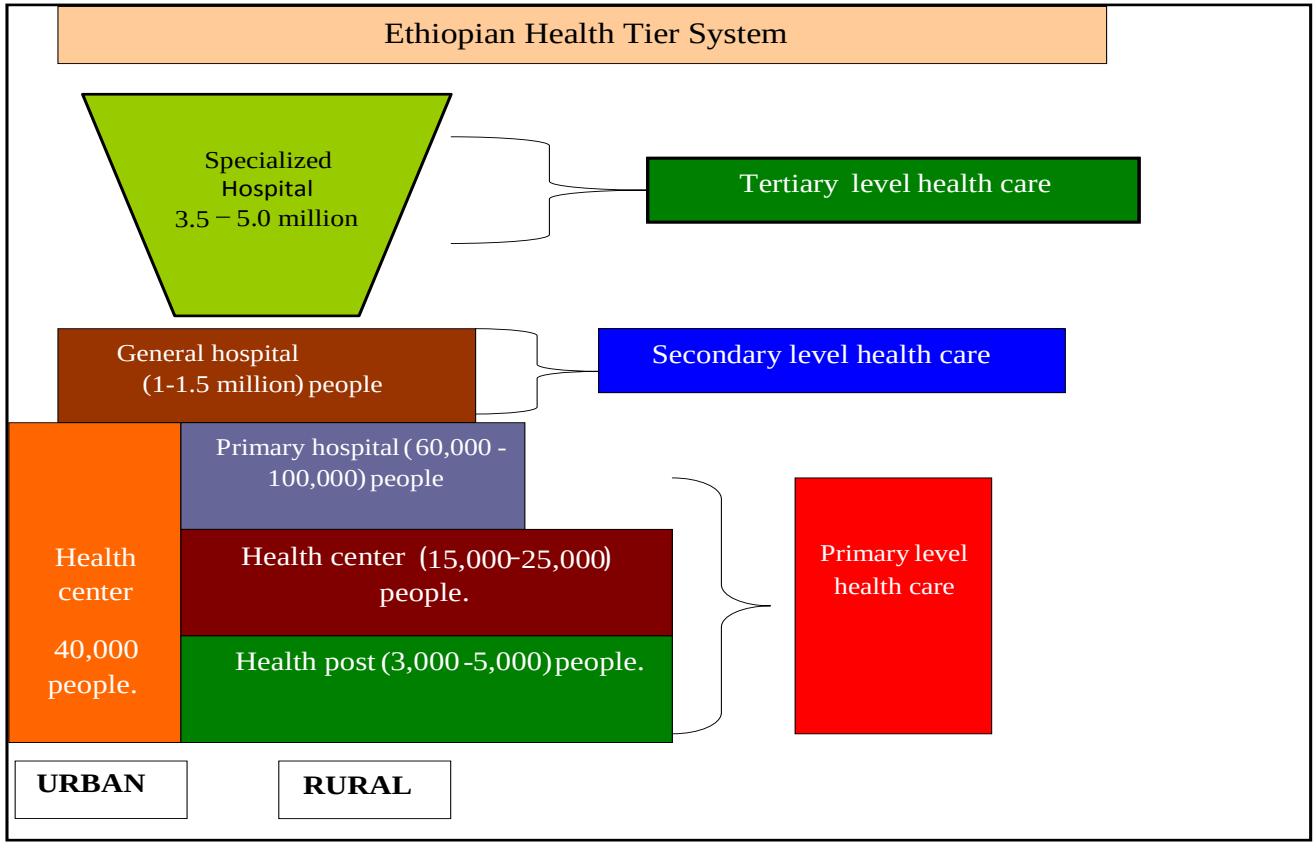
Vision

- “To see healthy, productive and prosperous Ethiopians”

- **Mission**

- To promote health and wellbeing of Ethiopians through **providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services of the highest possible quality in an equitable manner.”**

Ethiopian Healthcare System



Ethiopian Healthcare Policy

The Health Policy of Ethiopia is the result of a critical examination of the nature, magnitude and root causes of the prevailing health problems of the country and awareness of newly emerging health problems

General Policy Directions-1

1. Democratization and decentralization.
2. Development of the preventive and promotive components of health care.
3. Development of an equitable and acceptable standards.
4. Promoting and strengthening of intersectoral activities.
5. Health Development Army.
6. Collaboration with neighbouring countries.

7. Development of appropriate capacity building based on assessed needs.

8. Provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford to pay

9. Promotion of the participation of the private sector and nongovernmental organizations in health care.

Ethiopian health system evolution, organizational structure and function

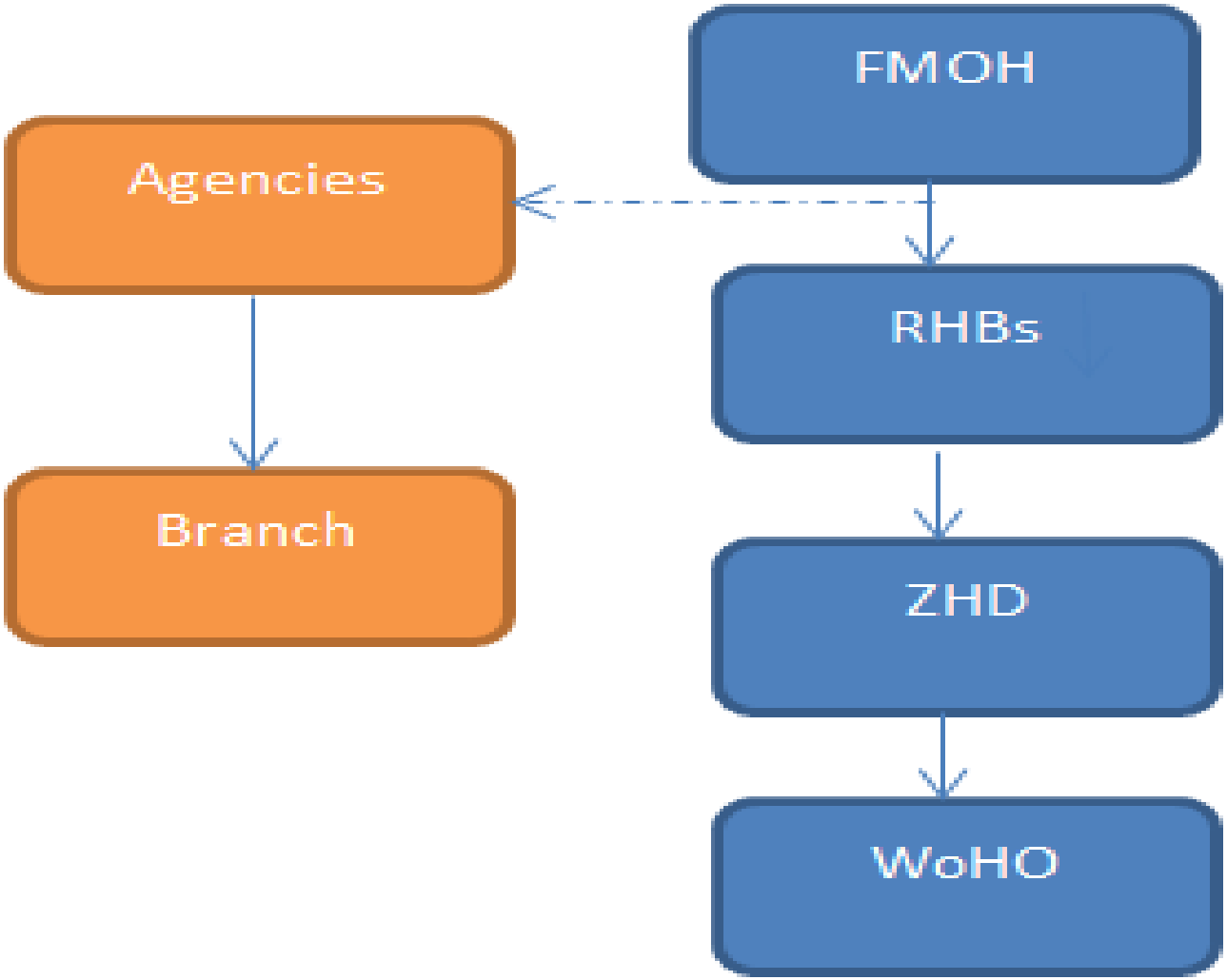
- In 1947, the first Ethiopian health legislation, known as “Public Health Proclamation of 1947”, was formulated and stated that the government was in charge of the health of the people. This proclamation laid a cornerstone in the establishment of the Ministry of Health (MOH) in 1948

- The reconstruction (hospitals/clinics) period (1941-1953)
- The basic health services period (1953-1974)
- The primary health care period (1974-1991)
- The sector wide approach period (1991-)

Current structure and function

- Currently the Ethiopian health system structurally organized in consisting of the Federal Ministry of Health, Regional Health Bureau, Zonal Health Office and Woreda Health office

Structure



Mandates of the FMOH

- Initiate policies and laws, prepare plans and budget, and upon approval implement same;
- Ensure the enforcement of laws, regulations and directives of the Federal Government
- Undertake studies and researches;
- Enter into contracts and international agreements in accordance with the law; Give assistance and advice as necessary to Regional executive organs.

- The agencies focus on ensuring safety, efficacy, quality and proper use of drugs; improving the knowledge, attitude, behavior and practice of the population on prevention and control of disease and healthy life style; conducting public health and nutrition researches and studies.

- The autonomous health institutions report both to FMOH and to MOFED.

Mandates of RHBs

- Prepare, on the basis of the health policy of the country, the health care plan and program for the people of the region, and to implement same when approved;
- Ensure the adherence of health laws, regulations and directives issued pertaining to public health in the region;

- Organize and administer hospitals, health centers, Health Posts, research and training institutions that are established by the regional government;
- Issue license to health centers, clinics, laboratories and pharmacies to be established by NGOs, OGAs and private investors; supervise same to ensure that they maintain the national standards.
- Ensure that professionals who are engaged in public health services in the region operate within standards;

- Ensure adequate and regular supply of effective, safe and affordable essential drugs, medical supplies and equipment in the region;
- Cause the application, together with modern medicine, traditional medicines and treatment methods whose efficiency is ascertained; -
- Cause the provision of vaccinations, and take other measures, to prevent and eradicate communicable diseases

Mandates of Woreda Health Offices

- The mandate of woreda health offices is to manage and coordinate the operation of the primary health care services at woreda levels.
- They are responsible for planning, financing, monitoring and evaluating of all health programs and service deliveries in the woreda.

HSTP Transformational Agendas

- **Transformation in equity and quality of health care**
  - Equal access to essential health services
  - Equal quality of care for all
- **Information Revolution**
  - reforming the methods and practice of collecting, analyzing, presenting and disseminating information
- **Woreda Transformation**
  - Aims to narrow the gap b/n the high and low performing woredas.
  - Transforming PHCU
- **Caring, Respectful and Compassionate Health**

Thank You!

Annex X

Primary Health Care, Community Health, and Community Health Workers

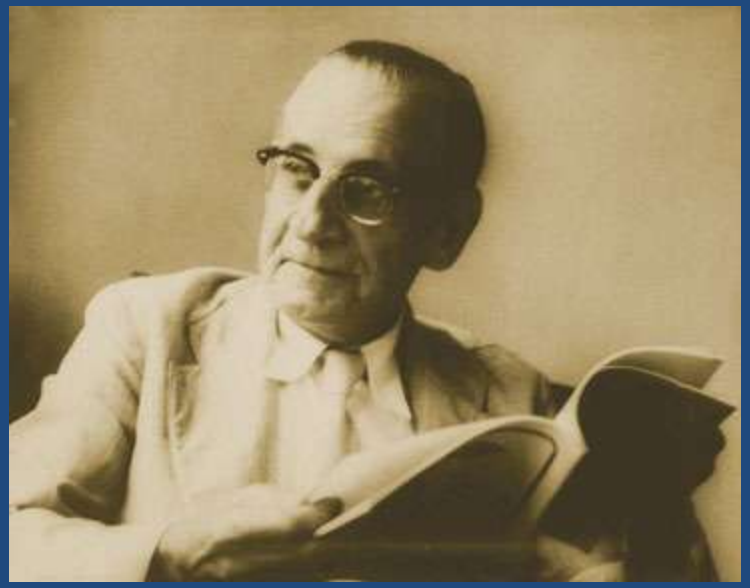
Henry Perry, MD, PhD, MPH
Health Systems Program
Department of International Health

Outline

- Historical perspectives
- Conceptual models of PHC
- The emergence of community-based PHC and the re-emergence of CHWs

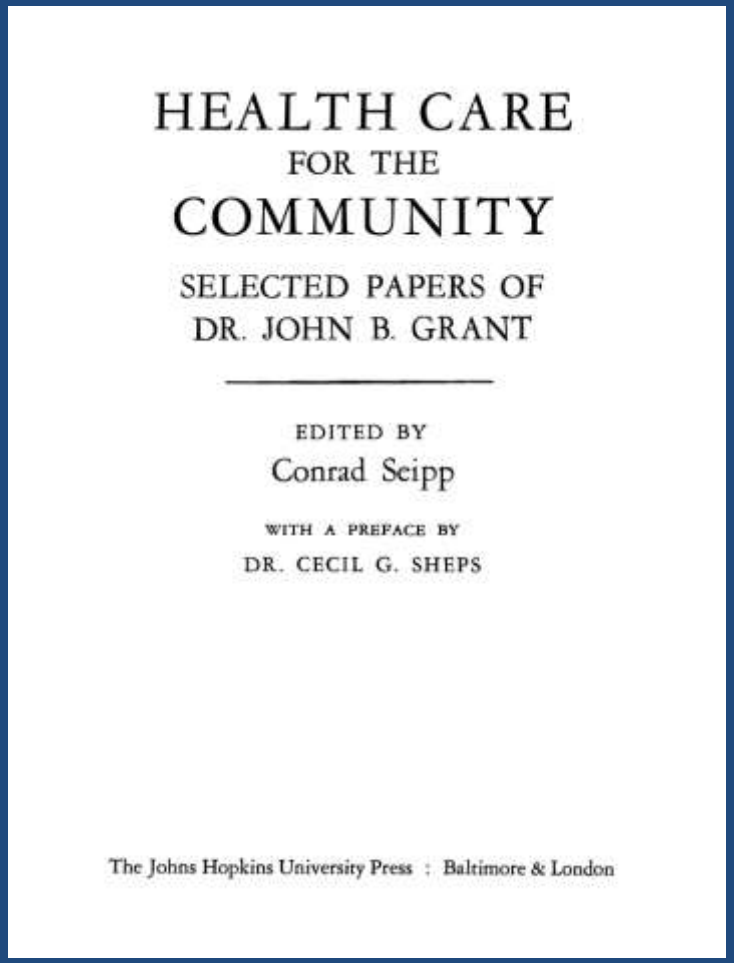
John B. Grant, Father of Primary Health Care and of Jim Grant

J.B. Grant with the 2nd District, Department of Public Health of Peking, China, in 1933



The “Bible” of Primary Health Care

Links the community to health systems, to development more broadly, and to training and research


HEALTH CARE
FOR THE
COMMUNITY

SELECTED PAPERS OF
DR. JOHN B. GRANT

EDITED BY
Conrad Seipp

WITH A PREFACE BY
DR. CECIL G. SHEPS

The Johns Hopkins University Press : Baltimore & London

1963

Ding Xian, 1930s
The Prototype of the Barefoot Doctor

- First example of primary health care (in the Alma Ata sense)

- Trained “farmer scholars” to record vital events, vaccinate against smallpox, administer simple treatments, give health education talks, and maintain wells

John Gordon, Professor of Epidemiology, Harvard School of Public Health, 1940s and 1950s, and Mentor of Carl Taylor and John Wyon

Worked with John Grant and the Rockefeller Foundation in China in the 1930s

Routine systematic home visitation for surveillance

Towering Figures in the Development and Evolution of Primary Health Care

Halfdan Mahler, Director General of the World Health Organization, 1973 - 1988

James Grant, Executive Director of UNICEF, 1980-1995

Carl Taylor, 1916-2010

Carl Taylor

- "The acknowledged leader of primary care over the second half of the 20th century"
  - John Rohde, Special Assistant to James Grant, UNICEF Executive Director, 1980-1995

- "He is the greatest public health expert I have come across"
  - Halfdan Mahler, W.H.O. Director General, 1973-1988

Drs. John and Elizabeth Taylor were Medical Missionaries to India for 53 years

Camp Life during Carl Taylor's Childhood

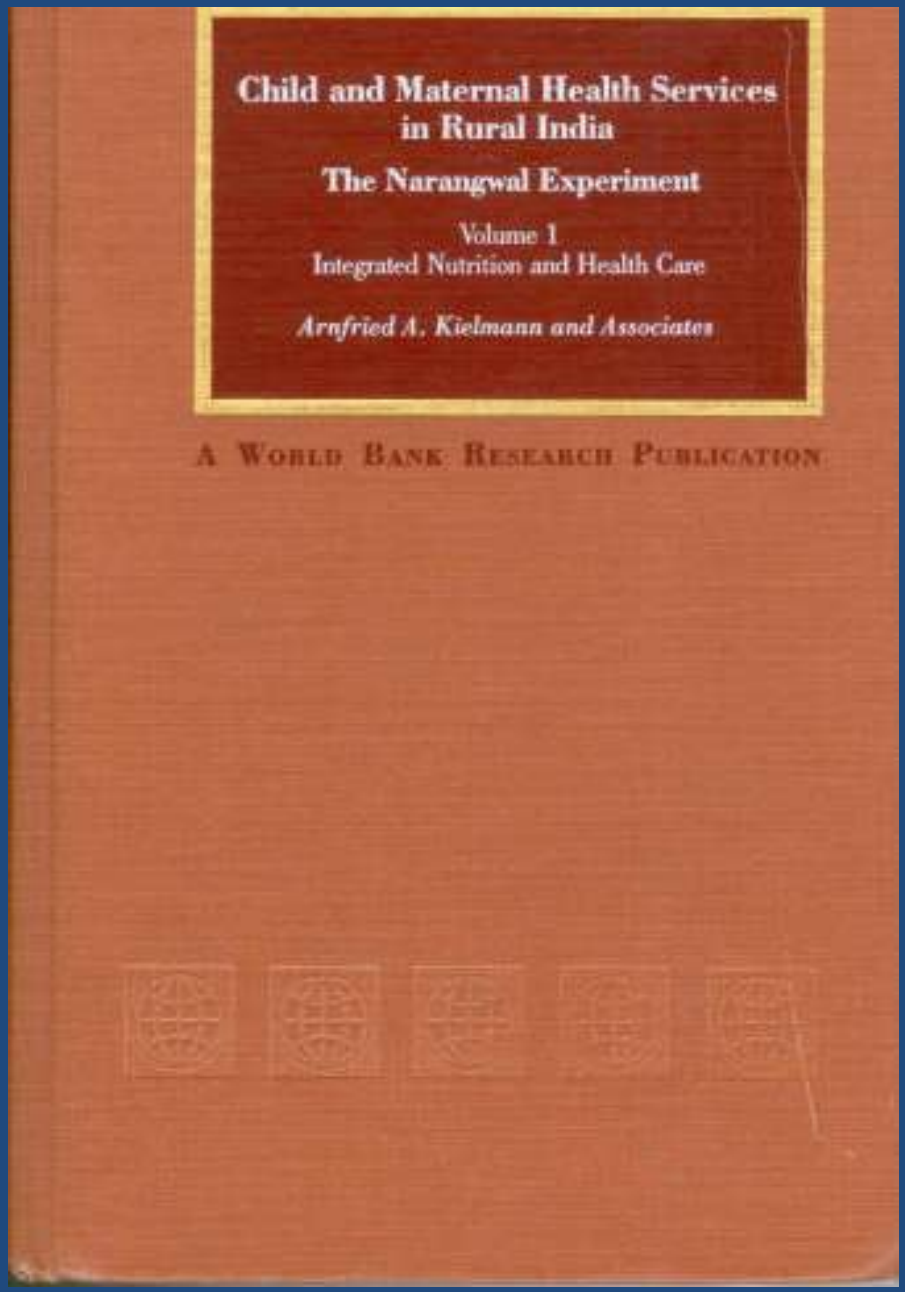
Carl Taylor (far left) with His Parents and Siblings

Carl Taylor (center, in shorts) with John Wyon (center to left of Carl Taylor) with Village Leaders in Khanna

The Narangwal Project, 1965-73

Narangwal Community-based Activities

Engagement of High-Level Ministry of Health Officials in Reviewing Project Progress


Child and Maternal Health Services in Rural India
The Narangwal Experiment
Volume 1
Integrated Nutrition and Health Care
Arnfried A. Kielmann and Associates
A World Bank Research Publication

Prelude to 1978 Alma-Ata Conference

- Medical mission hospitals
- Christian Medical Commission
- Health by the People monograph
- Top-down, medical model of curative care not relevant for 80% of the world's population
- Carl Taylor special consultant to Halfdan Mahler in preparation for conference – played key "behind the scenes" role in writing Alma-Ata Declaration

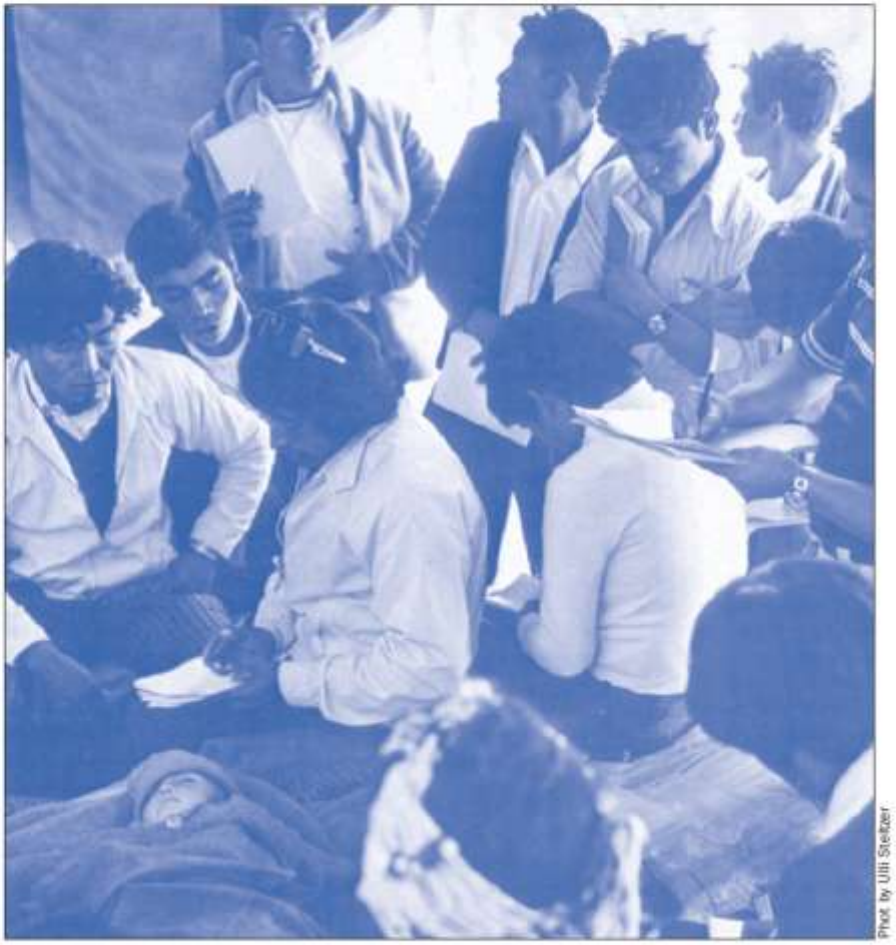
Christian Medical Commission Survey

- Health of people who lived close to a mission hospital was no better than people who lived further away
- How could this be?

The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach

| Socrates Litsios, ScD

The primary health care approach was introduced to the World Health Organization (WHO) Executive Board in January 1975. In this article, I describe the changes that occurred within WHO leading up to the executive board meeting that made it possible for such a radical approach to health services to emerge when it did. I also describe the lesser-known developments that were taking place in the Christian Medical Commission at the same time, developments that greatly enhanced the case for primary health care within WHO and its subsequent support by nongovernmental organizations concerned with community health.



Phot. by Ulli Steltzer

Health promoters at the bedside of a sick child, Chimaltenango Hospital.

HEALTH BY THE PEOPLE

Edited by

KENNETH W. NEWELL

Director,
Division of Strengthening of Health Services,
World Health Organization,
Geneva, Switzerland

WORLD HEALTH ORGANIZATION
GENEVA
1975

International Conference on Primary Health Care, Alma Ata, Kazakhstan, 1978

Health for All by the Year 2000

Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

- Why hasn’t this vision of Primary Health Care become the organizing framework for health improvement in poor countries?
- How is it unrealistic and naïve?
- How is it a timeless and enduring vision for global health?

Alma-Ata Definition of Primary Health Care

- Very different from the developed country concept of primary medical care
- Based on first principles – the key components available to any society for maximizing health and the conditions for promoting good health
- It broadens the medical model to include social and economic factors
- It is integrated and comprehensive but recognizes the importance of selective approaches
- "…honoured the resilience and ingenuity of the human spirit and made space for solutions created by communities, owned by them, and sustained by them."
  - Chan, 2008

Spirit of Alma Ata in Words of Raj Arole

- “Health services, no matter how efficient, cannot change the condition of the marginalized people unless they are helped to become self-reliant and the root problems addressed…. People who are poor and illiterate are like uncut gems hidden under the dirt and stone. Given the opportunity, they can reach their full potential and live as responsible, sensitive human beings, possessing self-reliance and the liberty to shed those old customs and traditions that impede health and development.”
  - Arole and Arole, 1994

(cont.)

- “Medicine needs to be demystified and knowledge shared freely with people so they can attain and maintain good health…. Hierarchical attitudes have to be replaced by a team spirit and equality. The realisation that knowledge not only gives power, but that sharing knowledge also increases self-esteem is important in the development of a team spirit.”
  - Arole and Arole, 1994

Challenges That Arose to the Alma Ata Vision

- Too broad and idealistic with an unrealistic time table
- Selective approaches gained support from the donor community
- The “twin engines” of EPI and ORS
- GOBI-FFF (growth monitoring, oral rehydration, breastfeeding, immunizations, food supplementation, female literacy, family planning)
  - Easy to monitor and evaluate
  - Indicators of success and reporting

SPECIAL ARTICLE

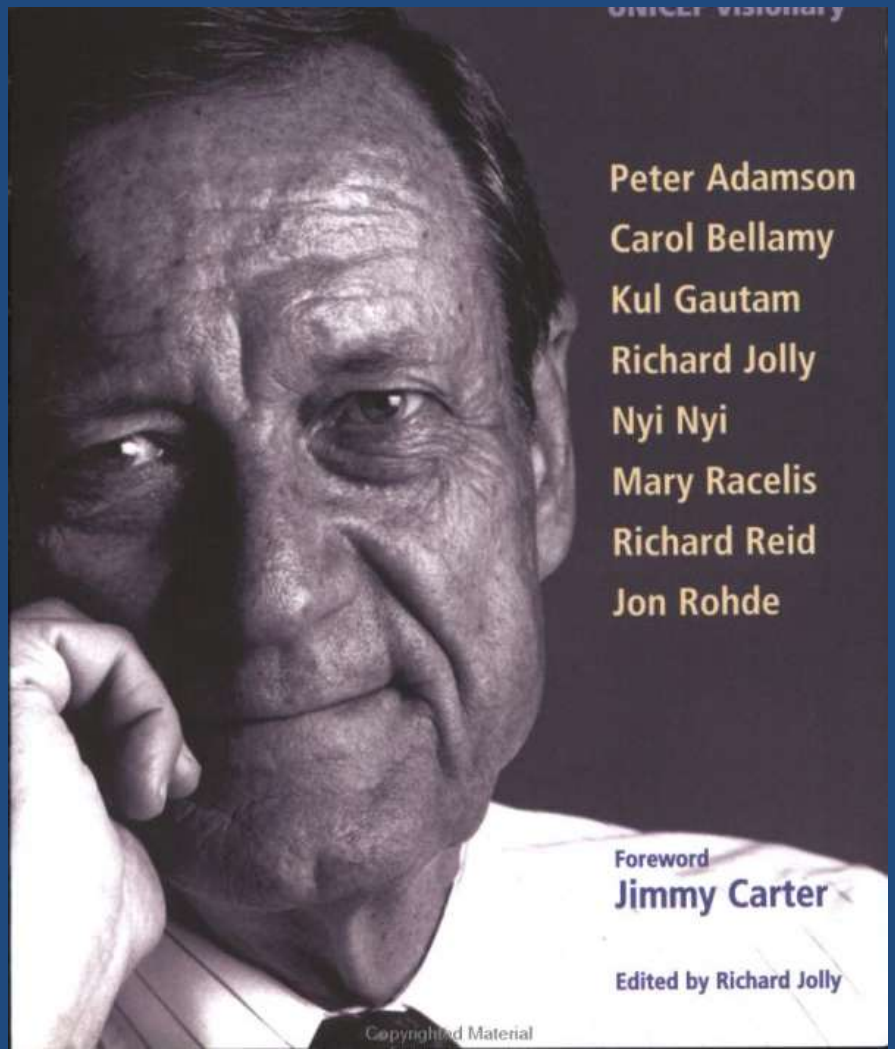
SELECTIVE PRIMARY HEALTH CARE

An Interim Strategy for Disease Control in Developing Countries

JULIA A. WALSH, M.D., AND KENNETH S. WARREN, M.D.

Abstract Priorities among the infectious diseases affecting the three billion people in the less developed world have been based on prevalence, morbidity, mortality and feasibility of control. With these priorities in mind a program of selective primary health care is compared with other approaches and suggested as the most cost-effective form of medical intervention in the least developed countries. A flexible program delivered by either fixed or mobile units might include measles and diphtheria–pertussis–tetanus vaccination, treatment for febrile malaria and oral rehydration for diarrhea in children, and tetanus toxoid and encouragement of breast feeding in mothers. Other interventions might be added on the basis of regional needs and new developments. For major diseases for which control measures are inadequate, research is an inexpensive approach on the basis of cost per infected person per year. (N Engl J Med 301:967-974, 1979)

James Grant, Executive Director of UNICEF, 1980-1995



Reasons for Rapid Loss of Momentum of Health for All Movement

- WHO leadership and country level weak (and medical orientation of the World “Disease” Organization)
- Lack of strong successes to build on (and lack of strong scientific evidence of progress)
- Cold War politics – association of Health for All with a communist/socialist agenda
- Loss of financial resources in Ministries of Health during the global financial crisis of the 1980s

Unresolved Dilemmas between Alma-Ata PHC and Selective PHC

- Diseases in less-developed countries are socially and economically sustained and need a political response to make real progress (addressing the social determinants of health)
- The major diseases in poor countries are a natural (not social) reality that require technical solutions (addressing the biomedical determinants of health)
- What should be the proper balance between selective and comprehensive approaches? Is there a “middle way”?

Selective Disease-Specific Approaches Are the Dominant Form of Global Funding Today

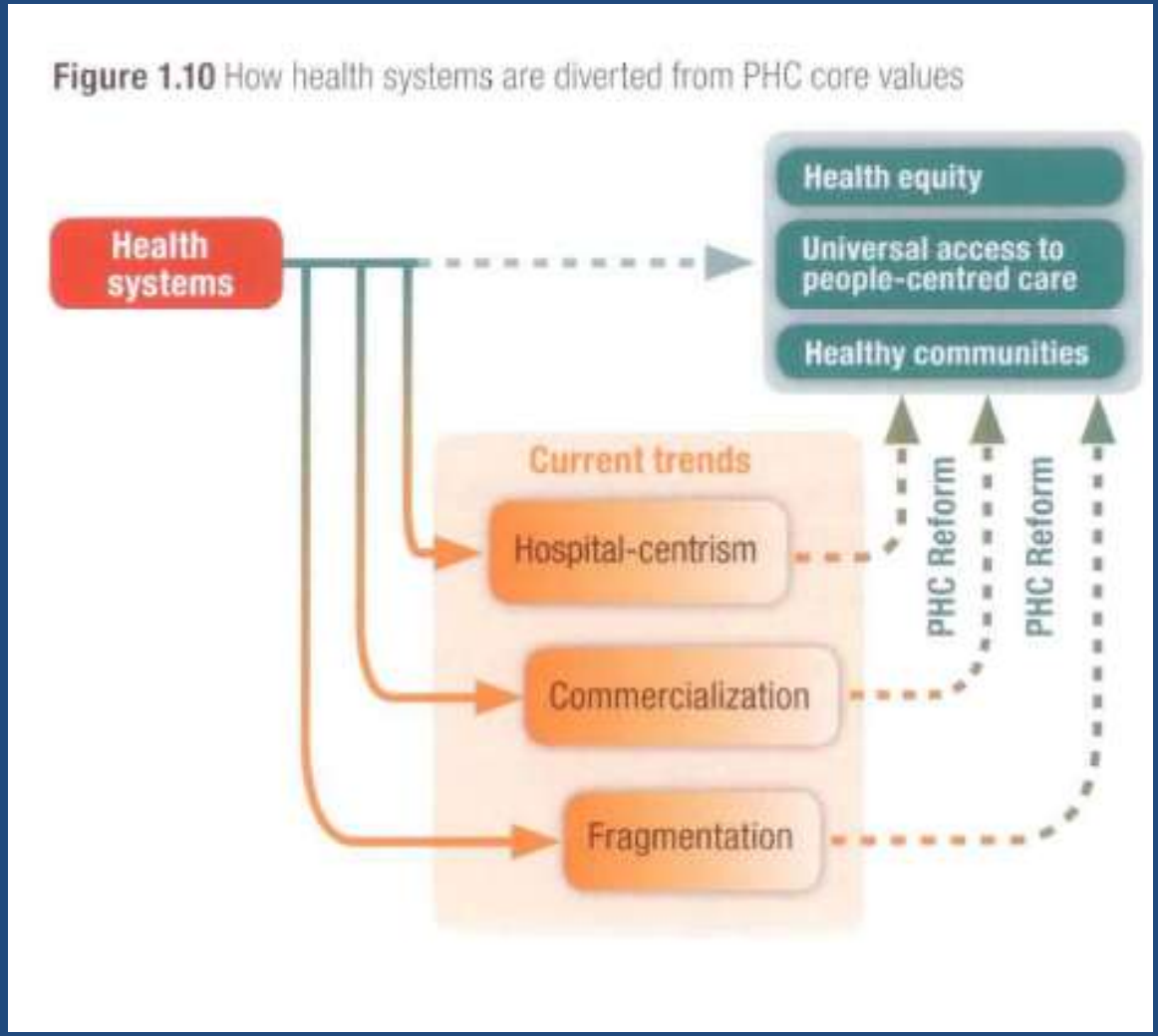
- PEPFAR
- Global Fund to Fight AIDS, Tuberculosis and Malaria
- President's Malaria Initiative
- GAVI and Global Polio Eradication Initiative

- But widespread agreement that more emphasis on horizontal/integrated/systems strengthening approaches also needed

Are We All “Diagonalists” Now?

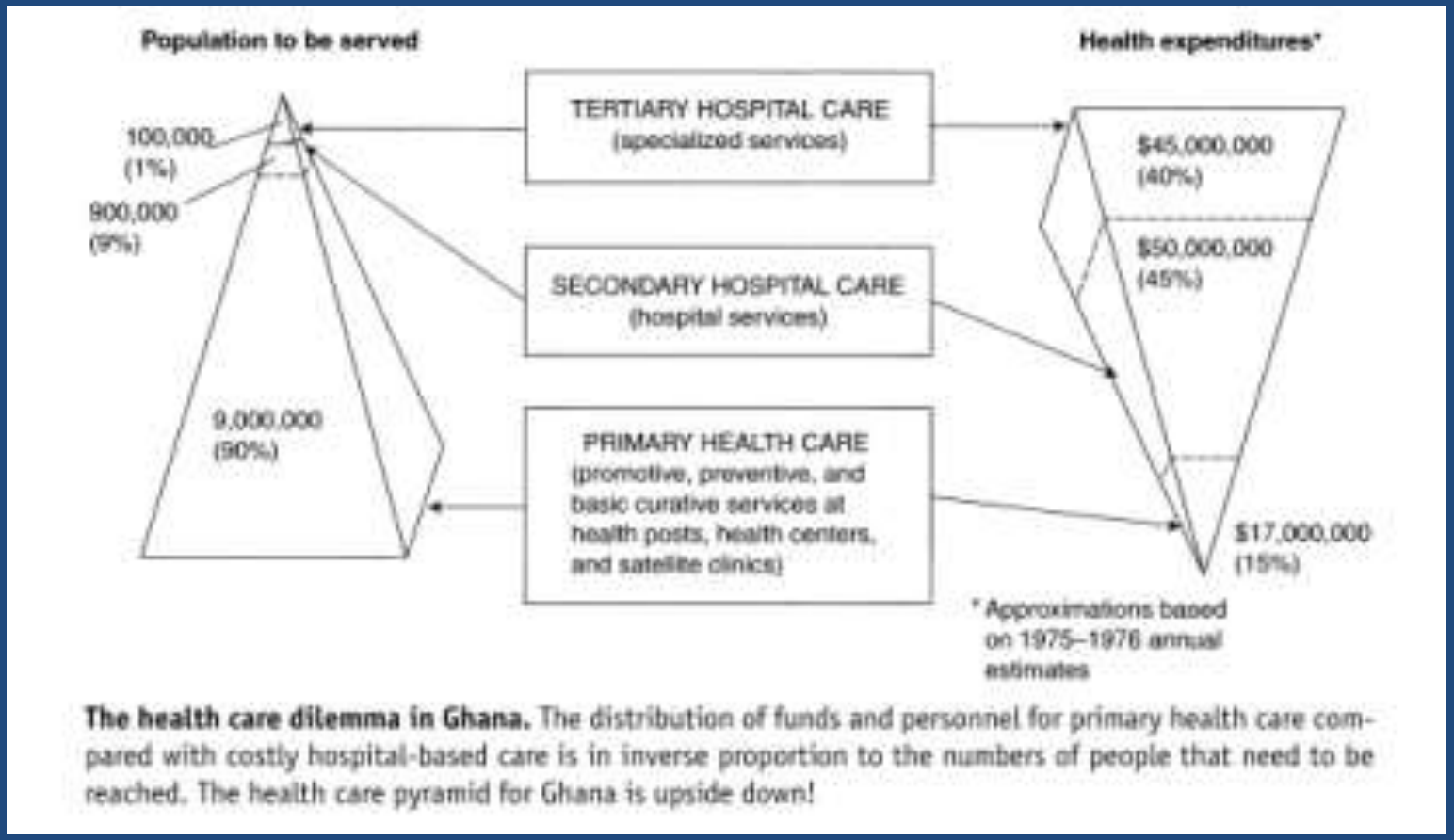
- Both vertical and horizontal programs need to co-exist
- Horizontal: integrated, demand-driven, resource-sharing health services
- Vertical: focuses, proactive, disease-specific interventions
  - Sepulvida et al., 2006

Other Detractors to Strong Primary Health Care Programs



WHO, 2008 (Primary Health Care: Now More Than Ever)

Hospital-Centrism: Health Systems Built around Hospitals and Specialists



The health care dilemma in Ghana. The distribution of funds and personnel for primary health care compared with costly hospital-based care is in inverse proportion to the numbers of people that need to be reached. The health care pyramid for Ghana is upside down!

Source: MOH, Republic of Ghana, *A Primary Health Care Strategy for Ghana*, 1978

Public Health and Primary Health Care

"Public health is the science and art of social utilization of scientific knowledge for medical protection by maintaining health, preventing disease, and curing disease through organized community efforts."

-- John Grant, 1940

There are three kinds of public health: disease-oriented, service-oriented, and community-oriented. Each complements the other like the legs of a three-legged stool.

-- John Wyon, 1990

Primary Health Care: What Do the Words Mean?

- Primary
  - First contact
  - Basic (some would say “inadequate quality”)
  - Essential (is emergency simple inexpensive life-saving surgery or life-promoting surgery such as C-section and cataract surgery primary health care?)
  - Addressing “first causes” (multi-sectoral, including education, nutrition and water and sanitation)

- Health or Health Care
  - Preventive and curative medical services
  - Biomedical disease orientation (and passive recipient of medical services) versus creating conditions/ environments that are healthy or health-promoting
  - Health as a “social phenomenon whose determinants cannot be neatly separated from other social and economic determinants”
  - Social/community/household/behavioral determinants of health

Primary Health Care: An Ambiguous Mental Model?

- Medical care system delivery concept vs. multi-sectoral Alma Ata concept
- Health system model vs. production of health model (World Health Organization vs. World "Disease" Organization) – household production of health model
- Facility-based care versus community-based primary health care

The World Health Report **2008**

Primary Health Care

Now More Than Ever

World Health Organization

THE LANCET

Volume 372 · Number 9642 · Pages 863-1008 · September 13-19, 2008 www.thelancet.com

Alma-Ata 30 years on:

"Health for all need not be a dream buried in the past."

See Editorial page 863

Five PHC Frameworks

- Alma Ata
- Community-Oriented Primary Health Care
- CBPHC: Community-based primary health care
- CBIO: Census-based, impact-oriented approach
- Care Groups/Participatory Women's Groups

Alma Ata Concept of PHC

- "… essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford …"
- It addresses the main health problems in the community
- Includes promotive, preventive, curative, and rehabilitative services

(cont.)

- Includes:
  - Promotion of food supply and proper nutrition
  - Adequate supply of safe water and basic sanitation
  - Maternal and child health care, including family planning and immunizations
  - Prevention and control of locally endemic diseases
  - Appropriate treatment of common diseases and injuries
  - Provision of essential drugs

(cont.)

- Includes as well:
  - Agriculture
  - Animal husbandry
  - Food
  - Education
  - Housing
- Requires and promotes:
  - Maximum community and individual self-reliance and participation in planning, organization, operation and control of PHC

(cont.)

- Should be sustained and integrated into functional and mutually supportive referral systems leading to comprehensive health care for all and giving priority to those most in need
- Relies on physicians, nurses, midwives, auxiliaries and communities workers as applicable – as well as traditional practitioners as needed – to work as a health team and to respond to the health needs of the community

Key Alma-Ata Concepts

The three “pillars” of Alma-Ata

- Equity
- Community participation
- Inter-sectoral development

COPC

South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde
P.O. Box 643, Cape Town Posbus 643, Kaapstad
Vol. 26, No. 6 Cape Town, 9 February 1952 Weekly 2s 6d

THE PHOLELA HEALTH CENTRE

A PROGRESS REPORT *

SIDNEY L. KARK, M.B., B.CH.
Institute of Family and Community Health, Durban
and
JOHN CASSEL, B.SC., M.B., B.CH.
Pholela Health Centre, Bulwer, Natal

Community-based Primary Health Care

- Services provided outside of health facilities
- Usually provided by some type of community-based worker

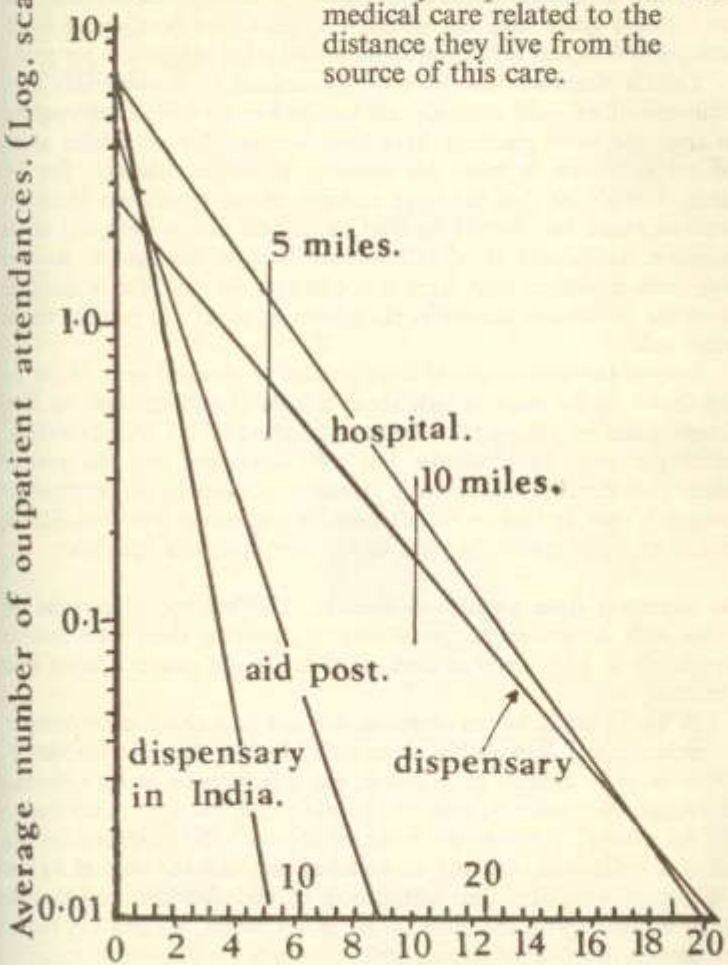
Examples of Community-Based Primary Health Care

- BRAC Health Program
- Community-based family planning
- Community IMCI (Integrated Management of Childhood Illness)

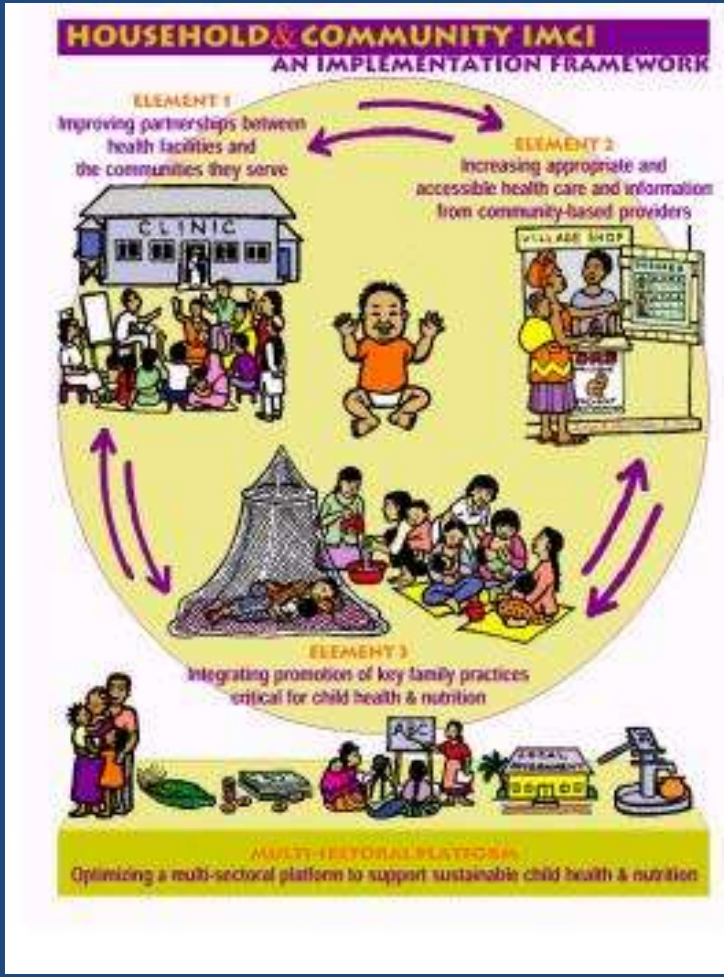
Integrated Management of Childhood Illness (IMCI)

- Facility-based IMCI
- Community-based IMCI

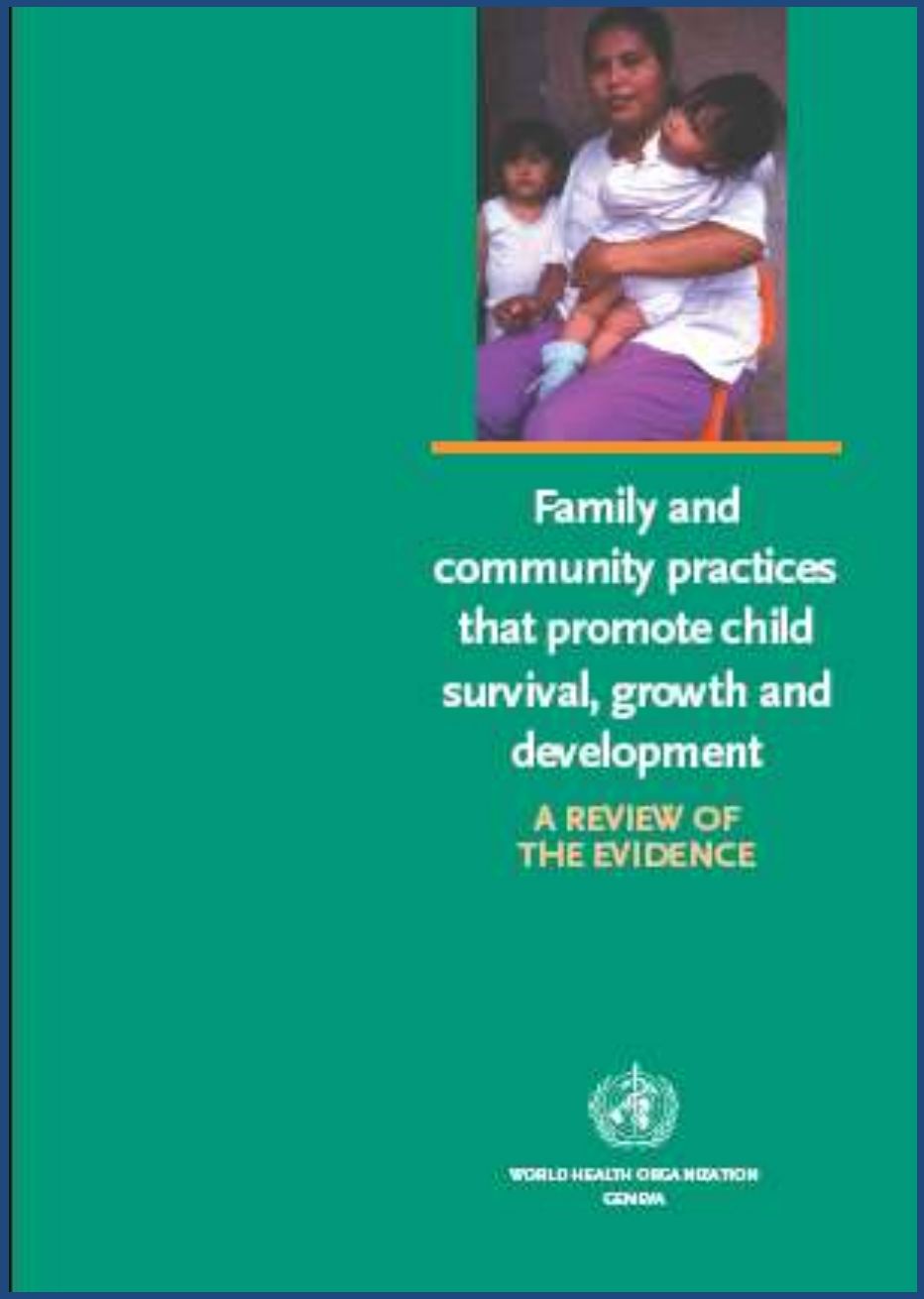
Fig. 6. The average number of times annually outpatients attend for medical care related to the distance they live from the source of this care.



King, 1966


HOUSEHOLD & COMMUNITY IMCI
AN IMPLEMENTATION FRAMEWORK
ELEMENT 1
Improving partnerships between health facilities and the communities they serve
ELEMENT 2
Increasing appropriate and accessible health care and information from community-based providers
CLINIC
VILLAGE SHOP
ELEMENT 3
Integrating promotion of key family practices critical for child health & nutrition
MULTI-SECTORAL PLATFORM
Optimizing a multi-sectoral platform to support sustainable child health & nutrition


COMMUNITY CASE MANAGEMENT (CCM)
of Sick Children
Children Who Benefit
Basic Medicine & Supplies
Community Health Care
Family Support
Community Support



http://whqlibdoc.who.int/publications/2004/9241591501.pdf

A Review of the Evidence

How Effective Is Community-Based Primary Health Care in Improving the Health of Children?

Summary Findings
Report to the Expert Review Panel

Henry Perry[1] and Paul Freeman[2], Study Directors

Sundeep Gupta[3] and Bahie Mary Rassekh[4], Study Coordinators

Community-Based Primary Health Care Working Group, International Health Section American Public Health Association

7 July 2009

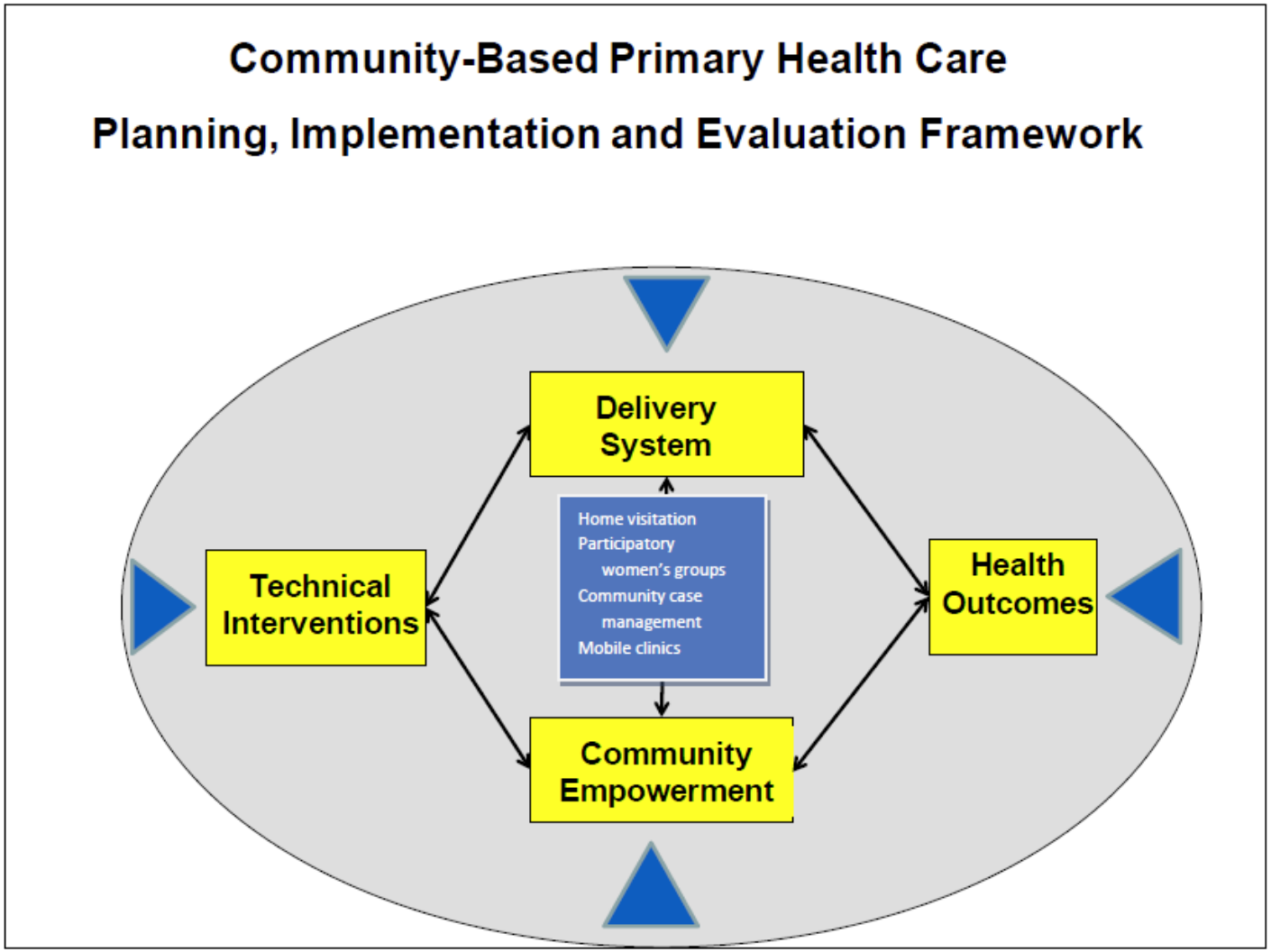


Figure 2. A conceptual framework for planning, implementing and evaluating the effectiveness of proven technical interventions in routine field situations at scale

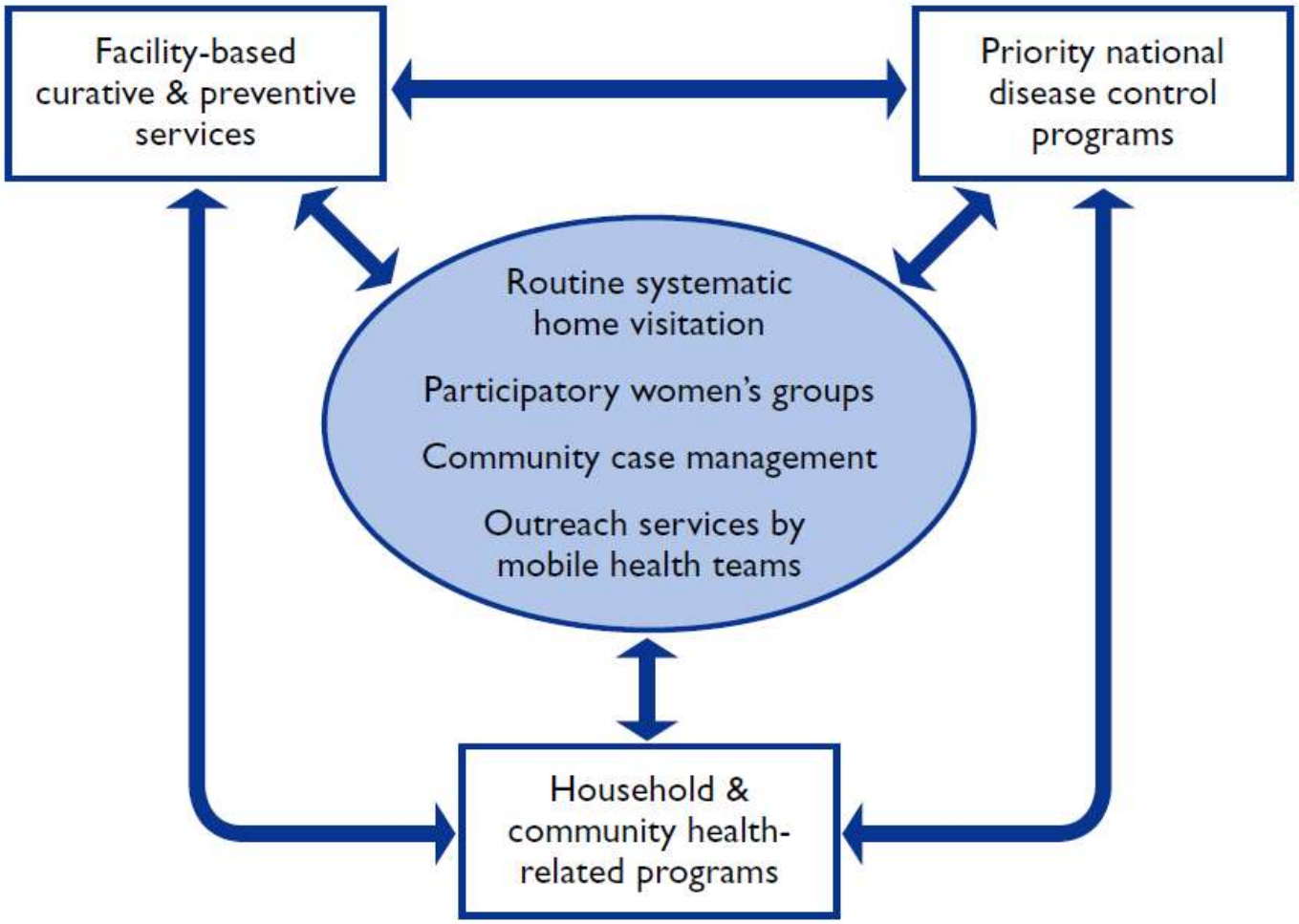
Note: Blue triangles represent contextual factors.

Framework of Public Health (the Health of the Public)

- Disease-oriented public health
  - Control specific diseases or conditions
- Services-oriented public health
  - Ensure that those who need services get them
- Community-oriented public health
  - Work with communities to help them improve their health

- All three are equally important and are like the legs of a three-legged stool
  - John Wyon

FIGURE 1: FRAMEWORK FOR MAXIMUM IMPROVEMENT IN COMMUNITY HEALTH



Community Systems Strengthening Framework
January 2010

Global Fund to fight AIDS, Tuberculosis and Malaria

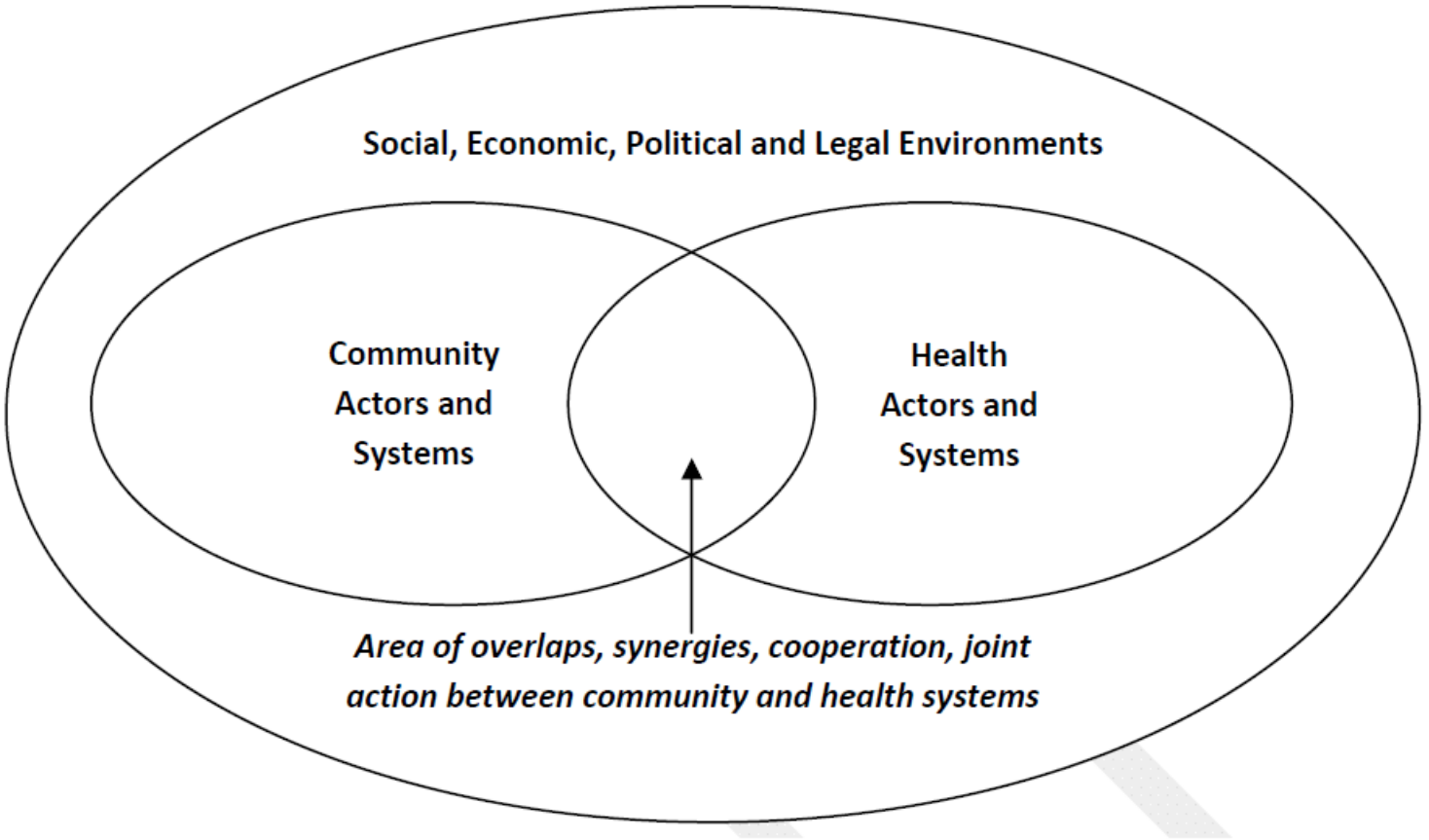


Figure 1: Community and health actors & systems – complementary and connected

Examples of Types of Community Involvement/Participation

At community leadership level

- Village health committees
- Associations of village health committees
- Village development committees
- Health action committees
- Community leadership committees
- Meetings with chiefs/mayors/elders/imams
- Imams as community mobilizers
- Community meetings/assemblies
- Community pharmacies
- Self-sufficient maternity homes

At household level

- Health days (for community clean up)
- Model mothers
- Competitions among mothers for healthiest babies
- Breastfeeding support groups
- Husbands and mothers-in-law as targets for messages
- Pregnant women's groups
- Mothers' clubs
- Child clubs

CBIO Framework

PERGAMON

Social Science & Medicine 48 (1999) 1053–1067

SOCIAL SCIENCE & MEDICINE

Attaining health for all through community partnerships: principles of the census-based, impact-oriented (CBIO) approach to primary health care developed in Bolivia, South America

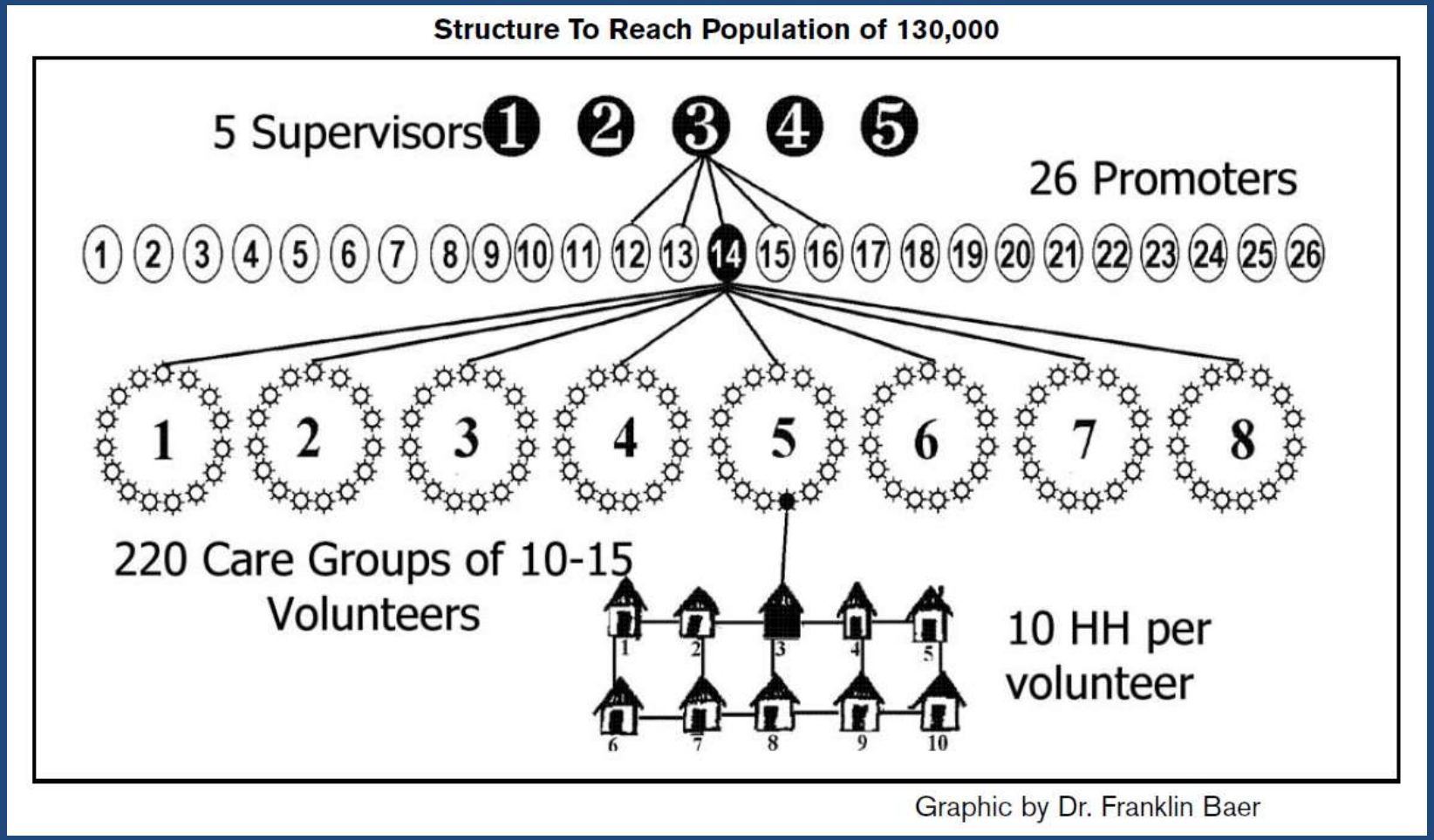
Henry Perry[a,*], Nathan Robison[b], Dardo Chavez[c], Orlando Taja[d], Carolina Hilari[b], David Shanklin[e], John Wyon[f]

Participatory Women's Groups/ Care Groups

- Care Group model
- Facilitated women's groups
- BRAC Village Organizations

Pieter Ernst, Pioneer Developer of the Care Group Model

The World Relief Original Care Group Program in Gaza Province, Mozambique



Examining the evidence of under-five mortality reduction in a community-based programme in Gaza, Mozambique

Anbrasi Edward[a], Pieter Ernst[b], Carl Taylor[a,*], Stan Becker[c], Elisio Mazive[d], Henry Perry[e]

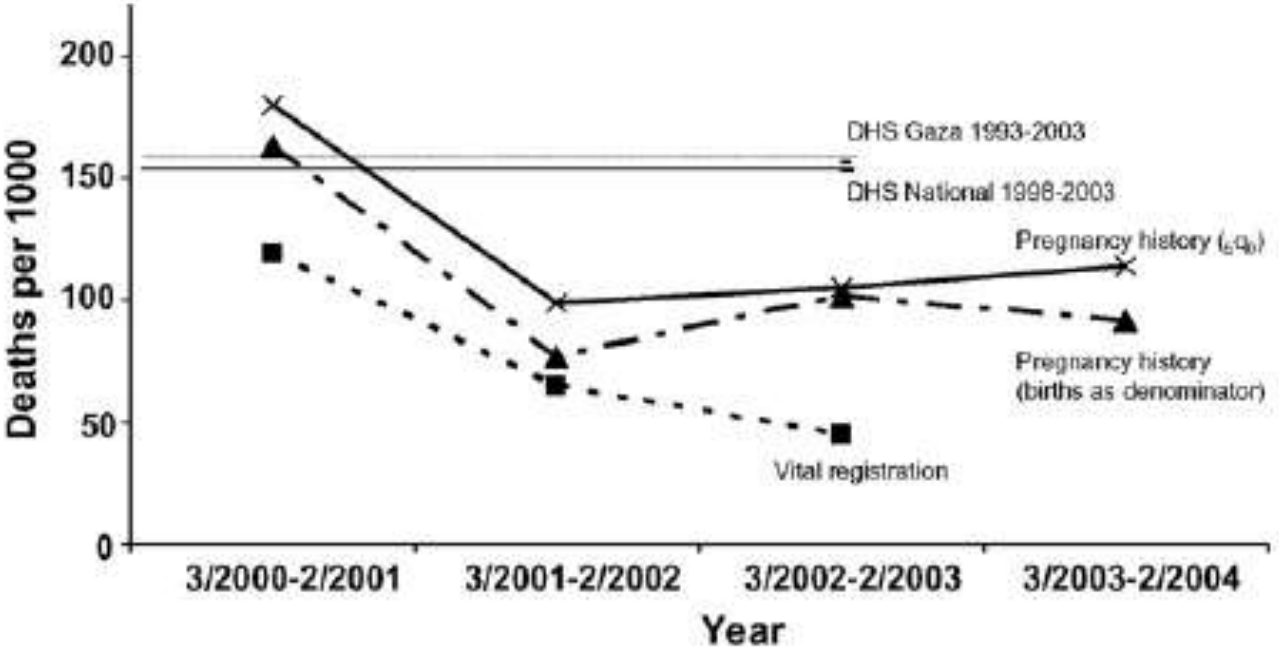


Figure 3 Under-five mortality in Chokwe district, 2000—2004. DHS: Demographic and Health Survey.

Transactions of the Royal Society of Tropical Medicine and Hygiene (2007) 101, 814—822

Table 2 Estimates (and 95% CI) of care-seeking and behavioural change practices of caretakers

Process indicator	Baseline (Oct. 1999)		Final (July 2003)	
	N	% (95% CI)	*N*	% (95% CI)
Mothers reporting initiation on BF within 1 h of delivery	—	—	299	71
Children with diarrhoea treated with ORT	115	53 (43.9–62.1)	110	94 (89.6–98.4)
Children with diarrhoea given extra food for 2 weeks following diarrhoea episode	115	4 (4.2–7.6)	110	87 (80.7–93.3)
Households with latrines	300	28 (10.4–45.6)	300	75 (70.1–79.9)
Children who slept under ITN the previous night	0	—	240	85 (80.5–89.5)
Children with fever treated at health centre/post within <24 h	25	28 (10.4–45.6)	20	90 (76.9–103..2)
Children with fast or difficult breathing treated at health centre/post within <24 h	50	2 (1.9–5.9)	15	60 (35.2–84.8)
Children with severe malnutrition (< −3 Z-scores)	—	—	265	14 (9.82–18.2)
Mothers reporting increased food intake (past pregnancy)	300	44 (38.4–49.6)	300	82 (77.7–86.4)
Mothers reporting delivery by trained provider (last pregnancy)	300	65 (59.6–70.4)	300	87 (83.2–90.8)
Children fully immunised	128	74 (66.4–81.6)	123	89 (83.5–94.5)
Caretakers who knew three ways to prevent STIs/AIDS	300	0.3 (0.3–0.9)	300	56 (50.4–61.6)

BF: breastfeeding; ORT: oral rehydration therapy; ITN: insecticide-treated bed net; STI: sexually transmitted infection.

Reducing child global undernutrition at scale in Sofala Province, Mozambique, using Care Group Volunteers to communicate health messages to mothers

Thomas P Davis, Jr,[a] Carolyn Wetzel,[a] Emma Hernandez Avilan,[b] Cecilia de Mendoza Lopes,[c] Rachel P Chase,[d] Peter J Winch,[d] Henry B Perry[d]

Findings: More than 90% of beneficiary mothers reported that they had been contacted by CGVs during the previous 2 weeks. In the early implementation project area, the percentage of children 0–23 months old with global undernutrition (weight-for-age with z-score of less than 2 standard deviations below the international standard mean) declined by 8.1 percentage points ($P<0.001$), from 25.9% (95% confidence interval [CI]=22.2%–29.6%) at baseline to 17.8% at endline (95% CI=14.6%–20.9%). In the delayed implementation area, global undernutrition declined by 11.5 percentage points ($P<0.001$), from 27.1% (95% CI=23.6%–30.6%) to 15.6% (95% CI=12.6%–18.6%). Total project costs were US$3.0 million, representing an average cost of US$0.55 per capita per year (among the entire population of 1.1 million people) and US$2.78 per beneficiary (mothers with young children) per year.

Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial

Lancet 2004; 364: 970–79

See Comment page 914

Dharma S Manandhar, David Osrin, Bhim Prasad Shrestha, Natasha Mesko, Joanna Morrison, Kirti Man Tumbahangphe, Suresh Tamang, Sushma Thapa, Dej Shrestha, Bidur Thapa, Jyoti Raj Shrestha, Angie Wade, Josephine Borghi, Hilary Standing, Madan Manandhar, Anthony M de L Costello, and members of the MIRA Makwanpur trial team

Mother and Infant Research Activities (MIRA), PO Box 921,

Figure 2: **Typical women's group meeting**
Picture courtesy of Thomas Kelly and Save the Children, USA.

Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis

- 7 randomized controlled trials
- 37% reduction in maternal mortality
- 23% reduction in neonatal mortality

Prost et al., Lancet, 2013

Engaging the Community as a Partner

Alma-Ata: Rebirth and Revision 5

Community participation: lessons for maternal, newborn, and child health

Mikey Rosato, Glenn Laverack, Lisa Howard Grabman, Prasanta Tripathy, Nirmala Nair, Charles Mwansambo, Kishwar Azad, Joanna Morrison, Zulfiqar Bhutta, Henry Perry, Susan Rifkin, Anthony Costello

Primary health care was ratified as the health policy of WHO member states in 1978.[1] Participation in health care was a key principle in the Alma-Ata Declaration. In developing countries, antenatal, delivery, and postnatal experiences for women usually take place in communities rather than health facilities. Strategies to improve maternal and child health should therefore involve the community as a complement to any facility-based component. The fourth article of the Declaration stated that, "people have the right and duty to participate individually and collectively in the planning and implementation of their health care", and the seventh article stated that primary health care "requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care". But is community participation an essential prerequisite for better health outcomes or simply a useful but non-essential companion to the delivery of treatments and preventive health education? Might it be essential only as a transitional strategy: crucial for the poorest and most deprived populations but largely irrelevant once health care systems are established? Or is the failure to incorporate community participation into large-scale primary health care programmes a major reason for why we are failing to achieve Millennium Development Goals (MDGs) 4 and 5 for reduction of maternal and child mortality?

Lancet, 2008

The Process of Community Empowerment

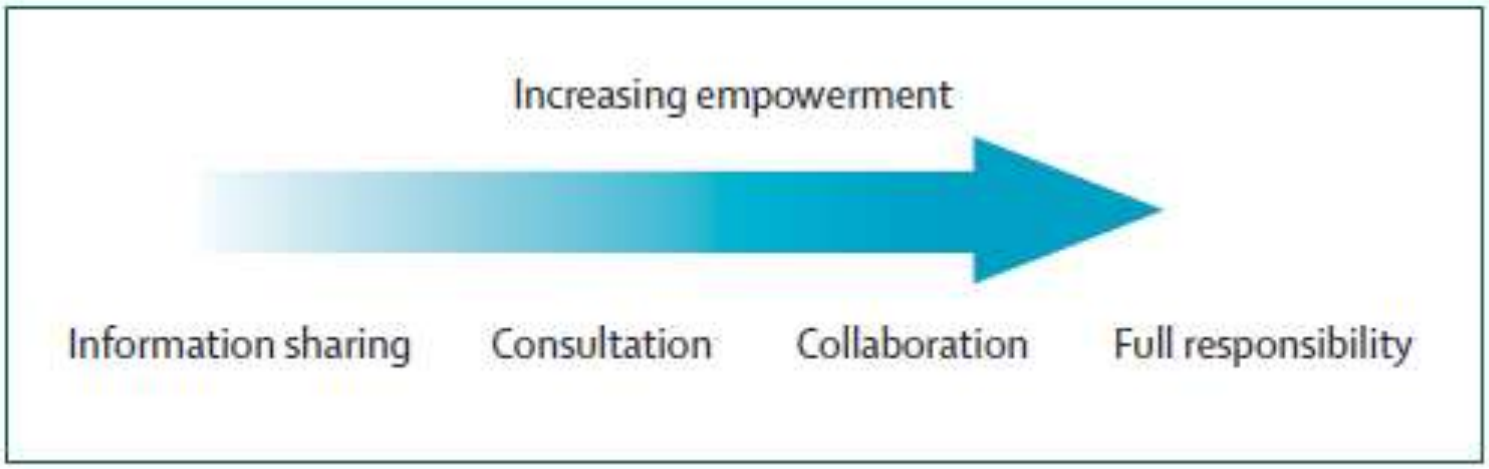


Figure 1: **From passive to active community participation**

Rosato et al., 2008

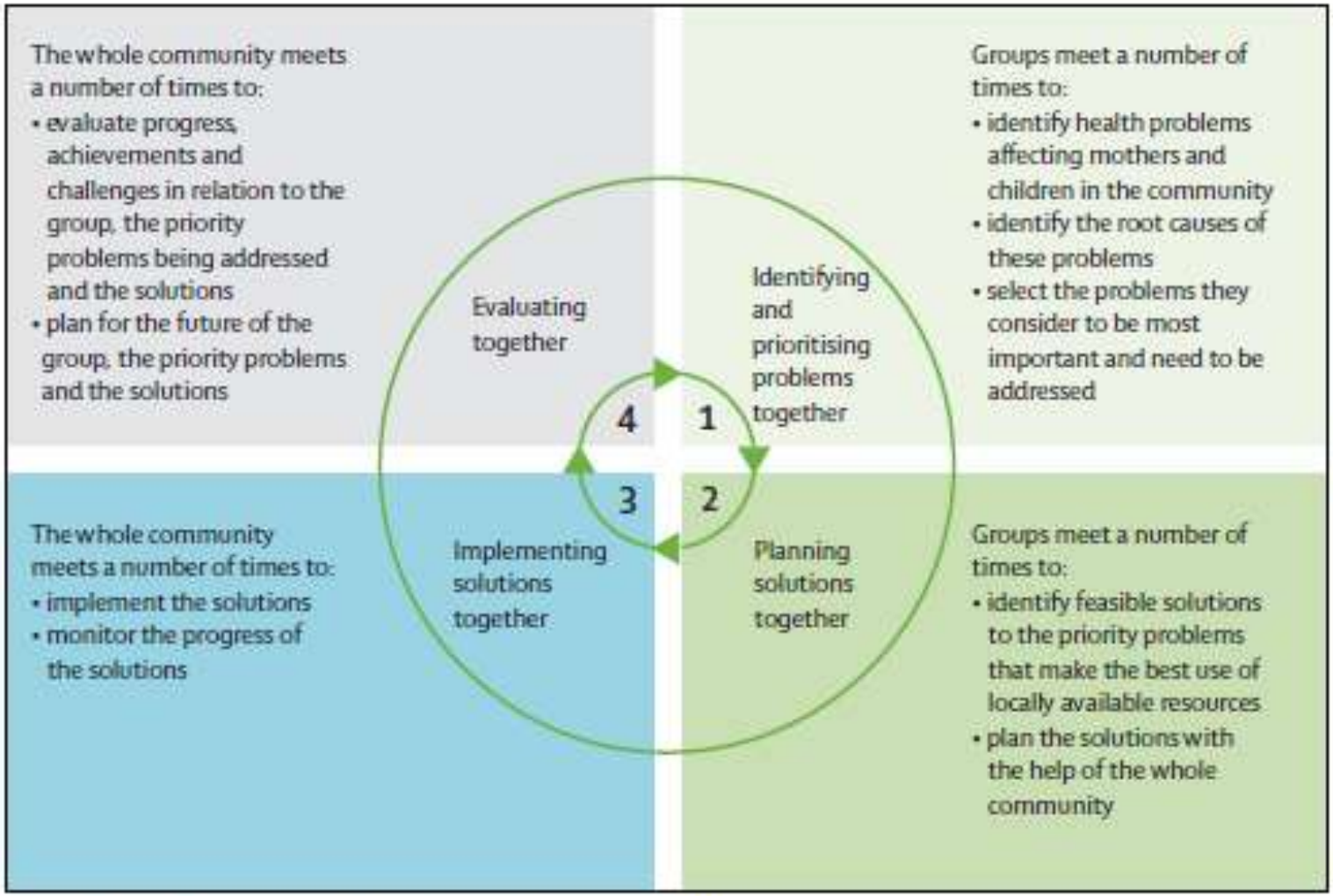


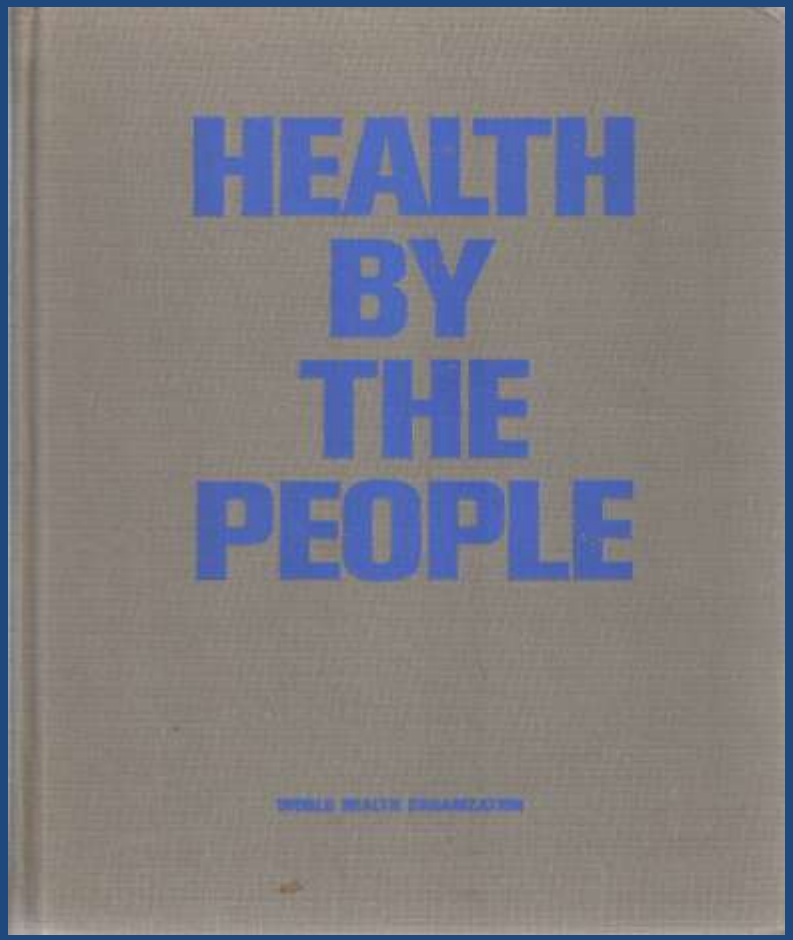
Figure 2: **Women's groups community mobilisation action cycle**

The Warmi project in Bolivia developed a model for community mobilisation using this community action cycle.[40] Women's groups discuss and prioritise their problems, develop strategies to solve them, and, after engaging with other community members, implement and evaluate these solutions. The completed Makwanpur (Nepal) trial and ongoing trials in Mumbai (India), Jharkhand and Orissa (India), Mchinji (Malawi), Dhanusha (Nepal), and Bangladesh are assessing the effect of different women's group models, developed from this model, on mother and child health (table).

The Re-Emergence of Community Health Workers

Early Experience with CHWs – 1960s to 1980s

- China (Barefoot Doctors)
- Indonesia (based at Pos Yandus)
- India (Jamkhed)
- Nepal (VHWs)
- Tanzania
- Zimbabwe (VHWs)
- Nicaragua (Brigidistas)
- Honduras
- Brazil



CONTENTS

1975

Declaration of Alma Ata – 1978

Called for basic health services – promotive, preventive, curative and rehabilitative – to be provided by "health workers, including physicians, nurses, midwives, auxiliaries and *community workers* [italics added] as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

The Declaration also recognized the importance of providing health services “as close as possible to where people live and work.”

Failure of Large-scale CHW Programs in the 1980s

- Local selection of CHWs often politically motivated
- Lack of supervision and support (including necessary supplies and medicines) and integration into the primary health care system
- Lack of funding (global recession in the 1980s and structural adjustment/neo-liberal economics/the Washington consensus)
- Lack of strong evidence of effectiveness of the approach
- The power of selective approaches (EPI, ORS, FP)

Reasons for Renewed Interest in CHWs

- Growing evidence of effectiveness of CBPHC in reducing maternal and child health
- Lack of progress in reaching MDGs and continued low coverage of key interventions
- Seen as critical for increasing access to and coverage of key interventions
- Critical for effective and sustainable TB and HIV programs
- Potential to reach most remote and poorly-served populations, thereby improving equity
- Some interventions more effectively delivered by CHWs rather than by facility-based health workers
- Recognition in India and South Africa that CHWs will be needed after the epidemiologic transition has been achieved (for chronic disease care and care of the elderly)

Examples of Types of Community Outreach Workers

- CHWs/VHWs
- Health agents
- Promoters
- Family health workers
- Peer educators
- Family planning agents
- Malaria/nutrition agents
- Community case management workers
- Lead mothers
- Community health extension workers
- Animators
- Community health officers
- Mobile clinic team
- Care groups
- “Socoristas”
- “Accompagnateurs”
- Health surveillance assistants
- Community surveillance volunteers
- Auxiliary nurses
- Bridge to health teams
- Nutrition counselor mothers

Activities that CHWs Can Carry Out

- Routine systematic home visitation – identify those in need and build relationship of trust
- Community mobilization
- Water and sanitation interventions
- Nutrition
- Vector control
- Treatment of large numbers of patients with common conditions
- HIV/AIDS and tuberculosis
- Community case management of childhood illness

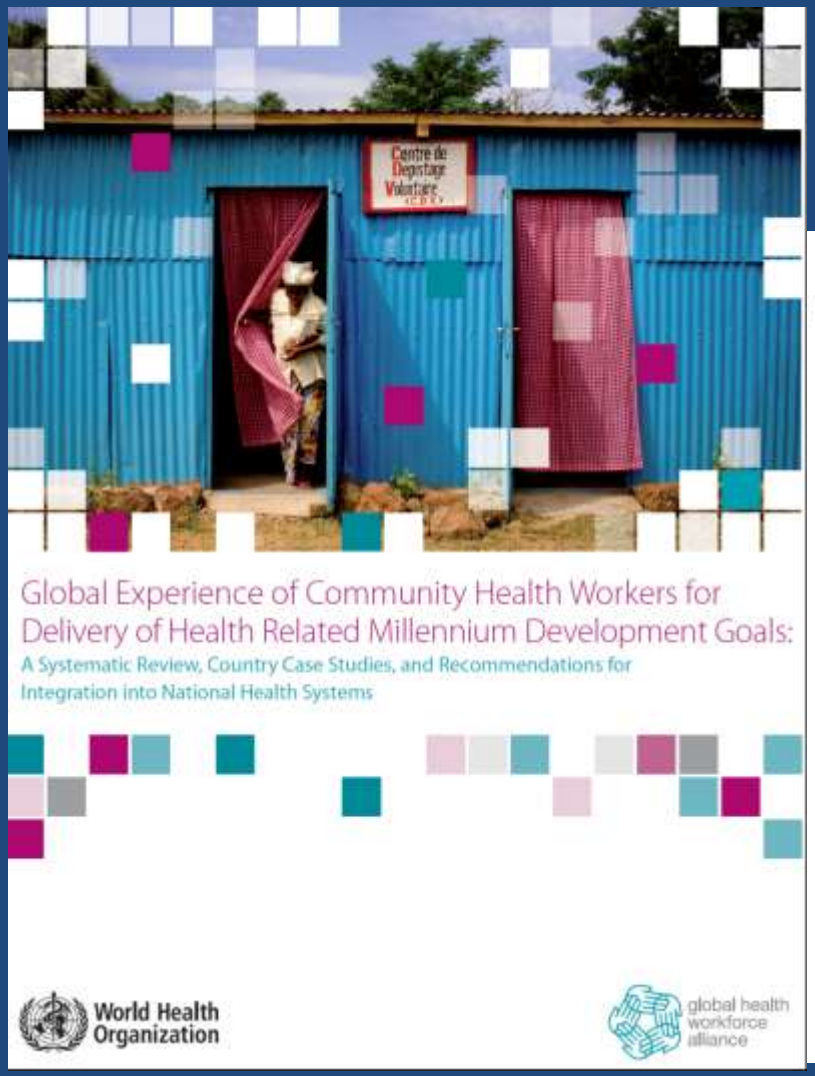
Community Case Management by CHWs (iCCM)

- Diagnosis of pneumonia and treatment with antibiotics
- Diagnosis of diarrhea and treatment with ORS and zinc
- Diagnosis of malaria by Rapid Diagnostic Test and treatment with Artemisinin combination therapy

BRAC CHWs – A "Maximalist" Approach

- Routine systematic home visitation
- Promote of health, nutrition and hygiene
- Treat 10 common diseases and sell essential drugs
- Implement DOTS
- Sell iodized salt, delivery kits, condoms, pills, soap, etc.
- Social mobilization for NID and Vitamin A campaigns
- Collect health information and ensure timely referrals

Shasthya Shebika providing DOTS



World Health Organization

global health workforce alliance

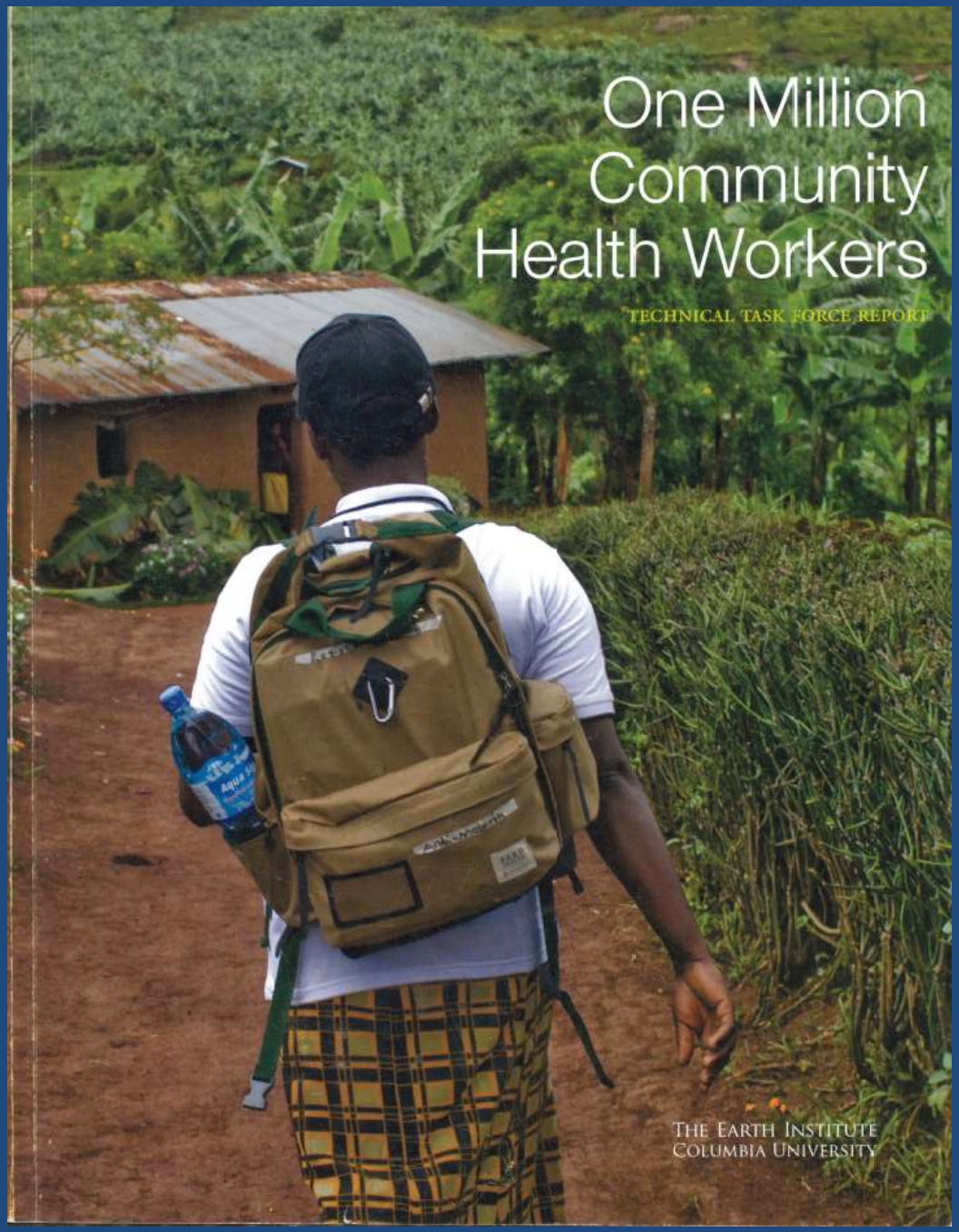
Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems

Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo* and Luis Huicho**

Division of Women & Child Health, The Aga Khan University, Karachi, Pakistan
*Makerere University School of Public Health, Kampala, Uganda
**Universidad Peruana Cayetano Heredia, Universidad Nacional Mayor de San Marcos and Instituto de Salud del Niño, Lima, Peru

Available at:
http://www.who.int/workforcealliance/knowledge/publications/alliance/Global_CHW_web.pdf

2010



Report can be downloaded at:

http://millenniumvillages.org/files/2011/06/1mCHW_TechnicalTaskForceReport.pdf

2011

- Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guidance for Program Managers and Policy Makers, Henry Perry and Lauren Crigler, Editors (available on-line later this fall)

How Effective Are Community Health Workers?

An Overview of Current Evidence with Recommendations for Strengthening Community Health Worker Programs to Accelerate Progress in Achieving the Health-related Millennium Development Goals

September 2012

Henry Perry and Rose Zulliger

Departments of International Health and Health, Behavior and Society

Johns Hopkins Bloomberg School of Public Health

http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/review%20of%20chw%20effectiveness%20for%20mdgs-sept2012.pdf.

Also, forthcoming in Annual Reviews of Public Health

Examples of National-Scale CHW Programs

- India:
  - ASHA (Accredited Social Health Activists): 800,000
  - Anganwadi workers: 2 million
- Brazil:
  - Community Health Agents: 233,000
- Ethiopia (dual cadre):
  - Community Health Extension Worker: 38,000
  - Health Development Army/Community Health Promoters: 3 millilon
- Bangladesh:
  - BRAC *Shashtya Shebikas:* 80,000
- Nepal:
  - FCHVs (Female Community Health Volunteers): 50,000

Summing Up

Carl Taylor's Last Publication

What would Jim Grant say now?

Our greatest mistake has been to oversimplify the Alma-Ata vision of primary health care. Real social change occurs when officials and people with relevant knowledge and resources come together with communities in joint action around mutual priorities. The interplay between comprehensive (horizontal) and selective (vertical) approaches requires careful blending.[12] It is my conviction that, if Jim were here now, he would champion this blending, adapted to the local context with a focus on communities, to ignite the next child survival and development revolution.

www.thelancet.com Vol 375 April 10, 2010

More Information about Carl Taylor and His Legacy

http://www.jhsph.edu/dept/ih/carltaylor

Emergence of PHC Systems

"The emphasis has to shift from showing immediate results from single interventions to creating integrated, long-term, sustainable health systems, which can be built from a more selective primary health-care start."

Walley et al., Lancet 2008

“There is no universal solution, but there is a universal process to find appropriate local solutions”

Carl Taylor

Conclusion

- Primary health care is a deceptively simple concept
- It is a fundamental strategy for improving the health of populations
- Finding a locally appropriate way to link vertical and horizontal approaches in a way that is equitable, engages communities as partners, promotes community empowerment by linking the “top-down” with the “bottom-up” is the challenge for today and tomorrow

Primary Health Care:

A Redefinition, History, Trends, Controversies and Challenges

Henry B. Perry, MD, PhD, MPH

Senior Associate
Department of International Health
Johns Hopkins Bloomberg School of Public Health

3 September 2013

• 221.635.01/.81 CASE STUDIES IN PRIMARY HEALTH CARE (4 credits)

Courses

SECOND TERM

224.689.01 HEALTH BEHAVIOR CHANGE AT THE INDIVIDUAL, HOUSEHOLD AND COMMUNITY LEVELS

(Peter Winch, on-site)

THIRD TERM

221.635.01/.81 ADVANCES IN COMMUNITY-ORIENTED PRIMARY HEALTH CARE

(Henry Perry and Henry Taylor, on-line and on-site)

221.688.81 SOCIAL AND BEHAVIORAL FOUNDATIONS OF PRIMARY HEALTH CARE

(Bill Brieger, on-line)

FOURTH TERM

221.661.01 PROJECT DEVELOPMENT FOR PRIMARY HEALTH CARE IN DEVELOPING COUNTRIES

(Gilbert Burnham and Anbrasi Edward, on-site)

SPECIAL STUDIES IN PRIMARY HEALTH CARE

(Henry Perry, on-site)

Annex XI

ETHIOPIAN PUBLIC HEALTH INSTITUTE (EPHI)

INTERNATIONAL INSTITUTE FOR PRIMARY HEALTH CARE TRAINING

TRAINING MODULE:PRIMARY HEALTH CARE

Alemayehu Mekonnen (MD, MPH, Asso.Prof)
Ethiopian Public Health Association

Module objectives

- Understand basic principles, concepts and evolution of PHC
- identify approaches and Historical backgrounds of PHC
- Priorities at different periods
- strategies of PHC
- describe major achievements and success factors
- Implementation bottle necks and key challenges in implementing PHC- the Ethiopian context
- Identify the minimum requirements for implementing or establish a successful PHC in a country

PRIMARY HEALTH CARE (PHC)

- **Definition of PHC - adopted at Alma-Ata – in 1978**
  - Essential health care based on **practical, scientifically sound and socially acceptable methods and technology made universally accessible** to individuals and families in the community through their full participation and at a cost that the **community and country can afford to maintain** at every stage of their development in the spirit of self-reliance and self-determination.

Primary Health CARE (PHC)….

1. reflects and evolves from the economic conditions and **socio cultural and political characteristics** of the country and its communities
2. addresses **main health problems** in the community, providing promotive, preventive, curative and rehabilitative services

Primary Health CARE (PHC)…..

3. includes at least: 8 (Alma-Ata) later few added

a) education concerning prevailing health problems and the methods of preventing and controlling them

b) promotion of food supply and proper nutrition

c) an adequate supply of safe water and basic sanitation

d) MCH care, including FP

e) Immunization against the major infectious diseases

f) prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries;

g) provision of essential drugs

Primary Health CARE (PHC).....

4. involves, in addition to the health sector:

a) all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors

b) demands the coordinated efforts of all those sectors

Primary Health CARE (PHC).....

5. requires and promotes:

a) maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care

b) making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

Primary Health CARE (PHC)…..

6. should be sustained by:

a) integrated, functional and mutually supportive referral systems,

b) progressive improvement of comprehensive health care for all, and giving priority to those most in need;

Primary Health CARE (PHC).....

7. relies, at local and referral levels:

a) on health workers, including physicians, nurses, midwives, auxiliaries and community workers

b) as well as traditional practitioners as needed, suitably trained to work as a health team to respond to the expressed health needs of the community.

Evolution of Primary Health CARE (PHC):

Phases of public health evolution in Ethiopia	Corresponding historical period
Traditional medicine: immemorial	
Laying the Ground for 'Modern' Medicine, Upto1936	Unification and independence 1855-1896 Decade of consolidation 1896-1906 Power struggle 1908(6?)-1930 Emergence of absolutism 1930-35
The Italian interlude (1936-41)	The Italian occupation 1936-41
The hospital/clinic based period (1941- 1953)	From Liberation to Revolution 1941-74 Reconstruction period (Mosley, Greenfield 1965…) 1941-53
The Basic Health Services period (1953-1974)	From Liberation to Revolution 1941-74
The Primary Health Care period (1974 -1991)	The *Derge* period (1974-91)
The Sector Wide Approach period (1991 -)	EPRDF regime (1991-)

Evolution of PHC- the period of the 1980's

- The National Democratic Revolution Program that was declared in 1976 included social objective
- 10 years perspective plan was used
- Ministry of Health set a policy that reflected the following important directions:

a) emphasis on disease prevention and control;
b) priority to rural health services and their expansion; and
c) promotion of self- reliance and community involvement in health activities.

PHC under HSDP in Ethiopia

- Between 1995 to 2015….. 20 years
- Four 5 years planning cycle
- PHC has been a central part of the health sector reform
- The aim being to ensure full access to quality health services all people in the country.

Priority areas of PHC under HSDP in Ethiopia:

- Health Services delivery and quality of care including expansion and improvement of the quality of health extension program
- Integrated disease surveillance and public health emergency management; Hygiene and environmental health coverage;
- Strengthening of management of health facility including the hospital reform
- Improving the nutritional status of children <5 years

Priority areas of PHC under HSDP in Ethiopia:

- Prevention and control of communicable diseases including TB, Malaria and HIV/AIDS
- quality and availability emergency medical services; and Promoting and providing family health services
- Strengthening health system including pharmaceuticals, facility expansion and rehabilitation
- Pastoralist health services
- Human resource for Health (HRH)

PHC under Health Sector Transformation Plan (HSTP) in Ethiopia

- Transforming the woreda:
  - improving PHCU
  - Clear development of the HEP: 2nd generation of HEW
  - Strengthening the woreda management capacity
  - Scaling up of Community based Health Insurance
- Improving equity and quality of health services
- Information revolution
- Transforming the health workforce- Caring, Respectful and compassionate HRH

Goals and principles of PHC

- The ultimate goal of PHC is better health care for all
- WHO's 4 key elements to achieving the goal

a) reducing exclusion and social disparities in health

(universal coverage reforms)

a) Organizing health services around people's needs and expectations

(services delivery)

b) Integrating health into all sectors (Public Policy reforms)

c) Pursuing collaborative model of Policy dialogue (Leadership reforms)

Primary Health Care principles of Ethiopia

1. **Inter-sectoral collaboration and coordination**
2. **Community involvement/community ownership**
3. **Appropriate technology**
4. Equity
5. Focus on prevention of disease & Health promotion
6. Decentralization.

Strategies and components of PHC in Ethiopia

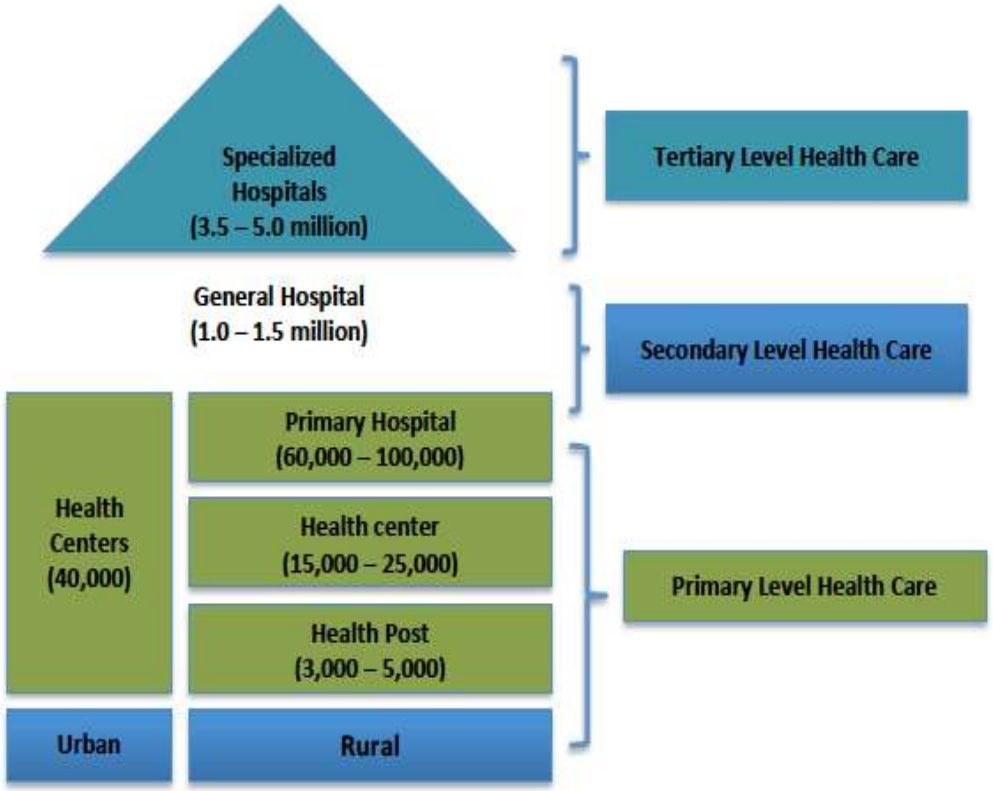
- Reducing the leading risk factors to the population health
- Reducing excess morbidity and mortality of the population with a focus on poor and marginalized populations
- Developing sustainable health system

Three types of activities-PHC

- **Disease oriented PHC,**
  - consists of local efforts to control diseases which constitute a significant disease burden in the population
- **Services-oriented PHC,**
  - consists of efforts to extend basic personal health care services to the entire population
- **Community oriented PHC,**
  - consists of efforts to work in partnership with

Organization of Primary Health Care in Ethiopia

- **Between 1980-1997:** a 6 tier-health service system
- **Between1998-2010:** a four tier - PHCU (1 HC + 5 HPs), DH, ZH and SH
- At present



- **Management structures**
  - Regional Health Bureaus
  - Zonal Health department
  - Woreda Health office
    - **Primary hospital** , Health center and Health Posts
- **Monitoring and Accountability mechanisms**
  - Governing Boards- Hospital, Health Centers
  - RMNCH Score cards
  - Performance review meetings at different levels
  - Woreda based annual planning

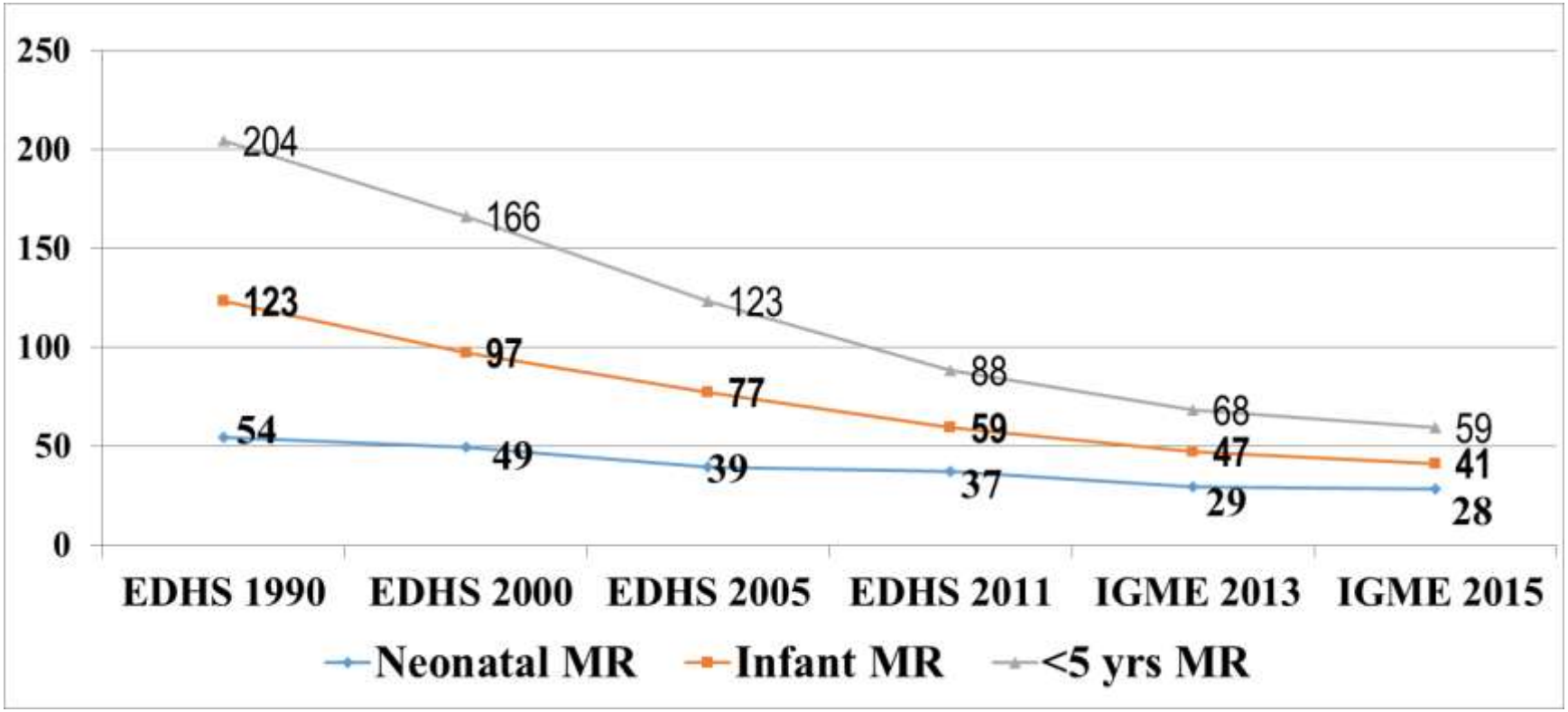
Financing PHC in Ethiopia

- reforms in HCF to protect the poor,
- to introduce equitable financing mechanisms.
- Government's 03 strategies to generate finance
  - government budget allocation
  - fees retention and utilization
  - introduction of CBHI schemes

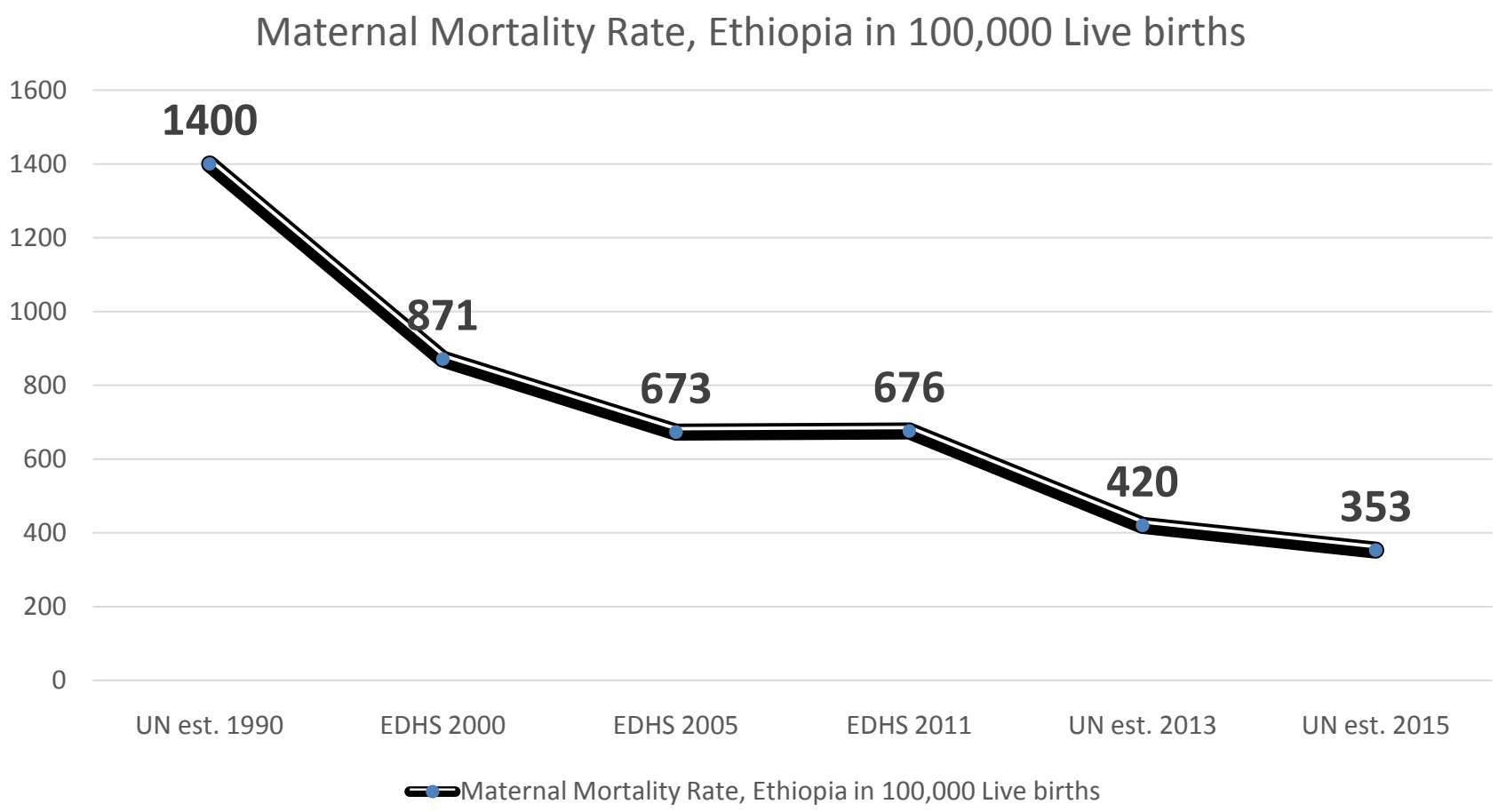
Achievements and success factors

- Improved estimated average life expectancy at birth to 64 from 45 in the 1990's
- Adult mortality rate dropped by > 42% in females and 47% in men based on the 1990's estimate (World Health Statistics Report, 2014)
- MDG targets (Child health, maternal health, malnutrition, HIV, Malaria, access to clean water etc)

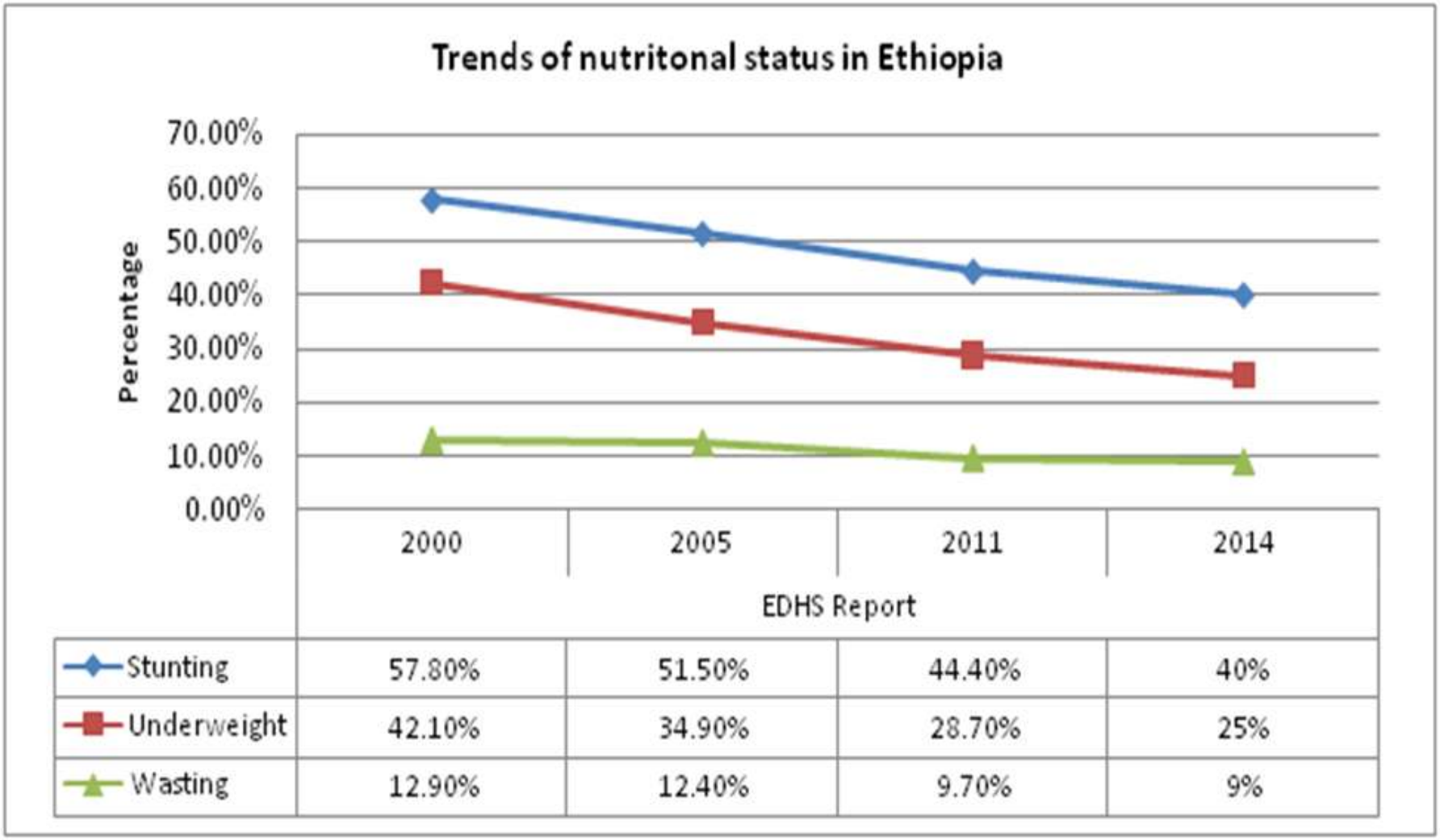
Achievements and success factor



Achievements and success factor



Achievements and success factor



	2000	2005	2011	2014
Stunting	57.80%	51.50%	44.40%	40%
Underweight	42.10%	34.90%	28.70%	25%
Wasting	12.90%	12.40%	9.70%	9%

Success factors

- Leadership and strong political commitment
- Improved coverage of PHC services through the HEP
- Improved Economic growth
- Improved literacy
- Solid community platforms for services delivery, promotion and utilization
- Strong partnership and support

Major implementation bottlenecks

- Limited infrastructure at the PHCU level
- Difficulty in achieving intersectoral collaboration
- Inadequate health service coverage and mal-distribution for available health services
- High turnover of HRH
- Absence of clear context specific guidelines or directives on implementation – Pastoralist, urban HEP

Major Challenges

- Limited resource allocation – the Abuja target is not yet met
- deep rooted social norms affecting the utilization of health services
- limited enforcement of existing legal rules and regulations

Minimum requirements to replicate a successful PHC system and program implementation

- **Policy level**
  - Strong government commitment to mobilize and allocate optimal domestic resources
  - Establishing strong partnership and coordination mechanisms to support the planning, implementation and evaluation of PHC systems and programs
  - Ensuring solid accountability mechanisms to oversee the functioning of PHC and bringing transparency of governance
  - Establishing operational inter-sectoral collaboration mechanisms and platforms

Minimum requirements to replicate a successful PHC system and program implementation

- **Programmatic and Organizational level**
  - Clear definition of responsibilities of the structures and the management bodies
  - Clear guidelines and standards should be in place for each level the PHC
  - Define a clear strategy and approach for bottom up planning and monitoring and decision making

Minimum requirements to replicate a successful PHC system and program implementation …cont

- **Programmatic and Organizational level**
  - Proper strategy to HRH development including career development, training and rotation plans, motivation and retention mechanisms across all levels.
  - Reliable supply-chain management capacity at all levels including proper forecasting, procurement and distribution system.
  - Better information system for evidence based decision making,

Review questions: policy makers

- Would you say commitments at a government level to realize and achieve PHC approach in one's country?
- If you are in a position to persuade others on PHC approach, how do you go about it? Specific to your role/contribution

Discussion points: policy makers

- **What role/s** of law/policy makers like you should play in the realization of PHC in your Country? And how that can be realized?

- **What laws/policies** do you believe shall be in place and/or be enforced for better PHC in your respective Country?

- **Could you pinpoint and discuss** on laws/ regulations that hinder the proper implementation PHC in your respective Country?

Annex XII

Human Resources for Health in Ethiopia

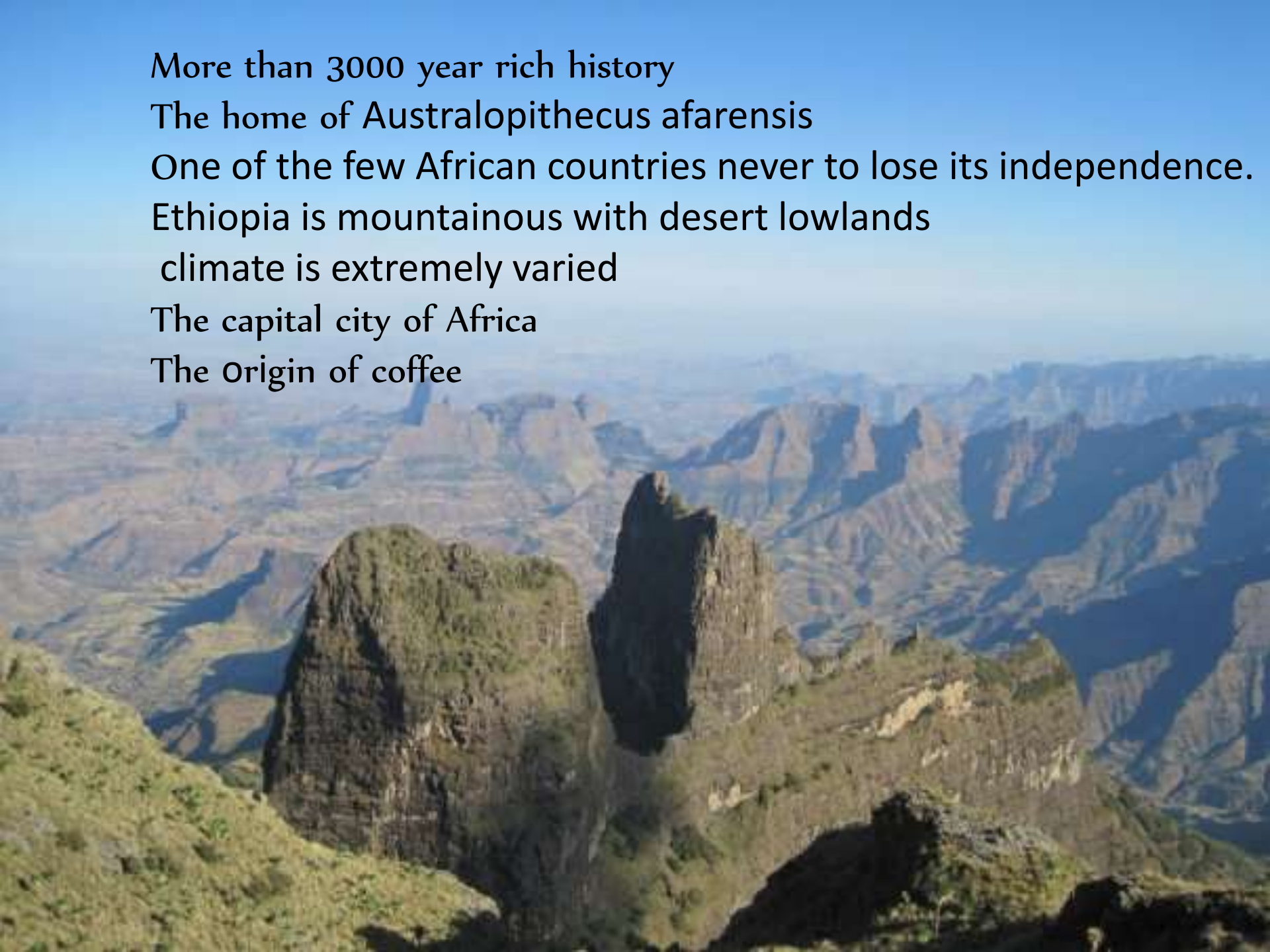
Addis Ababa, August 2016

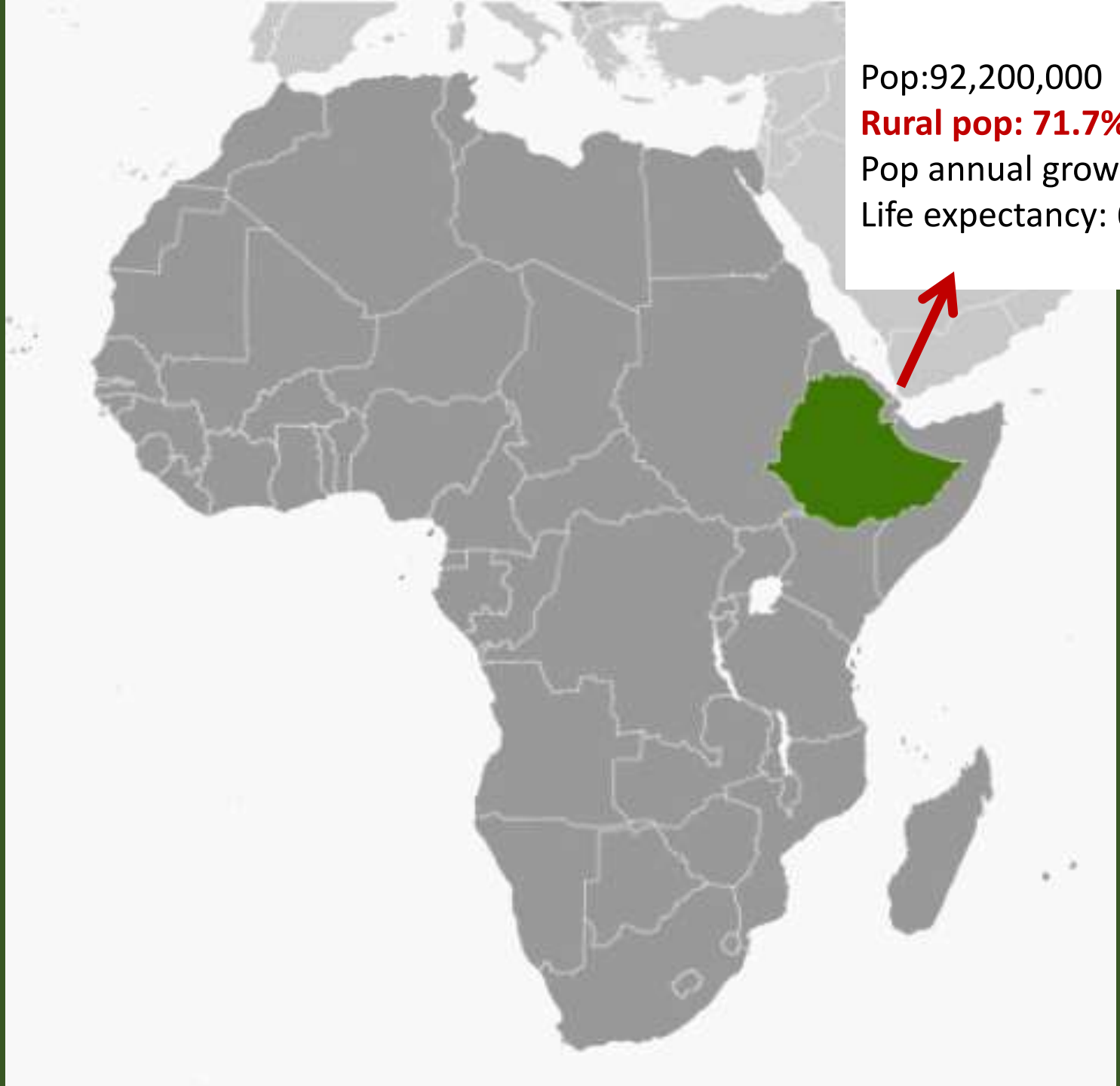
Ministry of Health, Ethiopia

Presentation Outline

1. Background
2. Policy Background
3. National HRH Strategy
4. Decentralization and Coordination
5. Pre-Service Training, Quality Assurance and Regulation
6. In-Service Training and Continuing Professional Development
7. Financing
8. Motivation and Retention
9. Outcomes

Background Information


More than 3000 year rich history
The home of Australopithecus afarensis
One of the few African countries never to lose its independence.
Ethiopia is mountainous with desert lowlands
climate is extremely varied
The capital city of Africa
The origin of coffee



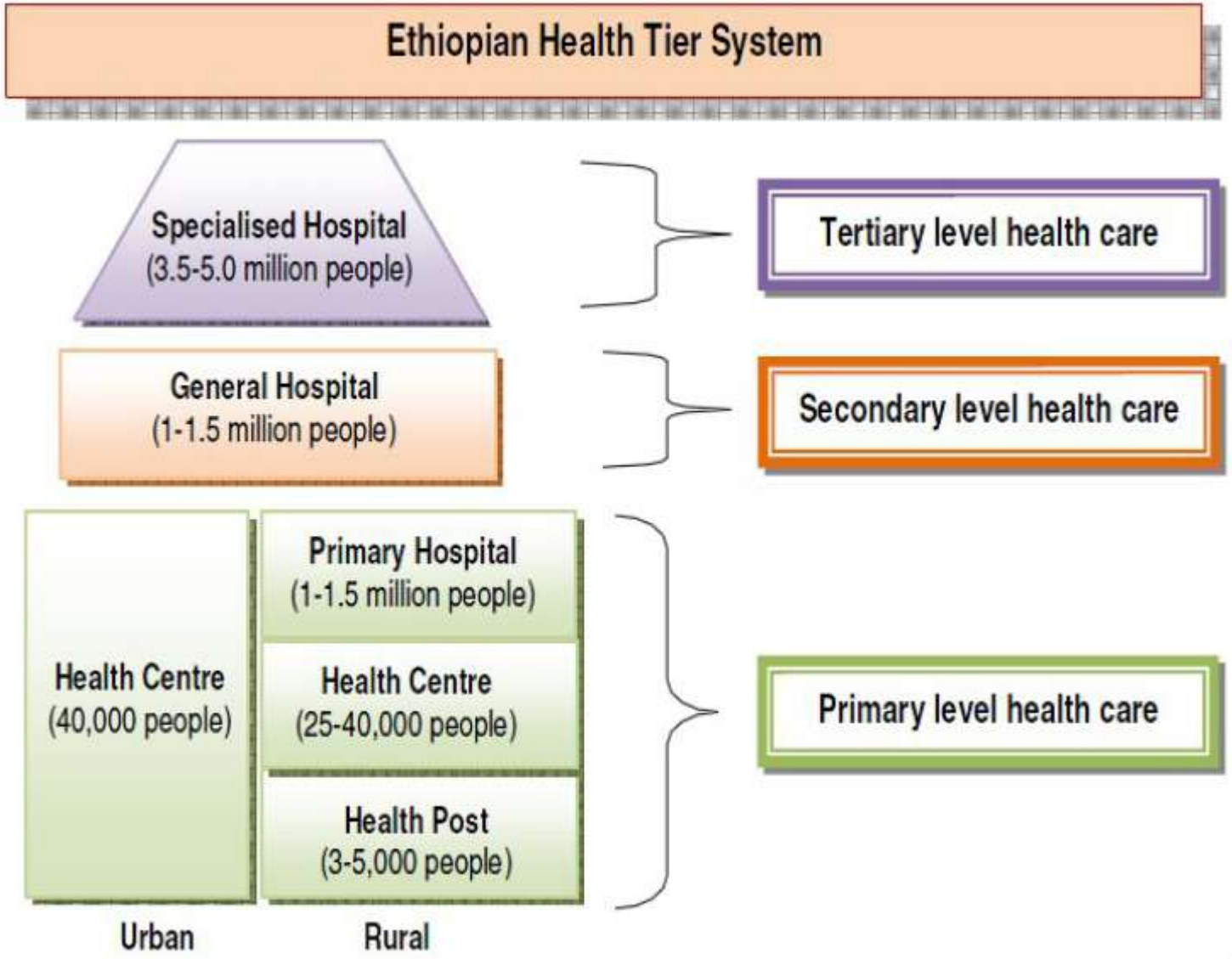
Pop:92,200,000

Rural pop: 71.7%

Pop annual growth:2.6%

Life expectancy: 64 years

Health System Levels



Policy Background

- **Envisioning Ethiopia's Path towards Universal Health Coverage**-- A long-term health sector transformation roadmap through Strengthening Primary Health Care

and

- **The Health Sector Transformation Plan (HSTP)** is the first phase of the "Envisioning document" as well part of the second **Growth and Transformation Plan II** of the country. HSTP has three primary objectives: Ensuring Equity and Quality Universal Health Coverage and

National HRH Strategy of Ethiopia

Vision:

- See adequate number of well qualified, committed, compassionate, respectful and caring health workers contributing to the health sector vision of Ethiopia

Goal:

- Ensure that committed, skilled and motivated health workers are available to provide universal access to health care in Ethiopia

National HRH Strategy of Ethiopia

Four **objectives** are organized into four outcome areas:

1. HRH **policy, planning and partnership** strengthened at all levels
2. **Quantity, quality and equitable deployment and distribution** of the health workforce
3. **Leadership, governance and HR management** capacity and practices strengthened at all levels of health system
4. Improved **attraction and retention** of health professionals including measures for improving their commitment, distribution, performance, remuneration and their working and living conditions.

National HRH Strategy of Ethiopia

Eight strategic issues were identified for the HRH

1. Improve education and training of health workers.
2. Improve the imbalances in professional skill mix and geographic distribution
3. Improve quality of pre-service education and in-service training
4. Strengthening leadership and governance capacity of the health workforce.
5. Optimizing the utilization, retention and performance of the available health workforce.
6. Improving health workforce information and generation of evidence for decision-making.
7. Strengthening HRH regulatory capacity
8. Strengthening health workforce partnership and

Decentralization and Coordination Mechanisms of HRH Development and Recruitment

- Federal Ministry of Health
- Ministry of Education
- Ministry of Science and Technology
- Ministry of Civil/Public/ Service
- Ministry of Finance and Economic Cooperation
- Health Training Institutions
- Regional Health Bureaus
- Woreda Health Offices
- Health Facilities
- Health Professional Associations
- Health Research Institutions
- Private Sector
- Partners

Pre-Service Training

- Health science training institutions have been significantly expanded (2009-2015)
- Five priority initiatives (medical education, midwifery, emergency surgical officers training, anesthesia and HEWs) strengthened to address the HRH crisis in the country

Task Shifting (sharing) was considered and implemented on: Tailored to country needs

- Health Extension Workers (HEW)
- Health officers (non-physician clinicians)
- Accelerated Midwifery
- Emergency Surgical Officers (ESOs)
- Ethiopian Field Epidemiology Training Program (EFETP)

HRH Indicators	2009	2015
Medical schools	7	35 (7 private)
Health science collages		23
Public midwifery schools	23	49
Health professional density	0.84/1000	>2.2/1000
Physician density	1/42706	>1/11500
Nurses density	1/5000	1/2132
Midwifery	1/57000	1/9650
HEWs	30950	39000

Quality Assurance and Regulation of Health Education

- A strategic document that focuses on health professional education was developed to revitalize the quality assurance system of higher education in Ethiopia in collaboration with HERQA.
- Accreditation is a mandatory requirement for higher education institutions in Ethiopia and is managed by –the "Higher Education Relevance and Quality Agency" (HERQA)
- HERQA in collaboration with Universities, MOH and partners has developed two levels of quality assurance standards (accreditation & quality improvement) for medicine, health officers, nursing, midwifery, medical laboratory, pharmacy and anesthesia.
- National Licensing examinations (Lower and Higher)

In-Service Trainings and Continuing Professional Development

- IST guidelines and directive has been developed, endorsed and disseminated to standardize and institutionalize in service training for health care providers in the country.
- CPD implementation guideline has been developed and endorsed to maintain and update health professional knowledge, skill and attitude.

Financing the Health Workforce

Ethiopian health sector is financed from various sources including

- The government
- Bilateral and multilateral donors and
- Individuals out of pocket.

- Ethiopian government finances the largest portion of activities in health services and management with only less than 20% contributions coming from private sector.
- A portion of this resource allocated towards health workforce **planning, development and management.**
- The public sector **employs and remunerates** all public sector employees; develop health infrastructure and provide for equipment and supplies to keep the health workforce performing, motivated and retained in the system.
- Education and training is another major category of government's health sector spending; with rapid expansion of higher education facilities and increased intakes of medical and health sciences students

Motivation and Retention

Some of the existing motivation and retention schemes include:

- Health workers are placed two steps higher on the civil service salary scale compared to other civil servants of equivalent rank.
- Health workers who have been deployed by the Ministry of health are exempted from paying cost sharing of their university (pre service) education.
- The mandatory service expected from Physician who is willing to work in emerging regions and hard to reach areas is half shorter than those who will serve in the main towns.
- Private wing practices (private practices in public facilities) in specialized and regional hospitals have created a fertile ground to generate additional income.

Motivation and Retention

- Education and training opportunities (with government sponsorship) are available for health workers at all levels.

- Financial incentives for health workers that were standardized in all regions have been initiated ; these include duty, housing/house allowance, top up, and allowances for risks and management positions.

- Other non-financial incentives such as housing, loans, transport facilities, anniversary schemes etc. have been proposed but are yet to be implemented as they require further review and approval by the relevant authorities.

Outcomes

Ethiopia has made significant improvements in many health indicators:

- The country has reduced **under-five mortality by two-third** from the 1990 baseline meeting the MDG target three years ahead of the schedule;
- New HIV infection has gone down by more than **90%**
- and there has been **no generalized malaria epidemic in more than 8 years**.
- Maternal mortality reduced by **72%,** and Contraceptive Prevalence Rate (CPR) increased from **29%** in 2011 to **48%** in 2015.
- Life expectancy at birth has been increased from
- The great success registered is mainly due to **a well-coordinated, extensive efforts and intensive investment of the government, partners and the community at large** to strengthen and expand the primary health care.

Recommendations

- Political commitment for increased health workforce from all sectors
- Align all policies and plans and have ONE Plan ONE Budget and ONE Report
- Strong country leadership with partnership and coordination of contributions from development partners
- More emphasis and focus on expansion of primary health care

Mobilization and engagement of community in health issues

Thank you!

Annex XIII

Harmonization and Alignment on Budget

MDG PF

GRANT MANAGEMENT UNIT

FEDERAL MINISTRY OF HEALTH, ETHIOPIA ,

AUGUST, 2016

Out line

- Introduction
- Harmonization and alignment
- MDG PF/SDG PF
- JFA
- Overview of Pfor R

Introduction

- The SDG Performance Fund is pooled funding mechanism managed by the FMOH using the Government of Ethiopia procedures.
- *It is one of the GoE"s preferred modalities for scaling up Development Partners assistance in support of HSTP/HSDP.*

Harmonization and Alignment in Ethiopia

- Development and signing of the Code of Conduct in 2005
- HHM manual in 2007
- International Health Partnership
- JFA and establishment of MDG PF 2009

Major focus of the Harmonization and Alignment efforts

- One joint Plan: HSDP and annual woreda plan
- One Budget: MDG PF
- One Report: HMIS, JRM, ARM, joint surveys

MDG Performance Fund

- MDGPF pools non-earmarked partner funds.
- Specific scope of activities to be financed are determined through a consultative process involving all key stakeholders every year.
- The Joint Financing Arrangement (JFA)sets out the overarching governance and reporting requirements for the Fund.
- As of 2015, 11 partners are contributing to MDGPF

Background

- Was established in 2007 with GAVI HSS contribution.
- Reformed after the JFA was signed by MoFED, MOH and seven DPs in 2009.
- IC and EKN joined 2011/2012.
- The WB and GAVI joined in 2013.
- EU also joined In…….2015

JFA

- **Scope of MDG fund and JFA**:
  - Eligible Expenditures: any priority of the government are eligible except salary costs (at either Federal or sub-national levels)
- **Responsibilities of the FMoH:**
  - Carries overall responsibility and accountability for the performance of the health sector as a whole, including the MDG Fund, ensuring that all activities undertaken within the sector contribute to HSDP goals and priorities.

JFA

- **Responsibilities of DPs:**
  - Providing resources to the MDG Fund in line with principles of aid effectiveness, the commitments of the IHP Compact and the procedures set out in the JFA.

- **Institutional arrangement and decision making:**
  - The dialogue, governance and decision-making of the MDG Fund is provided by the existing health sector coordination framework which consists of a two tier collaborative governance system made up of the JCF and the JCCC.

JFA

- **Planning:**
  - The HSDP targets, priorities and costing form the basis of the annual planning process.
  - The Woreda based planning process is the only sector planning process modality for the annual operational plan in the health sector
- **Flow of funds:**
  - The FMOH maintains the foreign currency account in the National Bank of Ethiopia for the MDG Fund
  - Signatories disburse according to a mutually agreed disbursement schedule and in line with the Ethiopian Fiscal Year

JFA

- **Procurement:**
  - The FMoH would be the budget holder for the MDG Fund and will delegate the procurement of goods to PFSA
  - The PFSA will utilise its own procurement manuals in accordance to its proclamation (553/2007)
- **Reporting:**
  - Quarterly activity based reports are sent to all signatories
  - Annual performance will be included as part of the annual report for the sector

JFA

- **Reviews and evaluation:**
  - This will be common to all DPs and will be aligned with FMOH processes
  - FMOH and DPs will maintain a close dialogue around reviews and evaluation through the JCCC and JCF
- **Audit:**
  - Internal Audit: quarterly
  - External Audit: once in a year, to be done by ASC, ToR to be agreed jointly, report is due nine months after the end of the FY

Total income to MDG PF in USD and El

DP	2001 E.C	2002 E.C	2003 E.C	2004 E.C	2005 E.C	2006 E.C	2007 E.C	2008 E.C	Total
DFID	4,407,267	17,341,660	43,314,566	81,577,544	106,964,000	142,558,200	101,647,000	45,344,460	538,747,430
Spain	6,210,963	13,562,960	6,416,510	6,846,500		658,648	1,112,199		34,807,780
Irish Aid		1,924,660	2,217,960	3,484,284	2,047,516	3,181,362	13,620,726	6,911,116	33,387,624
UNFPA		1,000,000	1,000,000	995,189		2,000,000			4,995,189
WHO		664,303	300,969	698,773		148,337			1,812,382
UNICEF				500,000	1,000,000	900,000	500,000	455,000	3,355,000

Cont....

DP	2001 E.C	2002 E.C	2003 E.C	2004 E.C	2005 E.C	2006 E.C	2007 E.C	2008 E.C	Total
IC				3,793,853			3,544,799	2,724,005	10,062,657
Australia				7,445,900	8,400,000				15,845,900
EKN					5,700,000	7,142,827	14,862,788	15,874,899	43,580,514
WB						35,393,073	34,521,883	3,667,317	73,582,273
GAVI					3,127,741	35,480,034		20,742,868	59,350,643
EU								7,650,273	7,650,273
Total	10,618,232	34,493,584	53,250,005	105,342,043	127,239,257	227,462,481	169,809,395	103,369,938	831,584,932

Overview of PforR

- Provides US$120 million (US$100 million credit and US$20 million grant) during a five year period
- Supports Ethiopia Health Sector Transformation plan IV (HSTP)
- Disburses against achievement of results measured through 8 indicators
- Focuses on strengthening institutional capacity

Disbursement Linked Indicators (DLIs)

- Indicators are selected based on:
  - Evidence of their contribution to MDGs
  - Under the span of control of the government
  - Achievable in the time-frame being considered
  - Objectively measurable and verifiable

- The targets for the DLIs have been established based on global experience and the track record of Ethiopia

DLIs and Disbursement

- Each DLI has a monetary value. Partial disbursement will be made for partial achievement
- Fund from the World Bank will be disbursed to MDG Performance Fund once results achievement are verified
- Disbursement from the PforR operation will support activities under the MDGPF with the exception of high-value procurement
- The planning, implementation, reporting, audit and governance all follow the JFA

Thank you!

Annex XIV

Evaluations by Tanzanian and Lesotho delegates

General constructive criticism

About the program

1. not tailored according to each countries need
2. Should focus more on the request of the trainees
3. Should elaborate more on task shifting and task sharing
4. Should have a good understanding on the learning needs of the other countries

About the Presentation

1. Class hours are too long
2. Avoid repetition of slides
3. Have presenters meet prior to the presentation to avoid repetition
4. Some presentations were obscured

About other services

1. Transport was not very good and driver was not very welcoming
2. Hygiene in the restroom was not good
3. Presenters should be on time
4. There was not access to wifi
5. Should include lunch services to save time

Acknowledgements

IIfPHC's special thanks go to the Federal Ministry of Health and Johns Hopkins Bloomberg School of Public Health for availing all the necessary support and providing trainers for the sessions. Thank you also to all trainers for sharing their knowledge and practical aspects on their respective topics.

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IIfPHC's special thanks also go the Melinda and Gates Foundation for supporting the establishment of IIfPHC and making it possible for Ethiopia to share its experience to other African countries.