Federal Democratic Republic of Ethiopia
Ministry of Health

HSDP IV

Annual Performance Report

EFY 2003 (2010/2011)

Version 1

HEALTH SECTOR DEVELOPMENT PROGRAMME IV

ANNUAL PERFORMANCE REPORT

EFY 2003 (2010/11)

VERSION 1

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ACRONYMS

AECID	Agencia Española de Cooperación Internacional para el Desarollo (Spanish Aid Agency)
AFP	Acute Flaccid Paralysis
AHOTP	Accelerated Health Officers Training Program
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ARV	Antiretroviral
AWD	Acute Watery Diarrhoea
BCC	Behaviour Change Communication
BCG	Bacillus Calmette Guerin
BEmONC	Basic Emergency Obstetric and Neonatal Care
BoFED	Bureau of Finance and Economic Development
BPR	Business Process Re-engineering
BSC	Balanced Score Card
CAR	Contraceptive Acceptance Rate
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBHI	Community Based Health Insurance
CBN	Community Based Nutrition
CDC	Centre for Disease Control
CDTI	Community Directed Treatment Intervention
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CEO	Chief Executive Officer
CFR	Case Fatality Rate
CHD	Community Health Day
CIS	Community-based Information System
CL	Cutaneous Leishmaniasis
CLTS	Community Led Total Sanitation
CME	Continued Medical Education
CPD	Continuing Professional Development
CSW	Commercial Sex Worker
DFID	Department for International Development
DOTS	Directly Observed Treatment – Short course
DP	Development Partner
DSIS	Disease Surveillance Information System
EDHS	Ethiopia Demographic and Health Survey
EFY	Ethiopian Fiscal Year
eHMIS	Electronic Health Management Information System
EHNRI	Ethiopian Health and Nutrition Research Institute
EmONC	Emergency Obstetric and Neonatal Care
EMR	Electronic Medical Record
ENCU	Emergency Nutrition Coordination Unit
EOS	Expanded Outreach Strategy

EPA	Environmental Protection Authority
EPI	Expanded Program on Immunization
ERCS	Ethiopian Red Cross Society
ERIA	Enhanced Routine Immunization Activity
ERTA	Ethiopian Radio and Television Agency
ETB	Ethiopian Birr
FAMS	Financial Administration and Management System
FF	Family Folder
FMHACA	Food, Medicine and Healthcare Administration and Control Authority
FMOH	Federal Ministry of Health
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GC	Gregorian Calendar
GIS	Geographic Information System
GTP	Growth and Transformation Plan
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
HCF	Health Care Financing
HCT	HIV Counselling and Testing
HDA	Health Development Army
HEP	Health Extension Program
HepB	Hepatitis B
HEW	Health Extension Worker
HF	Health Facility
HH	Household
HiB	Haemophilus Influenzae type B
HIT	Health Information Technician
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Health Officer
HP	Health Post
HPF	Health Pooled Fund
HPN	Health, Population and Nutrition
HR	Human Resources
HRD	Human Resources Development
HRH	Human Resources for Health
HRIS	Human Resources Information System
HRM	Human Resources Management
HSDAM	Health Service Delivery, Administration and Management
HSDP	Health Sector Development Program
HW	Health Worker
IC	Italian Cooperation
ICT	Information and Communication Technology
IDD	Iodine Deficiency Disorder
IEC	Information, Education, Communication
IESO	Integrated Emergency Surgery Officer
IHP	International Health Partnership
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IOC	Iodized Oil Capsule
IPFSMIS	Integrated Pharmaceuticals Fund and Supply Management Information System
IRS	Insecticide Residual Spray
IRT	Integrated Refresher Training
IT	Information Technology

ITN	Insecticide Treated Net
IUCD	Intra-Uterine Contraceptive Device
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financial Arrangement
JSC	Joint Steering Committee
KHIIC	Kebele Health Insurance Initiative Committee
KOOW	Kebele Oriented Outreach Worker
LLIN	Long-Lasting Insecticide-treated Net
mHealth	Mobile Health
MBB	Marginal Budgeting for Bottlenecks
MDG	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MOFED	Ministry of Finance and Economic Development
NAC	National Advisory Committee
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NICU	Neonatal Intensive Care Unit
NIMH	National Institute of Mental Health
NMR	Neonatal Mortality Rate
NNP	National Nutrition Program
NTD	Neglected Tropical Disease
OPD	Outpatient Department
OR	Operations Research
OTP	Outpatient Therapeutic Program
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PBS	Protection of Basic Services
PFSA	Pharmaceutical Fund and Supply Agency
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PICT	Provider-Initiated HIV Counselling and Testing
PLWHA	People Living With HIV/AIDS
PLW	Pregnant and Lactating Woman
PMTCT	Prevention of Maternal to Child Transmission of HIV
PMU	Project Management Unit
PNC	Postnatal Care
PPM-DOTS	Public Private Mix DOTS
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RHB	Regional Health Bureau
SAM	Severe Acute Malnutrition
SARS	Severe Acute Respiratory Syndrome
SHI	Social Health Insurance
SNNPR	Southern Nations, Nationalities and Peoples Region
STI	Sexually Transmitted Infection
TB	Tuberculosis
TLPC	Tuberculosis and Leprosy Prevention and Control
TOT	Training of Trainers
TSF	Targeted Supplementary Feeding
TVET	Technical and Vocational Education and Training
U5MR	Under 5 Mortality Rate

UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOPS	United Nations Organization for Project Service
USD	United States Dollar
USI	Universal Salt Iodization
VAS	Vitamin A Supplementation
VHF	Viral Hemorrhagic Fever
VL	Visceral Leishmaniasis
WHISC	Woreda Health Insurance Steering Committee
WHO	World Health Organization
WoFED	Woreda Finance and Economic Development
WorHO	Woreda Health Office

Executive Summary



EXECUTIVE SUMMARY

The Health Sector Development Programme IV (HSDP IV) has articulated three Strategic Themes and ten Strategic Objectives, and has set detailed performance indicators, targets and initiatives for each Strategic Objective. This report highlights the major achievements and challenges of the health sector in EFY 2003, under the three Strategic Themes: Health Service Delivery and Quality of Care, Leadership and Governance and Health Infrastructure and Resources.

HEALTH SERVICE DELIVERY AND QUALITY OF CARE

This Strategic Theme comprises of the services provided by the Health Extension Program (HEP), maternal and newborn health services, child health services, national nutrition program, prevention and control of communicable and non-communicable diseases, public health emergency preparedness and response, and quality of health services.

1. In order to strengthen the HEP, the organization and mobilization of the Health Development Army (HDA) has started in EFY 2003 to capacitate families who are lagging behind in terms of adopting safe health practices; training has been carried out in all agrarian regions and implementation has commenced in SNNP and Tigray Regions. In EFY 2003, the target was to train and graduate 3,627,668 model households, but the number of households that graduated in the year was 2,198,924 (60.6% of the annual target). As a result, the cumulative number of graduated households was 12,178,630 (88.9% of the cumulative annual target) corresponding to 69.9% of the total eligible households (17,427,888).
2. With regard to hygiene and environmental sanitation, it was planned to increase the number of households with latrines from 12,673,106 (75% of latrine coverage) in EFY 2002 to 14,730,588 (86% of latrine coverage) in EFY 2003. In EFY 2003, the cumulative number of households with latrine was 14,993,248, achieving the target set for the year in the Core Plan.
3. Concerning maternal health indicators, Antenatal Care (ANC) coverage 1+ (at least one visit) increased from 71.4% in EFY 2002 to 82.2 % in EFY 2003, and Postnatal Care (PNC) coverage increased from 36.2% in EFY 2002 to 42.1% in EFY 2003, while the percentage of deliveries attended by skilled health personnel remained stable at 16.6% (16.8% in EFY 2002). Conversely, clean and safe delivery service coverage by Health Extension Workers (HEW) declined from 17.0% in EFY 2002 to 14.7 % in EFY 2003. Contraceptive Acceptance Rate (CAR) remained stable at 61.7% (61.9% in EFY 2002). The proportion of pregnant women counselled and tested for Prevention of Mother to Child Transmission of HIV (PMTCT) increased from 22.0% to 33.4% and the proportion of deliveries of HIV-positive women who received a full course of Antiretroviral (ARV) prophylaxis increased from 8.3% in EFY 2002 to 9.3% in EFY 2003. In EFY 2003, only ANC (82.2%) surpassed the target (80.4%). This poses a challenge for the sector and the following measures were articulated in HSDP IV to increase skilled attendance at delivery: accelerated training of midwives and emergency surgery officers, equipping Health Centers (HCs) to provide Basic Emergency Obstetric and Neonatal Care (BEmONC) services, equipping all hospitals including primary hospitals to provide Comprehensive Emergency Obstetric and Neonatal Care (CEmONC), improving availability of safe blood and pharmaceutical supplies and strengthening the referral system. Significant developments are taking place with respect to the implementation of measures aimed at increasing skilled attendance at delivery.

4. Pertaining to immunization coverage indicators, Pentavalent 3 vaccine coverage decreased from 86.0% in EFY 2002 to 84.7% in EFY 2003, measles vaccine coverage from 82.4% to 81.5%, while the full immunization coverage reached 74.5% which was above EFY 2002 performance (72.3%). At the end of EFY 2003, the cumulative number of HCs providing Integrated Management of Neonatal and Childhood Illnesses (IMNCI) was 1,720.

5. Regarding Vitamin A Supplementation (VAS), in EFY 2003, 12.5 million children aged 6-59 months received the first dose of VAS, a performance above the achievement in EFY 2002 (10.7 million), with a national coverage of 110% (above the target of 98% set for the year). Similarly, among 2-5 years old children eligible for de-worming, the de-worming coverage (first round) increased from 93% to 112% (above the target of 97% set for the year). A total of 238 woredas were providing Community Based Nutrition (CBN) service at the end of EFY 2003. The percentage of underweight children under two years in CBN woredas showed an overall downward trend (from 18.4% at the end of EFY 2002 to 16.5% at the end of EFY 2003).

6. There was a steep increase in the number of facilities providing HIV Counselling and Testing (HCT), PMTCT and Antiretroviral Therapy (ART) services in the EFY 1998-2003 period; in particular, the increase was from 2,184 in EFY 2002 to 2,309 in EFY 2003 for HCT, from 1,352 to 1,445 for PMTCT and from 550 to 743 for ART in the same period. The number of HCT services was high, slightly increasing from 9,445,618 in EFY 2002 to 9,448,880 in EFY 2003, below the target (9,466,645) set for the year at the national level. A total of 8,365 HIV-positive mothers received ART treatment in EFY 2003, amounting to 9.3% of those eligible (90,311), which was above the EFY 2002 performance (6,990), but far below the target set for the year (18,026). Out of 14,276 HIV-positive births, 4,945 newborns (34.6%) received PMTCT prophylaxis in EFY 2003.

7. A linear increase was observed in the number of People Living with HIV/AIDS (PLWHA) ever enrolled, ever started and currently on ART over the past years; in particular, there was an increase between EFY 2002 and EFY 2003 from 473,772 to 580,919 for PLWHA ever enrolled in HIV/AIDS care, from 268,934 to 333,434 for those ever started and from 207,733 to 247,805 for those currently on ART.

8. In EFY 2003, it was planned to distribute 11,091,890 Long-Lasting Insecticide-treated Net (LLINs) for provision to new households as well as for replacement purposes, with 4,279,165 LLINs being actually distributed to regions. As a result, there was an increase in the cumulative number from 35,237,701 in EFY 2002 to 39,516,866 in EFY 2003. With regard to vector control, the plan was to implement Indoor Residual Spray (IRS) in 6,925,168 households in EFY 2003. However, 4,636,787 (67.0% of the target) households were sprayed. A decrease in the number of malaria cases reported through PHEM surveillance system was observed from over 3 million in EFY 2002 to 2.6 million in EFY 2003.

9. Fluctuations were observed in Tuberculosis (TB) indicators in EFY 2003: TB treatment success rate showed a downward fluctuation (from 84.0% to 82.5%) and TB cure rate slightly increased from 65.2% to 66.5% in the same period. TB detection rate also increased from 36.0% in EFY 2002 to 36.8% in EFY 2003, below the target set for the year (59%). Of note is the fact that TB detection rate was calculated from estimates of incidence rate of smear-positive TB derived from models produced by WHO. However, a TB prevalence survey was carried out in EFY 2003 to produce actual estimates in the country, with preliminary results showing a TB incidence rate of smear-positive TB (101 per 100,000 population) which was lower than the WHO estimate (163 per 100,000 population). This will lead to an increase in TB case detection rate. For EFY 2003, WHO estimates were used waiting for final endorsement of the TB prevalence survey results.

10. For the epidemic prone diseases under surveillance, the number of cases reported in EFY 2003 is as follows: 738 cases of Acute Watery Diarrhoea (AWD) (with an average Case Fatality Rate – CFR – of 0.4% at the national level); 38,288 suspected cases of measles (CFR=0.5%); 140,867 cases of dysentery (CFR=0.01%); 1,324 cases of meningococcal meningitis (CFR=2.9%); and 323,008 cases of typhoid fever (CFR=0.004%). Appropriate responses have been made to contain the transmission of the epidemic prone diseases. No polio cases were reported in EFY 2003, and there was zero report of cases of Severe

Acute Respiratory Syndrome (SARS), Viral Hemorrhagic Fever (VHF), and Yellow Fever.

11. Quality improvement is an integral part of any service delivery and to address this issue the Federal Ministry of Health (FMOH) has taken steps to ensure that all facilities have a Quality Management Committee and designed a reference manual to provide guidance on its implementation. In EFY 2003 the preparation of guidelines, manuals, standard operating procedures and the selection of the quality indicators were finalized. A number of activities concerning Quality of Health Services were performed in relation to Health Facility Reform, improvement of emergency services, blood safety, the referral system and the national laboratory system.

LEADERSHIP AND GOVERNANCE

The Leadership and Governance chapter comprises of evidence based planning, monitoring, evaluation, policy formulation and implementation. It also includes the development and implementation of a regulatory framework. Different activities such as the following had been performed in EFY 2003:

12. The status of implementation of the first year of HSDP IV was monitored by the FMOH and regions using various monitoring and reporting mechanisms.

13. One of the major planning activities performed during EFY 2003 was the finalization of the Woreda-based Core Plan for EFY 2004.

14. Regarding implementation of the Health Management Information System (HMIS), two regions (Dire Dawa and Harari) implemented fully, while Addis Ababa, Gambella and Benishangul Gumuz fully implemented HMIS last year but in EFY 2003 their implementation status is below 100% coverage due to the addition of newly constructed HCs. The other regions are in various stages of implementation. It is expected that these regions will be able to complete the scaling up of the HMIS in EFY 2004. At the national level, the HMIS has been implemented in 75% of the hospitals and 69% of the HCs. To enable the woredas and zones to lead and sustain the implementation process, supervisory level training has been provided to 1,864 professionals since EFY 2001. These supervisors, along with mentors from the FMOH and Development Partners (DPs), conducted 5 days training to 42,031 staffs in all regions.

15. In order to initiate rural Family Folder (FF) in all HPs, the Guideline on Rural Family Folder was finalized and training given for 1,284 health extension supervisors and 8,589 HEWs. FFs adequate for six million rural families were distributed and 3,256 (22%) HPs have started to implement the rural FF. On the other hand, the design of the Urban FF has been finalized and piloting is underway in Addis Ababa.

16. In EFY 2003, a Joint Review Mission (JRM) was conducted to review the level of achievement of the strategic objectives of HSDP IV, including the status of initiatives and targets set for the year. An assessment on the progress of "One Plan-One Budget and One Report" was also carried out by international consultants. The purpose of the assessment was to identify and document the barriers preventing partners from aligning their plans and budgets with "One Plan-One Budget and One Report" framework and from becoming part of the JFA which is the most preferred financing modality. Two evaluation studies on information use and HMIS data quality were conducted in EFY 2003, the first one in six regions and the second one in all regions. The study results were shared with regions and the HMIS National Advisory Committee (NAC). Two editions of the Policy and Practice Quarterly Health Bulletin were prepared in EFY 2003, and distributed to stakeholders. The statistical booklet "Health and Health-related Indicators" was also published in EFY 2003 as in the previous years.

17. In EFY 2003 operations researches (OR) were performed by Ethiopian Health and Nutrition Research Institute (EHNRI) in relation to HIV/AIDS, TB, malaria, other communicable diseases, nutrition and traditional medicine.

18. The regulatory system has been strengthened and activities related to Inspection and Quality Control of "Products", "Premises", "Professional Practice" and "Food Products" had been accomplished. These include the granting of permits for 4,686 types of drugs imported into the country, entry permits for 284,870 tons of foods and related items, export permits for 101,489 tons of foods and related items, inspection of 645 imported raw materials and 144 drug manufacturing, import/export and distribution

enterprises, as well as the registration and licensing of 6,001 graduates (out of the planned 9,000 health professionals).

19. With respect to gender mainstreaming, which is a cross-sectoral program, various awareness raising activities on sexual abuse were undertaken using different types of mass media targeting the public and various groups. Exchange of experiences and best practices was made with the participation of almost all regions and other stakeholders, and an indicative plan for EFY 2004 has been prepared.

HEALTH INFRASTRUCTURE AND RESOURCES

20. In EFY 2003, 903 new HPs were constructed, increasing the cumulative total to 15,095 HPs, which was still below the target (16,273) set for the year. The ratio HPs to population reached 1:5,427 at the national level in EFY 2003. A total of 1,200 HPs were equipped, reaching the cumulative total of 13,727 HPs equipped at the end of EFY 2003 (90.9% of the available HPs).

21. In EFY 2003, 518 HCs were newly constructed, reaching the cumulative total of 2,660 (2,142 HCs were already completed in EFY 2002). A total of 516 HCs were still under construction, therefore the cumulative total of HCs constructed and under construction reached 3,176 at the end of EFY 2003 (96.3% of the target set for the year)

22. In EFY 2003, regions reported the construction of 19 new hospitals and ongoing construction of 22 hospitals, while ongoing construction, expansion and rehabilitation work of federal hospitals is underway. The total number of public hospitals available at the end of EFY 2003 was 122.

23. With respect to training , a document comprising of Level IV unit of competencies for HEWs and Level IV Curriculum has been prepared and 1,100 trainees are being trained in six regions. The Accelerated Health Officer Training Program has come to an end. At the end of EFY 2003, a total of 5,431 health officers have graduated, surpassing the planned target (5,000) by 8.6%. In EFY 2003 there were 252 Integrated Emergency Surgery Officers (IESO) trainees participating in the three years Master Degree Program in the five universities (Gondar, Haromaya, Hawassa, Jimma and Mekele Universities) and 6,006 medical students (1st to 6th year) in nine Universities and at the St. Paul Millennium Medical College. In order to start the accelerated training of nurse midwives, curriculum has been prepared and the training of 1,634 trainees started in six regions. To start Diploma-level training of nurse anaesthetists, training curriculum of one year duration has been prepared and transmitted to Regional Health Bureaus (RHB) that have capacity for training this category of health professionals.

24. The Pharmaceutical Fund and Supply Agency (PFSA) has carried out a number of activities in EFY 2003 which included the following: out of the planned procurement of drugs and medical equipment worth ETB 3.619 billion, drugs and medical equipment worth ETB 3.586 billion have been procured. Various types of capacity building trainings on rational drug use, management and use of medical equipment and supplies, preparation of drug list and guidelines and related issues have been provided to 1,580 health professionals drawn from health facilities. Drug and Therapeutics Committees have been set up in 474 health facilities and 350 facilities have prepared the List of Drugs and Medical Equipment for procurement purposes. Integrated Pharmaceuticals Fund and Supply Management Information System (IPFSMIS) has been established in 202 health facilities.

25. The Parliament of the Federal Democratic Republic Ethiopia unanimously ratified the Social Health Insurance (SHI) Proclamation in EFY 2003. The feedbacks on SHI consultations held in the regions and at the federal level institutions were gathered and a refined SHI regulation has been prepared for subsequent endorsement by the Council of Ministers.

26. The FMOH endorsed the Community Based Health Insurance (CBHI) prototype directive in EFY 2003. With the exception of Tigray Region, all the three pilot regions adapted CBHI directive into their regional context. CBHI prototype by-laws was produced by the FMOH and pilot regions adapted it to their regional context. A total of 37,195 HHs were registered in all pilot regions and woredas. All the schemes in 13 CBHI pilot woredas generated a total of ETB 2.5 million from paying HHs. A total of 18,831, 12,339, 5,002, and 1,023 paying households have been registered in Amhara, SNNP, Oromia and

Tigray Regions, respectively. An assessment on human resources, infrastructure, laboratory and medical equipment, and availability of drugs and medical supplies in HCs located in the CBHI pilot woredas was undertaken and measures are being taken to strengthen health facilities.

27. To improve and strengthen the financial management system, FMOH has taken four initiatives. These are introducing Integrated Financial Management Information System (IFMIS), grant management system, hiring of financial technical assistants and contracting out of some of the accounting functions to accountancy firm.
28. The percentage share of the health budget from the total budget was 10.0% (10.4% in EFY 2002). The percentage of regional block grant budget allocated to the health sector ranged from 4.7% in Addis Ababa to 14.5% in Dire Dawa City Administration. The per capita allocation on health increased from ETB 39.8 in EFY 2002 to ETB 49.0 in EFY 2003.
29. Comparison between commitment and disbursement of donors' funds shows that in EFY 2003 a total of USD 485.44 million was committed by DPs for public modalities, out of which USD 422.35 million (87.0%) were disbursed. This represents an absolute increase in the amount of funds committed and disbursed to public implementing agencies in Ethiopia's health sector. However, the disbursement rate (87%) has decreased slightly from EFY 2002 (89%). In EFY 2003, the gross amount of funds disbursed by DPs for the sector increased by 15% from the previous year (from USD 368.47 million in EFY 2002 to USD 422.35 million in EFY 2003).

CHALLENGES

Some of the major challenges encountered during implementation of the EFY 2003 Core Plan include the following:

- Non-integrated monitoring and evaluation on HEP;
- Shortage of midwives, doctors and anaesthetists;
- Shortage and attrition of highly skilled professionals;
- Low coverage of skilled delivery and newborn care;
- Shortage of drugs, medical supplies, equipment and commodities;
- Long time taken in reverting the blood transfusion service from the Ethiopian Red Cross Society (ERCS) to FMOH;
- Weak referral system;
- Shortage of means of transport for supportive supervision;
- Absence of standardized Continuing Professional Development (CPD) programmes;
- Inadequate availability of resources compared to health care needs;
- Poor progress in adopting a common budgetary framework and reporting format by Development Partners (DP);
- Slow response of many DPs to join the International Health Partnership (IHP) Compact and Joint Financing Arrangement (JFA); and
- Inadequate capacity for fund liquidation, reporting and auditing.

In spite of such constraints, the health sector has registered significant progress in terms of designing the right policies and strategies, laying down the infrastructure for health care delivery and building up the institutions necessary for sustainable provision of equitable access for quality health services for the people of Ethiopia. As a result of the efforts made to implement innovative and high impact interventions, the health care system has achieved significant results in terms of progress in the implementation of priority health programs, such as maternal and newborn health, child health, and prevention and control of HIV/AIDS, Malaria and Tuberculosis.

These achievements however should not mask the recurrent existence of challenges such as the low percentage of deliveries attended by skilled health attendants (16.6%), low proportion of deliveries attended by HEWs (14.7%), low TB case detection rate (36.8%) and very low PMTCT coverage of HIV positive mothers (9.3%).

ARM EFY 2003 should examine the root causes for these formidable challenges facing the health sector within the framework of past implementation experiences and come up with appropriate recommendations to overcome these challenges in the coming years.

CHAPTER I

INTRODUCTION



Introduction

Thirteen years have passed since the launching of the first phase of the Health Sector Development Program (HSDP), which has currently reached its fourth stage-HSDP IV. Since its launching in 1997/98, a wide range of stakeholders have gathered every year to review the progress made and the challenges encountered during implementation. The Annual Review Meeting (ARM) is, therefore, one of the major forums for monitoring and evaluation of progress in the implementation of the HSDP.

As in previous years the objective of the thirteenth ARM is to review the performance of the sector in the Ethiopian Fiscal Year (EFY) 2003 (2010/11), identify achievements and constraints encountered in the implementation of the plan, and come up with remedial measures.

As one of the core agenda items at the ARM, the Annual Performance Report has proved to be very useful in highlighting areas of progress and current challenges in the health sector. It is one of the major management tools that assess sector progress in achieving the HSDP outputs and outcomes.

The Annual Performance Report for EFY 2003 (2010/11) marks the beginning of HSDP IV (2010/11 to 2014/15), and mainly focuses on the progress made during the first year of the fourth sector development program. For purposes of comparison and review of trends, however, it takes into consideration the performance through the HSDP III period with respect to selected indicators for which data are available.

Thus, the report provides highlights on:

- Sector performance for the first year of HSDP IV using core indicators;
- Performance against the Core Plan using national and regional level indicators;
- Trends of achievements;
- Regional comparisons;
- Status of implementation of the health sector support system; and
- Health sector financial report for EFY 2003 including analysis of allocation to the health sector and contribution from Development Partners (DP).

As for previous years, the development process of this Annual Performance Report for EFY 2003 (2010/11) was participatory, involving stakeholders from Regional Health Bureaus (RHB), the various Directorates of the Federal Ministry of Health (FMOH), and agencies accountable to the FMOH and DPs. In the preparation of the report, a uniform structure of presentation has been followed by indicating in each section the background, targets (where applicable), achievements, challenges and the way forward.

This Annual Performance Report relied heavily on routine service and administrative data, in particular the Health Management Information System (HMIS). Challenges identified with HMIS data included late and incomplete reporting, limited data quality for some indicators, and inconsistency between woreda (district) and regional data submitted through the quarterly HMIS reporting system and that submitted through the Program Annual Reports. In order to maintain consistency with previous reporting periods, this Annual Performance Report used the HMIS aggregated quarterly reports for the entire financial year (2010/11) with the exception of data for certain programs not covered by the HMIS.

Other key sources of information included: previous Annual Performance Reports during HSDP III, HSDP IV, reports by FMOH Programs and other central level institutions, and surveys and studies undertaken by

various stakeholder institutions.

This report is divided into five chapters:

Chapter 1 is an Introduction that covers the background of the Annual Performance Report and a brief description of the report's contents;

Chapter 2 covers an overview of the sector performance for EFY 2003 with respect to Health Service Delivery and Quality of Care;

Chapter 3 deals with implementation status concerning Leadership and Governance;

Chapter 4 details the performance in the area of Infrastructure and Resources; while

Chapter 5 outlines the Conclusions of the report.

The main chapters (chapters 2, 3, and 4) are based on the Strategic Themes or the "Sector's Pillars of Excellence", followed by a description of the strategic results. Each chapter ends with a section on challenges encountered as well as the way forward for enhanced programmatic performance.

The report is made up of five sections, and contains 31 tables and 49 figures that depict progress, decline, comparison and trends over time in the implementation of the first year of HSDP IV.

CHAPTER II

HEALTH SERVICE DELIVERY AND QUALITY OF CARE



Health Service Delivery and Quality of Care

Improving access to health services is one of the HSDP IV strategic objectives. It is expected that better accessibility will lead to improvements in the health of mothers, neonates, children, adolescents and youth as well as to reduce the burden related to Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Tuberculosis (TB), malaria and other communicable and non-communicable diseases.

The expected outcome will be increased citizen's confidence in the health system and proactive seeking of prevention and treatment services from health facilities. People have to believe and develop confidence that they will be able to receive the best medical care when needed and can reduce their risk of contracting diseases, ultimately reaching a better health status.

To achieve these results, the Health Extension Programme (HEP) is acting as a primary vehicle for prevention, health promotion, behavioural change communication and basic curative care through effective implementation of essential health packages.

2.1
Health Extension Program

HEP is a package of basic and essential promotive, preventive and selected high impact curative health services targeting households to improve the health status of families with their full participation, using local technologies and the community's skill and wisdom to produce and maintain their own health. Based on the philosophy of right knowledge and skill transferred to households, it can bring key maternal, neonatal and child health interventions to the community.

In doing so, HEP is currently implemented in agrarian, urban and pastoral areas of the country. In EFY 2003, much has been done to meet the targets set for the year.

In order to strengthen and improve the HEP, EFY 2003 plan included organization and mobilization of the Health Development Army (HDA) to capacitate families who are lagging behind in terms of adopting safe health practices.

HDA is the key strategy to scale up best practices by organizing and mobilizing families. The HDA will be a network created between five households and one model family to influence one another in practicing healthy life style. This network of families will be provided with technical support and training by Health Extension Workers (HEW) to implement the packages of HEP. HDA will help to expand the successful HEP experiences deeper into communities and families. They will be engaged in the promotion and prevention activities at household and community level, including the regular coordination of structured community dialogue sessions, with the guidance of the HEWs. Thus, HDA will help improve community ownership and scale up the best practices. With regard to the organization of the HDA, in EFY 2003 training was carried out in all regions and implementation has been initiated in SNNP and Tigray Regions.

Regarding the model family program, progress was made in EFY 2003 to increase the number of graduated households. In EFY 2002, the cumulative number of graduated households was 9,979,706, while the target set for EFY 2003 was to train and graduate additional 3,627,668 households; however, the number of households graduated in EFY 2003 was 2,198,924 (60.6% of the annual target). As a result, the cumulative number of graduated households was 12,178,630 (88.9% of the cumulative annual target). Of note is the

fact that this cumulative number (12,178,630) was 69.9% of the total eligible households (17,427,888).

According to the new Business Process Re-engineering (BPR) arrangement, the following section summarizes the progress that has been made with regard to HEP in agrarian (Tigray, Amhara, Oromia and SNNP), urban (Harari, Addis Ababa and Dire Dawa), and pastoral (Afar, Somali, Benishangul Gumuz and Gambella) regions in EFY 2003.

2.1.1
Agrarian HEP

In the agrarian areas the cumulative number of graduated model households (HH) reached 11,978,032 in EFY 2003. Amhara was the only region performing above its regional target (108.1%) (Figure 1). The remaining agrarian regions performed below their respective targets set for the year, reaching 91.1%, 90.2%, and 79.3% of the targets in Tigray, Oromia, and SNNPR, respectively (Table 1).

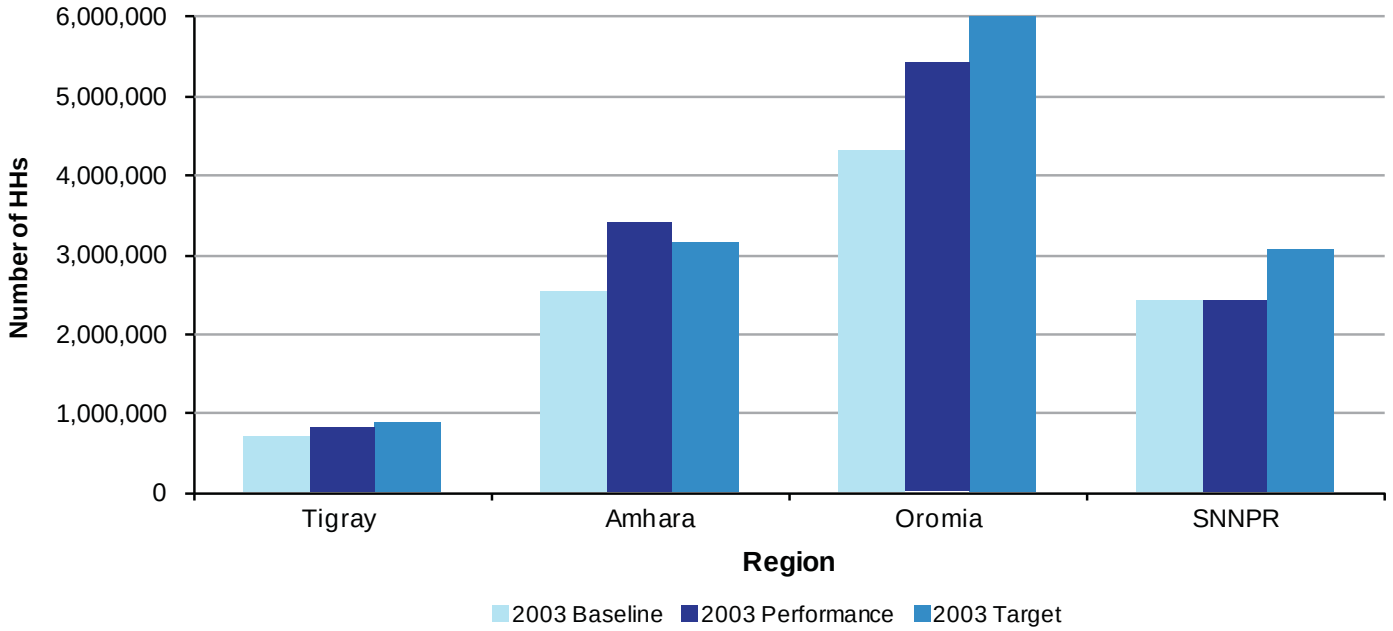


Figure 1: Comparison of Baseline, Performance and Target of the Cumulative Number of Graduated Households in Tigray, Amhara, Oromia and SNNP Regions (EFY 2003)

Table 1: Comparison of Baseline, Performance and Target for the Number of Model Households Graduated with Percentage of Target Achievement in Tigray, Amhara, Oromia and SNNP Regions (EFY 2003)

Region	Cumulative number of Graduated Households at the end of EFY 2002	Number of Graduated Households in EFY 2003	Cumulative number of Graduated Households at the end of EFY 2003	EFY 2003 target for the number of Graduated Households	Annual performance (%)	EFY 2003 target for the cumulative number of Graduated Households	Cumulative performance (%)	EFY 2003 eligible number of Households	Percentage of Graduated Households (out of the total eligible) at the end of EFY 2003 (%)
	(A)	(B)	(C)= (A+B)	(D)	(E)= (B*100)/(D)	(F)	(G) = (C*100)/(F)	(H)	(I) = (C*100)/(H)
Tigray	703,152	89,010	792,162	166,773	53.4%	869,925	91.1%	1,082,353	73.2%
Amhara	2,508,472	874,669	3,383,141	619,981	141.1%	3,128,453	108.1%	4,282,512	79.0%
Oromia	4,300,287	1,085,430	5,385,717	1,670,237	65.0%	5,970,524	90.2%	6,343,451	84.9%
SNNPR	2,417,012	0	2,417,012	631,806	0.0%	3,048,818	79.3%	3,441,806	70.2%

To complement the turnover and for newly constructed Health Posts (HP), a total of 1,278 HEWs were trained and deployed in Amhara and SNNP Regions. Moreover, a total of 1,322 HEWs are now under training to fill the gap in Amhara, SNNP and Tigray Regions.

Corresponding to other health promotion activities, two documentary films entitled "Healthy and Productive Community" and "Health from Where to Where" were produced and screened. Besides, programs on Prevention of Mother to Child Transmission (PMTCT) of HIV service, nutrition, family planning, hygiene and environmental health, TB case detection and referral system were produced and aired to the community through the Ethiopian Radio and Television Agency (ERTA).

2.1.2
Urban HEP

A cumulative number of 63,355 households were graduated as Model Families in the framework of the urban HEP: 55,151 in Addis Ababa, 5,790 in Dire Dawa, and 2,414 in Harari at the end of EFY 2003. No region performed above its regional target set in EFY 2003 (Figure 2). The level of target achievement for the cumulative number of graduated households was 22.2% in Addis Ababa, 20.2% in Dire Dawa, and 13.6% in Harari (Table 2). The low performance is due to the late commencement of the program in urban areas.

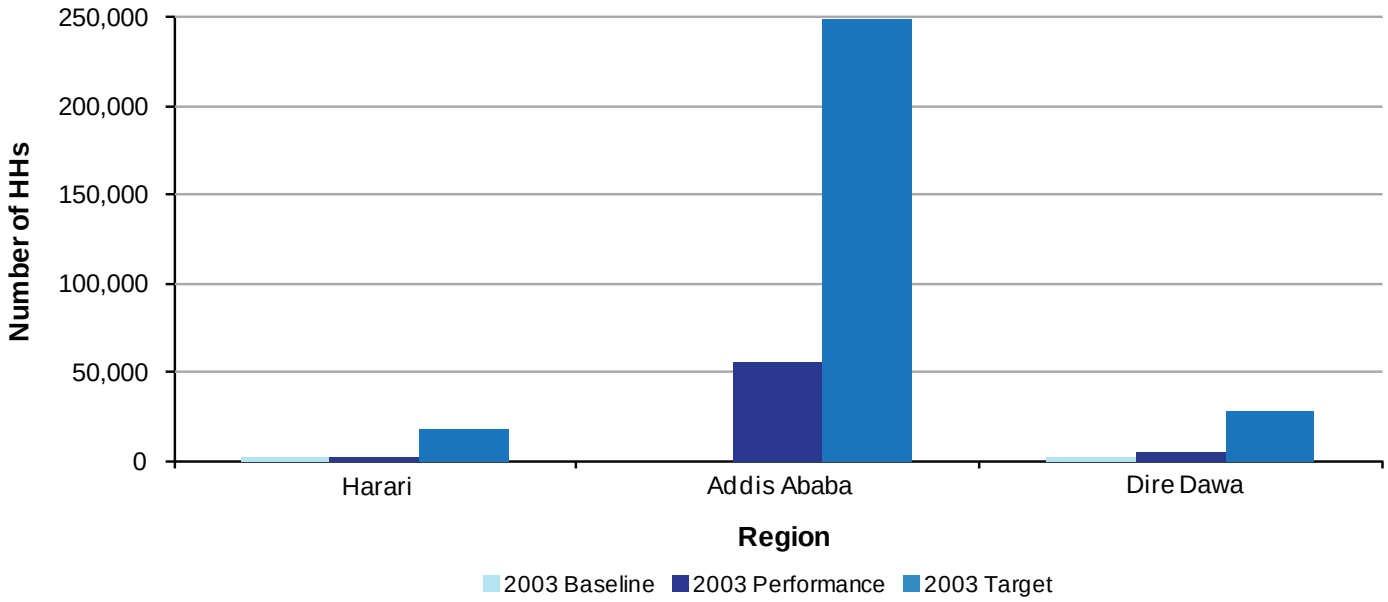


Figure 2: Comparison of Baseline, Performance and Target of the Cumulative Number of Graduated Households in Harari, Addis Ababa and Dire Dawa (EFY 2003)

Table 2: Comparison of Baseline, Performance and Target for the Number of Model Households Graduated with Percentage of Target Achievement in Harari, Addis Ababa and Dire Dawa (EFY 2003)

Region	Cumulative number of Graduated Households at the end of EFY 2002	Number of Graduated Households in EFY 2003	Cumulative number of Graduated Households at the end of EFY 2003	EFY 2003 target for the number of Graduated Households	Annual performance (%)	EFY 2003 target for the cumulative number of Graduated Households	Cumulative performance (%)	EFY 2003 eligible number of Households	Percentage of Graduated Households (out of the total eligible) at the end of EFY 2003 (%)
	(A)	(B)	(C)= (A+B)	(D)	(E)= (B*100)/(D)	(F)	(G) = (C*100)/(F)	(H)	(I) = (C*100)/(H)
Harari	2,159	255	2,414	15,591	1.6%	17,750	13.6%	52,094	4.6%
Addis Ababa	0	55,151	55,151	248,939	22.2%	248,939	22.2%	725,758	7.6%
Dire Dawa	2,400	3,390	5,790	26,198	12.9%	28,598	20.2%	84,093	6.9%

2.1.3
Pastoral HEP

In EFY 2003, the cumulative number of graduated model households in pastoral areas reached 137,243 (Figure 3). Benishangul Gumuz was the best performing region, reaching 60.0% of its regional target set for EFY 2003, followed by Somali Region (42.9%) and Afar (6.9%). Gambella did not graduate any model household (Table 3).

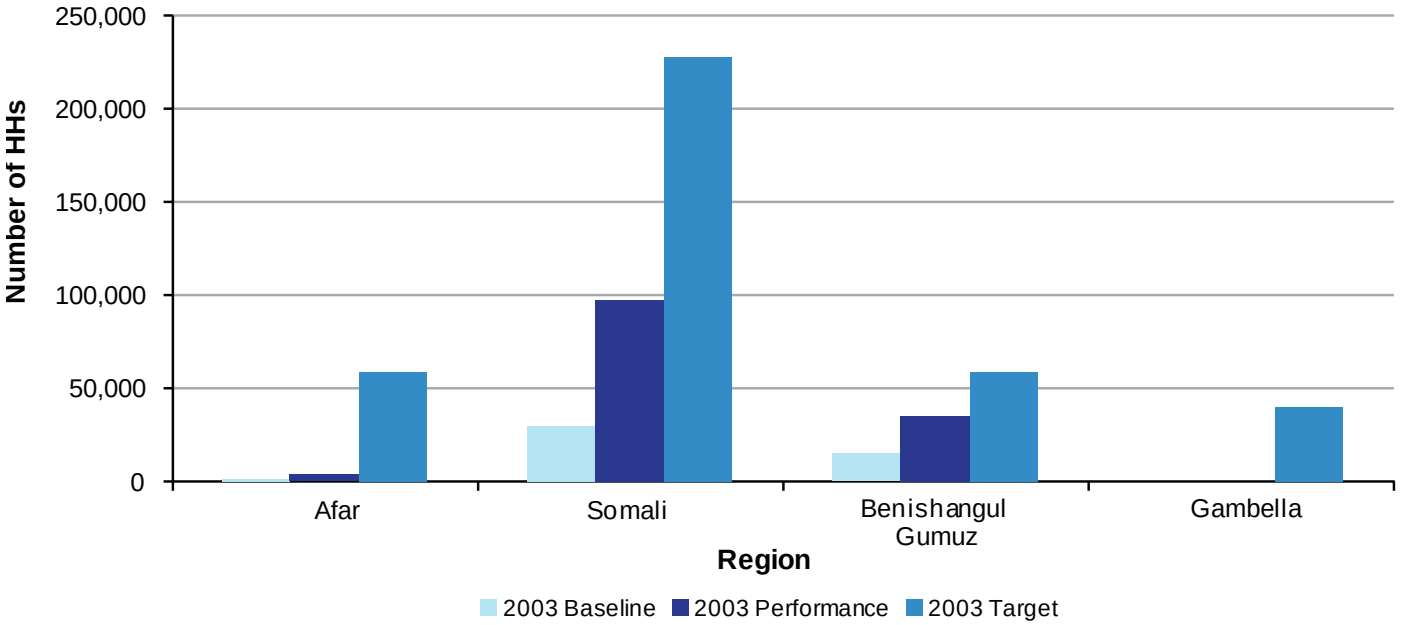


Figure 3: Comparison of Baseline, Performance and Target of the Cumulative Number of Graduated Households in Afar, Somali, Benishangul Gumuz and Gambella (EFY 2003)

Table 3: Comparison of Baseline, Performance and Target for the Number of Model Households Graduated with Percentage of Target Achievement in Afar, Somali, Benishangul Gumuz and Gambella (EFY 2003)

Region	Cumulative number of Graduated Households at the end of EFY 2002	Number of Graduated Households in EFY 2003	Cumulative number of Graduated Households at the end of EFY 2003	EFY 2003 target for the number of Graduated Households	Annual performance (%)	EFY 2003 target for the cumulative number of Graduated Households	Cumulative performance (%)	EFY 2003 eligible number of Households	Percentage of Graduated Households (out of the total eligible) at the end of EFY 2003 (%)
	(A)	(B)	(C)= (A+B)	(D)	(E)= (B*100)/(D)	(F)	(G) = (C*100)/(F)	(H)	(I) = (C*100)/(H)
Afar	130	3,910	4,040	58,765	6.7%	58,895	6.9%	270,075	1.5%
Somali	30,490	67,184	97,674	105,079	63.9%	227,903	42.9%	745,324	13.1%
Benishangul Gumuz	15,604	19,925	35,529	43,581	45.7%	59,185	60.0%	167,788	21.2%
Gambella	0	0	0	40,719	0.0%	40,719	0.0%	78,355	0.0%

Implementation of the HEP in pastoralist areas is slow and, to address the challenges, formative and process evaluation was conducted to identify the bottlenecks and come up with practical solutions.

Twenty seven higher officials and HEW supervisors from Somali Region and 42 HEW supervisors and 13 professionals from Gambella Region made experience sharing visits to different zones of SNNPR and Hawassa and Shashemene towns.

2.2
Hygiene and Environmental Health Services

With regard to hygiene and environmental sanitation, it was planned to increase the number of households with latrines from 12,673,106 (75.0% of latrine coverage) in EFY 2002 to 14,730,588 (86% of latrine coverage) in EFY 2003. However, in EFY 2003, the cumulative number of households with latrine was 14,993,248, achieving the target set for the year in the Core Plan.

Comparison of latrine coverage across agrarian regions showed that the highest coverage was observed in SNNPR (96.3%) and Oromia (96.1%), followed by Amhara (87.1%) and Tigray (70.0%). Only Amhara Region performed above its regional target set in EFY 2003 (Figure 4).

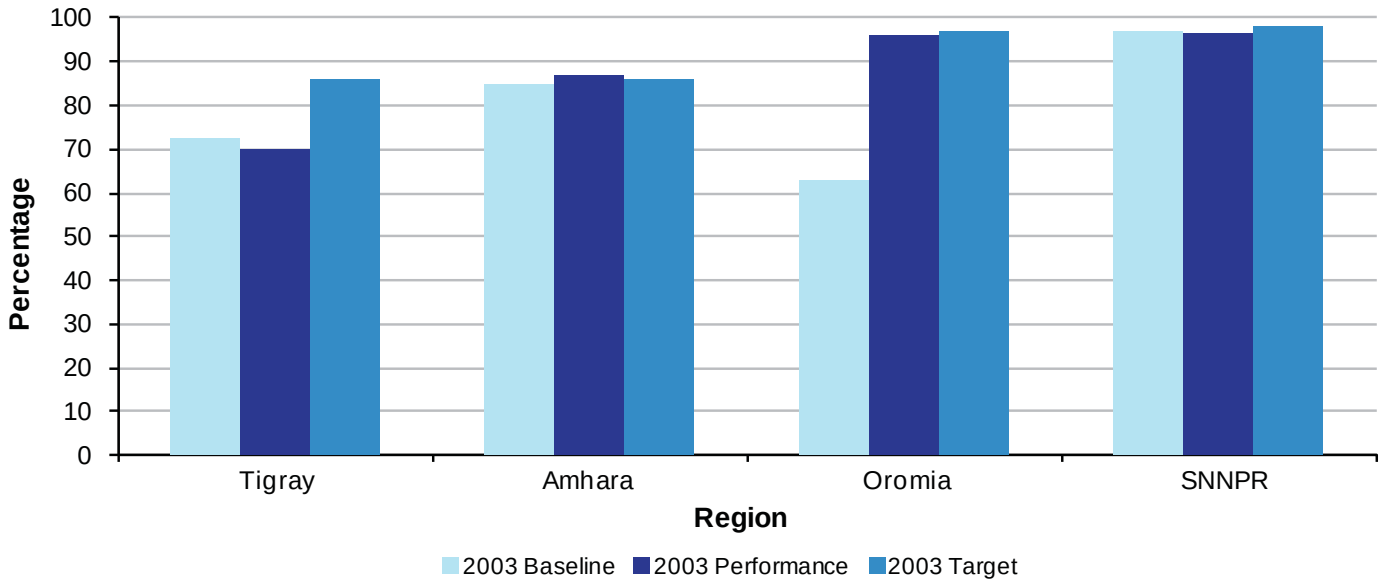


Figure 4: Comparison of Baseline, Performance and Target of Latrine Coverage in Tigray, Amhara, Oromia and SNNP Regions (EFY 2003)

The comparison of latrine coverage in urban areas shows that Addis Ababa achieved the best performance in EFY 2003 (91.1%), followed by Harari (41.9%) and Dire Dawa (31.8%). No urban region achieved its regional target (Figure 5). The decrease in latrine coverage may be related to the expansion of the urban population due to the migration from rural to urban areas (mainly in slum areas with poor access to latrine services); however, underreporting may also contribute to the downward pattern observed in urban areas.

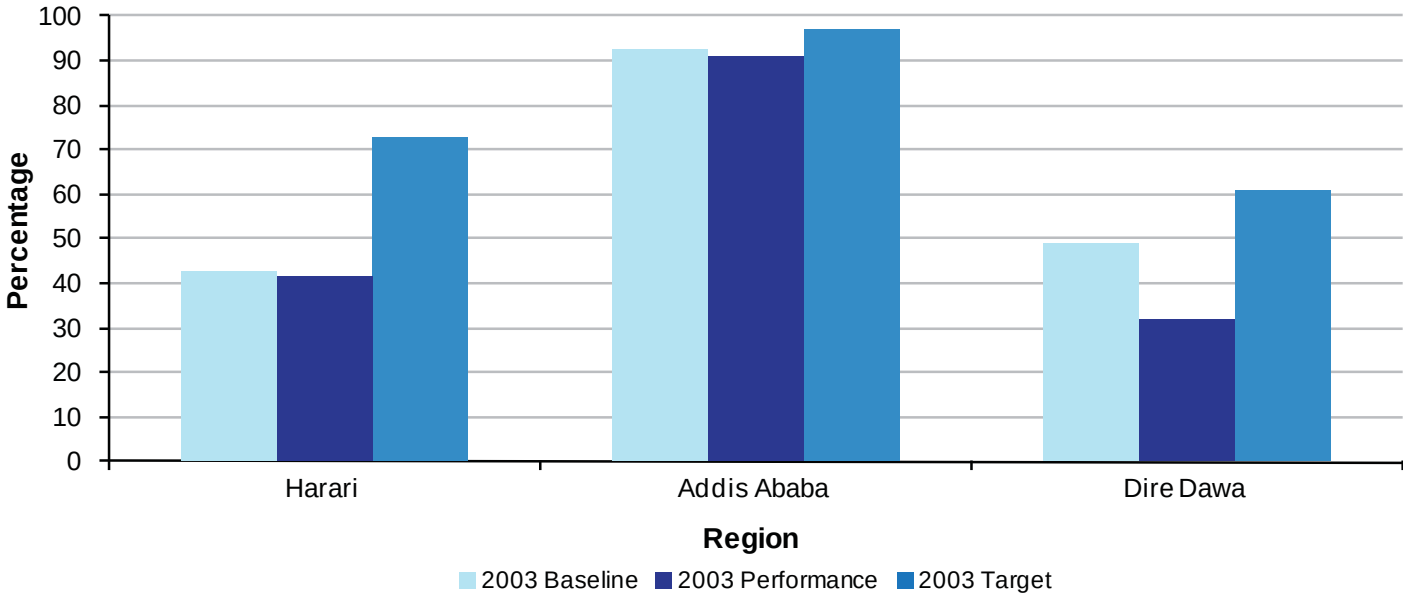


Figure 5: Comparison of Baseline, Performance and Target of Latrine Coverage in Harari, Addis Ababa and Dire Dawa (EFY 2003)

In the same year low latrine coverage was observed in pastoral areas: 40.0%, 34.6%, 16.6% and 6.3% in Somali, Benishangul Gumuz, Gambella and Afar Regions, respectively. No pastoralist region achieved its regional target set for the year (Figure 6).

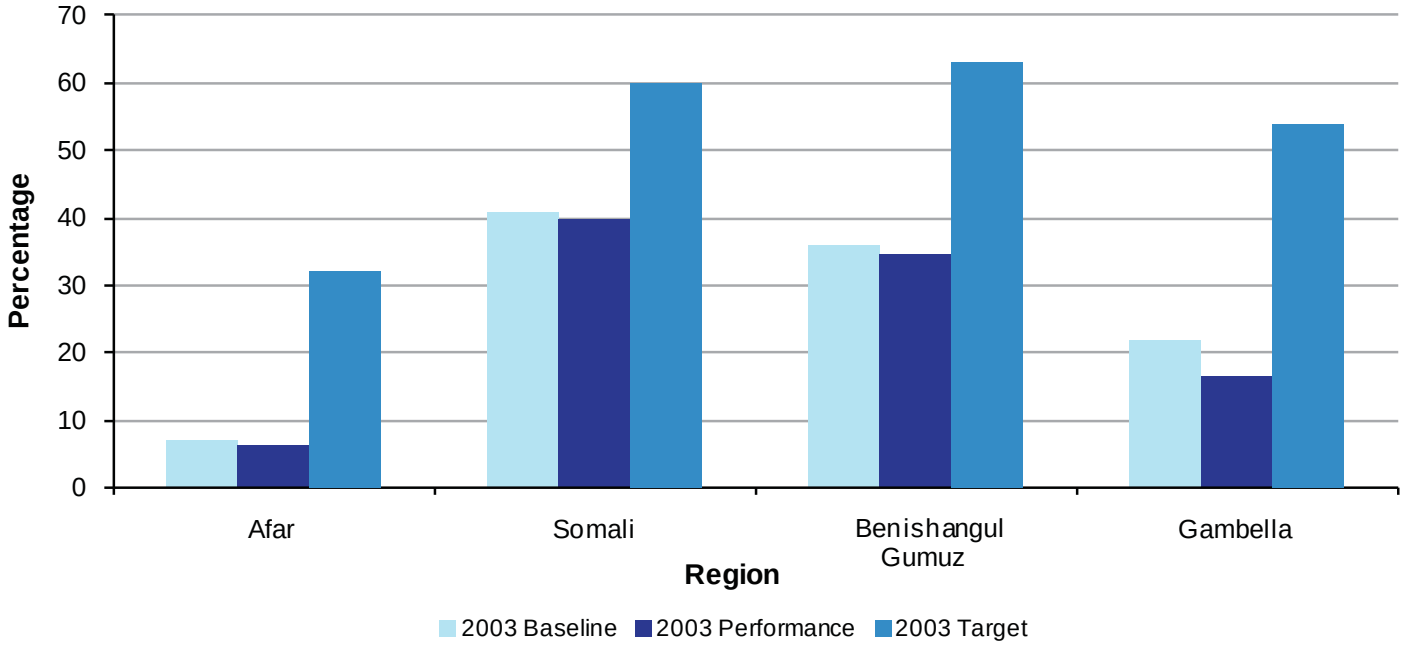


Figure 6: Comparison of Baseline, Performance and Target of Latrine Coverage in Afar, Somali, Benishangul Gumuz and Gambella (EFY 2003)

With regard to hygiene and environmental health services, the following activities were also carried out in EFY 2003:

- In line with the Libreville Declaration, a five year strategic plan was designed on Hygiene and Environmental Sanitation;
- A five year strategic plan was prepared on Climate Change and submitted to the Environmental Protection Authority (EPA);
- Concerning Community Led Total sanitation (CLTS), a total of 455 HEW supervisors and other related public health professionals were trained as trainers on implementation and certification of CLTS; and
- Regarding water quality and safety, Training of Trainers (TOT) was given for 89 individuals on testing kits and these trainers in turn trained 196 professionals; besides, a total of 25 testing kits were distributed to different regions.

Challenges

- Non-integrated Monitoring and Evaluation (M&E) on HEP;
- Limited experience sharing capacity;
- Limited capacity on implementation modalities of HEP in pastoralist areas;
- Shortage of water quality and safety testing kits; and
- Uncoordinated support from partners.

Way forward

- Strengthen M&E on HEP and the progress of the new HDA;
- Strengthen the capacity of regions on experience sharing and adopt best practices;
- Ensure full implementation of the pastoral HEP;
- Avail adequate amount of water quality and safety testing kits; and
- Strengthen harmonization and alignment according to the principle of "One Plan, One Budget and One Report".

2.3 Maternal and Newborn Health Services

The Government of Ethiopia is committed to achieve Millennium Development Goal 5 (MDG5) to improve maternal health, with a target of reducing Maternal Mortality Ratio (MMR) by three-quarters over the period 1990 to 2015. Accordingly, the FMOH has applied multi-pronged approaches to bring about reduction in maternal and newborn morbidity and mortality.

In light of the development of new initiatives and enhanced efforts to reach the MDG targets in reproductive health, it was found essential to revise the National Reproductive Health Strategy for the remaining period 2011- 2015. In addition to the previous components, the Strategy now incorporates Maternal and Newborn Health. The main strategies for reduction of maternal and neonatal mortality in Ethiopia are: (i) empowering women, men, families, and communities to recognize pregnancy-related risks; (ii) ensuring access to a core package of maternal and neonatal health services including access to transportation facilities; and (iii) creating an environment supportive to safe motherhood and newborns. Increasing community awareness on complication readiness and birth preparedness, availability of basic and comprehensive Emergency Obstetric and Neonatal Care (EmONC), and thus reduction in the occurrence of obstetric complications and deaths, are the main targets to monitor progress. In particular, concerning reduction of neonatal mortality, the initiative articulated in HSDP IV includes establishment of newborn corners and intensive care units in Primary Health Care Units (PHCU).

As envisaged in the draft Revised Reproductive Health (RH) strategy, a draft Road Map for Accelerating the Attainment of the Millennium Development Goals (MDG) Related to Maternal and Newborn Health in Ethiopia (2011 – 2015) has been prepared, incorporating the above mentioned strategies, and will be implemented as a priority program in HSDP IV.

Achieving good maternal health requires quality reproductive health services and a series of well-timed interventions to ensure women's safe passage to motherhood. For monitoring purposes, a set of key indicators were selected: each one represents a link of the continuum of care and is connected with other dimensions of health and health systems. A measure of contraception - Contraceptive Acceptance Rate (CAR) - is presented as a tracer of reproductive health. Antenatal Care (ANC) coverage provides a measure of access to the health system and is critical to ensuring proper coverage of care to identify maternal risks and improve health outcomes for the mother and the newborn. Measures of coverage of skilled care at birth and birth attendance by HEWs, as well as Postnatal Care (PNC) services, are critical elements of the continuum of care. HIV-related indicators are included to emphasize the need towards a more holistic approach to health care, and to promote further integration of PMTCT and maternal health services. These indicators are summarized in Table 4 showing, for each indicator, EFY 2003 baseline, performance and target, as well as the overall HSDP IV targets set for EFY 2007.

The percentage of deliveries attended by skilled health personnel is a key intervention for reducing maternal deaths and it is considered as a proxy indicator for measuring improvements in maternal mortality. However, the performance is very low and further efforts have to be made to increase the number of deliveries assisted by skilled health personnel. Furthermore, the percentage of deliveries attended by HEWs is also low and even showing a downward fluctuation. It is expected that, along with HEWs, the Health Development Army, once established and mobilized, could make a difference by promoting institutional deliveries.

ANC care coverage 1+ (at least one visit) increased from 71.4% in EFY 2002 to 82.2 % in EFY 2003, and PNC coverage increased from 36.2% in EFY 2002 to 42.1%, while the percentage of deliveries attended by skilled health personnel remained stable at 16.6% (16.8% in EFY 2002) (Figure 7). Conversely, clean and safe delivery service coverage (by HEWs) declined from 17.0% in EFY 2002 to 14.7 % in EFY 2003. CAR remained stable at 61.7% (61.9% in EFY 2002). The proportion of pregnant women counselled and tested for PMTCT increased from 22.0% to 33.4% and the proportion of deliveries of HIV-positive women who received a full course of Antiretroviral (ARV) prophylaxis increased from 8.3% in EFY 2002 to 9.3% in EFY 2003. In EFY 2003, only ANC (82.2 %) surpassed the target (80.4%).

Table 4: Maternal Health Indicators (EFY 2003 Baseline, Performance and Target and HSDP IV Target)

Indicators	EFY 2003 Baseline	EFY 2003 Performance	EFY 2003 Target	HSDP IV Targets (EFY 2007)
Antenatal care coverage	71.4%	82.2%	80.4%	90%
Percentage of deliveries attended by skilled health personnel	16.8%	16.6%	27.0%	62%
Clean and safe delivery service coverage (Percentage of deliveries attended by HEWs)	17.0%	14.7%	34.4%	38%
Postnatal care coverage	36.2%	42.1%	50.3%	78%
Contraceptive acceptance rate	61.9%	61.7%	65.8%	82%
Percentage of pregnant women counselled and tested for PMTCT	22.0%	33.4%	36%	83%
Percentage of deliveries of HIV-positive women who received a full course of ARV prophylaxis	8.3%	9.3%	24%	77%

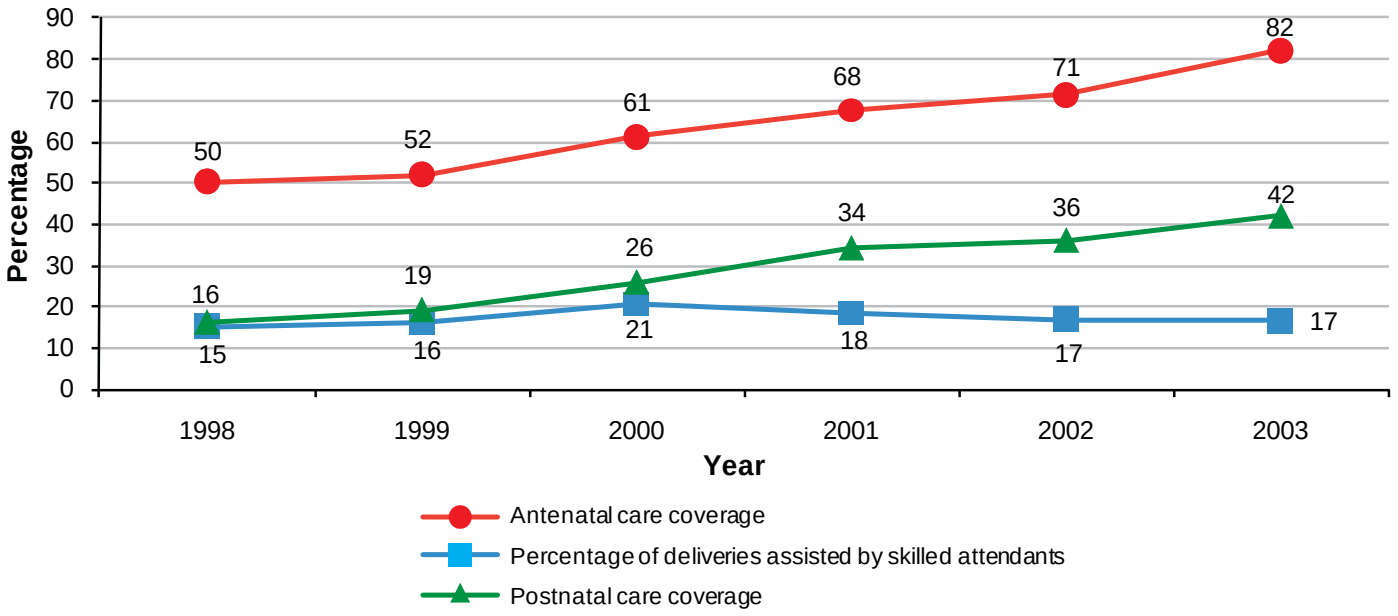


Figure 7: Trend in Antenatal Care Coverage, Percentage of Deliveries Attended by Skilled Health Personnel and Postnatal Care Coverage (EFY 1998- 2003)

2.3.1 Regional Distribution of Antenatal Care Coverage

Performance in ANC coverage showed wide variation across regions, ranging from 26.4% in Afar Region to over 100% in Addis Ababa. Five regions (Tigray, Amhara, Harari, Addis Ababa, and Dire Dawa) achieved their target. Besides the mentioned regions, other four regions improved their performance in EFY 2003 (Afar, Oromia, SNNP, and Gambella), while the performance decreased in Somali and Benishangul Gumuz (Figure 8).

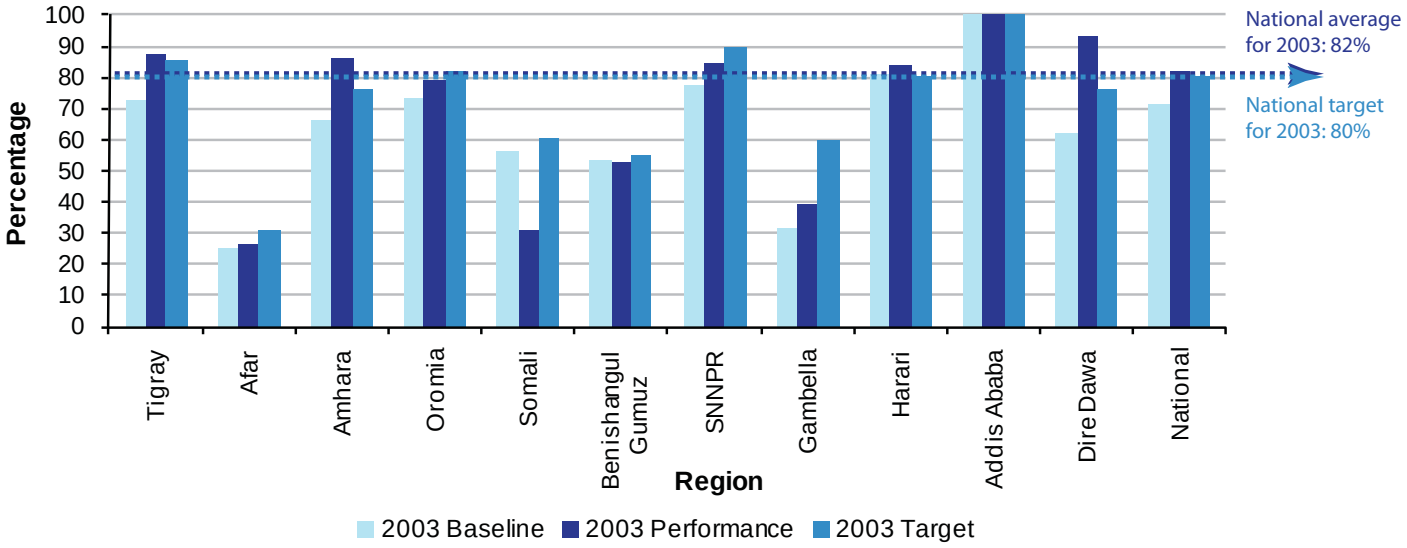


Figure 8: Comparison of Baseline, Performance and Target of Antenatal Care Coverage by Region (EFY 2003)

2.3.2
Regional Distribution in the Percentage of Deliveries Assisted by Skilled Health Personnel

The percentage of deliveries assisted by skilled health personnel was stable at 16.6% in EFY 2003, which was lower than the target of 27.0% set for the year.

There was wide variation across regions, ranging from 7.4% in Afar to 67.4% in Addis Ababa. Compared to the baseline, an increase was observed in five regions (Benishangul Gumuz, SNNP, Gambella, Addis Ababa, and Dire Dawa), while a decrease was observed in other six regions (Figure 9). It is only one region (Gambella with 13.6% performance) that exceeded its regional target (11.5%).

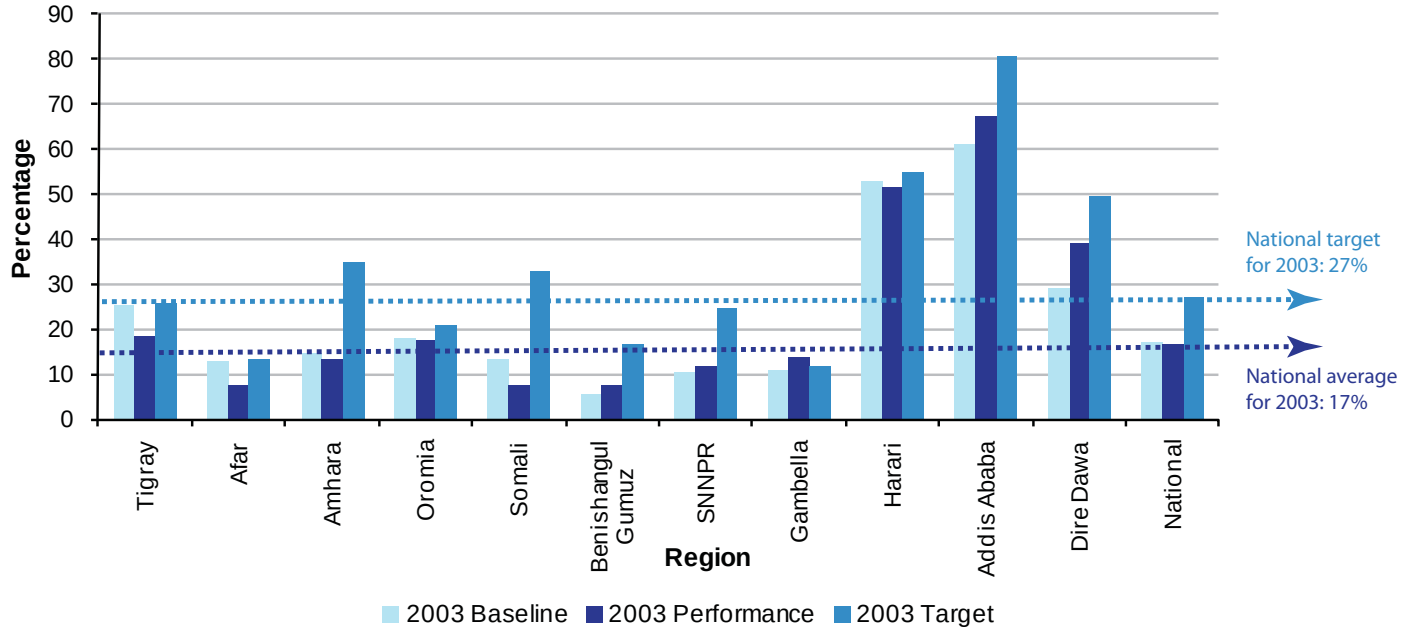


Figure 9: Comparison of Baseline, Performance and Target of the Percentage of Deliveries Assisted by Skilled Health Personnel by Region (EFY 2003)

Most maternal deaths occur during delivery and the postpartum period. Emergency obstetric care, skilled birth attendants, postpartum care, and transportation to medical facilities if complications arise, are all necessary measures to reduce maternal mortality. The high maternal and newborn mortality in the country is due to the three delays: (i) delay in seeking skilled emergency obstetric care; (ii) in reaching the health facility; and (iii) in receiving a timely intervention after reaching the facility. Hence, strategies have been designed and relevant

activities are being performed to remove the bottlenecks accounting for the low rate of institutional deliveries.

To solve the first delay, the strategic direction adopted by the FMOH is to strengthen and expand the HEP. For this purpose, the work of organizing and mobilizing the HDA at all levels is being performed intensively.

To solve the second delay related to issue of transportation, 53 ambulances were distributed to 10 regions and have started to provide the needed service at woreda level, while the procurement of 315 ambulances is underway. The procurement of ambulances will continue until the planned target (800 ambulances) will be achieved.

To solve the third bottleneck related to capacity for timely intervention, the following activities have been planned: (i) training of human resources; (ii) provision of adequate drugs, medical supplies and equipment; (iii) equitable placement of adequate number of health professionals in health facilities; and (iv) promotion of professional ethics of health workers. In order to initiate and continue to provide Basic Emergency Obstetric and Neonatal Care (BEmONC) in 1,915 HCs in a more intensive manner, TOT was given for 84 professionals who in turn gave training for 309 professionals. BEmONC services thus started to be provided in 752 HCs. In addition, by giving training for 33 health professionals and providing financial, material and technical assistance to health facilities, Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) service started to be given in 69 hospitals. The accelerated training of nurse midwives has started and 1,634 midwives are being trained in six regions, while 252 Integrated Emergency Surgery Officers (IESO) are under training in five universities.

2.3.3
Regional Distribution of Clean and Safe Delivery Service Coverage

A decline was observed in the clean and safe delivery service coverage, from 17.0% in EFY 2002 to 14.7% in EFY 2003, a level that is well below the target set for the year (34.4%). Wide variations were observed across regions, ranging from 0.3% in Afar to 31.7% in SNNPR. An increase in performance was observed in three regions (Somali, Gambella and Dire Dawa), while a decrease was observed in six regions (Tigray, Afar, Oromia, Benishangul Gumuz, SNNP and Harari). Amhara showed the same performance in EFY 2002 and 2003, far below its regional target. These services were not supposed to be performed in Addis Ababa. None of the regions achieved its regional target (Figure 10). Of note is the fact that the decline in the clean and safe delivery service coverage observed in some regions (such as in SNNPR) may be explained at least partly by the expansion of HCs and the subsequent provision of skilled care at birth in the catchment area. However, explanation should be sought for the simultaneous decline in coverage of deliveries attended by skilled personnel and those attended by HEWs observed in some regions (Tigray, Afar, Oromia, and Harari).

Training on clean and safe delivery was provided for 11,324 rural HEWs and, to decrease the maternal mortality

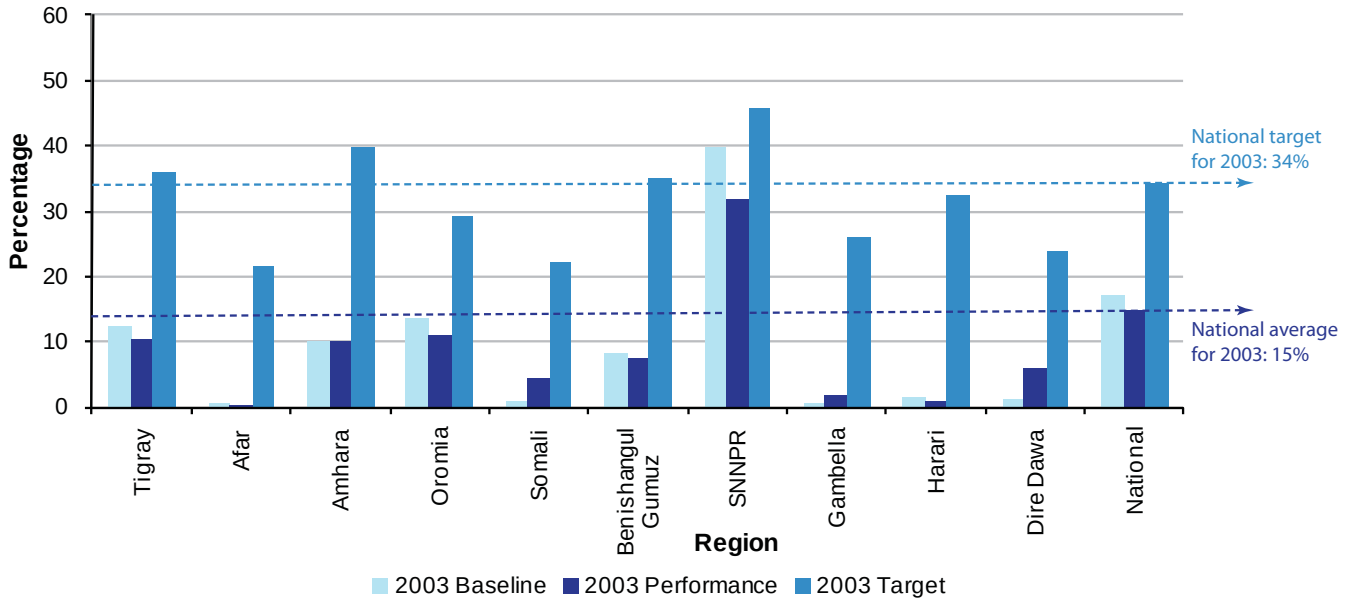


Figure 10: Comparison of Baseline, Performance and Target of the Clean and Safe Delivery Service Coverage (EFY 2003)

caused by post partum haemorrhage, Misoprostol capsules adequate for 192,800 mothers were procured and distributed to regions. Furthermore, training on the use of Magnesium Sulphate was given for 380 professionals and Magnesium Sulphate adequate for the use of 109,700 mothers was distributed to health facilities.

2.3.4
Regional Distribution of Postnatal Care Coverage

Unlike EFY 2002, the highest coverage in EFY 2003 was observed in Dire Dawa (64.5%), which was the only region achieving its regional target (Figure 11). In addition to Dire Dawa, an increase was observed in other five regions (Amhara, Oromia, SNNP, Gambella and Harari). A decrease was observed in five regions (Tigray, Afar, Somali, Benishangul Gumuz, and Addis Ababa).

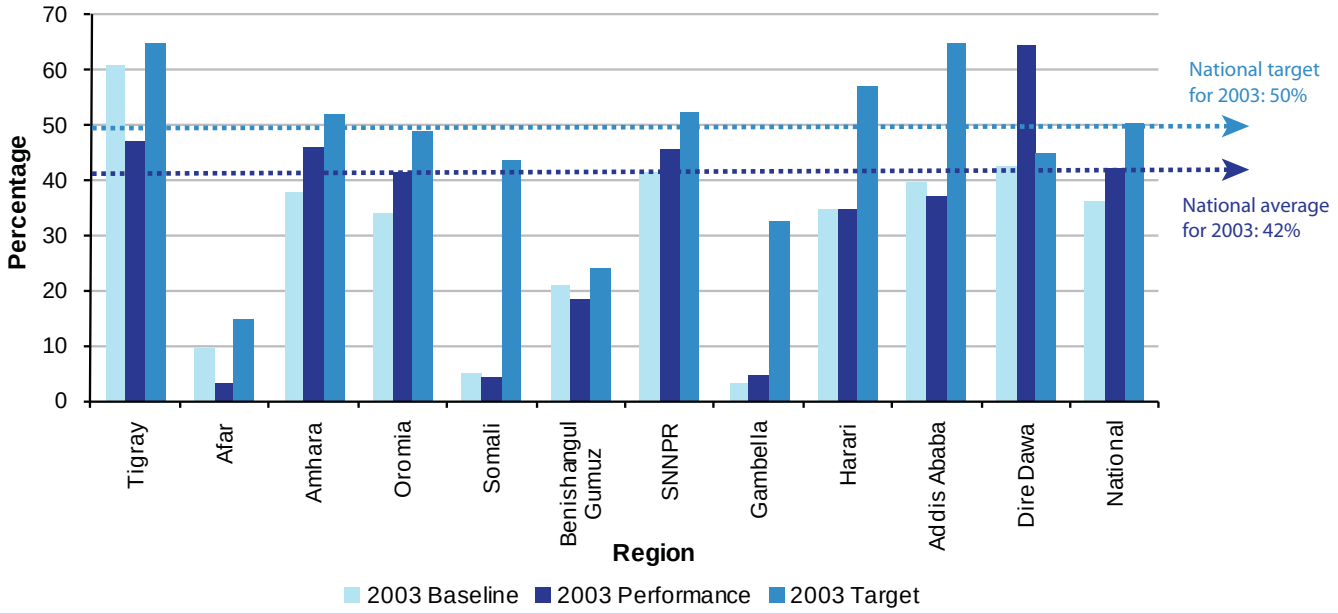


Figure 11: Comparison of Baseline, Performance and Target of Postnatal Care Coverage by Region (EFY 2003)

2.3.5
Trend in the Contraceptive Acceptance Rate

Contraceptive Acceptance Rate (CAR) is the proportion of women of reproductive age (15-49 years) who are not pregnant and are accepting a modern contraceptive method (new and repeat acceptors). Each acceptor is counted only once, the first time s/he receives contraceptive services in the calendar year. The CAR remained stable at 61.7% in EFY 2003, and was below the target of 65.8% set in EFY 2003 (Figure 12).

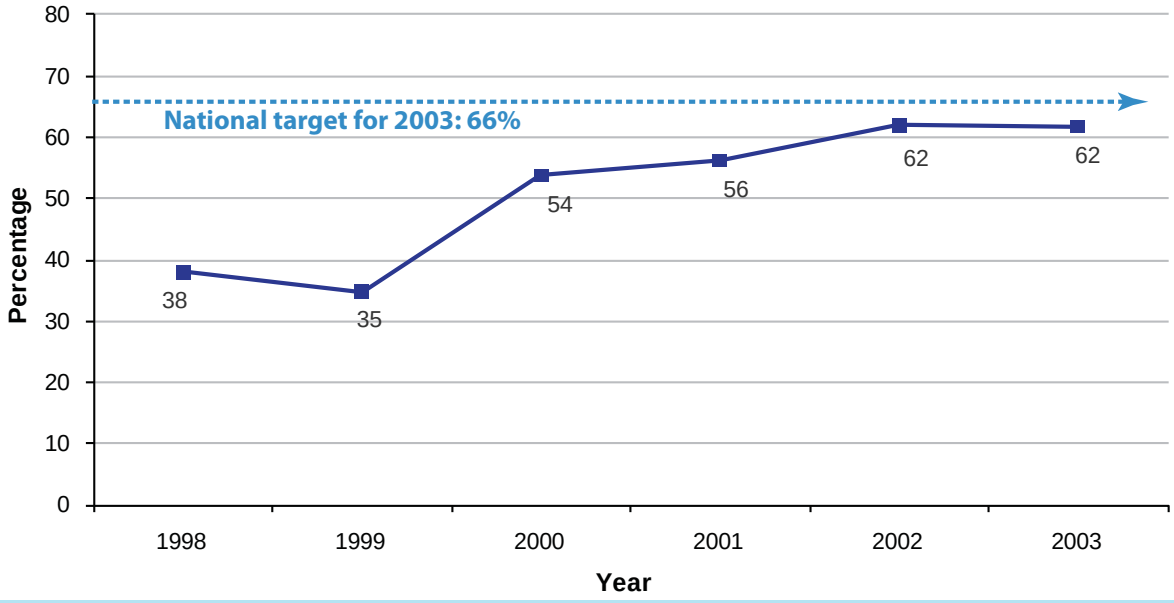


Figure 12: Trend in Contraceptive Acceptance Rate (EFY 1998-2003)

Concerning Family Planning (FP) services, the plan in EFY 2003 was to: (i) distribute contraceptives adequate for 10,013,282 women to health facilities on time; (ii) provide training on Implanon for 524 health professionals, 22,760 HEWs and 1,840 Health Extension Supervisors; (iii) translate Family Planning Decision Making Tool into Amharic, Afan Oromo and Tigrigna; and (iv) to prepare Training Guideline on Implanon Insertion.

According to the plan, regular and emergency contraceptives adequate for 10 million women of reproductive age were distributed to all regions. After provision of TOT on long acting FP methods (Implanon insertion and removal skills) for 496 rural health extension supervisors using the Training Guideline on Implanon, training was provided to 4,984 rural and urban HEWs. Training on Comprehensive Family Planning Services was also given for 292 health workers. Family Planning Decision Making Tool was translated into Amharic, Afan Oromo and Tigrigna and printing is underway for distribution to both HEWs and other care providers working at HCs and hospitals. Furthermore, promotional and awareness raising activities on long acting contraceptives - Implanon and Intra-Uterine Contraceptive Device (IUCD) - were carried out in all regions, except Afar, Somali and Gambella, while the same activities on short acting contraceptives were carried out in every region.

2.3.6
Regional Distribution of Contraceptive Acceptance Rate

Wide variations across regions were observed in EFY 2003, with the lowest rate (6.4%) being reported from Afar Region, and the highest (88.6%) from Amhara Region. An increase was observed in five regions (Amhara, Oromia, Benishangul Gumuz, Gambella and Harari), while there was a decrease in six regions (Tigray, Afar, Somali, SNNPR, Addis Ababa and Dire Dawa). In EFY 2003, it is Amhara and Oromia Regions that performed above their annual targets (Figure 13). As explained before, the low rates observed in pastoralist areas are due to negative influences primarily caused by cultural and religious beliefs and practices and low level of community awareness about family planning services. This situation demands a concerted effort to scale up community-based advocacy and Information, Education, Communication and Behaviour Change Communication (IEC/BCC) activities in these areas.

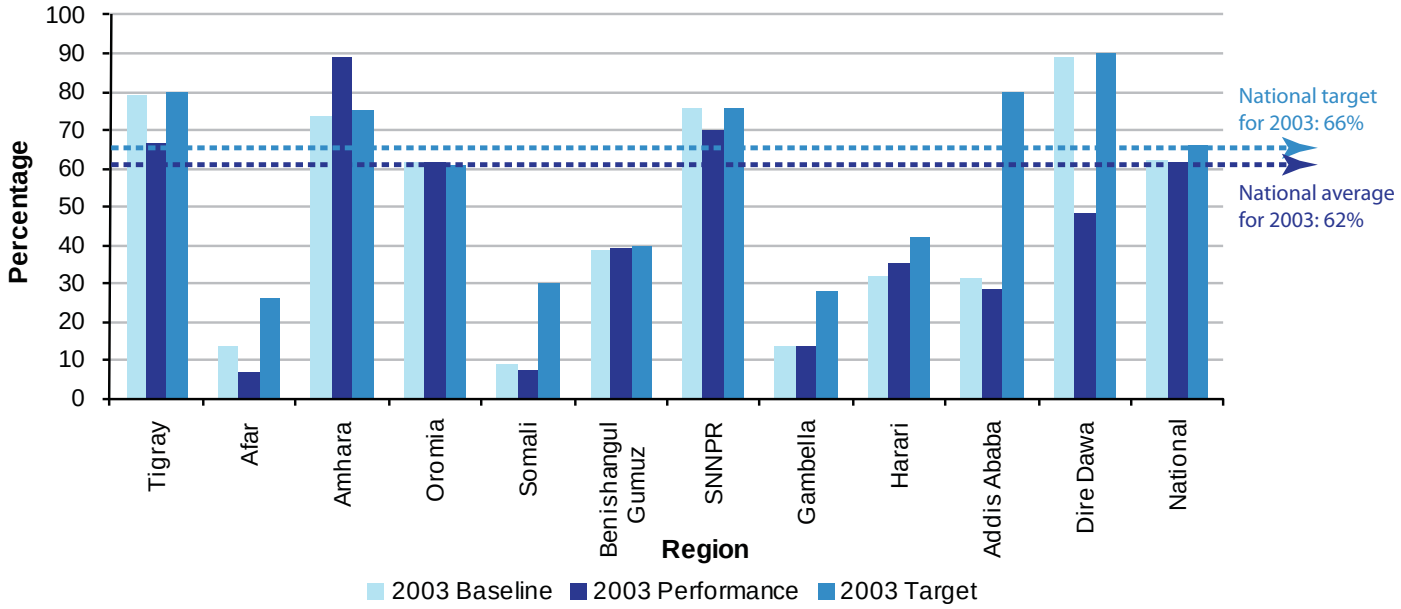


Figure 13: Comparison of Baseline, Performance and Target of Contraceptive Acceptance Rate by Region (EFY 2003)

2.3.7
Abortion Care

In order to strengthen the provision of clean abortion services along the line indicated in the Revised Abortion Law, training was given for 33 professionals in pastoralist areas and for 139 professionals in agrarian regions. As a result, it was possible to give abortion care for 87,361 clients out of the planned 101,564.

2.3.8
Other Performances

The Safe Motherhood Month, which was launched for the first time in January 2010, was celebrated for the second time in EFY 2003 with more focus given to the regions, and various activities related to social mobilization and awareness creation were performed.

The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) was also launched for the first time in January 2010 in accordance with the Maputo Plan of Action, whereas in EFY 2003 there was a follow up meeting on CARMMA at the level of Africa Region and Ethiopia participated actively in that meeting.

With respect to the development of Guidelines and other RH tools, the Management Protocol on Selected Obstetrics Topics and the FP Service Guideline were prepared, while the FP Training Package is being prepared. Based on the current World Health Organization (WHO) Recommendation, the revision of PMTCT Guideline, PMTCT Training Package and Implementation Manual was completed in EFY 2003.

IEC/BCC activities were carried out on FP especially on IUCD, focused ANC and danger symptoms and signs of pregnancy. Birth preparedness chart was also prepared during EFY 2003.

With respect to neonatal care, newborn corners are being established by the Ethiopian Paediatric Society in 50 hospitals and 50 HCs. Towards this end, a baseline survey has been carried out, and 200 Health Workers (HW) (two per facility) have been trained and procurement of equipment is underway. Furthermore, to enhance the implementation of Helping Baby Breath Strategy, training on neonatal resuscitation has been given to 2,100 HWs.

With regard to improving adolescent health, much has been done in EFY 2003 starting from designing a strategy to giving training for different professionals and heads of HCs on youth reproductive health and youth friendly services. In EFY 2003, 33 youth centers started providing family planning services and 20 youth centers started providing reproductive health and HIV Counselling and Testing (HCT) services in addition to health facilities.

Challenges

- Gaps in midwives, doctors and anaesthetists which constrains the delivery of EmONC services;
- Absence of 24 hours a day and 7 days a week service in most health facilities, especially in HCs;
- Lack of a separate newborn corner and absence of a neonatal unit in health facilities;
- Low coverage of skilled delivery and newborn care;
- Shortage of drugs, medical supplies, equipment and commodities;
- Inadequate quality of trainings;
- Widespread harmful traditional beliefs and practices, low status of women and inability to make decisions on health issues, male domination, etc. hampering the access to maternal health services and the use of family planning methods;
- Low level of infection prevention skills, involvement of HEWs in other activities and inability to focus on and implement the HEP fully;
- Funding gap for health systems; and
- Weak referral system.

Way Forward

- Scale-up the training of midwives and improve the availability of human resources capable to provide Basic EmONC services in all health centres;
- Provide round the clock delivery services in HCs nation-wide;
- Establish a newborn unit in all hospitals, Neonatal Intensive Care Unit (NICU) in selected hospitals

and a newborn health corner in all delivery rooms and maternity wards of all health facilities;

- Provide C-EmONC in all hospitals and selected HCs by putting up functional maternities, nurseries, maternity theatres and laboratory services;
- Ensure availability of drugs, medical supplies and FP commodities in health facilities;
- Scale up the competency training for HEWs to provide clean and safe delivery;
- Raise the awareness of the HDA on women empowerment and harmful traditional beliefs and practices and enable them to change the situation by becoming role models;
- Make HEWs to focus on and spend their working time fully on health extension activities and thereby provide uninterrupted prevention, care and follow up services;
- Deploy female HEWs in pastoralist communities;
- Provide cascade training on infection prevention; and
- Implement a functional Referral Strategy.

2.4 Child Health Services

One of the priorities in HSDP IV is improving child health, which set a target for the reduction of under five mortality rate from 101 to 68 per 1,000 live births and the infant mortality rate from 77 to 31 per 1000 live births. The progress made in Ethiopia in this regard is encouraging. Preliminary results from the Ethiopia Demographic Health Survey 2010 (EDHS 2010) show that Under 5 Mortality Rates (U5MR) declined to 88 per 1000 live births from 123 per 1000 live births in EDHS 2005, while Infant Mortality Rate (IMR) declined to 59 per 1000 live births from 77 per 1000 live births in EDHS 2005. Neonatal Mortality Rate (NMR) showed a slight decline from 39 (EDHS 2005) to 37 (EDHS 2010) per 1000 live births.

In order to reduce child mortality, several activities were articulated in HSDP IV, including strengthening routine immunization, expansion of community and facility-based Integrated Management of Neonatal and Childhood Illnesses (IMNCI), establishing newborn corners and NICUs, capacity building on program management for child health services, strengthening HEP and implementing locally relevant and effective child health interventions in pastoralist areas. Still special emphasis is given to the Expanded Program on Immunization (EPI) (with campaigns supplementing regular routine programs when necessary) and IMNCI.

2.4.1 Immunization

Ethiopia is a very diverse country, with a need for development of specific strategies for reaching each area. By the implementation of approaches like Reaching Every District and Sustainable Out-reach Services, the present target is to increase the coverage in all priority (including hard-to-reach) areas. The vaccine preventable diseases included in the EPI in Ethiopia are measles, diphtheria, pertussis, tetanus, polio, hepatitis B (HepB), *Haemophilus Influenzae* type b (Hib), and tuberculosis. In EFY 2003, preparatory activities were completed for the introduction of two additional vaccines to prevent pneumonia caused by *Streptococcus Pneumoniae* and diarrhoea caused by Rotavirus.

In EFY 2003, the target was to reach 90% coverage for Pentavalent 3 vaccine, 86% for measles vaccine, and 80% for full immunization. A slight decrease was observed for Pentavalent 3 vaccine coverage (from 86.0% in EFY 2002 to 84.7% in EFY 2003) and measles vaccine coverage (from 82.4% to 81.5%), while full immunization coverage increased from 72.3% to 74.5% in the same period: however, the performance was below the target set for the year (Table 5).

Table 5: Immunization Coverage Indicators (EFY 2003 Baseline, Performance and Target and HSDP IV Target)

Indicators	EFY 2003 Baseline	EFY 2003 Performance	EFY 2003 Target	HSDP IV Target
Pentavalent 3 Vaccine Coverage	86.0%	84.7%	90.0%	96.0%
Measles Vaccine Coverage	82.4%	81.5%	86.0%	90.0%
Full Immunization Coverage	72.3%	74.5%	80.0%	90.0%

As depicted in the Figure 14, the immunization coverage showed an upward trend during the HSDP III period (up to EFY 2002), with a downward fluctuation in EFY 2003 for the Pentavalent 3 and measles vaccines and an upward fluctuation for the full immunization coverage.

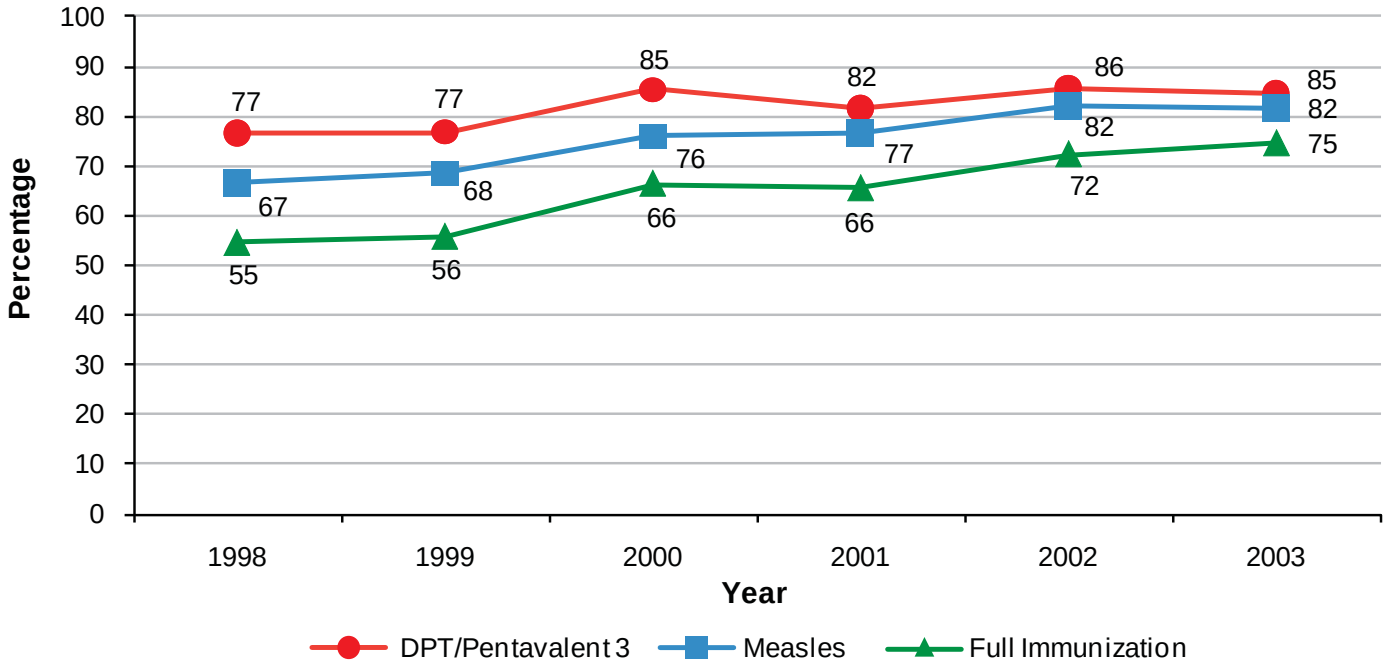


Figure 14: Trend in DPT/Pentavalent 3 Immunization Coverage, Measles Immunization Coverage and Full Immunization Coverage (EFY 1998 - 2003)

2.4.1.1 Regional Distribution of Pentavalent 3 immunization coverage

Pentavalent 3 coverage was 84.7% at the national level in EFY 2003, below the performance in EFY 2002 (86.0%) and short of the target (90%) set for the year.

The highest coverage (98.8%) was found in Benishangul Gumuz Region, where the Enhanced Routine Immunization Activities (ERIA) were successfully implemented, including house to house registration of the target group, implementation of immunization, and supervision (Figure 15). Two regions (Amhara and Benishangul Gumuz) performed above their annual target, while, in addition to the two mentioned regions, an increase in performance was observed in five other regions (Tigray, SNNP, Gambella, Addis Ababa and Dire Dawa). A decline in performance was observed in the remaining four regions (Afar, Oromia, Somali, and Harari), with Somali showing the lowest performance (34.0%).

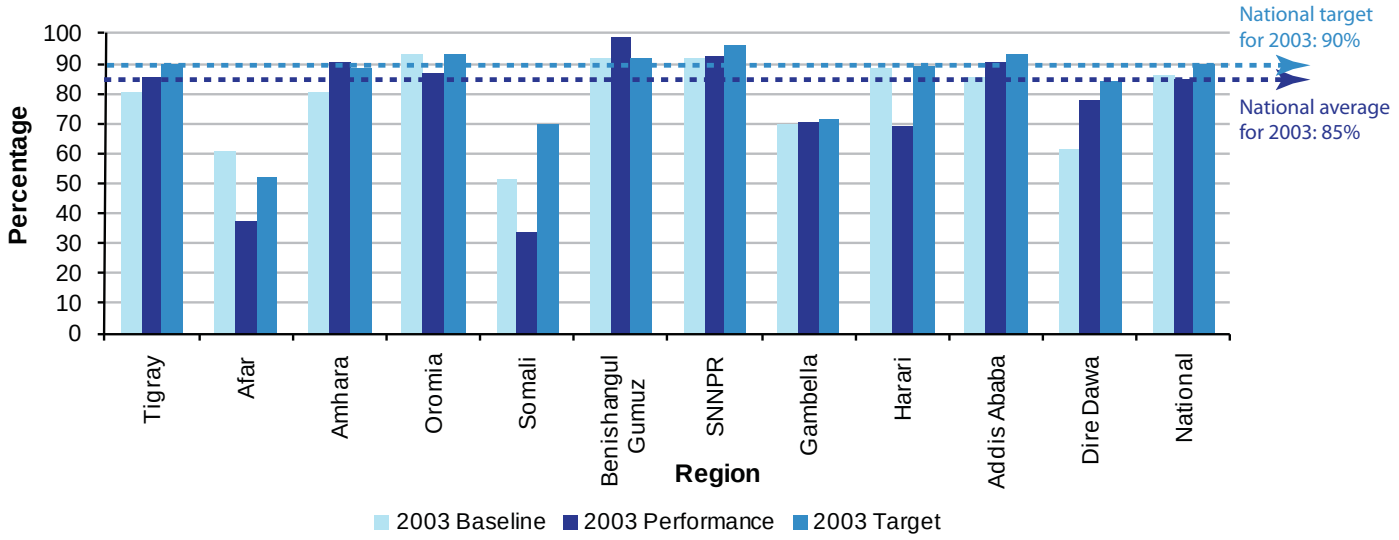


Figure 15: Comparison of Baseline, Performance and Target of Pentavalent 3 Immunization Coverage by Region (EFY 2003)

2.4.1.2 Regional Distribution of Measles Immunization Coverage

In EFY 2003, there was a slight decrease in the measles immunization coverage (81.5%) from EFY 2002 performance (82.4%), short of the target set for the year (86%). Regional distribution showed that Benishangul Gumuz was the best performing region (above 100%) and Somali performed the least (34.0%) (Figure 16). Two regions (Amhara and Benishangul Gumuz) performed above the target set for the year. Tigray, Addis Ababa and Dire Dawa showed a better performance in EFY 2003 than in EFY 2002, but below their regional target. The remaining six regions (Afar, Oromia, Somali, SNNP, Gambella, and Harari) performed below the EFY 2002 achievement and below the target set for EFY 2003.

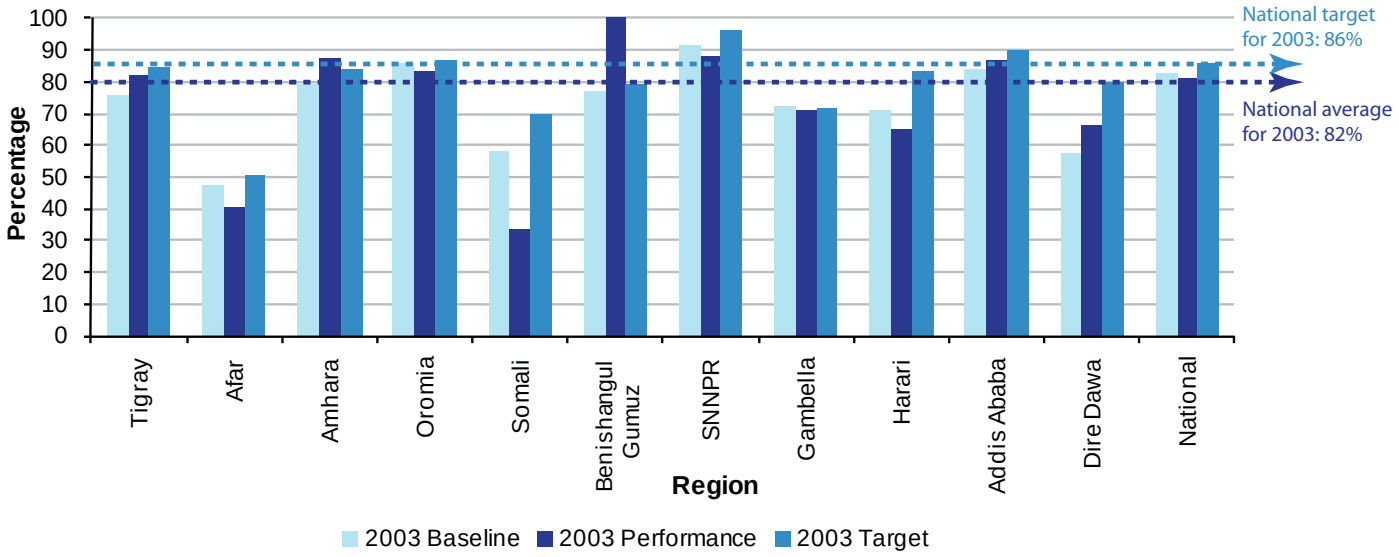


Figure 16: Comparison of Baseline, Performance and Target of Measles Immunization Coverage by Region (EFY 2003)

To strengthen the immunization program, a national measles immunization campaign was conducted by mobilizing the community, with logistics, technical and financial support provided to regions by FMOH and DPs.

ERIA especially for measles immunization were organized by preparing and communicating a protocol to concerned regions. On top of this, TOT on the implementation protocol of enhanced routine immunization was given for 239 health professionals.

2.4.1.3
Regional Distribution of Full Immunization Coverage

In EFY 2003, the full immunization coverage reached 74.5% which was above EFY 2002 performance (72.3%), but below the target (80%) set for the year. The highest coverage was observed in Addis Ababa (84.4%) and the lowest one in Somali Region (11.9%) (Figure 17). Only Amhara Region performed above the target set for EFY 2003. On the other hand, Tigray, Oromia, Benishangul Gumuz, Addis Ababa, and Dire Dawa performed higher than in EFY 2002, but below their regional target. The remaining five regions (Afar, Somali, SNNP, Gambella, and Harari) achieved below their EFY 2002 performance.

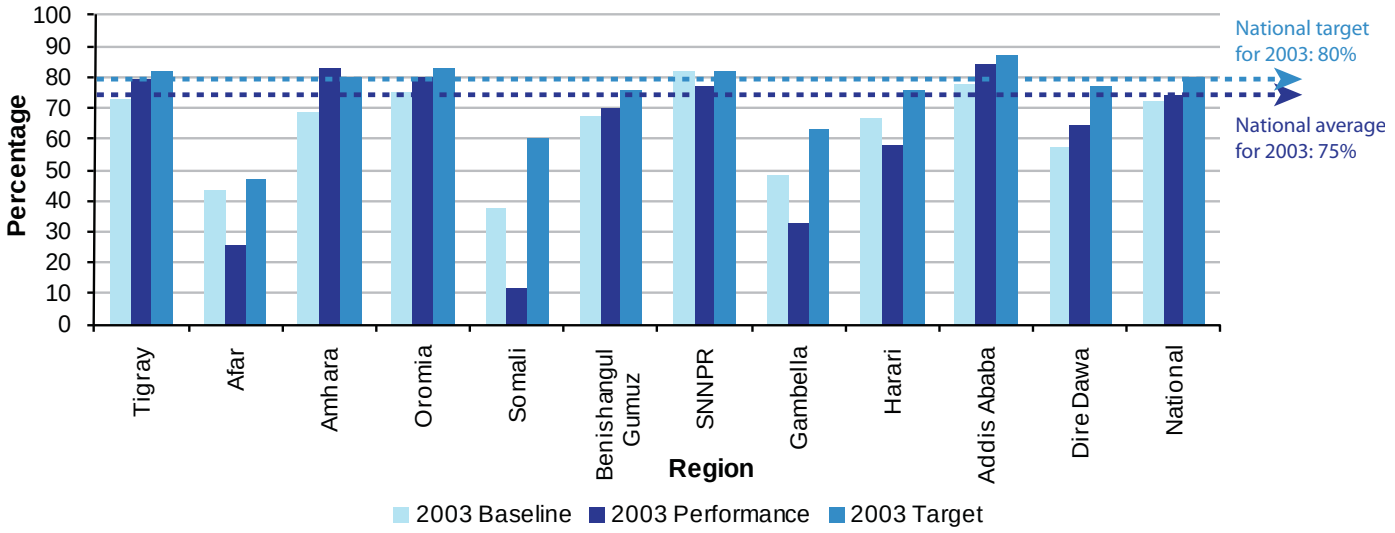


Figure 17: Comparison of Baseline, Performance and Target of Full Immunization Coverage by Region (EFY 2003)

2.4.2
Cold chain system

Regarding cold chain management, training on basic cold chain system maintenance and vaccine management was given for 148 technicians in EFY 2003. Moreover, different spare parts used in the cold chain system especially for refrigerators were procured and distributed to regions.

2.4.3
The Integrated Management of Neonatal and Childhood Illnesses

The IMNCI is the strategy to improve the quality of management of childhood illnesses, linking preventive and curative services so that programs, such as immunization, nutrition, and control of malaria and other infectious diseases, are implemented in an integrated manner. It is therefore an integrated approach to child and neonatal health that focuses on the well-being of the whole child and the neonate. IMNCI aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age.

The number of HCs providing IMNCI increased from 1,267 in EFY 2002 to 1,720 in EFY 2003 (Table 6). To strengthen service implementation, TOT was given for 92 health professionals and a total of 605 health professionals were trained on IMNCI. In line with community IMNCI, training at master's level was provided to 62 health professionals, TOT to 600 professionals and training on program implementation to 687 HEWs.

Table 6: Distribution of Health Centers Providing IMNCI by Region (EFY 2003)

Regions	Cumulative number of HCs providing IMNCI in EFY 2002	Cumulative Number of HCs providing IMNCI service at end of EFY 2003	Cumulative number of HCs Available in EFY 2003
Tigray	119	172	183
Afar	11	18	50
Amhara	398	513	724
Oromia	367	419	991
Somali	13	13	85
Benishangul Gumuz	15	15	30
SNNPR	289	513	513
Gambella	8	8	24
Harari	6	7	8
Dire Dawa	26	27	37
Addis Ababa	15	15	15
National	1,267	1,720	2,660

Challenges

- Shortage of spare parts and accessories for refrigerators;
- Limited implementation capacity on newly introduced approaches and procedures;
- Limited technical support and communication; and
- Slow progress in the transition of outreach services into regular routine immunisation services provided by HEP.

Way forward

- Strengthening cold chain management system through regular supply of spare parts and accessories for refrigerators;
- Program prioritization and integration; and
- Expedite the transition of outreach immunization services to regular routine EPI.

2.5 National Nutrition Program

In order to strengthen the National Nutrition Program (NNP), the focus was on reducing malnutrition and improving child feeding as well as on implementing Vitamin A supplementation and de-worming with integration of the campaign activities into regular routine services. The targets set for EFY 2003 in the Core Plan were:

- Increase the Vitamin A Supplementation (VAS) coverage (two doses) among children 6-59 months to 98%; and
- Increase the de-worming coverage (two doses) among 2-5 years children to 97%.

2.5.1 Vitamin A Supplementation and De-worming

The Enhanced Outreach Strategy (EOS) for child survival is a strategic approach designed to bridge the long-term national food security and the immediate response to tackle high rates of child mortality and malnutrition. The program encompasses core, cost-effective and high-impact interventions. The EOS provides a package of essential preventive services every six months to children aged 6-59 months and to Pregnant and Lactating Women (PLW). The main components of the EOS/ Targeted Supplementary Feeding (TSF) are screening of children for malnutrition using Mid-Upper Arm Circumference, Vitamin A supplementation and de-worming.

Community Health Days (CHD) are quarterly events organised by HEWs at the kebele level to screen children, pregnant and lactating women for malnutrition, and to refer those malnourished to the TSF and HPs with Outpatient Therapeutic Program (OTP) services, as well as to provide by-

annual Vitamin A supplementation and de-worming to the children. Up to date, CHDs have been implemented in 170 woredas of Tigray, SNNP, Amhara, and Oromia Regions, and it is planned to extend CHDs to all the woredas.

In EFY 2003, 12.5 million children aged 6-59 months received the first dose of Vitamin A supplementation, a performance above the achievement in EFY 2002 (10.7 million). The coverage ranged between 61% in Addis Ababa and over 100% in six regions (Afar, Amhara, Oromia, Somali, Benishangul Gumuz, and SNNP), with a national coverage of 110% (above the target of 98% set for the year) (Figure 18). The coverage above 100% may be explained by the methodology used to estimate the age limit of 59 months for eligibility purpose: in fact, in absence of the documentation of age, the height of children was measured, and those below 110 cm were considered under 5 years and therefore eligible. This may have included children older than 59 months, who were short or stunted, therefore inflating the numerator.

Reports on the second round were available only from 4 regions (Tigray, Amhara, Oromia, and SNNP), showing a similar pattern of high coverage as in the first round.

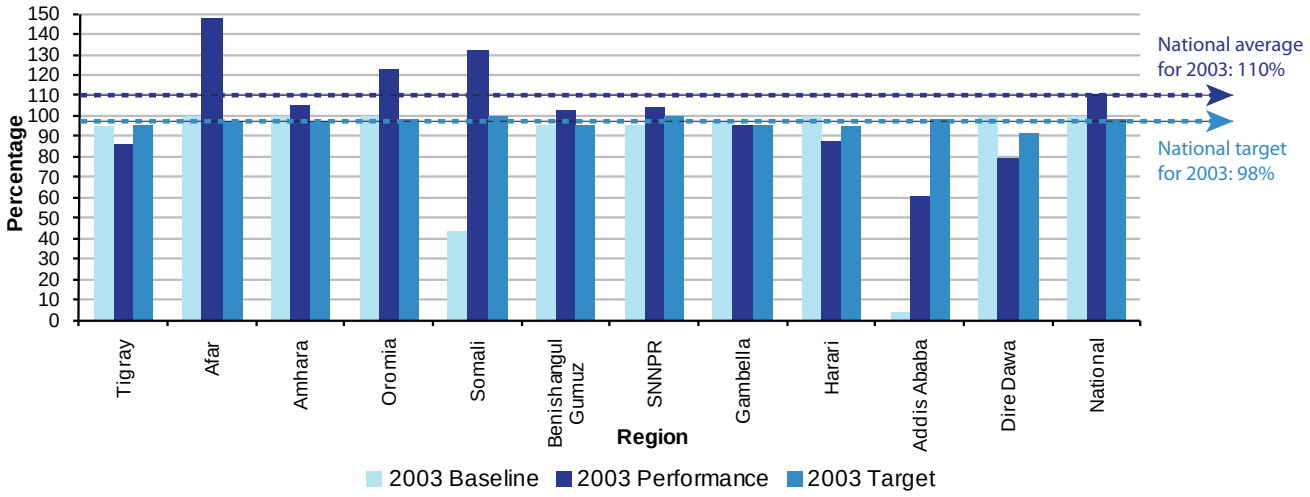


Figure 18: Comparison of Baseline, Performance (First Round) and Target of Coverage of 6-59 Months Children Supplemented with Vitamin A by Region (EFY 2003)

Similarly, the de-worming coverage (first round) increased from 93% to 112% (above the target of 97%), with Tigray showing the lowest coverage (87%) and six regions (Afar, Amhara, Oromia, Somali, Benishangul Gumuz, and Harari) showing a coverage above 100% (Figure 19). As for Vitamin A supplementation, reports on second round were available only from 4 regions (Tigray, Amhara, Oromia, and SNNP), showing high coverage.

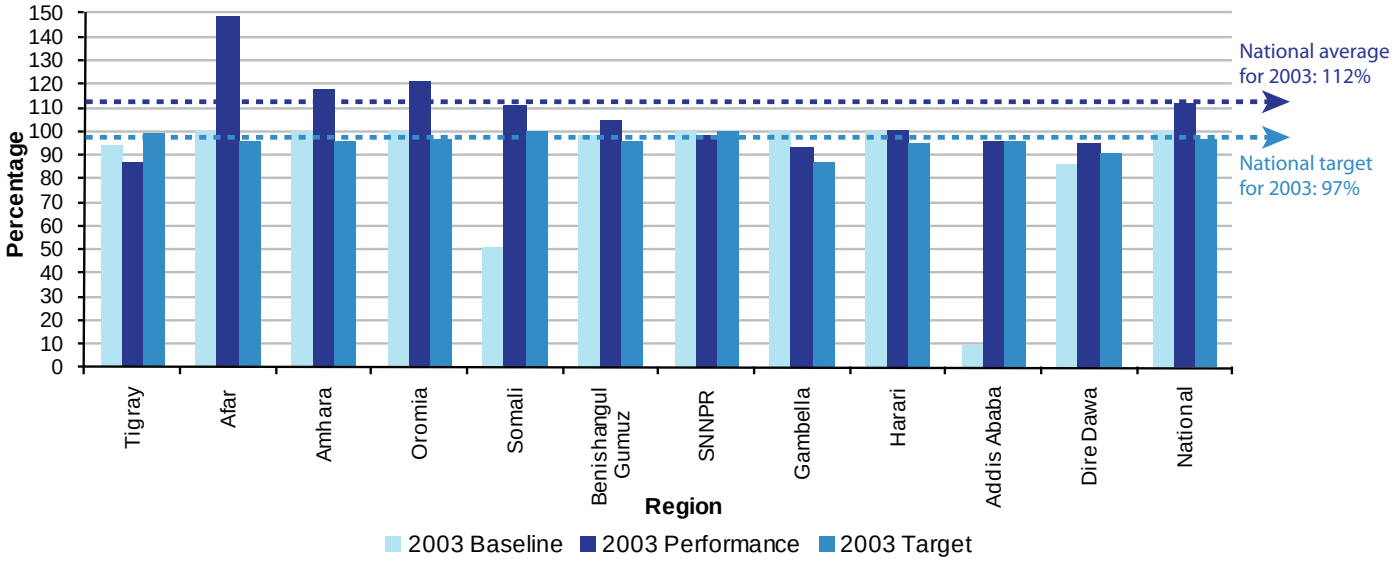


Figure 19: Comparison of Baseline, Performance (First Round) and Target of Coverage of 2-5 Years Children De-wormed by Region (EFY 2003)

2.5.2
Management of Severe Acute Malnutrition

In EFY 2003, out of 11,309 "hot spot" HPs, 6,925 (61.2%) were providing OTP service; furthermore, about half (47%) of HCs were also providing OTP service. More than 90% of hospitals and 16% of HCs managed severely malnourished cases at in-patient setup. This increased access to nutrition services resulted in the treatment (in out-patient and in-patient settings) of 266,924 severely malnourished children, of which 81.8% were cured, 5.6% were defaulter, 3.2% were non-responder, 8.7% were transferred, and 0.7% died in EFY 2003.

During the year, 2,500 tons of therapeutic food were procured and distributed to all regions.

2.5.3
Community Based Nutrition

In order to prevent malnutrition in children, family and community should be the first line of protection. Community-Based Nutrition (CBN) aims to build up the capacity and the ownership of communities and families to make informed decisions on child care practices. The major implementation approaches include the growth monitoring, promotion and community conversation to assess the nutritional status of their children, analyze the causes of malnutrition and take action.

With regard to CBN, the plan for EFY 2003 included providing financial and technical assistance as well as logistic support to strengthen 238 CBN woredas; accordingly, computers and other accessories were distributed to 177 CBN woredas in Tigray, Amhara, Oromia, and SNNP Regions.

A total of 238 woredas were providing CBN service at the end of EFY 2003. About 400,000 children under two years were weighed (with 47% report completeness rate). The percentage of underweight children under two years of age in CBN woredas showed an overall downward trend over the past three years (reaching 16.5% at the end of EFY 2003, out of which 12.2% were with moderate underweight and 4.3% with severe underweight) (Figure 20).

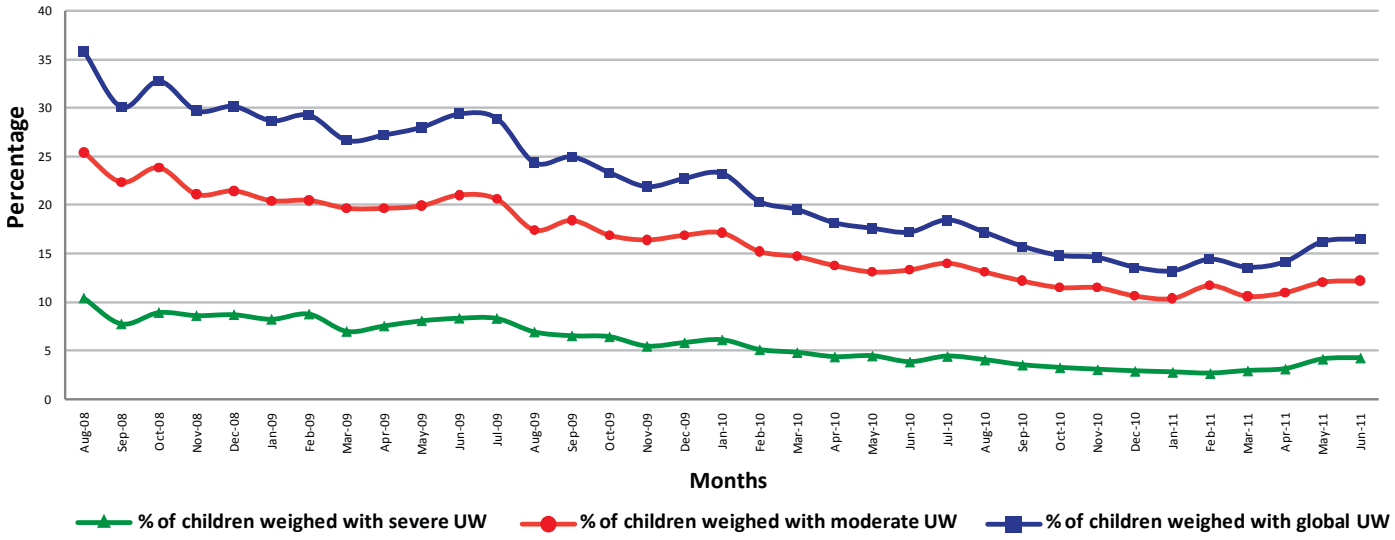


Figure 20: Trend in Percentage of Underweight Children Under Two Years of Age in CBN Woredas (2008-2011 GC)

2.5.4
Iodization of Salt

Iodine Deficiency Disorders (IDD) were recognized as one of the major public health problems in Ethiopia. Salt is being produced mostly using traditional methods in Afdera and Dobi in Afar Region as well as in Hargele in Somali Region. A total of about 30,000 tons of iodized salt was produced and distributed in EFY 2003 (10% of the demand).

Some of the problems encountered during the implementation include the following:

- Lack of strong commitment and programme ownership by salt producers;
- Poor handling and utilization of available iodization capacity;

- Poor adaptability of imported machines to the environment, lack of spare parts, and inadequate maintenance service; and
- Lack of legislative support for salt iodization.

In EFY 2003, a major achievement was the ratification of the Salt Regulation No. 204/2011 by the Council of Ministers, stipulating that "No person shall import, store, transport, distribute, or sale non-iodized salt for human consumption".

Preparation is underway for the full enforcement of the Salt Regulation by the Food, Medicine and Healthcare Administration and Control Authority (FMHACA). Iodization capacity was reassessed, consensus was reached among the stakeholders, particularly the salt producers, and a joint action plan was developed to move forward and achieve the Universal Salt Iodization (USI) by EFY 2004. A prototype iodization machine was produced locally, with high capacity and more durable performance, and the result of field testing was very promising. Bulk production will be negotiated with the National Metal Engineering Corporation.

In EFY 2003 four tons of potassium iodate were delivered by partners, with additional effort being underway to secure 24 additional tons of potassium iodate for the initial one year bridging period. However, a challenge is represented by the price escalation of potassium iodate in the global market.

About 70,000 Rapid Test Kits were procured and will be distributed to HEWs and salt distributors. HEWs are expected to take active role in assessing coverage and quality of iodized salt at household level.

Technical assessment and mapping of salt sites in Hargele Woreda in Somali Region were conducted. According to the report, an estimated 137,000 MT of salt were annually produced in the area. Both technical and material support is being delivered to engage salt producers in salt iodization. The same assessment was carried out in Afdera and Dobi in Afar Region in EFY 1999 (2007 Gregorian Calendar-GC).

The final round of Iodized Oil Capsule (IOC) supplementation was conducted in Amhara, Tigray, Oromia, SNNP and Benishangul Gumuz Regions. Children 6-23 months old and PLW were the target groups. The IOC coverage among 6-23 months children ranged between 105% in SNNPR and 66% in Benishangul Gumuz, while, among PLWs, it was between 86% in Oromia Region and 72% in Amhara Region. IOC, which was introduced as an interim bridging strategy, will be phased out in EFY 2004 when it is planned to achieve USI in the country.

2.5.5
Other Micronutrient Interventions

One of the most prevalent maternal nutritional deficiencies in Ethiopia is the iron deficiency anaemia. To address this problem, the FMOH planned to provide iron folate tablet for PLWs. Based on this plan, more than 750,000 boxes of 1,000 iron folate tablets were procured and distributed to all regions with IEC/BCC materials being prepared in English, Afan Oromo, Amharic and Tigrigna languages.

2.5.6
Other Nutrition Related Activities

In the EFY 2003, the revision of the National Nutrition Programme (NNP) has been started and will be finalized in the coming EFY 2004. Some nutrition guidelines were also revised, namely the Management of Severe Acute Malnutrition and HIV/Nutrition Guidelines. The Guideline on Management of Moderate Malnutrition is being revised by the Emergency Nutrition Coordination Unit (ENCU) but not yet finalized.

In EFY 2003 three national consultative workshops were conducted, the first being on the accelerated stunting reduction to produce a draft strategy which will be incorporated in the revised NNP. The second workshop was on food fortification to establish the National Alliance for Food Fortification. Different donors, United Nations (UN) agencies, Non-Governmental Organizations (NGO) working in micronutrient intervention, private industry representatives, consumer associations and sector government ministries participated in the workshop. The third workshop was jointly organized by FMOH, Ministry of Agriculture and partners on linking food security and nutrition in order to improve both nutrition status and food security in Ethiopia.

Challenges

- High turnover of trained health professionals;
- Absence of guideline on procedure for iodine test;
- Lack of harmonization and alignment by DPs; and
- Limited understanding on malnutrition by the community.

Way Forward

- Ensure retention of staff;
- Provide the guideline on procedure of iodine test;
- Fill knowledge gap on malnutrition through advocacy activities; and
- Promote healthy life style and prevent harmful traditional practices.

2.6 Prevention and Control of Communicable Diseases

Different activities were implemented in EFY 2003 to reduce the disease burden related to communicable diseases, especially HIV/AIDS, TB and malaria. The following section briefly explains what has been targeted and what has been achieved during the year.

2.6.1 HIV/AIDS Prevention and Control

As it had been in the previous phases of HSDP, HIV/AIDS is one of the top priorities of HSDP IV. The targets set during HSDP IV are to: (i) provide HCT services to 9.2 million people annually; (ii) increase the percentage of people aged 15-24 using condom consistently with non-regular partners from 59% to 95%; (iii) increase the proportion of eligible children who are receiving ART to 95%; (iv) increase the proportion of eligible pregnant women receiving ART to 95%; (v) increase the proportion of eligible adults receiving ART from 53% to 95%; (vi) increase the number of patients ever started ART from 246,347 to 484,966; (vii) increase the number of Sexually Transmitted Infections (STI) cases treated from 39,267 to 180,000; (viii) reduce the incidence of HIV in adults from 0.28% to 0.14%; and (ix) increase the proportion of population aged 15-49 years with comprehensive knowledge of HIV/AIDS from 22.6% to 80%.

2.6.1.1 Current status of HIV/AIDS in Ethiopia

According to the Single Point Estimate, the adult HIV prevalence was estimated at 2.4% in EFY 2003 (1.9% among males and 2.9% among females). Urban and rural HIV prevalence rates were estimated at 7.7% and 0.9% respectively. Wide variations were observed across regions, ranging between 9.2% in Addis Ababa and 0.9% in Somali Region. The HIV incidence was estimated at 0.29% in the same year.

The total number of HIV-positive people was estimated at 1,216,908 and, out of them, 397,818 were eligible for ART. HIV-positive pregnant women were 90,311 and HIV-positive births were 14,276. A total of 28,073 AIDS deaths and 804,184 AIDS orphans were estimated in the year.

Trend in the number of facilities providing HCT, PMTCT and ART services

There was a steep increase in the number of facilities providing HCT, PMTCT and ART services in the EFY 1998-2003 period (Figure 21): in particular, the increase was from 2,184 in EFY 2002 to 2,309 in EFY 2003 for HCT, from 1,352 to 1,445 for PMTCT and from 550 to 743 for ART in the same period.

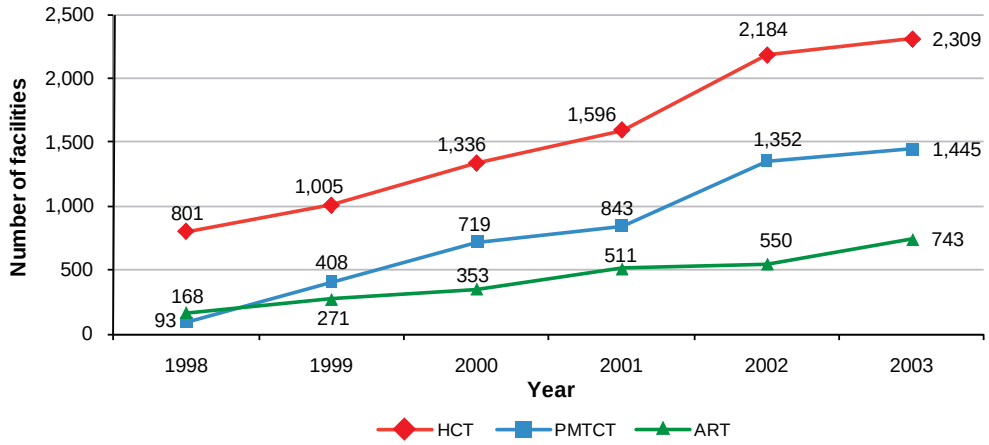


Figure 21: Trend in the Number of Facilities Providing HCT, PMTCT, and ART Services (EFY 1998-2003)

2.6.1.2
HCT Service

The number of HCT services was high, slightly increasing from 9,445,618 in EFY 2002 to 9,448,880 in EFY 2003 (Figure 22), below the target (9,466,645) set for the year at the national level. The average HIV positivity rate was 1.3% (1.1% among males and 1.6% among females) at the national level. Wide regional variations were found, ranging between 5.8% in Addis Ababa and less than 1% in SNNPR and Somali Region (0.6% and 0.8%, respectively).

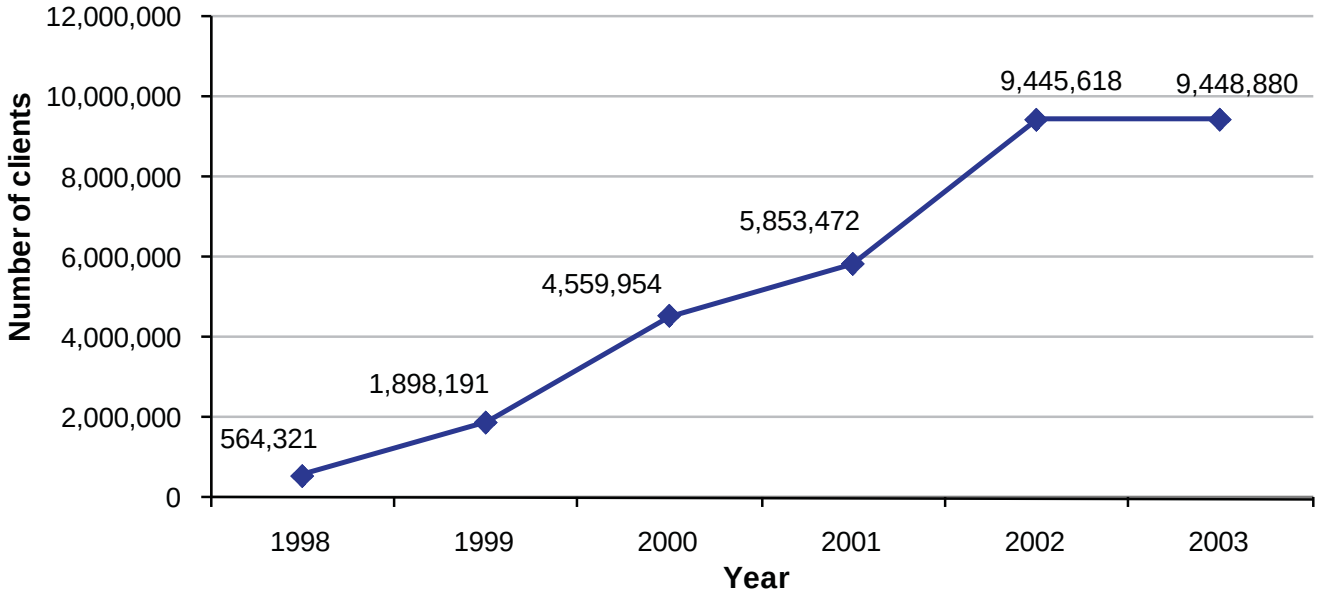


Figure 22: Trend in the Number of Clients Using HCT (EFY 1998 - 2003)

There were variations across regions, with seven regions (Afar, Oromia, Somali, Benishangul Gumuz, SNNP, Harari and Addis Ababa) increasing the number of clients using HCT in EFY 2003 with respect to the previous year (Figure 23). Seven regions achieved their regional target (revised by HIV/AIDS Prevention and Control Office – HAPCO): Tigray, Afar, Amhara, Oromia, SNNP, Harari, and Dire Dawa. Four regions (Somali, Benishangul Gumuz, Gambella, and Addis Ababa) performed below target.

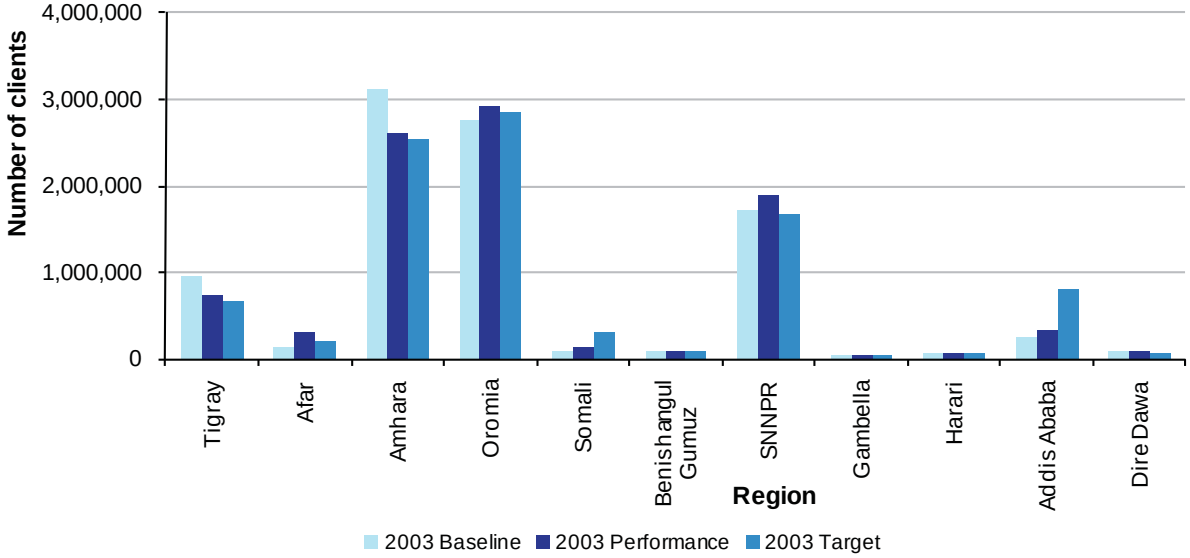


Figure 23: Comparison of Baseline, Performance and Target of the Number of Clients Using HCT by Region (EFY 2003)

On the occasion of the World AIDS Day, panel discussion and tele-conference were organized by the Ethiopian Radio and Television Agency (ERTA) to raise community awareness. HCT services were promoted for vulnerable groups of the population as well.

A total of 6,664,300 HIV test kits were procured and distributed to regions. On the other hand, to prevent and control HIV and STI transmission, a total 173,808,688 packs of condom were distributed to regions.

Besides, drugs adequate for the treatment of 429,425 STI cases were distributed to regions. Furthermore, TOT was organized on syndromic management of STI for 75 health professionals, while 475 health professionals took the cascade training.

2.6.1.3
Prevention of Mother to Child Transmission of HIV

A total of 8,365 HIV-positive mothers received ART treatment in EFY 2003, amounting to 9.3% of those eligible (90,311), which was above the EFY 2002 performance (6,990), but far below the target set for the year (18,027). Out of 14,276 HIV-positive births, 4,945 newborns (34.6%) received PMTCT prophylaxis in EFY 2003. Despite the increase in ANC coverage observed in the past years, PMTCT coverage is still low (9.3%): this large discrepancy should be investigated and related issues should be addressed in the framework of the integration of ANC and other maternal health services (in particular skilled care at birth) with PMTCT services.

In EFY 2003, there were variations across regions, with only two regions (Harari and Dire Dawa) performing above the target set for the year, while four regions (Afar, Oromia, Benishangul Gumuz, and Gambella) performed below the EFY 2002 performance. The remaining five regions (Tigray, Amhara, Somali, SNNP, and Addis Ababa) performed above the EFY 2002 performance, but below the EFY 2003 target. The highest number of HIV-positive mothers provided with PMTCT prophylaxis was in Amhara Region (2,464), followed by Addis Ababa (1,689) and Oromia (1,669), showing the same pattern found in EFY 2002. Similarly, the least number of HIV-positive mothers provided with PMTCT were seen in Afar (25), followed by Gambella (48) (Figure 24).

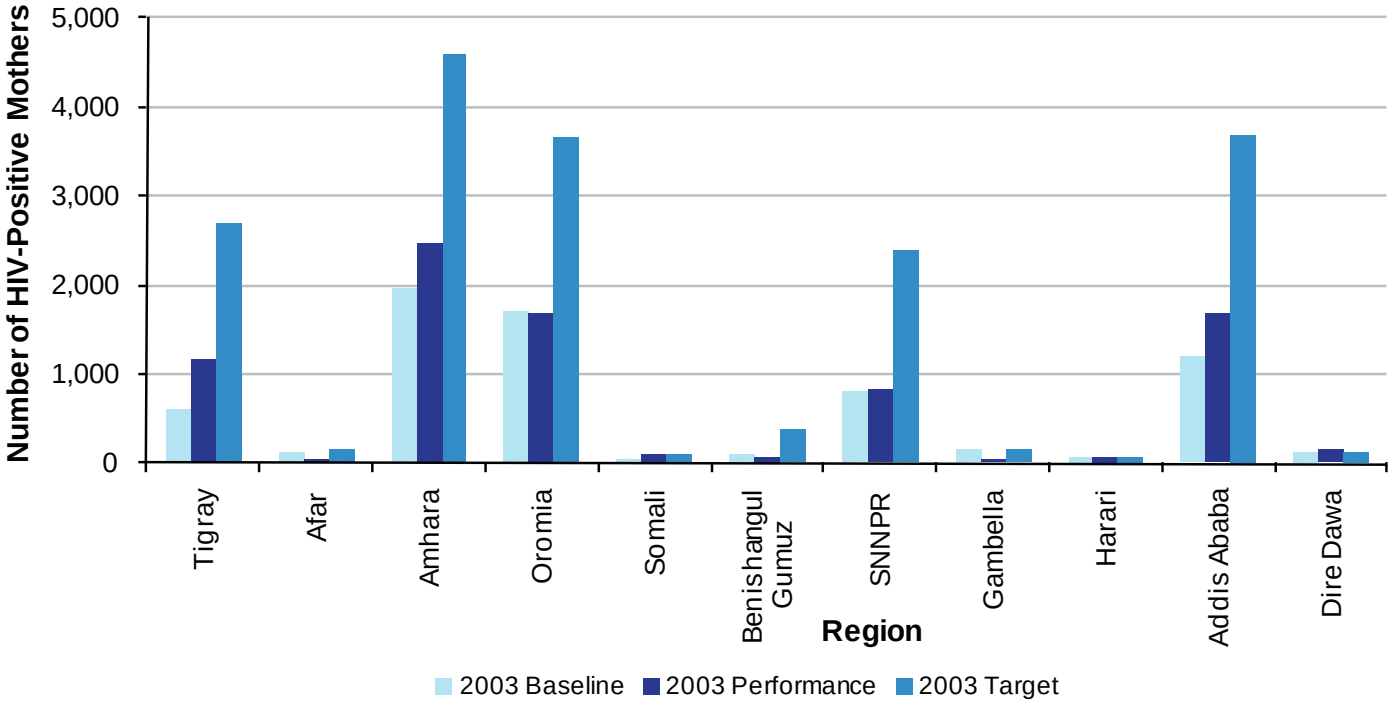


Figure 24: Comparison of Baseline, Performance and Target of the Number of HIV-Positive Mothers Provided with PMTCT Prophylaxis by Region (EFY 2003)

Out of 14,276 HIV-positive births, 4,945 newborns (34.6%) received PMTCT prophylaxis in EFY 2003.

2.6.1.4
Antiretroviral Treatment

A linear increase was observed in the number of People Living With HIV/AIDS (PLWHA) ever enrolled, ever started and currently on ART over the past years (Figure 25); in particular, there was an increase between EFY 2002 and EFY 2003 from 473,772 to 580,919 for PLWHA ever enrolled in HIV/AIDS care (+107,147), from 268,934 to 333,434 for those ever started (+64,500) and from 207,733 to 247,805 for those currently on ART (+40,072).

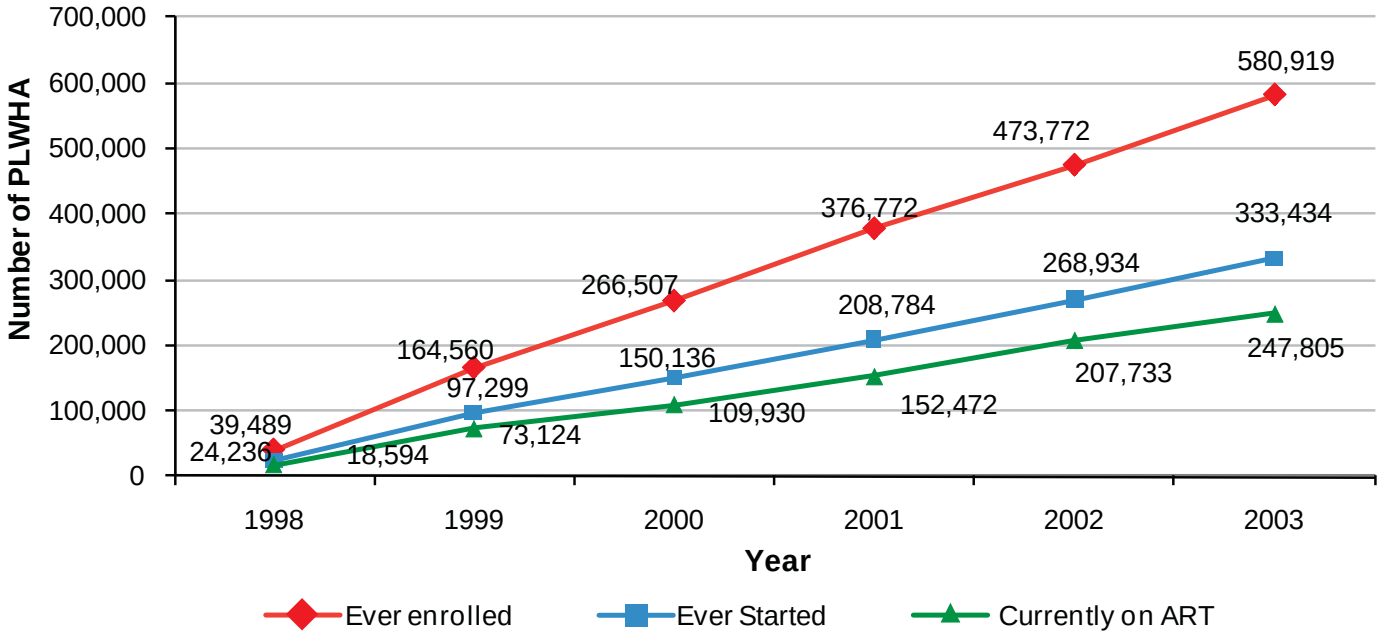


Figure 25: Trend in the Number of People Living With HIV/AIDS who Accessed Chronic HIV Care (EFY 1998 - 2003)

Figure 26 depicts the current pattern of access to chronic HIV care, showing the regional distribution of the cumulative number of PLWHA ever enrolled, ever started and currently on ART in EFY 2003: it is worth noting that Figure 26 is different from (and should not be confused with) the two following Figures 27 and 28 showing the regional comparison of EFY 2003 baseline, performance and target for the PLWHA ever started and currently on ART. The highest cumulative number of PLWHA ever enrolled was reported in Amhara (156,441), followed by Oromia (140,908) and Addis Ababa (124,983). The highest number of PLWHA ever started ART and currently on ART was found in Amhara Region (94,078 and 78,193, respectively), followed by Addis Ababa (76,035 and 54,667) and Oromia (73,632 and 52,748) Regions.

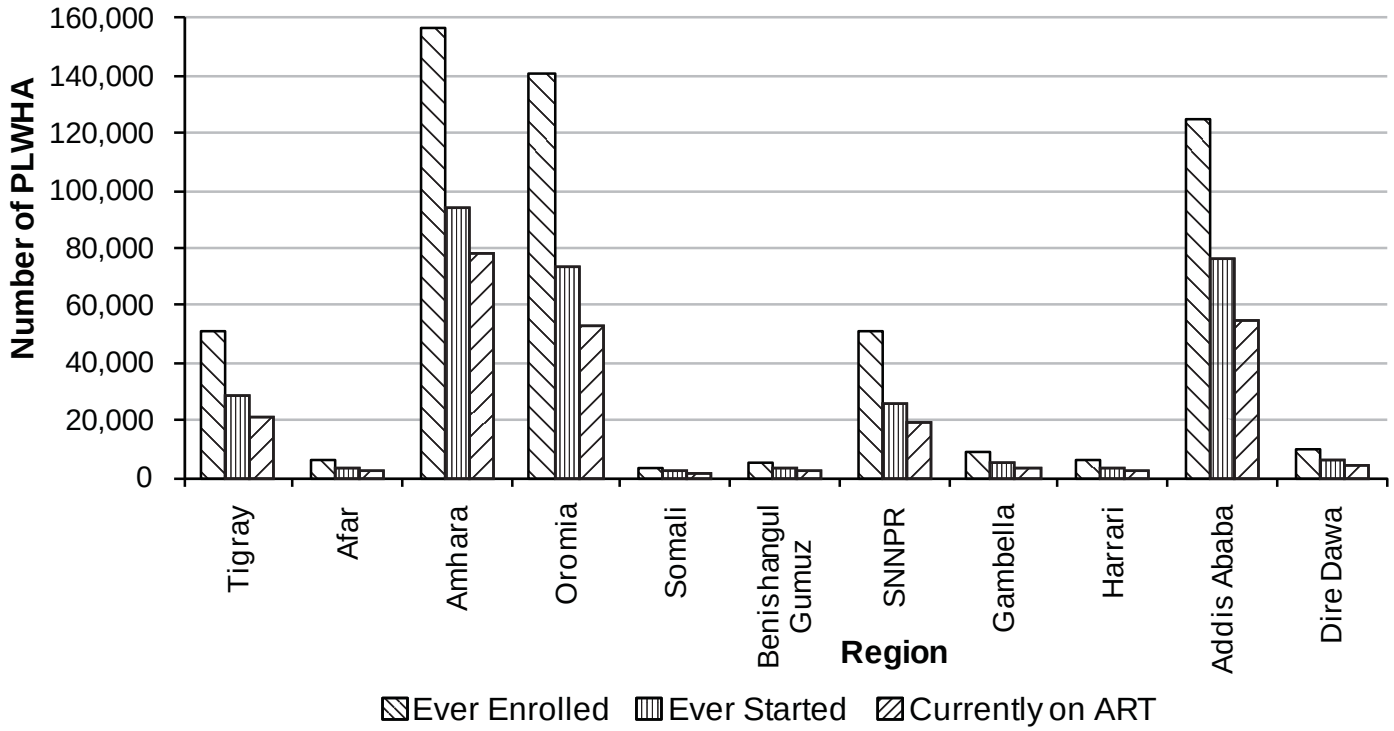


Figure 26: Distribution of PLWHA who Accessed HIV Chronic Care by Region (EFY 2003)

The comparison of EFY 2003 baseline, performance and target (revised by HAPCO) for the number of PLWHA ever enrolled showed that three regions (Gambella, Harari and Dire Dawa) surpassed their own regional target (Figure 27). At the national level, a cumulative number of 333,434 PLWHA ever started ART, out of the planned 409,670, was observed at the end of EFY 2003, with a target achievement of 81.4%.

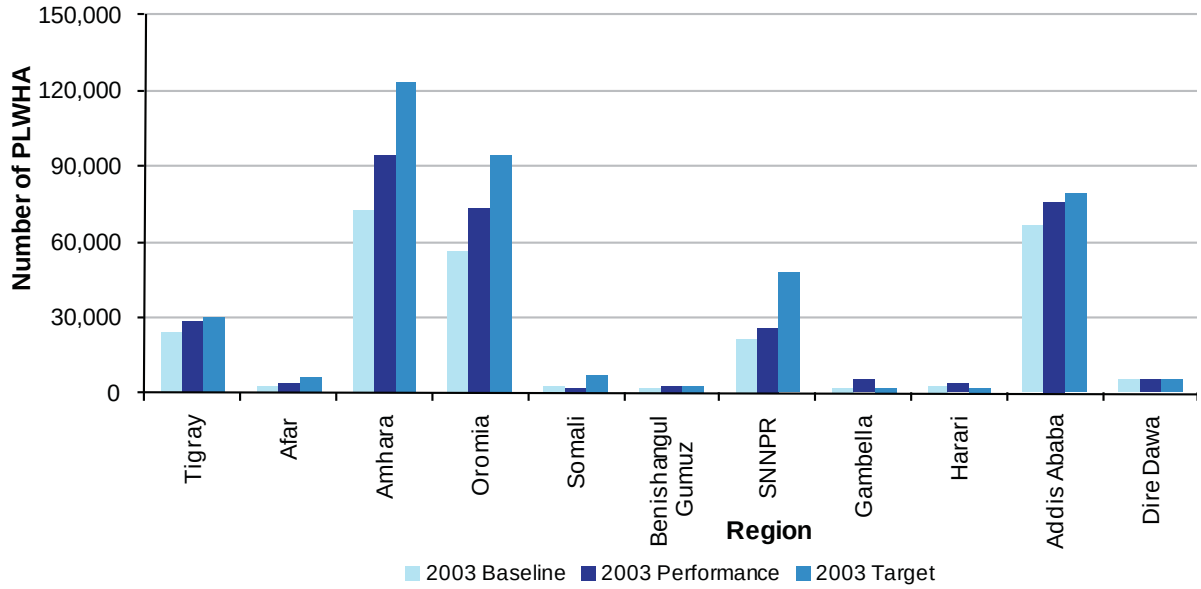


Figure 27: Comparison of Baseline, Performance and Target of the Cumulative Number of PLWHA who Ever Started ART by Region (EFY 2003)

Concerning PLWHA currently on ART, two regions (Gambella and Harari) achieved their regional target (revised by HAPCO). At the national level, out of the target of 315,531 set for the year, 247,805 PLWHA were currently on ART at the end of EFY 2003, with an average target achievement of 78.5% (Figure 28).

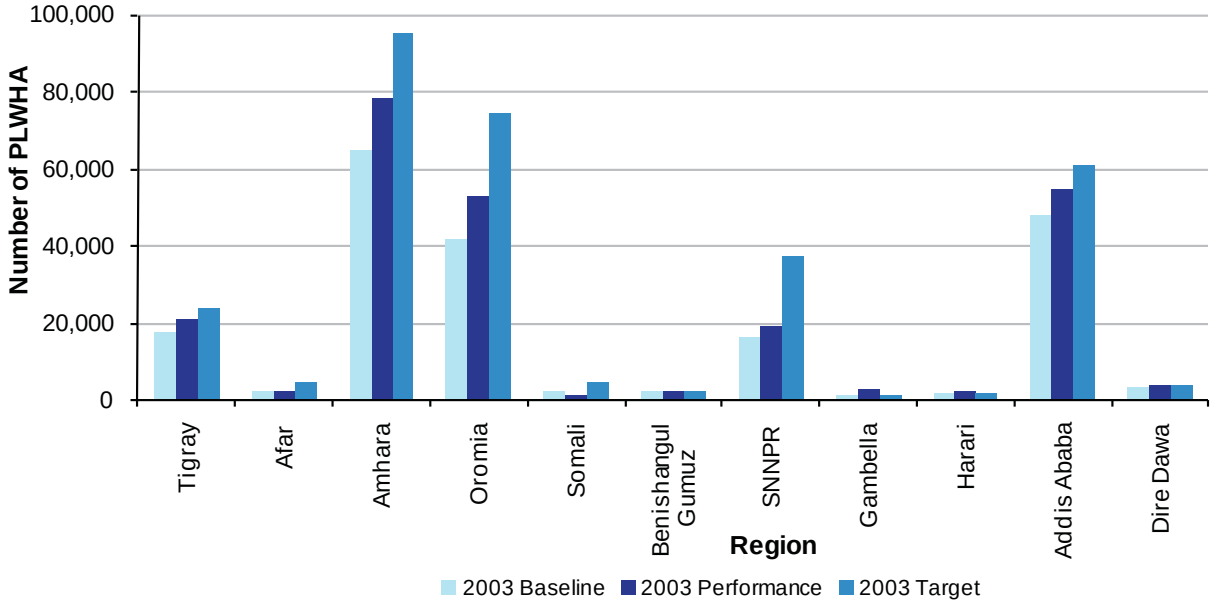


Figure 28: Comparison of Baseline, Performance and Target of the Number of PLWHA Currently on ART by Region (EFY 2003)

The ART coverage was 62.3% in EFY 2003, which is above the average in sub-Saharan African countries (53%).

With regard to drugs distribution, ART drugs adequate for treatment of 12,000 children and 219,631 adults were distributed to regions in EFY 2003.

The major activities carried out in EFY 2003 for care and support of orphans, PLWHA and Commercial Sex Workers (CSW) concerned the integration of health facilities and strengthening of referral system. Besides, PLWHA defaulters from chronic care and support were traced back by HEWs and Kebele Oriented Outreach Workers (KOOW).

In EFY 2003, a total of 354,660 orphans and vulnerable children received educational support, 231,238 received food support, and 23,267 received shelter support. Furthermore, a total of 43,256 orphans and vulnerable children received training on income generating activities, out of them, 37,209 got the initial capital. Besides, a total number of 103,659 PLWHA received food support, 56,300 PLWHA got training on income generating activities, and 36,028 got the initial capital. In addition, a total of 15,809 CSWs received training on income generating activities and 12,423 previously trained CSWs got the initial capital.

In summary, encouraging results were achieved in HIV/AIDS control, with combination of stable HIV prevalence, sustained prevention efforts and increased ART coverage. However, there was a very low PMTCT coverage, reflecting the inadequate access to PMTCT services as well as their poor integration with maternal services.

Challenges

- Absence of regular supportive supervision;
- Shortage of ART drugs and other HIV/AIDS related supplies;
- Poor integration of PMTCT and maternal services;
- Low percentage of deliveries attended by skilled health personnel;
- Poor community awareness on PMTCT services; and
- Difficulty in delivering services in pastoralist areas.

Way forward

- Enhance supportive supervision;
- Ensure regular provision of ART drugs and other supplies;
- Enhance the integration of PMTCT and maternal services;
- Scale-up and strengthen Health Development Army to promote community awareness.

2.6.2
Malaria Prevention and Control

A three-pronged approach was implemented, consisting of early diagnosis and effective treatment, selective vector control and epidemic prevention and control, with integration of malaria control activities into the basic health service delivery system.

Accordingly, the major activities planned in EFY 2003 focused on vector control, strengthening malaria case detection and treatment, and starting malaria elimination. In particular, it was planned to distribute 11,091,890 Long-Lasting Insecticide-treated Net (LLINs) for provision to new households as well as for replacement purposes. However, 4,279,165 LLINs were actually distributed to regions. As a result, there was an increase in the cumulative number from 35,237,701 in EFY 2002 to 39,516,866 in EFY 2003 (Figure 29).

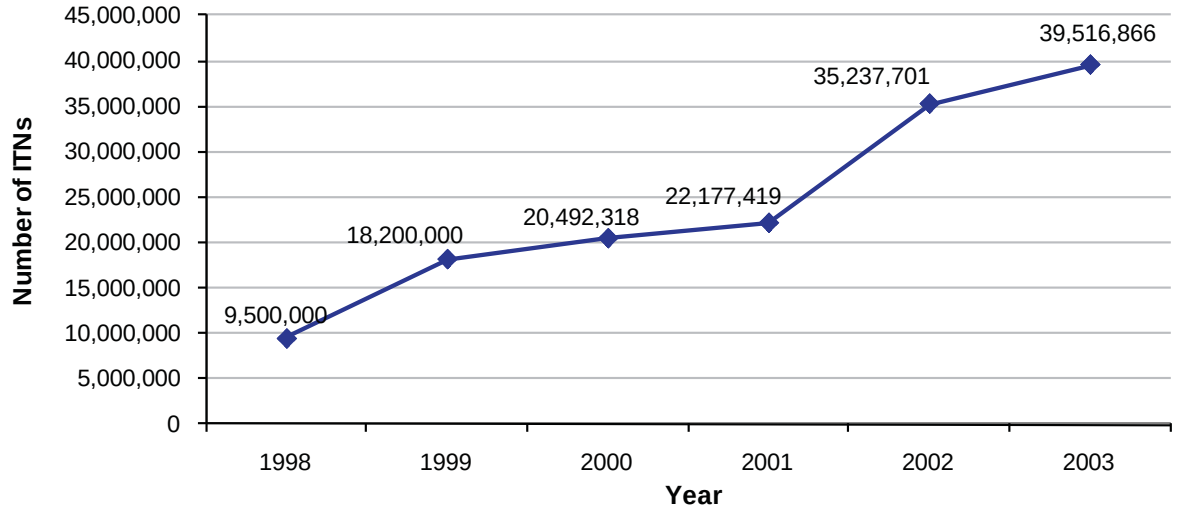


Figure 29: Trend in the Cumulative Number of Insecticide Treated Nets Distributed (EFY 1998-2003)

With regard to vector control, the plan was to implement Indoor Residual Spray (IRS) in 6,925,168 households in EFY 2003. However, 4,636,787 (67.0% of the target) households were sprayed. To facilitate the process, 5,825 spray pumps and 528 spare parts were distributed to respective regions. Besides, training was organized for 380

HEW supervisors and 1,106 HEWs on how to handle and maintain spray pumps.

For early detection and treatment of malaria cases, a total amount of 13,168,962 Rapid Diagnostic Test (RDT) kits and 5,058,582 strips of Coartem and chloroquine were procured and distributed to regions.

2.6.2.1 Trend in Malaria Cases

In EFY 2003, the total number of laboratory confirmed plus clinical malaria cases was 2,607,206, with the highest number being observed in Hamle (Figure 30). These data were reported through the Public Health Emergency Management (PHEM) surveillance system, which has been strengthened over the past years, but it has still limitations in reporting completeness (40% in EFY 2003). For trend analysis purposes, it is worth noting that there was underreporting in EFY 2002 Performance Report, and the full reports from regions were available after its publication, showing a total number of laboratory confirmed plus clinical malaria cases of over 3 million last year.

In EFY 2003, the highest number of suspected malaria cases was reported from SNNPR (1,155,390 corresponding to 44.3% of all cases), followed by Amhara Region (488,986 cases, 18.8% of the total), and Oromia Region (478,058 cases, 18.3% of the total) (Table 7). Out of these 2,607,206 suspected cases, 2,142,207 (82.2%) were tested, with a positivity rate of 43.3% (24.6% positive for *Plasmodium Falciparum* and 18.7% for *Plasmodium Vivax*).

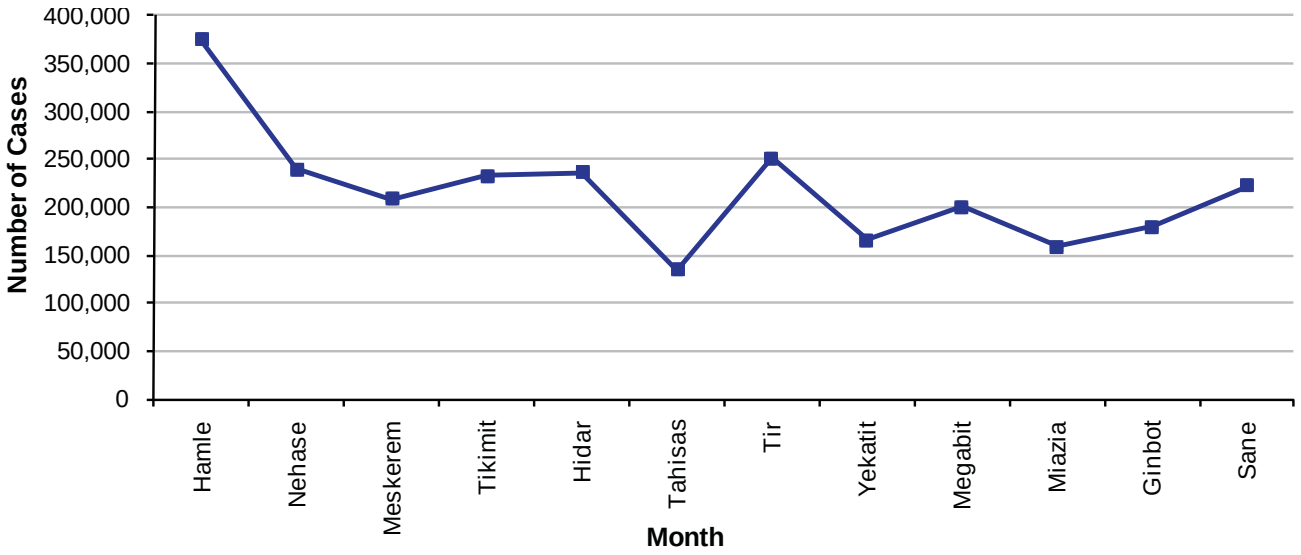


Figure 30: Trend in Laboratory Confirmed plus Clinical Malaria Cases by Month (EFY 2003)

Table 7: Distribution of Laboratory Confirmed plus Clinical Malaria Cases by Region (EFY 2003)

Region	Cases	
	Number	Percent
Tigray	379,877	14.6
Afar	32,571	1.2
Amhara	488,986	18.8
Oromia	478,058	18.3
Somali	148	0.0
Benishangul Gumuz	50,721	1.9
SNNPR	1,155,390	44.3
Gambella	18,246	0.7
Harari	504	0.0
Addis Ababa	2,666	0.1
Dire Dawa	39	0.0
National	2,607,206	100.0

The general trend of suspected malaria cases in the last decade (2001-10 GC) shows an increase in the first four year, reaching over 5.1 million of cases in 2004 GC, followed by a downward trend between 2005 and 2008 GC and a further increase in the two last years, with over 4 million of cases being reported in 2010 GC (Figure 31). It is important to note that the number of reporting units have increased over time as well as the reporting completeness, which, together with increased community awareness to seek treatment, may at least partly explain the increase in number of cases reported in the last two years.

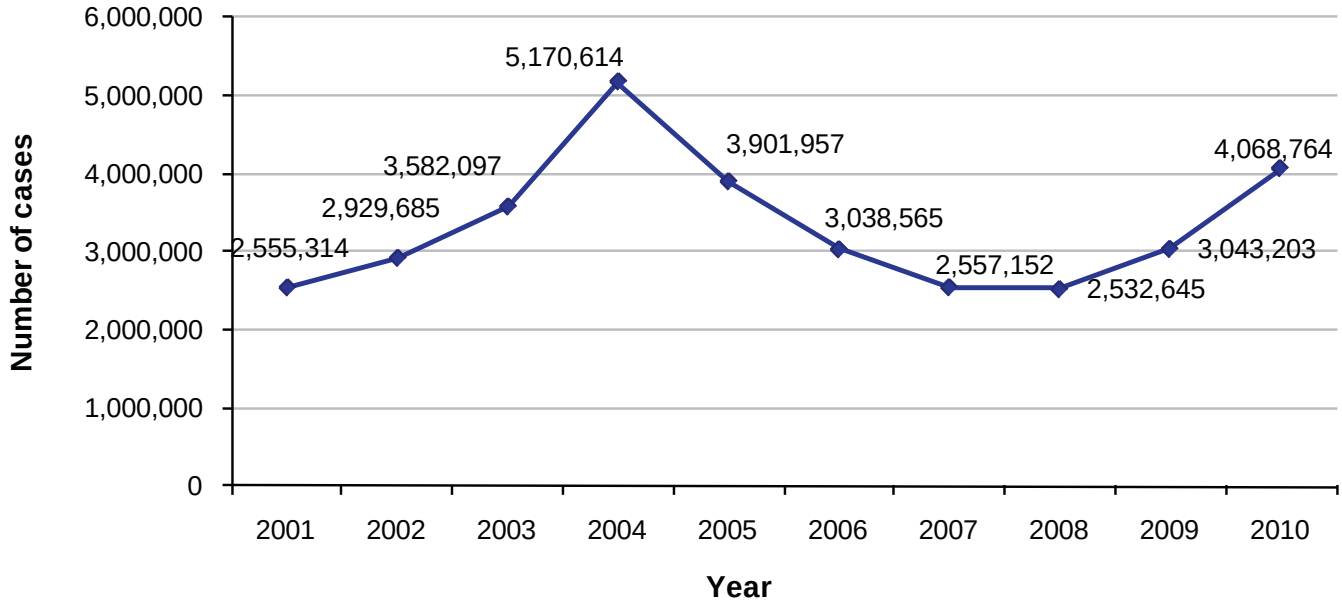


Figure 31: Trend in Laboratory Confirmed plus Clinical Malaria Cases by Year (2001-10 GC)

Challenges

- Inadequate utilization of Insecticide Treated Nets (ITN).

Way Forward

- Promote ITN utilization and awareness of the community on malaria prevention through HEWs and Health Development Army.

2.6.3
Tuberculosis and Leprosy Prevention and Control

According to the 2010 WHO Global TB Control Report, Ethiopia ranks 8th among the 22 high burden countries in the world and 3rd in Africa. The incidence rate of all forms of TB was estimated at 359 per 100,000 population in EFY 2003, while the incidence rate of smear-positive TB was 163 per 100,000. The prevalence of all forms of TB was estimated at 572 per 100,000, with the mortality rate due to TB being at 64 per 100,000. These estimates are derived from models. However, a TB prevalence survey was carried out in Ethiopia in EFY 2003 to produce actual estimates in the country, and preliminary results are showing a TB incidence rate of smear-positive TB (101 per 100,000 population) which was lower than the WHO estimate (163 per 100,000 population). Applying this new incidence rate will decrease the number of expected new smear-positive TB cases (denominator of the TB case detection rate) and increase the estimate of the indicator. For EFY 2003, WHO estimates were used waiting for final endorsement of the TB prevalence survey results.

The main objective of the Tuberculosis and Leprosy Prevention and Control (TLPC) is to reduce the incidence and prevalence of TB and Leprosy as well as the occurrence of disability and psychological suffering related to both diseases and the mortality resulting from TB to such an extent that both diseases are no longer public health problems.

Concerning TLPC the main targets set in HSDP IV are to: (i) increase the TB case detection rate to 75%; (ii) increase the TB treatment success rate from 84% to 90%; (iii) increase the percentage of confirmed Multi-Drug Resistant TB (MDR TB) cases put on correct second line anti TB treatment regimen from 2% to 55%; (iv) increase the proportion of PLWHA screened for TB from 15% to 80%; and (v) increase the TB cure rate from 67% to 85%.

To attain TLCP targets, the focus is on the expansion of community Directly Observed Treatment – Short course

(DOTS) through maximum use of HEP, strengthening case detection and management, addressing issues related to TB/HIV, MDR-TB and leprosy, engaging all care providers, and promoting operations research (OR).

In EFY 2003, it was planned to start TB case management at HP level, to increase the number of facilities that treat MDR-TB, and to strengthen leprosy case detection and treatment.

2.6.3.1 TB Prevention and Control

The target set for TB control in EFY 2003 was to increase TB detection rate from 36% to 59%, TB treatment success rate from 84% to 85%, and TB cure rate from 65% to 80%. Fluctuations were observed in EFY 2003: TB detection rate slightly increased from 36.0% in EFY 2002 to 36.8% in EFY 2003, below the target set for the year (59%), while TB success rate showed a downward fluctuation (from 84.0% to 82.5%) and TB cure rate slightly increased from 65.2% to 66.5% in the same period (Figure 32).

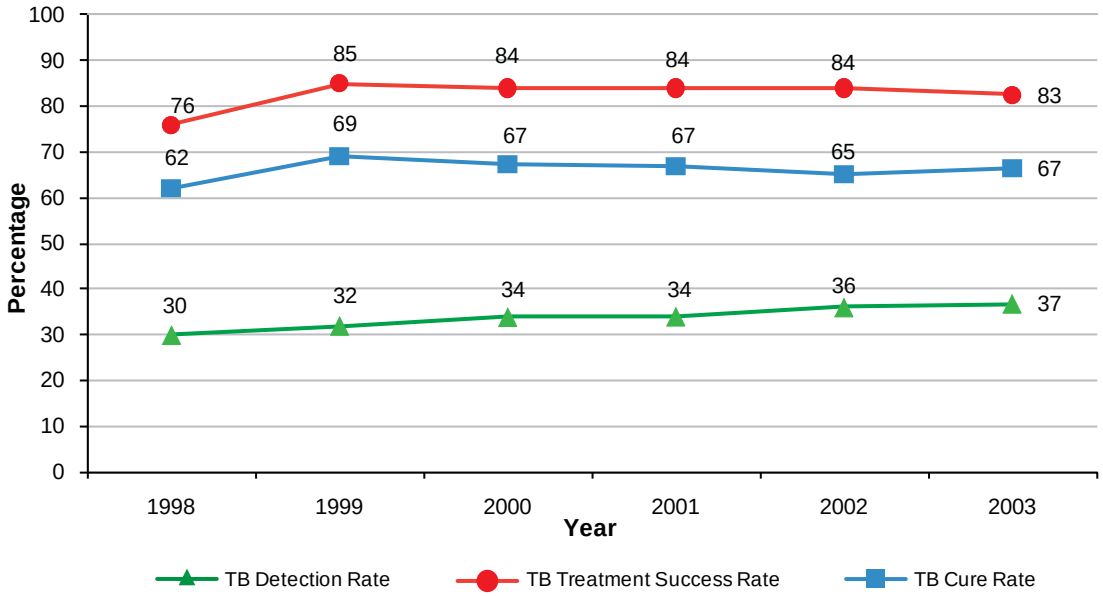


Figure 32: Trend in TB Case Detection Rate, TB Treatment Success Rate and TB Cure Rate (EFY 1998 - 2003)

2.6.3.1.1 TB Case Detection

In EFY 2003, a total of 49,155 new smear positive cases were detected, with a TB case detection rate of 36.8%, far below the target set for the year (58.7%). Variations were observed across regions, ranging from 10.3% in Somali Region to over 100% in Harari (Figure 33).

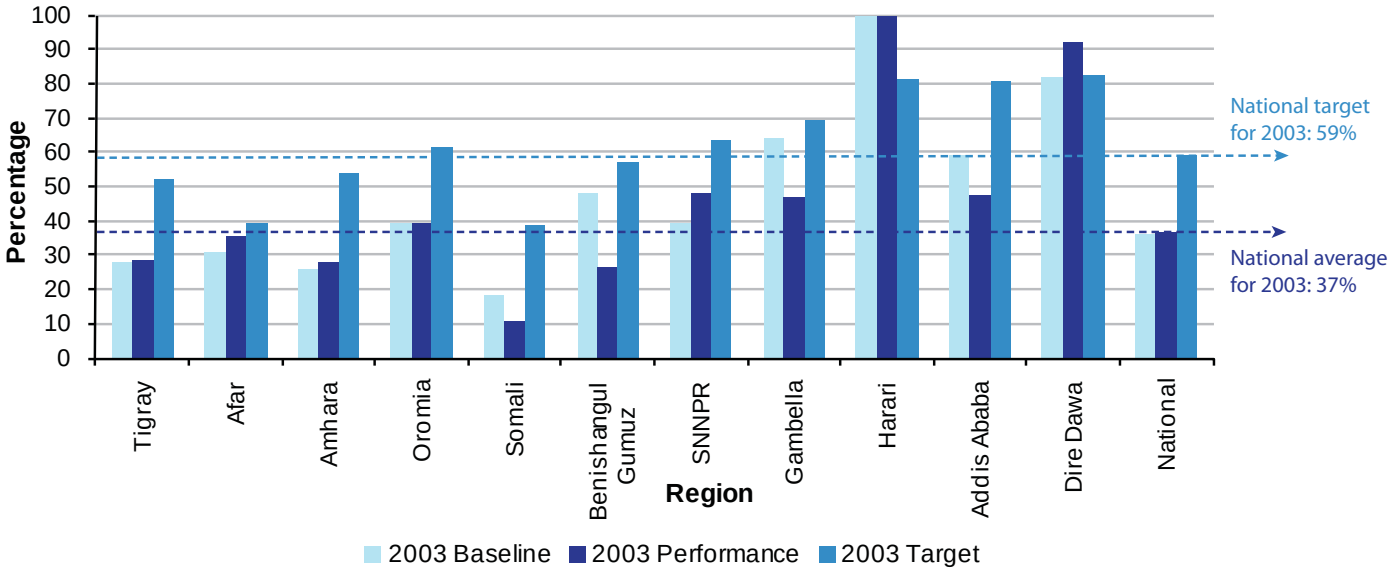


Figure 33: Comparison of Baseline, Performance and Target of the TB Case Detection Rate by Region (EFY 2003)

According to the national DOTS facility assessment carried out in February 2011, the vast majority of hospitals (92%) and HCs (95%) were implementing DOTS-based services. In addition, TB treatment follow-up under the DOTS strategy was given in 2,100 HPs across the country. Overall, there were 4,577 public DOTS facilities in the country. Concerning Public-Private Mix DOTS (PPM-DOTS), there were 317 PPM-DOTS facilities nation-wide (44 hospitals, 149 higher clinics, 95 medium clinics, and 29 lower clinics) which were owned and run by NGOs and other private institutions.

Regarding to community DOTS, procedure guideline and HMIS materials were prepared and distributed to HEWs.

2.6.3.1.2
TB Treatment Success Rate

In EFY 2002, the TB treatment success rate slightly decreased from 84.0% in EFY 2002 to 82.5% in EFY 2003, which was below the target set for the year (85%). Large variations were seen across regions, with the highest performance being observed in Gambella Region and the lowest one in Somali Region. Tigray, Amhara, Gambella, Addis Ababa and Dire Dawa Regions improved their performance in EFY 2003, while the remaining regions performed below EFY 2002 performance (Figure 34).

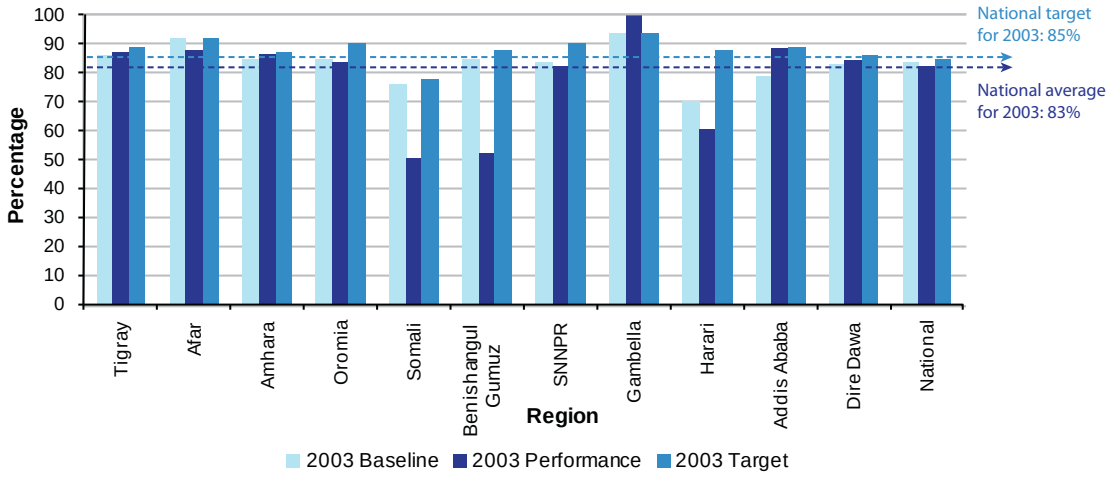


Figure 34: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2003)

2.6.3.1.3
TB Cure Rate

TB cure rate slightly increased from 65.2% in EFY 2002 to 66.5% in EFY 2003, which was below the target set for the year (80%) (Figure 35). The best performing regions were Tigray (85.8%), followed by Addis Ababa (76.4%), while five regions (Amhara, Somali, Benishangul Gumuz, Gambella and Harari) decreased their performance in EFY 2003 with respect to EFY 2002.

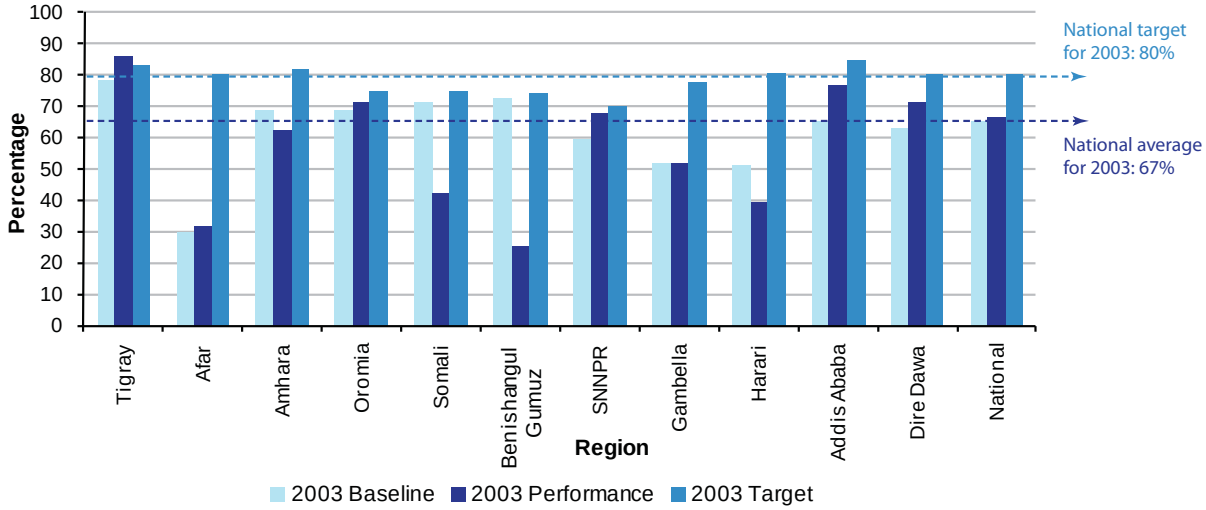


Figure 35: Comparison of Baseline, Performance and Target of the TB Cure Rate by Region (EFY 2003)

According to the recommendation made by WHO in 2010 to discontinue the regimen based on two months of rifampicin (2 HRZE/6 HE) and change to the regimen based on a full six month of rifampicin (2 HRZE/4HR) in order to reduce the number of relapses and failures, TOT was given for 30 health professionals and then a cascade training was given for 1,529 health professionals.

Furthermore, TOT was given on prevention and control of TB/HIV co-infection for 214 professionals.

Concerning MDR-TB, a total of 119 professionals were given training on the treatment regimen. Besides, MDR-TB treatment was started for a total of 218 patients in St. Peter 's Hospital, Gondar University Hospital and Dire Dawa Dil Chora Hospital.

Challenges

- Low community awareness about TB;
- Shortage of reagents;
- Poor quality of diagnostic laboratories;
- High staff turnover; and
- Incomplete and delayed reporting from some Health Facilities/Woreda Health Offices (HFs/WorHOs).

Way Forward

- Increase community awareness through HDA;
- Strengthen the supply of reagents;
- Improve the quality of laboratories;
- Implement staff retention mechanisms; and
- Strengthen programme planning, M&E and implementation capacity.

2.6.4
Neglected Tropical Diseases Prevention and Control

EFY 2003 is an important milestone for interventions targeting Neglected Tropical Diseases (NTD) as they were included in the HSDP IV and a five year draft national master plan for NTDs was finalized to help integration of activities and coordination of efforts. Dracunculiasis, onchocerciasis, leishmaniasis, lymphatic filariasis, trachoma, soil transmitted helminthiasis, schistosomiasis and podoconiosis are the eight NTDs prioritized in the master plan.

Dracunculiasis Eradication Program

Guinea worm disease is one of the diseases under eradication in Ethiopia. The disease is found only in Gog Woreda of Gambella Region. However, cross-border cases continued to be reported from Nyangatom Woreda of South Omo Zone and Surma Woreda of Bench Maji Zone. A total of 16 cases were reported in EFY 2003, of which two cases were imported from South Sudan. The rest 14 cases were reported only from Gog Woreda of Gambella Region within the Anyuak zone.

The major activities carried out in 2003 EFY include the following:

- Dracunculiasis disease surveillance activities were carried out and about 70% of woredas submitted zero case report on a weekly basis. Active case search was conducted in two at risk woredas (Surma and Nyangatom) in SNNPR;
- Annual review meeting was conducted in Gambella Region aimed at heightening dracunculiasis surveillance in the region;
- 20,000 posters and 120,000 brochures were distributed nationwide and community mobilization using mobile van was carried out; and
- Training on precertification activities for program managers and health workers were conducted in Oromia, Gambella, and SNNP Regions as well as supportive supervision in all regions.

Onchocerciasis and Lymphatic Filariasis

There are nine Community Directed Treatment Intervention (CDTI) projects running the Onchocerciasis Control Program in 10 zones and 77 woredas with a total population of 6,103,597. The annual target in EFY 2003 was to treat 4,882,478 people, with 4,405,833 being actually treated (therapeutic coverage=72%). Health workers and community drug distributors were trained in EFY 2003.

Though 36 lymphatic filariasis endemic woredas were identified nationwide, in EFY 2003 the elimination program was carried out in only five woredas in Gambella Region (co-implemented with the Onchocerciasis Program).

Leishmaniasis

Both visceral leishmaniasis (VL) and cutaneous leishmaniasis (CL) are endemic in Ethiopia with variable degree of endemicity. The visceral form is endemic in 5 regions, with the fertile low lands of Amhara and Tigray being highly affected.

Various efforts were made to control leishmaniasis. A total of 2,119 VL cases were reported and treated in EFY 2003. Leishmaniasis services were decentralized to reduce morbidity and mortality from VL in the endemic regions. Supplies were procured and distributed to endemic districts with the support of partners. The major activities implemented to control leishmaniasis were: (i) capacity building of health workers; (ii) early case detection and management; and (iii) surveillance of leishmaniasis cases with active case search through deploying outreach teams in the highly endemic regions. The vector control measures for leishmaniasis are integrated with the malaria vector control measures as both share similar strategies.

Leishmaniasis disease prevalence and distribution mapping is underway. The 2006 VL national guideline is under revision to include CL and revise the treatment protocol according to the 2010 WHO recommendations. Various efforts were made to improve public awareness on leishmaniasis, including printing and distribution of leaflets, brochures, and billboards.

Challenges

- Lack of prevalence and distribution mapping for most of the NTDs;
- Limitation in coordination of efforts and co-implementation of activities;
- Failure to identify source of dracunculiasis and cross border importation of cases; and
- Spread of leishmaniasis to new localities with high HIV/VL co-infection rate.

Way forward

- Finalize the mapping of NTDs;
- Endorse and implement the national NTD Master Plan;
- Increase dracunculiasis surveillance nationwide and community awareness on precertification activities; and
- Strengthen the control of leishmaniasis.

2.7 Prevention and Control of Non-Communicable Diseases

The growing burden of chronic non-communicable diseases is gaining increasing attention worldwide. Chronic Non-Communicable Diseases (NCD) such as heart disease, stroke, cancers, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 60% of all deaths.

A double burden of disease is already emerging in Ethiopia at the early stage of the epidemiological transition, with a mix of persistent, emerging and re-emerging infectious diseases and increasing prevalence of chronic conditions and injuries. This will lead to fundamental changes in the volume and composition of demand for health care, with a more complex case mix and more costly service utilization patterns. The FMOH has taken important steps to strengthen prevention and control of NCDs:

- A national strategy on prevention and control of chronic NCDs was developed and officially endorsed, outlining five major NCDs and the strategic approaches for their prevention and control, while the implementation plan is still under preparation;

- Targets and strategic initiatives for prevention of chronic NCDs were included in HSDP IV and in the annual core plan;
- NCD screening tools were integrated into the Urban Family Folder (FF) and Health Card; and
- Trainings were provided to strengthen the national capacity on NCDs.

Besides, awareness creation and promotion work was done especially on mental health through panel discussions and talk shows organized by ERTA in collaboration with FMOH, with participation of higher government officials, religious leaders, traditional healers, health professionals and community members.

The National Mental Health Strategy has being implemented in EFY 2003. In light of the dearth of skilled mental health professionals in the country, this strategy calls for an accelerated training and build up of cadres of mental health professionals. Furthermore, FMOH plans to develop a National Institute of Mental Health (NIMH) to guide, direct and supervise the overall development, implementation, and monitoring of the strategy. In partnership with academic and higher learning institutions, NIMH will also develop a Center of Excellence for Mental Health to serve as the major repository of cultural- and evidence-based knowledge and practices. The general objective of NIMH is to become a hub for promoting and developing evidence-based best practices in the areas of mental health services, training and research. NIMH will also play a catalytic role in promoting mental health in Ethiopia by providing technical assistance to hospitals, HCs, and HPs throughout the Regions.

Challenges

- Inadequate capacity (human, financial and logistic);
- Limited data and evidence on NCDs; and
- Lack of adequate funding for NCDs.

Way Forward

- Strengthen capacity on NCDs;
- Improve data collection and analysis on NCDs; and
- Mobilize resources to implement key strategies on injury prevention and chronic NCDs.

2.8 Public Health Emergency Preparedness and Response

This strategic objective aims to improve how the health system copes with existing and emerging disease epidemics, acute malnutrition, and natural disasters of national and international concern. The desired coping responses include improved health risk identification, early warning, response and recovery from the disasters. The expected outcomes of this strategic objective are early verification, rapid response and containment of public health emergencies.

The specific strategies that will be put in place during HSDP IV include: (i) community involvement; (ii) resource mobilization; (iii) integrated communication and information systems across multiple sectors; (iv) advanced operational readiness assessment; (v) multi-sectoral coordination for emergency preparedness and response; (vi) comprehensive training and evaluation; and (vii) proper application of Information and Communication Technology (ICT).

These strategies will contribute towards an effective early warning, preparedness, response, recovery and rehabilitation system.

Improving public health emergency communication, response and recovery is one of the strategic objectives in the EFY 2003 Plan of the Ethiopian Health and Nutrition Research Institute (EHNRI).

The plan for EFY 2003 included the implementation of the following key activities:

- Prepare and disseminate 52 Weekly Bulletins on reportable diseases;
- After the occurrence of a public health emergency, its verification, and knowledge of its occurrence at central level, notify concerned bodies within 30 minutes and provide information to the public within 12 hours;
- Provide information on about 60% of risk factors to concerned bodies within a specified period;

- Commence preventive and control activities for 75% of known and identified public health emergencies within 48 hours;
- Undertake relief and rehabilitation activities for 100% of members of society or health facilities affected by severe public health emergencies.

In this respect, the vast majority of the planned activities were performed in EFY 2003 and these achievements are summarized as follows.

In EFY 2003, surveillance of polio and measles was carried out at the national level, and the absence of wild polio virus in the country was confirmed through laboratory examinations.

Out of the 2,926 samples collected for examination of measles and rubella, measles virus was found in 54% and rubella virus in 4% of the tested samples, respectively; in addition, after the completion of laboratory intra-typic differentiation and polio virus isolation quality control tests, the EHNRI laboratory scored 100% in its compliance with international quality control standards. The laboratory thus maintained the high standard which it had held in the past.

Out of the above mentioned public health emergencies, 93% were identified and information transmitted to the concerned bodies within 30 minutes; once known at the central level, information was given to the public within 12 hours. Thus, capacity for controlling public health hazards was strengthened through timely provision of epidemic alert. In addition, as planned, the Weekly Bulletin on notifiable diseases was prepared and disseminated to the concerned stakeholders.

In order to prevent and control the above noted public health emergencies, drugs and medical equipment worth ETB 13 million (ETB 9.2 million from Government and ETB 3.8 million from partner organizations) were dispatched to Gambella, Oromia, Afar, Somali, Benishangul Gumuz and Tigray Regions. Furthermore, support for transportation of drugs was provided to Gambella, Benishangul Gumuz and Somali Regions.

In order to undertake vulnerability assessment and identification of health risks and to prevent epidemics and other public health emergencies, risk profile of major epidemic-prone diseases (acute watery diarrhoea, measles, malaria, and meningitis) was prepared and data were made available to concerned stakeholders. The preparation of this profile would enable timely implementation of preventive measures against the identified risk factors and thereby avert their occurrence.

A system was designed and put in place, enabling easy tracking of the type and quantity of different drugs, medical supplies and equipment stored at warehouses for epidemic response purposes. Based on this tracking system, gaps in drugs and medical equipment needed for management of major epidemic diseases were identified.

For health hazards (acute watery diarrhoea, measles, malaria, meningitis, floods and malnutrition) identified using data from the baseline assessment and the surveillance system, a humanitarian requirement document was prepared and disseminated to concerned stakeholders to solicit their support.

Two disease control guidelines (for acute watery diarrhoea and malaria) were prepared and are ready for printing. Training on public health emergencies as well as on these guidelines was given for 368 (295 males and 73 females) public health emergency management experts drawn from various regions.

2.8.1
Epidemic Prevention and Control

Regional distribution and weekly patterns of the main epidemic prone diseases are presented in this section. Data are collected and reported through the PHEM surveillance system. Since these are reportable diseases, the weekly pattern is presented according to the international standard (by WHO epidemiological week): therefore, the second half of 2010 GC (28th-52nd WHO epidemiological weeks) corresponds to the first half of EFY 2003, while the first half of 2011 GC (1st -27th WHO epidemiological weeks) corresponds to the second half of EFY 2003. For clarity purposes, the corresponding months of the EFY 2003 (from Hamle to Sene) are specified in the horizontal axis.

2.8.1.1
Acute Watery Diarrhoea

In EFY 2003, 738 Acute Watery Diarrhoea (AWD) cases and 3 deaths were reported from six regions (Afar, Amhara, Oromia, SNNP, Addis Ababa and Dire Dawa) (Table 8). The Case Fatality Rate (CFR) was 0.4%, which was better than the WHO international standard (CFR <1%). This indicates adequate AWD case management. Of note is the fact that the number of cases (738) reported in EFY 2003 was much lower than those reported in EFY 2002 (19,331), with CFR decreasing from 0.9% in EFY 2002 to 0.4% in EFY 2003. The highest number of AWD cases was reported from SNNPR (510), followed by Oromia (173) (in particular, from Sidama and Gedeo Zones of SNNPR and East Harerge and Guji Zones of Oromia Region).

The weekly pattern showed a peak in the epidemic weeks 40-44 (corresponding to the month of Tikimit) of EFY 2003 after the rainy season (Figure 36).

Table 8: Distribution of Acute Watery Diarrhoea Cases and Deaths by Region (EFY 2003)

Region	Cases		Deaths	
	Number	Percent	Number	CFR (%)
Tigray	0	0.0	0	0.0
Afar	4	0.5	0	0.0
Amhara	2	0.3	0	0.0
Oromia	173	23.4	2	1.2
Somali	0	0.0	0	0.0
Benishangul Gumuz	0	0.0	0	0.0
SNNPR	510	69.1	1	0.2
Gambella	0	0.0	0	0.0
Harari	0	0.0	0	0.0
Addis Ababa	2	0.3	0	0.0
Dire Dawa	47	6.4	0	0.0
National	738	100	3	0.4

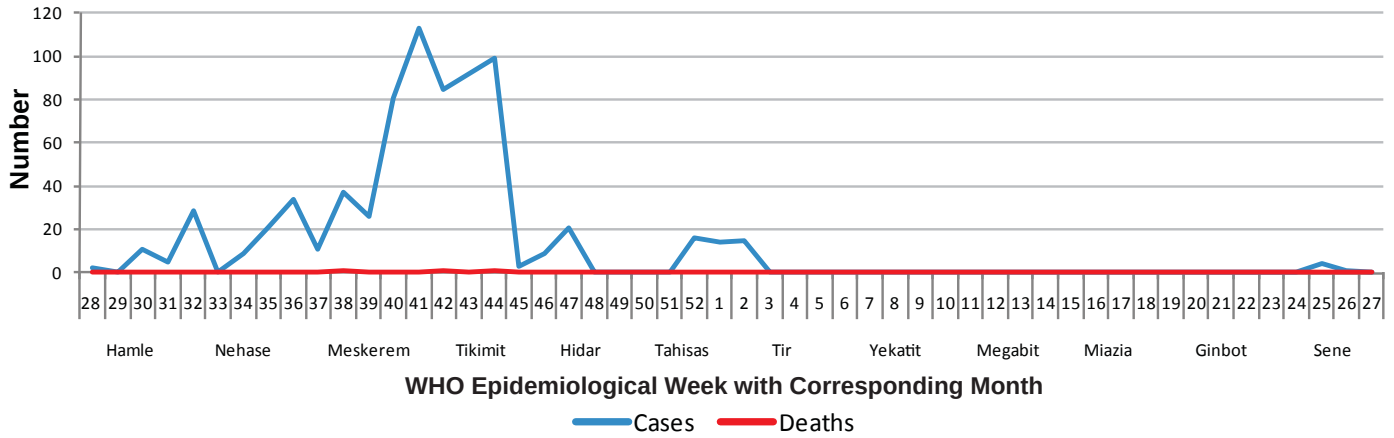


Figure 36: Trend of Acute Watery Diarrhoea Cases and Deaths by Week (EFY 2003)

2.8.1.2
Measles

In EFY 2003, 38,288 suspected measles cases and 182 deaths were reported from all regions except Somali (data were not available from this region) (Table 9). The highest number of suspected measles cases was reported from SNNPR (24,401), followed by Oromia (8,105). The average national CFR was 0.5%. The epidemiological trend is presented in Figure 37, showing the weekly distribution of cases and deaths.

Table 9: Distribution of Suspected Measles Cases and Deaths by Region (EFY 2003)

Region	Cases		Deaths	
	Number	Percent	Number	CFR (%)
Tigray	883	2.3	16	1.8
Afar	71	0.2	3	4.2
Amhara	3,400	8.9	46	1.4
Oromia	8,105	21.2	45	0.6
Somali	0	0.0	0	0.0
Benishangul Gumuz	692	1.8	27	3.9
SNNPR	24,401	63.7	41	0.2
Gambella	28	0.1	0	0
Harari	59	0.2	2	3.4
Addis Ababa	604	1.5	2	0.3
Dire Dawa	45	0.1	0	0
National	38,288	100	182	0.5

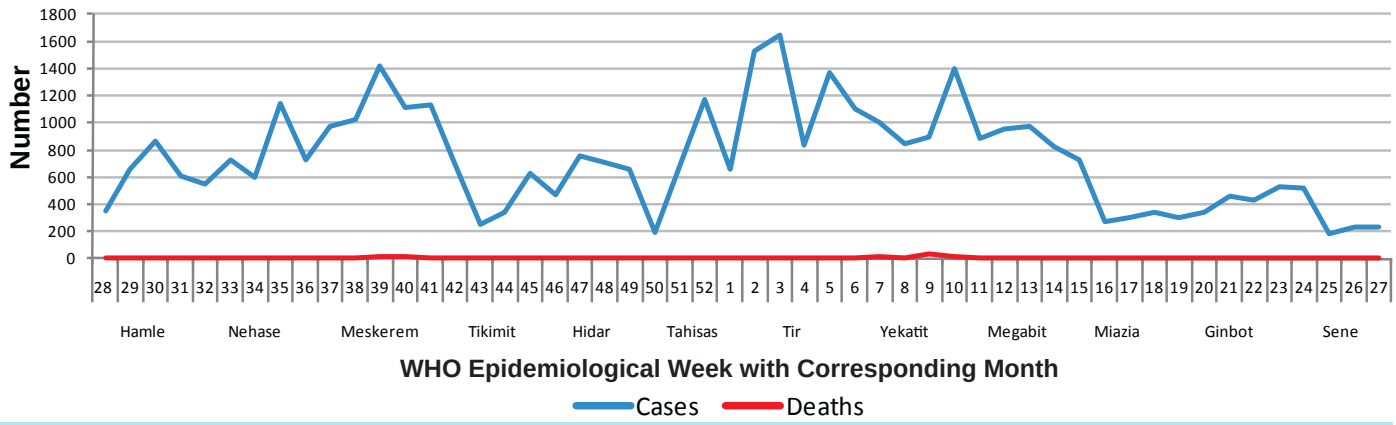


Figure 37: Trend of Suspected Measles Cases and Deaths by Week (EFY 2003)

2.8.1.3 Poliomyelitis

No polio cases were reported in EFY 2003. In order for a country to be declared polio free it must have no polio cases and have Acute Flaccid Paralysis (AFP) non-polio rate of at least 1 per 100,000 children under 15 years, demonstrating that the surveillance system is sensitive enough to detect polio cases. At the national level, the number of AFP non-polio cases reported from all regions and verified by the EHNRI polio laboratory was 705. The highest number of AFP non-polio cases was reported from Oromia (278 cases), followed by Amhara (152) and SNNPR (134).

2.8.1.4 Dysentery

In EFY 2003, 140,867 cases and 16 deaths (with a CFR of 0.01%) were reported from all regions. The highest number of cases was reported from Oromia (40,456), followed by SNNPR (38,734), Tigray (21,649), and Amhara (21,606) (Table 10). Week surveillance system, with subsequent underreporting, may account for the few cases reported by other regions.

Table 10: Distribution of Dysentery Cases and Deaths by Region (EFY 2003)

Region	Cases		Deaths	
	Number	Percent	Number	CFR (%)
Tigray	21,649	15.4	0	0.00
Afar	2,688	1.9	0	0.00
Amhara	21,606	15.3	0	0.00
Oromia	40,456	28.7	8	0.02
Somali	63	0.0	0	0.00
Benishangul Gumuz	2,247	1.6	0	0.00
SNNPR	38,734	27.5	8	0.02
Gambella	677	0.5	0	0.00
Harari	335	0.2	0	0.00
Addis Ababa	11,781	8.4	0	0.00
Dire Dawa	631	0.4	0	0.00
National	140,867	100.0	16	0.01

2.8.1.5 Meningococcal Meningitis

A total of 1,324 cases and 39 deaths were reported from all regions, with the highest number of cases being reported from Oromia (561), followed by SNNPR (394) (Table 11). The average national CFR was 2.9%. The epidemiological trend is presented in Figure 38, showing the weekly distribution of cases and deaths. The

Table 11: Distribution of Meningococcal Meningitis Cases and Deaths by Region (EFY 2003)

Region	Cases		Deaths	
	Number	Percent	Number	CFR (%)
Tigray	97	7.3	5	5.2
Afar	2	0.2	0	0.0
Amhara	81	6.1	4	4.9
Oromia	561	42.4	15	2.7
Somali	1	0.1	0	0.0
Benishangul Gumuz	84	6.3	0	0.0
SNNPR	394	29.7	10	2.5
Gambella	20	1.5	0	0.0
Harari	14	1.1	2	14.3
Addis Ababa	69	5.2	3	4.3
Dire Dawa	1	0.1	0	0.0
National	1,324	100	39	2.9

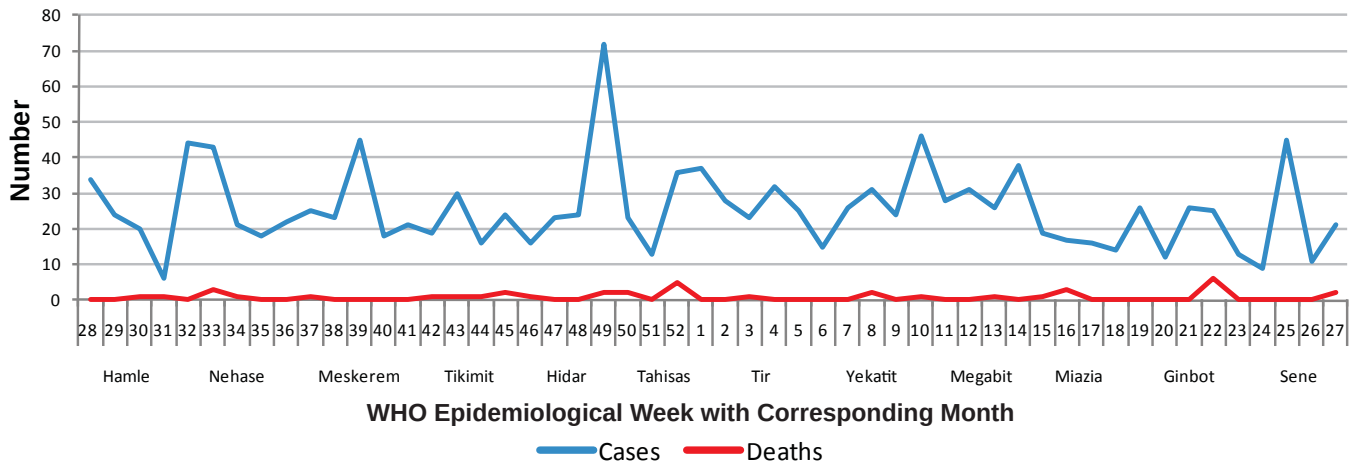


Figure 38: Trend of Meningococcal Meningitis Cases and Deaths by Week (EFY 2003)

number of cases indicated in the weekly trend was reported from different localities and, even if it looks like above the standard threshold to declare epidemics, it is much less than the threshold when disaggregated to specific localities.

2.8.1.6
Relapsing Fever

In EFY 2003, all regions, except Somali, reported a total number of 6,355 cases and 9 deaths. The highest number of cases was reported from Oromia (2,347) followed by SNNPR (2,314).

2.8.1.7
Typhoid Fever

A total of 323,008 cases of typhoid fever and 12 deaths with CFR of 0.004% were reported from all regions. The highest number of cases was reported from SNNP (142,823), followed by Oromia (103,327), and Addis Ababa (40,916) (Table 12).

Table 12: Distribution of Typhoid Fever Cases and Deaths by Region (EFY 2003)

Region	Cases		Deaths	
	Number	Percent	Number	CFR (%)
Tigray	5,514	1.71	0	0.000
Afar	1,229	0.38	0	0.000
Amhara	24,989	7.74	0	0.000
Oromia	103,327	31.99	0	0.000
Somali	7	0.00	0	0.000
Benishangul Gumuz	3,569	1.10	0	0.000
SNNPR	142,823	44.22	11	0.008
Gambella	325	0.10	0	0.000
Harari	215	0.07	0	0.000
Addis Ababa	40,916	12.66	1	0.002
Dire Dawa	94	0.03	0	0.000
National	323,008	100	12	0.004

2.8.1.8
Anthrax

A total of 1,096 suspected anthrax cases and 16 deaths (with a CFR of 1.5%) were reported from four regions (Tigray, Amhara, Oromia, and SNNP) (Table 13). The highest number of cases was reported from Tigray (396), followed by SNNPR (340), Amhara (296), and Oromia (64), while the highest number of deaths (9) were reported in SNNPR (56% of the total deaths), with Oromia accounting for 5 deaths (31%) and Tigray for 2 (13%).

Table 13: Distribution of Suspected Anthrax Cases and Deaths by Region (EFY 2003)

Region	Cases		Deaths	
	Number	Percent	Number	CFR (%)
Tigray	396	36.1	2	0.5
Amhara	296	27.0	0	0.0
Oromia	64	5.8	5	7.8
SNNPR	340	31.0	9	2.6
National	1,096	100.0	16	1.5

2.8.1.9
Rabies

In EFY 2003, 1,048 rabies cases and 25 deaths (with a CFR of 2.4%) were reported from 6 regions (Table 14). The highest number of cases was found in Oromia (444 cases), followed by Tigray (254), Amhara (225) and SNNPR (123). Only one case each was reported from Benishangul Gumuz and Addis Ababa. The absence of cases reported from pastoralist regions may reflect the culture of the population (with little connection of the communities with dogs) and also the weak surveillance system in these regions. The highest CFR was observed in SNNPR (4.1%): this may be due to late detection and treatment.

Table 14: Distribution of Rabies Cases and Deaths by Region (EFY 2003)

Region	Cases		Deaths	
	Number	Percent	Number	CFR (%)
Tigray	254	24.2	0	0.0
Amhara	225	21.5	5	2.2
Oromia	444	42.4	14	3.1
Benishangul Gumuz	1	0.1	0	0.0
SNNPR	123	11.7	5	4.1
Addis Ababa	1	0.1	1	100.0
National	1,048	100.0	25	2.4

2.8.1.10
Pandemic Influenza

Five H1N1 influenza cases (with zero death) were reported from Oromia Region in EFY 2003.

2.8.1.11
Other Epidemic Prone Diseases

In EFY 2003, there was zero report of cases of Severe Acute Respiratory Syndrome (SARS), Viral Hemorrhagic Fever (VHF), and Yellow Fever.

Challenges

- Difficulty in retention of high level professionals (with subsequent brain drain to other institutions and migration to other countries) due to the competition in the employment market and better conditions offered abroad; and
- Long duration of the procurement process with subsequent delay in the supply of equipments and materials.

Way Forward

- Ensure implementation of retention mechanism; and
- Speed the procurement process in line with the needs of the EHNRI.

2.9
Quality of Health Services

The strategic objective to improve quality of health services includes provision of health services as per the standard by health facilities at all levels. This standard includes speed of delivery, effectiveness of the services and patient safety, ethical considerations and professionalism in service delivery, and availability of the required inputs (HR, finance, pharmaceuticals etc.).

The delivery of quality health services is central to improving the health status of the population. HSDP IV will focus on a comprehensive and continuous quality monitoring mechanism that will enable all levels of the health system to look at all aspects of performance and quality of services. Improving the quality of services will be realized through scrupulous implementation of tools, manuals and standards that have been developed as part of BPR.

The expected outcome is the creation of a health system that satisfies the community's health care needs through the fulfilment of the required inputs, delivering safe and optimum quality of health services in an integrated and user-friendly manner.

The performance of the sector with respect to improving quality of services is presented in this section.

2.9.1
Quality Improvement

The FMOH is currently focusing on the institution of quality improvement processes in health facilities and in the activities of all health professionals and managers. Quality improvement is an integral part of any service delivery and to address this issue the FMOH has taken steps to ensure that all facilities have a Quality Management Committee and designed a reference manual to provide guidance on its implementation. In EFY 2003 the preparation of guidelines, manuals, and standard operating procedures, and the selection of the quality indicators, were finalized. Furthermore, the development of the training material for quality improvement was completed and the initial training conducted at federal level for five hospitals in Addis Ababa.

2.9.2
Health Facility Reform

Since EFY 1998, under the Ethiopian Hospital Management Initiative a lot of activities have been performed such as the development of guidelines for key areas of hospital management, preparation and application of monitoring and evaluation tools, and establishment of hospital management boards.

With regard to the activities carried out in EFY 2003, the Implementation Guideline for Hospital Reform, already prepared and distributed to RHBs in the previous year, was implemented in 100 hospitals. The Guideline was distributed to all hospitals in all regions. Training on the Guideline was given for Chief Executive Officers (CEO) of hospitals implementing the reform and for 500 professionals coordinating the implementation of the reform. TOT on infection prevention and nursing care was given in two rounds for 80 professionals drawn from regions and various hospitals. Training on basic nursing care was given for 1,000 nurses drawn from various regional hospitals.

A TOT Guideline on Nursing Care, Infection Prevention, Quality Management and Medical Records was prepared. In addition, preparation of an Ethics Guideline and a Guideline on uniforms was finalized.

In order to shorten the long waiting time for patients requiring surgical interventions, in collaboration with professional associations, surgical treatment was given for 377 patients at St. Paul's and Tikur Anbessa Hospitals. Egyptian health professionals performed similar surgical operations for 618 patients in Amhara, Dire Dawa, Addis Ababa, and Oromia Regions.

Based on the plan to hold quarterly review meetings, four meetings were held by all regions on problems encountered during the implementation of the Hospital Reform Guideline.

The FMOH carried out supportive supervision two times during EFY 2003 to facilitate the implementation of the Guideline on Hospital Reform in all regions.

To help implementation of the Hospital Reform Guideline at federal hospitals, the guideline was distributed and

training given to concerned bodies. Furthermore, training on quality management was given for heads drawn from these hospitals, and, to facilitate the implementation process, supportive supervision was made to these hospitals.

Implementation of the hospital reform is monitored weekly through officers assigned at these hospitals, and these hospitals have functioning management boards that meet regularly to solve management problems.

As part of the plan to develop a monitoring framework for HCs, the preparation of monitoring and evaluation tools was finalized. A pre-implementation assessment study on the HC reform guideline was conducted in 45 selected HCs located in five regions. Training on the Health Center Reform Implementation Guideline was given for HCs in Amhara, Tigray and Oromia Regions.

2.9.3
Hospital Emergency Services

In order to start provision of pre-hospital emergency medical services at woreda level, a Memorandum of Understanding was signed between Presidents of Regions and the Ministry of Health.

Standard for Ambulance Services was prepared. Fifty three ambulances were procured and distributed to regions: 3 for Harari, 3 for Dire Dawa, 8 for Addis Ababa, 8 for Benishangul Gumuz, 6 for Gambella, 5 for Afar, 10 for Somali, 2 for Amhara, 3 for Oromia and 5 for SNNPR.

TOT on ambulance services was given for 25 professionals from five University Hospitals (Mekelle, Gondar, Jimma, Hawassa, and Hiwot Fana University Hospitals) and Menelik II Health Science College.

Using the paramedics training curriculum developed earlier, training of Grade II Paramedic Technicians (Emergency Medical Technician II) started and training was given for 25 professionals drawn from Afar, Somali, Harari, Dire Dawa, Gambella and Benishangul Gumuz Regions.

To strengthen the hospital emergency services, training on "Advocacy and Quality Improvement on Trauma Care" was given for 25 health professionals drawn from RHBs and for hospital CEOs.

2.9.4
Referral System

A Guideline for the Implementation of the Referral Network was prepared in EFY 2002 and a technical working group was established to undertake in EFY 2003 remaining tasks such as developing a referral directory, standard operating procedures and policies.

Accordingly, the following activities were performed in EFY 2003. Professional staffs have been assigned and are monitoring and coordinating referral activities between health facilities at different levels of the health care system. In order to develop a referral directory, collection of data from 90 hospitals was completed, and preparation of the first draft of a Guideline for Liaison Officers was finalized.

2.9.5
Blood Safety

Since EFY 2002, the functions of the blood transfusion service are being reverted from ERCS to FMOH. As a continuation of this decision, in EFY 2003, data required for reassignment of human resources were submitted to the Civil Service Ministry and 59 posts were approved. At the same time financial assistance was provided to regions.

Blood supplies and equipment were procured. A total of 47,000 units of blood were collected from blood donors, much more than the planned collection of 35,500 units.

2.9.6
Utilization of Health Services

Health service utilization is measured by Out Patient Department (OPD) attendance per capita. It is the average number of outpatient visits (both first and repeat) per person per year, reflecting the interaction between demand and supply of outpatient care.

OPD attendance per capita fluctuated around 0.3 visit per person per year over the past 5 years, and the

performance in EFY 2003 was similar to the previous pattern of low health service utilization, below the target set for the year (0.6 visit per person per year) (Figure 39).

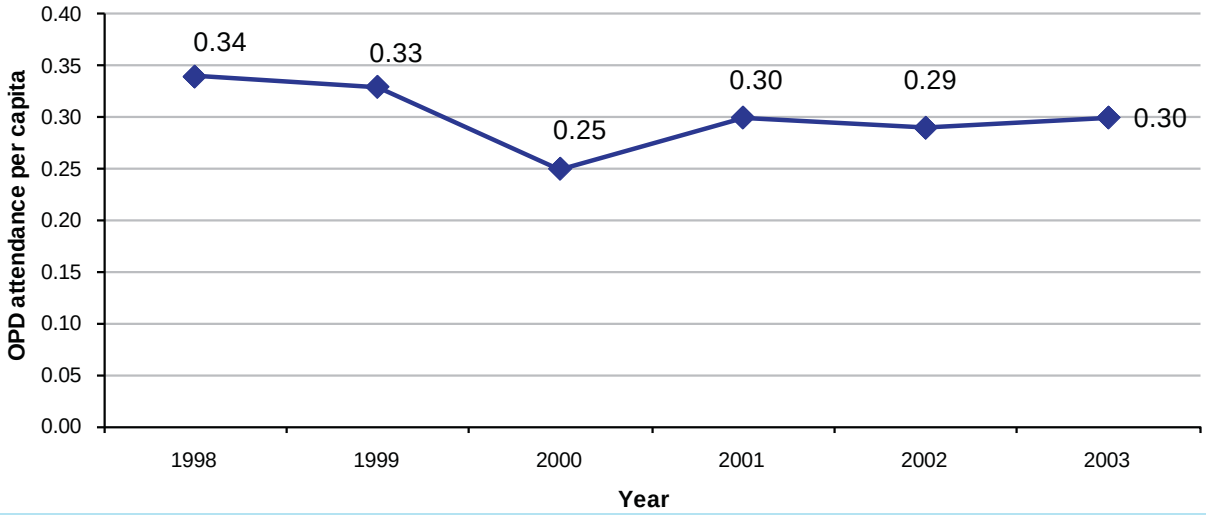


Figure 39: Trend in OPD Attendance Per Capita (EFY 1998-2003)

Wide variations were observed across regions, ranging between 0.7 visit per person per year in Tigray Region and 0.05 in Somali Region (Figure 40).

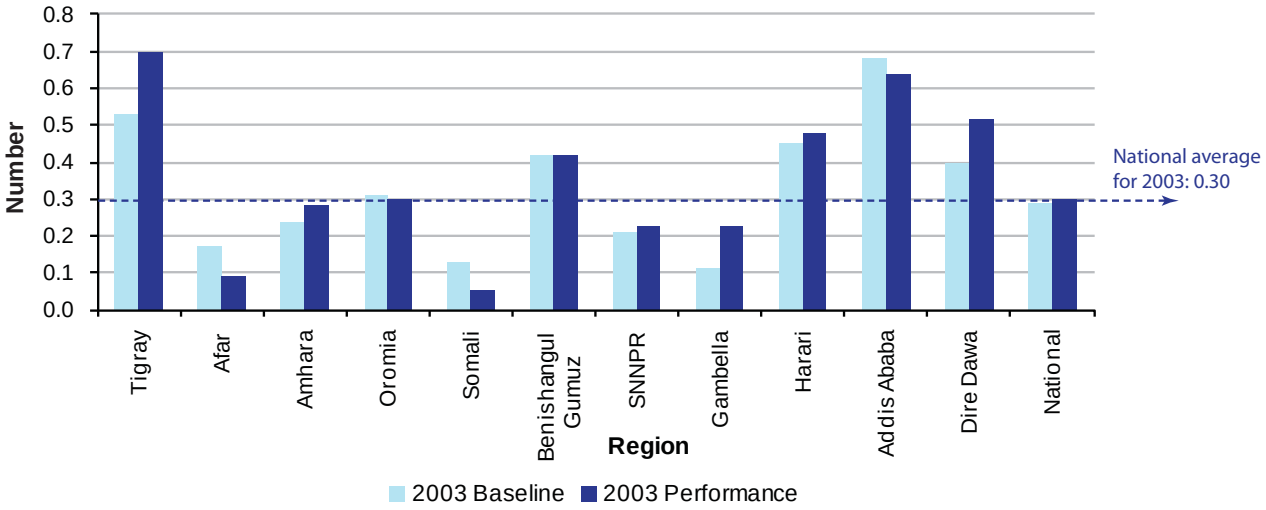


Figure 40: Comparison of Baseline and Performance of OPD Attendance per Capita by Region (EFY 2003)

Challenges

- Long time taken by the transition of the blood transfusion service from the ERCS to FMOH;
- Slow implementation of Health Care Financing (HCF) by federal hospitals;
- Lack of knowledge of performance evaluation system on the part of RHBs and hospitals;
- Variations in the implementation of private wings in regions; and
- Inability to deliver supply of drugs and medical equipment on time for some health facilities.

Way Forward

- Accelerate the transition of the blood transfusion service from the ERCS to FMOH;
- Speed the implementation of HCF by federal hospitals;
- Make the Performance Monitoring Team effective at all levels according to the standard of the HMIS;
- Address the reasons for the variation in private wing service observed in regions; and
- Strengthen the drug and medical equipment supply system.

2.10
National Laboratory System

In accordance with EHNRI Five Year Balanced Score Card (BSC) based strategic plan (2010-2015), laboratory standardization for integrated diagnosis of diseases will be necessary for all levels of the laboratory system to define the services required at each facility. This can be done through infrastructure upgrades, trainings, quality assurance, equipment maintenance, supply chain initiatives, and other strategies to assist the regional laboratories and upgrade their ability to provide laboratory services for integrated diseases. Standardization and building capacity at the regional and federal laboratories will enhance their ability and quality in performing specialized and referral tests, and implement Regional External Quality Assessment Scheme. Different guidelines, manuals, standard operating procedures and formats have to be developed to standardize the laboratory system and standards will be set so that all critical health issues can be addressed by Ethiopia's laboratory system.

Accordingly, to improve and maintain quality assured laboratories, to enhance laboratory quality system, and to strengthen the diagnostic capacity of laboratories were set as an objective during the strategic plan period.

In EFY 2003, using WHO/AFRO quality assurance standard (i.e. star 1, 2 and 3), 39 laboratories were upgraded. In doing so, initial baseline assessment was done on 45 laboratories. Feedback was provided and necessary amendments and corrections were made.

Among the laboratories, three consecutive trainings were given through supportive supervisions for staff of 24 laboratories. Furthermore, two training sessions were held and a supportive supervision was made to 21 laboratories. In order to build the capacity of laboratory professionals, a total of 1,470 laboratory technicians were trained in the fiscal year.

Besides, a total amount of ETB 35,878,029 was transferred to regions to sustain regional laboratories capacity on specimen handling and referral. Furthermore, essential laboratory equipments like TB smear culture media were supplied to the EHNRI central laboratory and regional laboratories in Tigray (Mekele), SNNP (Hawassa), Amhara (Bahirdar), Oromia (Adama); DNA-PCR machines were supplied to regional laboratories in Oromia (Jimma and Nekemte) and Amhara (Dessie); and viral load count machines were supplied to regional laboratories in Addis Ababa, Oromia (Adama and Jimma), Amhara (Bahirdar), Tigray (Mekele), SNNP (Hawassa), and Harari.

With regard to maintenance, a total of 436 equipments and machines found in regional laboratories were maintained. Besides, 149 heavy equipments and machines were maintained in the central laboratory of EHNRI in EFY 2003.

Challenges

- Inadequate HR capacity due to shortage of experienced professionals and high attrition;
- Repeated damages of laboratory equipment due to power interruptions;
- Shortage of laboratory inputs (reagents, supplies, equipment etc); and
- Lack of insurance for work related accidents.

Way Forward

- Replace damaged laboratory equipment through proper procurement and maintenance;
- Ensure adequate supply of laboratory inputs;
- Finalize and implement the study on compensation for work related accidents; and
- Study and implement proper recruitment and retention mechanisms and incentive packages for high level professionals in short supply.

CHAPTER III

LEADERSHIP AND GOVERNANCE

Leadership and Governance

This theme relates to planning, monitoring, evaluation, policy formulation and implementation that is evidence-based. It also includes the development and implementation of a regulatory framework. It incorporates the equitable and effective resource allocation and leadership development within the sector and the community. This section of the report highlights the progress made in the implementation of the strategic objectives under this theme in EFY 2003

3.1
Evidence-Based Decision Making by Enhanced Harmonization and Alignment

This strategic objective deals with the identification of health system bottlenecks; research; HMIS; performance monitoring; quality improvement; use of information for policy formulation, planning, and resource allocation. The expected outcomes of the strategic objective are proper generation and use of evidence at all levels of the health system to respond to critical health problems of the community; to realise the "One-Plan, One-Budget and One-Report" approach; and to effectively integrate and align health programmes and projects. The performance of the sector towards attainment of this objective in EFY 2003 has was as follows.

3.1.1
Planning

The sector's planning process follows the top down and bottom up approach. The Health Sector Strategic Plan was used as the basis for developing the EFY 2003 annual plan at all levels.

During the development of the annual plan, a technical working group was organized to facilitate the overall planning process. A Plan of Action was prepared and communicated to all regions after approval by FMOH management. The FMOH provided technical and financial support to all regions and woredas to facilitate the whole planning process. The preparation phase included the development of planning guidelines, manuals, formats and customization of Marginal Budgeting for Bottlenecks (MBB) tools. Actual implementation was started through providing TOT for 232 mentors at four sites (Adama, Mekele, Hawassa and Bahr Dar). All mentors were from regions, making this year planning different from the previous year's planning process in terms of capacity building, full participation and ownership by regions, zones and woredas. Each mentor was assigned for a maximum of five woredas to provide technical input, conduct hands–on training and support the planning process.

Actual woreda level planning sessions were conducted in every region at 175 sites in two rounds, with 232 facilitators and trainers, 4,375 participants from Woreda Administrations, WorHOs and Woreda Finance and Economic Development (WoFED), and 455 from 111 Hospitals, making a total of 5,062 participants. As a result, 805 woredas developed their respective annual plans using evidence-based approach and BSC as a framework.

Besides, FMOH and RHBs prepared EFY 2004 (2011/12) HSDP IV Woreda Based Annual Core Plan for the sector by collecting woreda plans from all woredas, aggregating woreda plans and reconciling them with regional and national

health sector development plans. This process helped to avoid discrepancies in performance measures (baselines and targets), and formulated strategic initiatives to be executed in the planning period both at federal and regional levels. Consultation with the HPN donor group was held on the overall direction and priorities of the EFY 2004 Core Plan.

3.1.2
Routine Data Collection and Aggregation

For EFY 2003, the plan was to implement the newly re-designed Health Management Information System (HMIS) in all Regions and also to conduct training for all health professionals in the implementing health facilities. Regarding implementation of the HMIS, Dire Dawa City Administration and Harari Region implemented fully. Addis Ababa, Gambella and Benishangul Gumuz Regions fully implemented HMIS but, due to the newly constructed HCs, only 77%, 64% and 69% of the HCs, respectively, are implementing HMIS. The other regions are at different stages of implementation of HMIS. At the national level, the HMIS has been implemented in 75% of the hospitals and 69% of the HCs (Table 15).

Table 15: Progress in the Scale-up of the HMIS at Health Facilities by Region (EFY 2003)

Region	Hospitals			Health Centers			Total Health Facilities		
	Available	Implementation	%	Available	Implementation	%	Available	Implementation	%
Tigray	14	14	100	183	168	92	197	182	92
Afar	4	4	100	50	12	24	54	16	30
Amhara	19	17	89	724	553	76	743	570	77
Oromia	42	25	60	991	592	60	1,033	617	60
Somali	7	4	57	85	44	52	92	48	52
Benishangul Gumuz	2	2	100	30	20	67	32	22	69
SNNPR	20	11	55	513	372	73	533	383	72
Gambella	1	1	100	24	15	63	25	16	64
Harari	2	2	100	8	8	100	10	10	100
Addis Ababa	10	10	100	37	26	70	47	36	77
Dire Dawa	1	1	100	15	15	100	16	16	100
National	122	91	75	2,660	1,825	69	2,782	1,916	69

To enable woredas and zones to lead and sustain the implementation process, supervisory level training was provided to 1,864 professionals since EFY 2001. These supervisors, along with mentors from the FMOH and DPs, conducted 5 days training to 42,031 staffs in all regions (Table 16). To support the implementation of HMIS in health facilities, forms and tools were distributed by FMOH to regions.

In order to improve the representativeness of HMIS as well as data quality, FMOH has also considered the implementation of HMIS in the private sector. To this effect, baseline assessment on the recording and reporting performance of private (both for-profit and not-for-profit) health facilities was conducted in two City Administrations (Addis Ababa and Dire Dawa) and Harari Region.

Table 16: Cumulative Number of Staffs Trained on HMIS by Region (EFY 2003)

Region	Training of trainers	Facility based training	Total Trained
Tigray	53	3,464	3,517
Afar	30	509	539
Amhara	59	10,501	10,560
Oromia	236	16,274	16,510
Somali	25	1,226	1,251
Benishangul Gumuz	34	961	995
SNNPR	1,323	4,256	5,579
Gambella	26	287	313
Harari	30	1,050	1,080
Addis Ababa	21	3,320	3,341
Dire Dawa	27	183	210
National	1,864	42,031	43,895

In order to initiate rural Family Folders (FF) in all HPs, Guideline on rural FF was finalized and translated to Amarigna, Oromifa and Tigrigna languages. Supervisory level training was given for 1,284 health extension supervisors and on the job training for 8,589 HEWs (Table 17). FFs adequate for 6.1 million rural families were distributed to Tigray, Amhara, Oromia, SNNP, Gambella, Dire Dawa, and Somali Regions, and 3,256 (22%) HPs have started to implement the rural FF. Regarding urban FF, the design was finalized and piloting is underway in Addis Ababa.

Table 17: Progress in the Scale-up of the Community-based Information System by Region (EFY 2003)

Region	Health Posts			HEW Supervisors Trained	HEWs Trained
	Available	Implementation	%		
Tigray	552	80	14	185	263
Afar	272	0	0	0	0
Amhara	3,093	178	6	44	394
Oromia	6,053	1,227	20	505	4,256
Somali	951	0	0	0	0
Benishangul Gumuz	339	0	0	0	0
SNNPR	3,603	1,737	48	542	3,606
Gambella	175	0	0	0	0
Harari	23	0	0	0	0
Dire Dawa	34	34	100	8	70
National	15,095	3,256	22	1,284	8,589

The Draft Regulation on HMIS was discussed by 330 professionals drawn from relevant stake holders in Amhara, Tigray, SNNP, Oromia, Addis Ababa, emerging regions, federal agencies and hospitals. The feedback from these consultations has been used to refine the draft regulations which will be presented to the Council of Ministers in EFY 2004 for approval.

3.1.3
Performance Monitoring and Coordination

The status of implementation of the first year of HSDP IV was monitored weekly, monthly, quarterly, and bi-annually by the FMOH and RHBs in accordance with the Guideline on BSC. Monitoring the implementation of EFY 2003 plan was done through bi-monthly meetings of the Joint Steering Committee (JSC) of the FMOH and RHBs. Quarterly meetings of the Joint Consultative Forum (JCF) and bi-weekly meetings of the Joint Core Coordinating Committee (JCCC) were also held.

In EFY 2003, most of the RHBs undertook their annual performance review meeting with woredas, zones and other stakeholders based on the Core Plan endorsed for the fiscal year. During these meetings, strengths and challenges of the respective regions were discussed. In EFY 2002, the national Annual Review Meeting (ARM) was conducted in Adama in the presence of partners, and other stakeholders representing federal, regional, woreda, and community level institutions and organizations.

As in previous years, in EFY 2003, issues of coordination, harmonization, financing and monitoring were addressed by the Joint FMOH-Health, Population and Nutrition (HPN) Donors Group Consultative Forum.

Bi-annual and annual performance reports have been submitted to the Prime Minister's Office and an annual Plan for Accelerated and Sustainable Development to End Poverty (PASDEP) report has been submitted to the Ministry of Finance and Economic Development (MOFED).

Two editions of the Policy and Practice Quarterly Health Bulletin have been prepared in EFY 2003, and distributed to stakeholders. Furthermore, Quarterly and Mid-year Health Indicators Booklet have been prepared in EFY 2003, and distributed to stakeholders. The statistical booklet "Health and Health-related Indicators" was also published in EFY 2003 as in the previous years.

3.1.4
Evaluation

In EFY 2003 a Joint Review Mission (JRM) was conducted to review the level of achievement of the strategic objectives of HSDP IV, including the status of the initiatives and targets set for the year. The review focused mainly on the following three strategic objectives: (i) improve access to health services; (ii) quality of health services; and (iii) health infrastructure. The report of the JRM is one of the presentations at ARM EFY 2003.

An assessment on the progress of "One Plan, One Budget, and One Report" was carried out by international consultants in EFY 2003. The purpose of the assessment was to identify and document the barriers preventing partners from aligning their plan and budget with the "One Plan, One Budget, and One Report" framework, and from becoming part of the JFA which is the most preferred financing modality. The results of the assessment are included as points to be addressed by group discussion sessions at ARM 2003.

Two evaluation studies on information use and HMIS data quality were conducted in EFY 2003, the first one in six regions and the second one in all regions. The study results were shared with regions and the HMIS National Advisory Committee (NAC).

Challenges

- Delay in the full scale-up of HMIS including CIS;
- Delay in printing HMIS registers and forms due to price increase and lack of capacity of printing enterprise;
- Inadequate use of information for evidence-based decision making at all levels;
- Untimely and incomplete reports of poor quality from regions;
- Delay in implementation of e-HMIS;
- Delay in the approval of the Regulation on HMIS; and
- Inadequate coordination with stakeholders and partners.

Way Forward

- Finalize the scale-up of HMIS;
- Ensure the printing of HMIS registers and forms;
- Strengthen the focus on use of information;
- Accelerate the implementation of e-HMIS;
- Speed-up the approval of the Regulation on HMIS for immediate implementation purposes; and
- Strengthen coordination mechanisms with stakeholders and partners.

3.2 Operations Research

Operations research is performed in the health sector in order to identify and study priority problems of public health importance and produce evidence that would help decision-makers to improve the services and develop realistic health sector policies, strategies and practices. In EFY 2003, the following operations research studies focusing on HIV/AIDS, nutrition and traditional medicine and herbal extracts have been conducted mainly by the EHNRI.

A national surveillance study on HIV/TB co-infection and a National TB Prevalence Survey were carried out in EFY 2003.

The efficacy of Coartem for the treatment of Falciparum Malaria was studied, data from six study sites (in Tigray, Amhara, Oromia, SNNPR, and Benishangul Gumuz Regions) were collected and analyzed, and the study report was submitted to the FMOH.

The aetiology of the unknown liver disease that has appeared in Tigray Region is under study in collaboration with various national and international institutions.

A National Food Consumption Survey that would enable the study of the nutritional pattern of communities across all regions is underway. Such research will assist the National Nutrition Program to become cost effective, more acceptable and problem solving for mothers and children.

The EHNRI is at present engaged in undertaking operations research studies, especially focusing on micronutrients essential for human health (such as iron, iodine etc.), supplementary food for children and national level nutrition data.

Through operations research the efficacy of one herbal extract for the treatment of hookworm, strongyloides and hymenolepis nana has been proved.

As a result of the efficacy shown by one of the herbal extracts for the treatment of *Plasmodium Falciparum* in

vitro, medium term toxicity study and study on preparation of the herbal extract in the form of drug are being undertaken by the EHNRI.

A study is being conducted using two herbal extracts for the treatment of mange mites, sheep ked and lice which are blood sucking parasites that cause skin diseases in animals. The study on live animals (in vivo) has proved the efficacy of the herbal extracts. Laboratory inputs for the drug formulation have been identified, and extensive study is being conducted as to how the two selected herbs can be reproduced and harvested both in terms of quantity and quality.

Other activities related to evidence-based decision making are the preparation of draft policy documents for submission to policy makers. In this connection, to help in the effort being made to eliminate malaria by GC 2020, a policy dialogue on the draft policy document entitled "Human Resource Capacity to Effectively Eliminate Malaria in Ethiopia" was conducted with the participation of various stakeholders. A draft policy brief on Misoprostol entitled "Prevention of Postpartum Haemorrhage in Ethiopia" was prepared. This will be followed by a policy dialogue and the resulting data will serve as an input for decision making purposes.

Scientific and ethical review work was performed in order to ensure that operations research projects address the country's health problems, and comply with ethical standards.

The revised draft Proclamation defining the powers and duties of the Ministry of Health, and the regulations on establishment of a Health Insurance Agency and Iodization of Salt were approved by the Council of Ministers. Regulations on Ethics of health workers, on HMIS and establishment of a Public Health Research Institute have been prepared and will be submitted to the Council of Ministers in due course.

3.3 Regulatory System

This strategic objective concerns mainly ensuring safety in the delivery of health services, products and practices. It also includes (i) preventing professional malpractice; (ii) strengthening quarantine services; (iii) enhancing environmental health activities; (iv) enforcing regulations and prevention of drug abuse; and (v) controlling institutional solid and liquid waste disposal.

The expected outcome is compliance with the health law and regulatory standards leading to community safety, healthy environment, and increased community confidence in the safe delivery of health services. HSDP IV aims to achieve this outcome through effective implementation of the Health and Health Related Regulatory Process. The design of the process has included development of comprehensive standards for all levels of health institutions along with standard operating procedures for premises, practices, products and personnel. There will be extensive capacity building under HSDP IV towards realizing effective regulation in the sector.

The implementation of this strategic objective includes the following key activities: (i) enhance community involvement in health and health related services and products regulation; (ii) undertake demand reduction and supply management activities for drugs prone to abuse; (iii) improve efficiency of hygiene and environmental health control activities; (iv) promote health regulatory laws; (v) issue special permits for import, export, manufacturing, distribution, wholesale and storage of substances; and (vi) ensure post-marketing surveillance and comprehensive capacity building.

The Food, Medicine, Health Administration and Control Authority (FMHACA) was re-established in EFY 2002 by Proclamation No. 189/2002 (189/2009). Its mandate is by and large to ensure safety in the delivery of health services, products and practices.

The following activities were carried out by FMHACA in EFY 2003.

3.3.1 Inspection and Quality Control of "Products"

In accordance with the annual plan, inspection was made four times per year, and certificates of competence provided for five specialized, teaching and referral hospitals.

After verification of their safety and quality, permits were given for 4,686 types of drugs imported into the country,

and inspection was made and import/export license provided to a sample of 645 imported raw materials.

Assessment and registration was made and registration certificate given for a sample of 977 modern drugs and vaccines.

Post market study on drugs was made three times per year (the plan was four times per year) and appropriate remedial measures were taken. Out of the five planned for the year, only one post market study on food products and water quality was conducted.

Technical assistance was provided to four regions in their effort to prepare legislation, regulations and guidelines for control purposes.

3.3.2
Inspection and Quality Control of "Premises"

Out of the planned 160, the permits of 144 enterprises were renewed. A total of 144 drug manufacturing, import/export and distribution enterprises were given certificates of good practice and inspected four times during the year.

Twenty nine food production enterprises, import and wholesale distribution enterprises and cross-regional institutions (universities, hotels, and remand homes) were registered and inspected four times during the fiscal year.

After proper inspection, entry/exit permits were given for 417 dead bodies or skeletal remains.

Inspection was made and entry permit given for 61,665 incoming passengers.

Inspection was made on the proper disposal of waste from two health and health related agencies under the FMOH, as well as on the proper disposal of expired drugs and foods in 51 institutions.

3.3.3
Inspection of "Professional Practice"

In EFY 2003, out of the planned 9,000 health professionals, 6,001 graduates were registered and licensed.

Training on rational drug use was given for 200 professionals (the planned number was 1,000). The public was given education on proper use of health and health related products and services.

The inter-ministerial committee set up to oversee and guide the control against the illegal use and circulation of narcotics and psychotropic substances was strengthened. Inspection was made concerning the need, forecasting, supply and use of narcotic and psychotropic substances, and a report was submitted to the International Narcotics Board on time.

Out of the 100 planned committees to be set up at Universities, 50 Anti-Drug Committees were set up to prevent and control addiction to narcotics and psychotropic substances. To prevent the improper use of narcotics and psychotropic substances, TOT was given for 100 inspectors drawn from regions.

Orientation was given to inspectors and health workers on legislation, regulation, guidelines and standards prepared on health and health related inspection services.

In order to control illegal health and health related trade and services, in particular to control dangerous drugs and addictive substances, a committee was established comprising of drug importers (at national level), youth, religious leaders and law enforcement bodies. In addition a "No Smoking Day" was observed by organizing a panel discussion and question and answer sessions as well as distributing banners.

3.3.4
Inspection of "Food Products"

Assessment, registration and provision of registration certificates were made for 39 food supplements out of the 52 planned for the year.

Safety inspection was made and import permit was given for 284,870 tons of imported food and food stuffs, a performance rate of 119% compared to the planned target of 240,000. Similarly, export permit was given for 101,489 tons of food and food stuffs destined for export, a performance rate of 84.6%.

3.4
Gender Mainstreaming

Proper attention has been given to gender mainstreaming, which is a cross-cutting program at all levels of the health system, with the goal of strengthening the participation of women and increasing their benefits mainly through mainstreaming and capacity building measures.

The following planned gender mainstreaming and women empowerment activities were carried out in EFY 2003.

Concerning sexual abuse, various awareness raising activities were undertaken using different types of mass media (radio and TV, drama, panel discussion, presentation of study reports, distribution of white ribbon, brochures etc.) for the public and various groups such as 178 participants from sector ministries and other concerned bodies, staff of FMOH, and representatives of partner organizations.

Exchange of experiences and best practices was made with the participation of almost all regions (Tigray, Amhara, Addis Ababa, SNNP, Oromia, Gambella, Benishangul Gumuz, Harari, and Dire Dawa) and other stakeholders, and an indicative plan for EFY 2004 was prepared.

A three-day awareness raising training on gender mainstreaming and gender analysis was provided in several rounds to 260 participants (57 females and 203 males) drawn from Amhara, Tigray, SNNPR, Gambella and Benishangul Gumuz. The participants were heads of RHBs, gender focal persons, heads/experts from plan and program units, and woreda and zone officials. At the same time, an indicative Plan on Gender for EFY 2004 was prepared by the participants for their respective region.

Awareness raising training on gender issues was given in four rounds for 100 participants (84 women and 16 males) from FMOH and for 98 participants (68 women and 30 males) from hospitals and agencies accountable to the FMOH.

March 8 -International Women's Day- was celebrated at the head office and at agencies and hospitals accountable to the FMOH in the presence of 1,172 participants (378 men and 794 women) from these institutions. Women with high level of performance were acknowledged on this Day by awarding a cup and certificates to those who won the competition.

Challenges

- Variation in availability of gender officers or focal persons at each level;
- Shortage of budget; and
- Low level of awareness on gender issues.

Way Forward

- Facilitate the inclusion of women representatives as part of management at regional and agencies level;
- Include gender perspective in the preparation of the budget;
- Give special attention to gender issues in emerging regions; and
- Review the checklist on supportive supervision from a gender perspective.

CHAPTER IV

HEALTH INFRASTRUCTURE AND RESOURCES



Health Infrastructure and Resources

4.1
Health Infrastructure Development, Rehabilitation and Maintenance

The Ethiopian health service is now restructured into a three tier system: the primary care level which comprises HPs, HCs and primary hospitals; the secondary care level which comprises general hospitals; and the tertiary care level which comprises specialized hospitals. Therefore, to organize the health facilities according to the new three tier system, standards were set in EFY 2003. Preliminary design and architectural work of the general hospital standard were completed. Besides, standard design to upgrade HC to primary hospital was endorsed and the final design on structural, electrical, sanitary work and other accessory work was finalized and communicated to regions. On the other hand, 90% of the structural design of the urban HC standard design was finalized.

4.1.1
Construction and Equipping of Health Posts

There was a linear increase in the cumulative number of Health Posts (HP) constructed over the past six years (Figure 41). In EFY 2003, 903 new HPs were constructed, increasing the cumulative total to 15,095 HPs, which was still below the target (16,273) set for the year. The HP to population ratio reached 1:5,427 at the national level in EFY 2003.

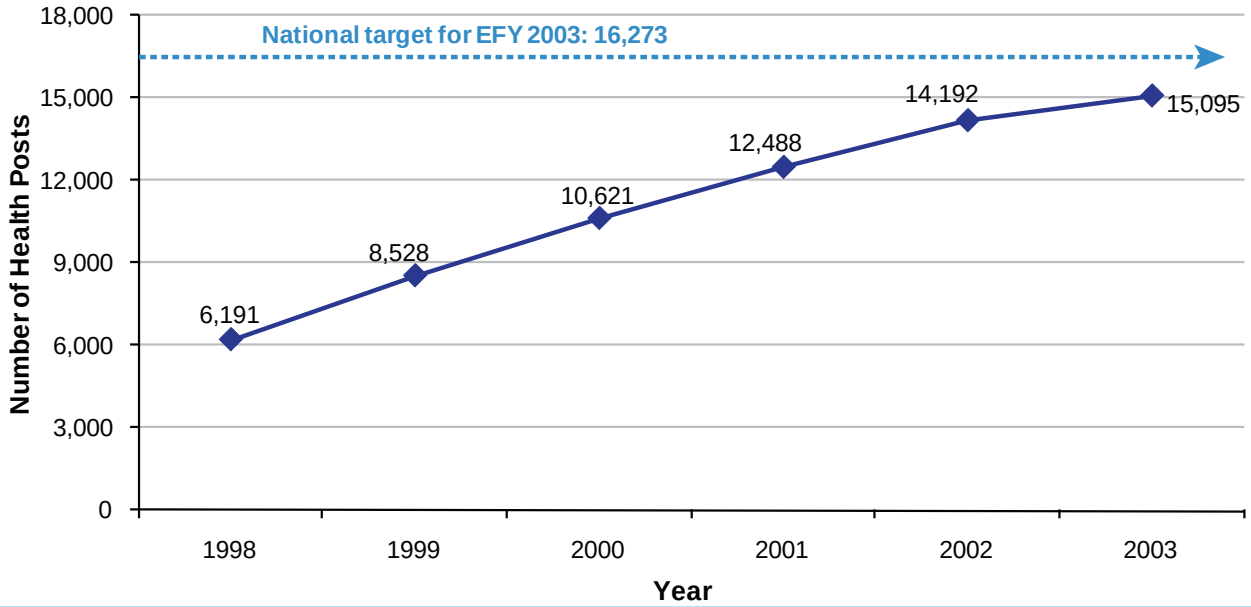


Figure 41: Trend in the Cumulative Number of Health Posts Constructed (EFY 1998 - 2003)

In EFY 2003, it was planned to construct 2,081 new HPs, but only 903 were completed (43.4% of the target). Somali, Amhara, and SNNP Regions showed the highest level of achievement (88.0%, 71.4% and 70.7%, respectively) (Table 18).

Table 18: Construction of Health Posts (EFY 2003)

Region	EFY 2003 target for the cumulative number of available HPs	Cumulative number of HPs available in EFY 2002	EFY 2003			Cumulative No. of HPs available in EFY 2003	EFY 2003 performance for the cumulative number of available HPs
			Plan	Completed	Annual performance (%)		
Tigray	714	552	162	0	0.0%	552	77.3%
Afar	330	251	79	21	26.6%	272	82.4%
Amhara	3,154	2,941	213	152	71.4%	3,093	98.1%
Oromia	6,624	5,930	694	123	17.7%	6,053	91.4%
Somali	985	701	284	250	88.0%	951	96.5%
Benishangul Gumuz	447	291	156	48	30.8%	339	75.8%
SNNPR	3,712	3,340	372	263	70.7%	3,603	97.1%
Gambella	253	132	121	43	35.5%	175	69.2%
Harari	20	20	0	3	-	23	115.0%
Dire Dawa	34	34	0	0	-	34	100.0%
Total	16,273	14,192	2,081	903	43.4%	15,095	92.8%

Concerning the cumulative number of HPs constructed, out of the 16,273 planned, 15,095 HPs were constructed at the end of EFY 2003 (92.8% of the target). Variations were observed across regions, with Harari showing the highest performance (115.0% of the target set for the year) and Gambella being the least performing region (69.2%). Dire Dawa did not construct any HP because it had already achieved its target last year.

The highest cumulative number of HPs available was in Oromia Region (6,053) followed by SNNPR (3,603) and Amhara Region (3,093) (Figure 42).

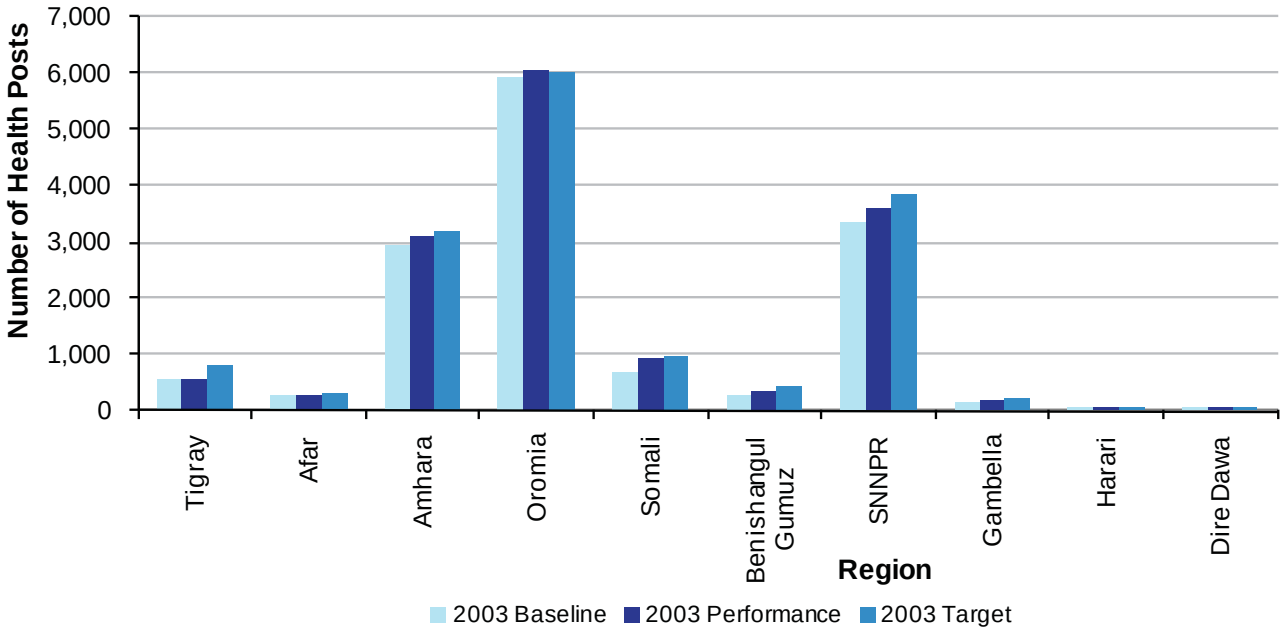


Figure 42: Comparison of Baseline, Performance and Target of the Cumulative Number of Health Posts Constructed by Region (EFY 2003)

4.1.1.1 Equipping of Health Posts

In EFY 2003, a total of 1,200 HPs were equipped, reaching the cumulative total of 13,727 HPs equipped at the end of EFY 2003 (90.9% of the available HPs).

The installation of Solar Power in HPs started in EFY 2002 after the agreement made by the FMOH with the Rural Energy Development Center; solar panels were installed in 200 HPs in EFY 2003. Besides, solar power panels and equipments for 345 HPs were procured and shipped to Ethiopia. Preliminary arrangements have

been carried out with respective regions and solar power panels will be installed in EFY 2004. Furthermore, the procurement of solar equipments for a total of 1,260 HPs is underway.

4.1.2
Construction and Equipping of Health Centers

To achieve the universal Primary Health Care (PHC) coverage, it was planned to construct a total of 3,299 HCs (including Addis Ababa) at the end of EFY 2003.

To achieve this target, FMOH and RHBs concluded an agreement during HSDP III whereby for every HC constructed by FMOH, the RHBs would have matched this by one HC to be constructed by the region (the so called "matching HC"). Besides, the FMOH agreed to supply the medical equipments for all newly constructed HCs. This agreement was updated, with 75% of the HCs to be constructed by FMOH and 25% by RHB in pastorialist regions as part of the special support given to these regions.

Accordingly, 518 HCs were newly constructed in EFY 2003, reaching the cumulative total of 2,660 (2,142 HCs were already completed in EFY 2002). A total of 516 HCs were still under construction, therefore the cumulative total of HCs constructed and under construction reached 3,176 at the end of EFY 2003 (96.3% of the target set for the year) (Table 19).

Table 19: Status of Health Centers Construction (EFY 2003)

	HSDP IV Target	EFY 2003 Baseline for HCs available	HCs available at the end of EFY 2003	EFY 2002 Baseline for HCs available plus under construction	HCs available plus under construction at the end of EFY 2003	EFY 2003 Target to HCs available plus under construction
	3,299	2,142	2,660	2,822	3,176	3,299
Baseline in EFY 1999 (including Addis Ababa)					668	668
Constructed by FMOH since EFY 1999					1,337	
Constructed by RHBs since EFY 1999					1,171	

Oromia was the region with the highest cumulative number of HCs constructed and under construction (1,126) in EFY 2003, reaching 97.9% of the regional target; it was followed by Amhara Region with 780 HCs (95.1%). Five regions reached the target set for the year: Tigray (199), SNNPR (674), Harari (8), Addis Ababa (99) and Dire Dawa (16) (Figure 43).

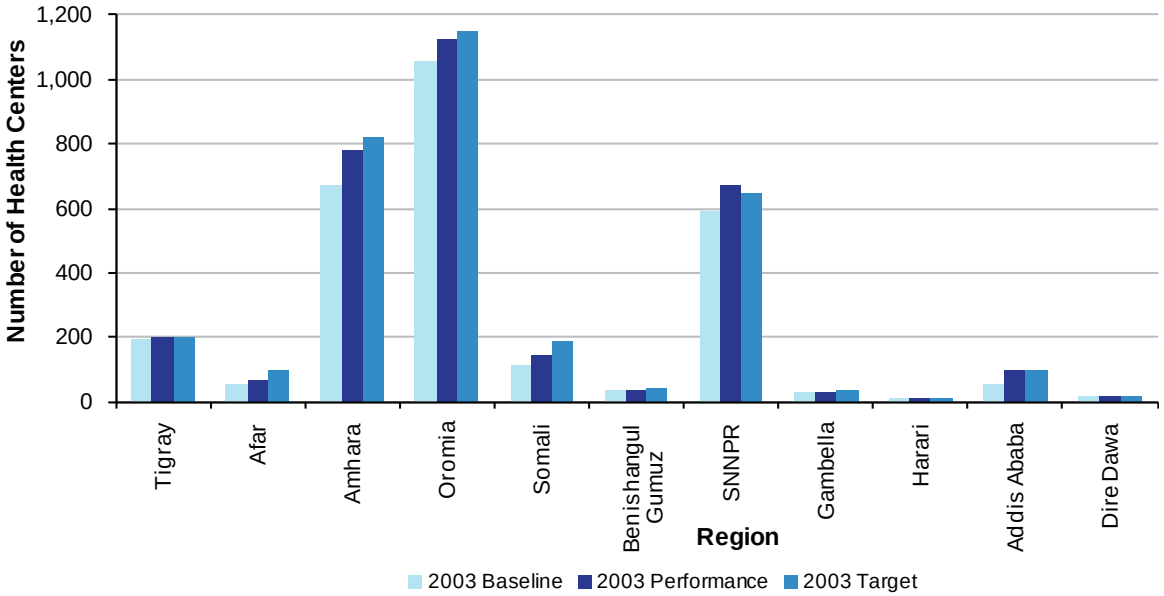


Figure 43: Comparison of Baseline. Performance and Target of the Cumulative Number of Health Centers Available and Under Construction by Region (EFY 2003)

Concerning the availability of HCs already completed at the end of EFY 2003, the highest cumulative number was found in Oromia (991), followed by Amhara (724) and SNNPR (513) (Figure 44).

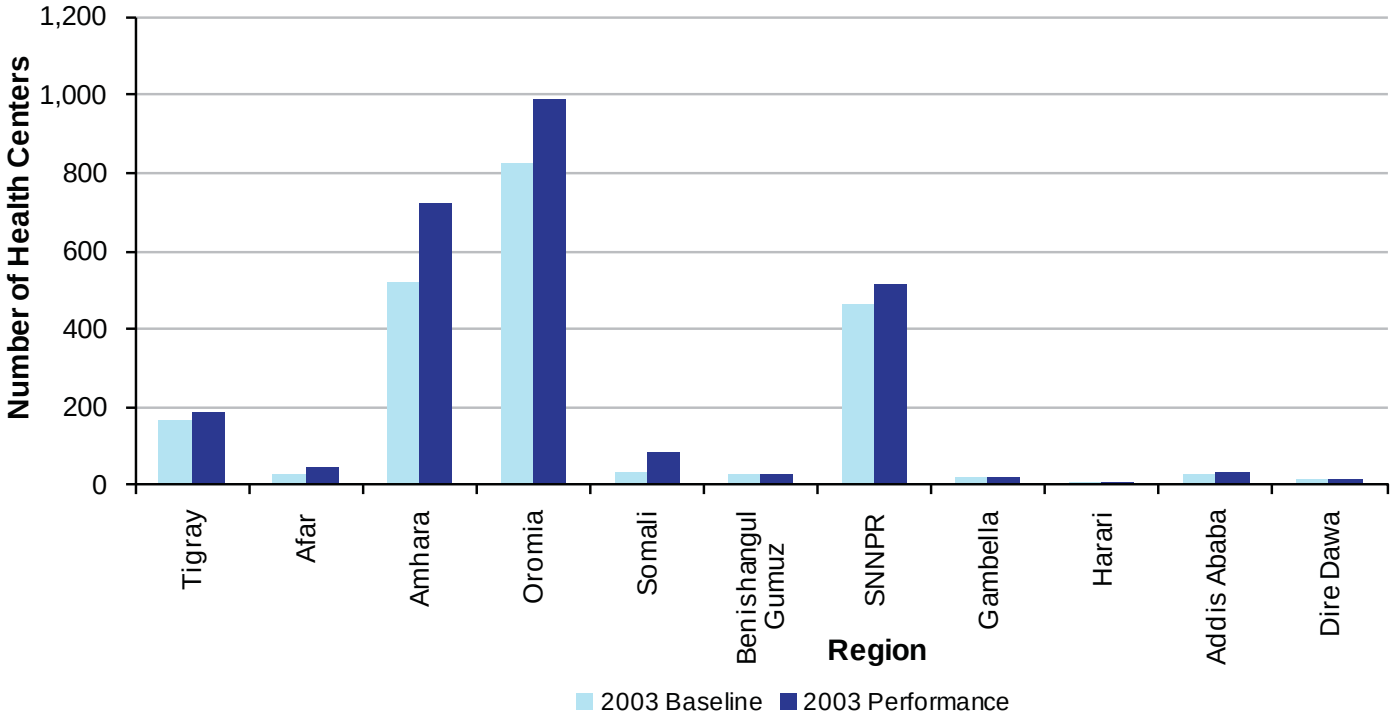


Figure 44: Comparison of Baseline and Performance of the Cumulative Number of Health Centers Available by Region (EFY 2003)

Nationally, the number of available HCs increased from 668 in EFY 1999 to 2,660 in EFY 2003 (Figure 45).

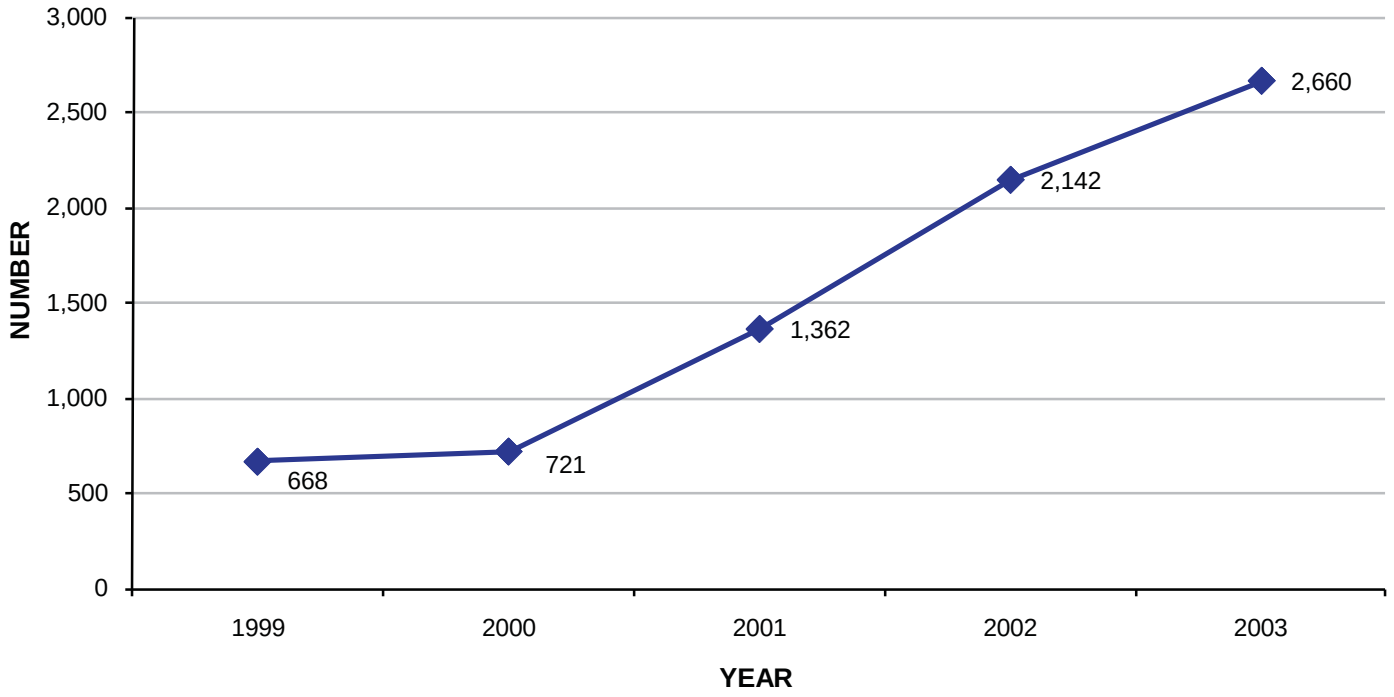


Figure 45: Trend in the Number of Available Health Centers (EFY 1999-2003)

4.1.2.1 Construction of Health Centers by FMOH

The revised target for FMOH was to construct 1,416 HCs. A total of 1,114 (78.7% of the target) sites were completed and 223 were under construction in EFY 2003 (Table 20).

Table 20: Status of Health Centers Construction Supported by FMOH by Region (EFY 2003)

Region	Total Number of Sites Planned	Number of Sites Available Plus Under Construction in EFY 2003	Number of Sites Completed at the End of EFY 2003
Tigray	86	86	79
Afar	43	43	36
Amhara	342	309	268
Oromia	517	473	421
Somali	96	96	52
Benishangul Gumuz	15	15	15
SNNPR	264	264	216
Gambella	15	15	14
Harari	5	5	5
Addis Ababa	25	23	0
Dire Dawa	8	8	8
Total	1,416	1,337	1,114

4.1.2.2
Construction of Matching Health Centers by the Regions

The revised plan for EFY 2003 was to construct 1,152 matching HCs, with 878 HCs being completed and 293 still under construction at the end of EFY 2003. The regions exceeding their regional target set for sites completed plus under construction in EFY 2003 were as follows: Tigray (73), Oromia (461), SNNPR (249), and Addis Ababa (52) (Table 21).

Table 21: Status of Matching Health Centers Construction by Region (EFY 2003)

Region	Total Number of Sites Planned	Number of Sites Available Plus Under Construction in EFY 2003	Number of Sites Completed at the End in EFY 2003
Tigray	72	73	64
Afar	20	8	0
Amhara	288	280	265
Oromia	441	461	378
Somali	44	32	18
Benishangul Gumuz	6	6	0
SNNPR	221	249	136
Gambella	7	7	2
Harari	1	1	1
Addis Ababa	50	52	13
Dire Dawa	2	2	1
Total	1,152	1,171	878

4.1.2.3
Equipping of Health Centers

In EFY 2003, medical equipment kits have packed and distributed for 868 health centers. Solar pannels were also installed for 97 health centers that lacked hydro-electric power

4.1.3
Construction, Rehabilitation and Expansion of Hospitals

4.1.3.1
Federal Hospitals

Construction

Amanuel General Hospital and Mental Health Research Institute: FMOH plans to develop and locate a National Institute of Mental Health (NIMH) at Kotebe area of Addis Ababa. The project has been conducted in two major phases; Phase I includes construction of the new general hospital with 161 inpatient beds for children and adults; it will be completed in the EFY 2004; while Phase II includes the construction of the research center and administration buildings; the development of the project proposal and TOR was completed and the design work has started in EFY 2003.

St. Paul's Millennium Medical College building: the first phase of the design was completed and started to provide dormitory services for 600 students; the second phase of the project is underway.

St. Paul's MCH building is under construction. The main objective is to provide a comprehensive and integrated health care for mothers and children. The project is the first in the country, with eight floors, 308 inpatient beds, 8 delivery rooms, two lecture rooms.

St. Paul's guest house building is also under construction. The main objective is to provide house for foreigners and Ethiopians, lectures rooms, meeting hall and other purpose rooms.

Dire Dawa quarantine office building: the construction work was completed in EFY 2003.

Maintenance

Alert Hospital construction and maintenance works: separate waiting area building for the existing out-patient diagnosis block was constructed and maintenance work for the training centre building within the hospital was performed. Provisional acceptance for the above projects was done in EFY 2003.

Existing Amanuel General Hospital and Mental Health Institution: the maintenance of the building was completed in EFY 2003.

St. Peter's TB specialized hospital multipurpose hall and office building: the construction of the new multipurpose hall and office building is underway and 35% of the construction work has been completed.

4.1.3.2
Regional Hospitals

In EFY 2003, seven regions reported the construction of 19 new hospitals. Ongoing construction of 22 hospitals was also reported by eight regions. In the same year the total number of hospital available reached 122 (Table 22).

Table 22: Status of Hospitals Construction by Region (EFY 2003)

Region	Newly Constructed	Ongoing Construction	Total Hospitals Available
Tigray	1	2	14
Afar	0	0	4
Amhara	7	7	19
Oromia	6	6	42
Somali	0	0	7
Benishangul Gumuz	2	1	2
SNNPR	1	2	20
Gambella	0	0	1
Harari	1	1	2
Addis Ababa	0	2	10
Dire Dawa	1	1	1
Total	19	22	122

Design

Primary Hospital Standard Design: The objective is to produce a standard design of primary hospital at the national level, with 30-50 beds according to the new tier system, serving a catchment area of 100,000 population. It also includes the expansion of the existing Type-A HC to primary hospital by incorporating additional functions. The design development process was completed and sent to all regions for construction stage.

St. Peter TB specialized hospital expansion building: the expansion of the hospital includes the merging of the outpatient campus located near Mesalemia and the inpatient campus located near Shiromeda, the building of new administration, outpatient department, emergency departments, MDR TB centre and other relevant facilities. By the end of the project the hospital will be transformed into a full-fledged general hospital by virtue of the newly added functions, but still maintaining its specialization in TB treatment. The development of the design process is underway and 40% of it has been completed.

4.1.3.3 Medical Equipment Management

The aim of medical equipment management is to standardize and facilitate health institutions to have a better medical equipment acquisition, utilization and disposal system. To improve the medical management system training has been given as per Ethiopian Hospital Reform Implementation Guideline for 110 staff in Oromia, 60 in emerging regions, 25 in Dire Dawa, 70 in Addis Ababa and 50 in Hawassa University Hospital. Training was conducted for 116 health facility maintenance and installation technicians and 75 medical equipment end users.

In order to identify the current status and establish a medical equipment management system, an assessment on the status of medical equipment distribution, maintenance, workshop and human resources of newly constructed health facilities has been completed.

A National medical equipment donation directive has been finalized through involvement of all relevant stake holders and development partners. In collaboration with Egyptian medical team 112 dysfunctional operation theatre and other medical equipments were maintained

Challenges

- Shortage of qualified contractors willing to take construction in remote sites;
- Shortage and high price of construction materials;
- Difficulty in expanding the pool of contractors with involvement of new contractors; and
- Shortage of bio-medical engineers and technicians at various levels.

Way forward

- Strengthening the collaboration with the Ministry of Works and Urban Development and regional and zonal authorities to ensure the availability of construction materials and mobilize qualified contractors; and
- Support the medical equipment technician training (TVET) and bio-medical engineering training.

4.2 Human Capital and Leadership

This strategic objective entails: (i) leadership development; (ii) human resource planning, development and management, including recruitment, retention and performance management; (iii) community capacity development; and (iv) technical assistance management.

The expected outcome of the strategic objective is adequate availability of skilled and motivated health staff committed to work and stay in a well managed sector.

HSDP IV will use a mix of strategies to achieve these outcomes, including: (i) ensuring demand driven production of human resources; (ii) maximizing use of available resources in producing key categories of health workers for which there is scarce supply; (iii) improving inter-sectoral collaboration in Human Resources Development (HRD); (iv) enhancing private sector involvement in HRH development; (v) enhancing quality assurance in the training of health professionals; (vi) using appropriate ICT to enhance quality and efficiency of medical education; (vii) improving geographic distribution of HRH; (viii) strengthening the regulatory system; and (ix) enhancing cost-effectiveness in staff retention and motivation schemes.

In order to produce higher and medium level human resources required at every level, some of the major

activities planned for implementation in EFY 2003 include: (i) increase the intake of medical students; (ii) motivate and retain health professionals; (iii) build the capacity of universities that provide training in Comprehensive Emergency Obstetric Care; (iv) prepare curriculum for midwives and anaesthetic nurses; (v) provide support for initiating training in Emergency Health Service; (vi) deploy various types of health workers who have graduated from higher education institutions; (vii) strengthen ethics among the leadership and workers; and (viii) establish a system that enables prevention of corruption and malpractices. The performance in implementing these activities in EFY 2003 was as follows.

More than 30,000 HEWs have already been trained and deployed in all parts of the country. They continue to provide a wide range of community-based health promotion and disease prevention services. Since 2008 the FMOH has been working to upgrade the skill and knowledge of HEWs from the current Level III to Level IV in accordance with the Ethiopian Occupational Standard. The Level IV curriculum and Ethiopian Occupational Standard were developed and endorsed by Federal Ministry of Education in 2008, and its level is equivalent to Diploma level training. The upgrading program will help the HEWs to provide better quality service and address the high service needs of the community.

The core objectives of the upgrading program are to improve the extent and quality of HEP services, to fill gaps identified in previous Level III HEP trainings, to improve the skills, knowledge and attitude of HEWs, to make significant contribution in achieving the health related MDGs, and to upgrade the career of HEWs.

4.2.1
Training
4.2.1.1
Health Extension Workers

In order to raise the occupational grade and units of competence of HEWs to enable them to provide quality health services, the plan included evaluation of the occupational grade of the HEWs and preparation of a training curriculum. Accordingly, a document comprising of Level IV unit of competencies and Level IV curriculum was prepared and, by giving training for 134 instructors and implementers, the training of 1,100 trainees has started in six regions. Even though the planned enrolment of HEWs for the upgrading program was 1,000, the six selected RHBs recruited 1,100 in EFY 2003, with a performance rate of 110%. The distribution of the trainees is shown in Table 23.

Table 23: Regional Distribution of HEWs Recruited for the Upgrading Program (EFY 2003)

Region	Number of HEWs recruited for the upgrading program
Tigray	40
Amhara	235
Oromia	524
SNNPR	208
Dire Dawa	55
Harari	38
Total	1,100

The duration of the training is one year, and Tigray, Oromia and SNNP Regions have already started to provide the training, while Amhara, Dire Dawa and Harari are making preparations to start the training soon. 15 Health Science Colleges located in the five regions and the Technical and Vocational Education and Training (TVET) Center located at Dire Dawa, are providing the training. Three training modules have been prepared and distributed to the six regions already, while the bid process for printing six more modules which incorporate nine subjects is underway.

4.2.1.2
Accelerated Health Officer Training Program

The Accelerated Health Officers Training Program (AHOTP) was launched in November 2005 in five universities and in 20 hospitals. The target set in HSDP III was to produce at least 5,000 health officers (both generic and post basic) in five years. Accordingly, at the end of EFY 2003 a total of 5,431 health officers have graduated, surpassing the planned amount by 8.6%. The summary of those who graduated from the five Universities is shown in Table 24.

Table 24: Summary of AHOTP Graduates by University and Type of Training (EFY 2003)

University	AHOTP Post Basic	AHOTP Generic	Grand Total
Hawassa	863	444	1307
Jimma	582	456	1038
Gondar	749	471	1220
Mekele	387	57	444
Haromaya	648	774	1422
Total	3,229	2,202	5,431

Thus, with the graduation of 5,431 health officers, the target for AHOTP has been fully met.

4.2.1.3
Integrated Emergency Surgery Officers

One of the major initiatives designed in EFY 2001 to address the HRH requirement for Emergency Surgery, CEmONC, and BEmONC at Primary Health Care Units was the training of the Integrated Emergency Surgery Officers (IESO). The three year Master Program was started in five Universities in EFY 2001. Currently the total IESO trainees available in the five universities are shown in Table 25.

Table 25: Number of IESO Trainees Available at Five Universities (EFY 2003)

University	1st Year	2nd Year	3rd Year	Total
Gondar	20	19		39
Haromaya	14	14		28
Hawassa	25	19	10	54
Jimma	25	20	17	62
Mekele	30	20	19	69
Total	114	92	46	252

As shown above 114 health officers have been enrolled for the IESO training program in EFY 2003, and, out of the 252 IESO trainees, 46 are expected to graduate in EFY 2004.

4.2.1.4
Medical Doctors

Improving the availability and equitable geographic distribution of medical doctors has been a priority area for the FMOH which has introduced new initiatives and built upon and scaled up previous successful initiatives. One of the initiatives implemented in EFY 2003 is the New Medical Education Initiative in selected hospitals under the health sector through the use of an innovative curriculum. A summary of the medical school trainees in EFY 2003 is shown in Table 26.

Table 26: Number of Medical Students by Year of Study and University (EFY 2003)

Universities	1st Year			2nd Year			3rd Year			4th Year			5th Year			6th Year			Total		
	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T
Adama	17	77	94	11	123	134	6	95	101										34	295	329
Bahir Dar			106			108			72												286
Addis Ababa	55	180	235	131	159	290	87	187	294	68	109	177	45	50	95	39	68	107	425	773	1,198
Hawassa			125			258			110			80			55			37			665
Haromaya			188			108			66												362
Jimma	28	194	222	35	178	213	44	155	199	25	123	148	29	83	112	18	125	143	179	858	1,037
Gondar	54	146	200	63	149	212	49	124	173	42	152	194	28	88	116	14	57	71	250	716	966
Mekele			175			184			199			119			29			80			786
Arbaminch	2	60	62	15	47	62	9	42	51												175
SPMMC			127			42			33												202
Total	156	657	1,534	255	656	1,611	195	603	1,298	135	384	718	102	221	407	71	250	438	888	2,642	6,006

Concerning the plan to increase the intake of medical students, advocacy work on the new draft curriculum for medical schools has been made to partners, five regional hospitals have been selected and the necessary inputs are being prepared. Consequently, by strengthening information technology at Adama and Yirgalem Hospitals, and forging linkages with St. Paul's Millennium Medical College, materials that would enable these hospitals to provide the medical training are being procured. In a similar manner, curriculum and draft implementation guideline have been sent for 10 Universities that have the capacity to start the training.

4.2.1.5
Health Information Technicians

A total of 1,380 students are on training in 15 Health Science Colleges implementing the training program. The training program focuses essentially in addressing the critical shortage of skilled Human Resources for Health (HRH) in data recording, analysis and reporting as well as in use of information for evidence-based decision making both at the point of data collection and also at the various levels of the national health care system. The current status of the three year generic training program in 15 Health Science Colleges is summarized in Table 27 (in phase two, 68 self sponsored students are included in Harari).

Table 27: Training Program of Health Information Technicians by Region (EFY 2003)

Regions	Phase I (EFY 2002 entry)	Phase II (EFY 2002 entry)
Oromia	326	0
Amhara	132	144
Tigray	236	50
SNNPR	130	112
Harari	80	170
Total	904	476

It is worth noting that the total number of expected graduates by EFY 2004 will be around 904 who will be ready to be deployed for duty at public health facilities throughout the country.

4.2.1.6
Other HRH Categories

In order to start the accelerated training of nurse midwives, curriculum has been prepared and the training of 1,634 trainees started in six regions. Supportive supervision has been made and feedback given to the 15 Health Science Colleges. To start Diploma-level training of nurse anaesthetists, training curriculum of one year duration has been prepared and transmitted to RHBs that have capacity for training this category of health professionals.

The training of Health Information Technicians (HIT) was initiated in EFY 2000 by the FMOH in collaboration with the Federal Ministry of Education and the TVET Agencies in 15 Health Science Colleges located in five regions (Tigray, Oromia, Amhara, SNNP, and Harari). The aim of this program is to sustain the M&E/HMIS reform. In EFY 2003, there were 1,380 trainees in these colleges.

In EFY 2003, there were 45 professionals taking the Master Degree Program in hospital administration at Addis Ababa and Jimma Universities. To improve emergency medical services, Addis Ababa University has started to provide post graduate training for 15 professionals.

Master Program Training in Nutrition has commenced at Gondar University in EFY 2003, and is being attended by 20 professionals.

4.2.2
Deployment

A total of 1,792 Health professionals who graduated from higher education institutions have been deployed to various RHBs and federal hospitals (Table 28).

Table 28: Number of Health Professionals Deployed by Occupation and Sex (EFY 2003)

Occupation	Female	Male	Total
Health Officers	149	440	589
Nurses	161	637	798
Radiographers	3	27	30
Anaesthetists	3	22	25
Midwives	43	85	128
Total	429	1,363	1,792

A total of 57 health officers have been deployed in various RHBs (10 in Amhara, 14 in SNNPR, 16 in Oromia, 2 in Gambella, 5 in Tigray, 3 in Afar, 4 in Somali, and 3 in Addis Ababa) in EFY 2003.

The number of medical school graduates deployed in EFY 2003 was 335 (95 from Addis Ababa University, 48 from Mekele University, 86 from Jimma University, 68 from Gondar University, and 38 from Hawassa University). These graduates had taken pre-deployment training.

A Draft Guideline on motivation of health workers and retention mechanisms was prepared and sent to regions for comments.

Awareness raising education on concept of ethics, harmful effects of corruption and its prevention, principles and practices of good governance, basic principles of ethics, customer handling practices, and resource utilization has been given to 450 workers by the Ethics and Anti-corruption Officer. Articles on dissemination of good ethics and consolidation of anti-corruption culture including the 12 ethics principles with their definitions have appeared in the newsletter of the Head Office at FMOH and have also been prepared in the form of brochures and distributed to concerned stakeholders.

Concerning the deployment of expatriate medical teams, the sixteenth Chinese medical team has arrived in Ethiopia, and 17 medical professionals have been deployed at Tikur Anbessa, St. Peter's, St. Paul's Millennium Medical College and Tulu Bolo Hospitals.

Eleven medical professionals from Cuba have been assigned to various health facilities in the country.

Twenty one medical specialists from the Republic of Korea have been deployed to various RHBs.

4.2.3
Human Resource Information System

In 2003, Human Resource Information System (HRIS) was implemented and upgraded in FMOH, EHNRI, in all RHBs and 9 hospitals. Training was conducted for relevant staff at the deployed sites.

Staff profile data base is being computerized based on the new categories approved by the Civil Service Ministry. Similarly HRIS Licence was deployed at EFMHACA and seven RHBs.

Challenges

- Shortage and attrition of highly skilled professionals; and
- Limited capacity of Human Resources Management (HRM) at all levels.

Way Forward

- Introduce Continuing Professional Development (CPD) program for technical and administrative staff linked to health sector needs and career development; and
- Provide training on HRM tools to human resource officers at various levels.

4.3
Pharmaceutical Supply and Services

The strategic objective of improving pharmaceutical supply and services as outlined in HSDP IV is designed to increase the availability of quality pharmaceuticals at an affordable price and in a sustainable manner. It also aims to achieve improved rational drug use and a significant reduction of pharmaceutical wastage.

The Agency has planned activities in EFY 2003 which includes: (i) ensuring the supply and quality of essential pharmaceuticals; (ii) strengthening and expanding modern storage facilities; (iii) strengthening transport management system; (iv) establishing an Integrated Pharmaceuticals Fund and Supply Management Information System; and (v) providing capacity building services to promote rational drug use. The performance of the planned activities in EFY 2003 is presented as follows.

4.3.1
Procurement

Out of the planned procurement of pharmaceuticals and medical equipment for ETB 3.62 billion in different packages, the Agency has procured pharmaceuticals worth of ETB 3.59 billion which indicates 99% of the plan achieved. During the budget year, the agency has undertaken custom clearance and distribution of pharmaceuticals worth of ETB 3.610 billion procured by DPs. The overall availability of pharmaceuticals and medical equipment for the year both by the Agency and DPs increased to ETB 7.19 billion.

The procurement of pharmaceuticals and medical equipment focused on primary health care services and major health programs.

In line with the National Growth and Transformation Plan (GTP) to substitute 50% of imported products and to increase pharmaceuticals and medical supplies export to USD 20 million, the Agency has designed and implemented different strategies to support local manufacturers. This includes the provision of 30% local preference margin, reward advance payments upon giving purchase order and signing tripartite agreement with the development bank to allow manufacturers to get loan for the remaining contract amount. Moreover, a technical committee has been established in consultation with all stockholders to support local manufacturers to realize the target set out in the GTP.

With regards to the affordability of products, as compared to the price charged by the private sector, PFSA was able to provide life saving and essential products with reasonable and below market prices. For instance, Insulin sold in the market at a cost of ETB 120 to 200, Glucose at a cost of ETB 60 to 80 and immunosuppressant drugs at a cost of ETB 50,000 have been supplied by PFSA for ETB 48 to 54, ETB 20 to 25, and ETB 2,000 to 3,000, respectively.

4.3.2
Storage and Distribution

The annual distribution plan for the year was ETB 5.5 billion and the performance shows that ETB 5.1 billion worth of pharmaceuticals have been distributed. Medical equipment kits have been packed and distributed for 868 HCs and 1,200 HPs. Adequate medical equipment kits are reserved for the newly constructed HPs, waiting for detailed information from respective regions for distribution to the facilities.

Based on the selected 140 types of essential pharmaceuticals and medical supplies, it was envisaged that continuous availability increased to 92%; equitable geographic distribution of drugs and medical equipment was conducted and special attention was given to health facilities in rural and remote areas.

4.3.3
Infrastructure

To strengthen and expand modern storage and distribution networks throughout the country, the Agency has planned to construct modern stores in selected sites of all regions. This will enhance the supply chain system implementation and reduce wastage observed at all levels and ensure the supply of the required drugs and medical equipment to all health facilities.

Accordingly, the construction of six new large warehouses, expansion of five existing warehouses and six new secondary medium warehouses and offices are started. The progress of the construction is promising, meanwhile the Agency is using 24 leased warehouses to keep up the distribution operations.

Existing warehouses of the agency and 80 selected health facility stores have been equipped with modern racks, shelves, forklifts, ladders and pallets. Sixteen heavy trucks have been procured at a cost of ETB 51.1 million.

4.3.4
Capacity building and Rational Drug Use

On the basis of the result of the supportive supervision made at selected 500 health facilities, the agency embarked on strengthening implementation capacity through arrangement of training on rational drug use, inventory management, Integrated Pharmaceuticals Logistics System (IPLS) Guidelines on the establishment of Drug and Therapeutics Committee management, and use of medical equipment and proper handling of reagents and chemicals. It was planned to give training on the above topics for 3,500 professionals and continuous training has been given for 4,360 professionals from selected health facilities.

Guideline on Pharmaceuticals Supply Management has been modified taking into consideration limitations and best practices observed during implementation. Pharmaceuticals that were overstocked at branch warehouses and at the health facilities stores have been redistributed to other branches and health facilities where there were shortages of these supplies. Expired drugs and medical supplies have been disposed from selected facilities with technical and financial support of the agency. Establishment of Drug and Therapeutics Committees (DTC) has been planned for 500 health facilities and out of these 474 health facilities have established DTCs and 350 health facilities have prepared their own list of drugs and medical equipment.

As part of the capacity building support to health facilities on IPLS, both ICT and paper based training have been provided in collaboration with DPs and 202 health facilities have received in-kind support like computers, printers, standardized request and reporting formats, and other printing materials to enhance inventory management system.

Challenges

- Financial gap for Revolving Drug Fund and delay in releasing funds for the services provided by the agency;
- Delay in the construction of warehouses and offices; and
- Delay of pharmaceuticals shipment from international suppliers/manufacturers.

Way Forward

- Solicit additional resources to support RDF system and to avail essential health commodities;
- Accelerate the provision of cement from manufacturers based on a tripartite agreement signed between the contractors, the agency and the manufacturers; and
- Conduct regular meetings and follow up contracts with local representatives of manufacturers.

4.4
Technology Transfer and Vaccine Production

In EFY 2003, hospital-based surveillance on Rota Virus has been conducted and report submitted to FMOH and WHO, paving the way for the introduction of the Rota vaccine into Ethiopia.

The evaluation of the new mobile CD4 equipment, that would enable patients to get their results on the same day at HC level and therefore facilitate the follow up of their health status, is underway.

The effectiveness of the new Rapid Diagnostic Test (RDT) for rabies has been evaluated vis-à-vis the existing method, and found to be fully effective. Hence, action plan has been prepared to introduce and scale up the use of the new method country wide.

The laboratory set up to evaluate the RDT for malaria has undertaken lot testing, long term testing and experimental work on quality assurance in order to make this laboratory a referral center for the Africa Region, by obtaining the certificate of competence.

To produce rabies vaccine from cell culture, two virus strains (namely, ERA and PV) required for production were granted by an international institution. It has been possible to prepare master virus seed and working virus seed prior to the commencement of production. Using the working virus seed as a starting point, 12,000 doses of rabies vaccine has been produced from cell culture on a trial basis, while 35,425 doses of Phermi vaccine for human and animal use have been produced using the existing vaccine production method and distributed to concerned bodies.

In order to prevent the serious health problems caused by iodine deficiency, seven laboratories (three in Afar, two in Amhara, one in Oromia, and one in Somali Region) have been established to perform quality control tests on iodized salt.

4.5
Health Information Technology

Health Information Technology (HIT) is an innovative solution to improve the quality and access of health services, as well as to promote evidence-based decision making at lower cost by introducing health-related technologies and practices.

In 2003 EFY, various HIT projects were implemented, comprising of mHealth, tele-education, telemedicine, and knowledge centre management.

4.5.1
Mobile Health

The term mHealth is used for interventions to support medical service provision and information sharing through mobile technology and medical devices. The mHealth spectrum ranges from simple mobile phone-based applications for the transfer of health information on basic handsets via Short Message Service (SMS) to highly sophisticated diagnostic applications that rely on advanced equipment and robust back-end data systems.

The study "mHealth in Ethiopia: Strategies for a New Framework" on the use of mobile technology to improve the capacity of HEP has been conducted.

4.5.2
Tele Education and Tele Medicine

The eGranary system facilitates personal access to relevant health journals and documents, representing also a retention mechanism for health professionals. By providing computers and training, the implementation of knowledge centers has commenced fully at Bishoftu Hospital (Oromia Region) and at Durame Hospital (SNNPR) in EFY 2003, and 40 health professionals have been trained to use the system.

Using satellite communication technology, Continued Medical Education (CME) in different clinical subjects has been given at Black Lion Hospital for 12 health professionals and medical students.

Telemedicine is an important component of e-health. It is one of the promising technologies to address issues related to quality, access, efficiency as well as shortage of health care professionals. It has unfolded the possibility of narrowing the gap between urban and rural areas and between the "haves" and "have not's". Through making services available to the needy in remotest areas, it can be a very useful tool for improving health for the people at large. In this regard, a "store and forward" telemedicine system was implemented to provide health service to the community by using Jimma University as a hub network.

A training and demonstration program on telemedicine, applying mobile technology, has been conducted for 15 officials from FMOH and referral and regional hospitals, and for 25 CEOs and Medical Directors.

With respect to the implementation of Information Technology projects, training has been provided and evaluation of tele-medicine activities has been carried out at Addis Ababa University and in three hospitals (Yirgalem, Arbaminch and Asella).

4.5.3
Electronic Medical Record

SmartCare is a comprehensive national Electronic Medical Record (EMR), reporting and analysis system (eHMIS). It is designed to enable better patient care, enhance efficiency and make the reporting and analysis system more accurate, timely and effective.

In EFY 2003, Smart Care-EMR latest software version with different components was deployed at 15 hospitals, 30 HCs and 26 health institutions (sub-cities, WorHOs and ZHDs). A total of 2,333 trainees drawn mainly from hospitals and HCs were trained on EMR in Oromia (East Shoa), Addis Ababa, Tigray, and Harari.

Availing complete and timely reports was one of the focus areas for EFY 2003. The design of this application was to enable electronic data reporting, archiving and data analysis. To this end an application, SmartCare eHMIS module, was designed and piloted; eHMIS was tested in Addis Ababa and evaluated for its functionality to support the decision making process. The updated version is being piloted in one zone in Oromia.

4.5.4
Geographic Information Systems for Health

The Geographic Information System (GIS) is a system that will enable the collection, storage, management, analysis, retrieval, modelling and visualization of spatially referenced information to improve monitoring of the spread of disease, modelling the future diffusion of the disease and planning of timely allocation of resources. In East Shewa Zone in Oromia Region, mapping of the community households and settlement areas has been completed. Training and support have been provided for health professionals, with 33 HIT and IT professionals from all regions having already received training on the GIS.

EHNRI is developing a software for the National Disease Surveillance Information System (DSIS-SmartCare module) that will enable the HEWs to send epidemic and surveillance reports from HPs to higher level health offices. HEWs will be provided with print out laminated map that show the catchments area of HPs with defined one by one km grid map with its kebele boundary and other spatial data such as roads, rivers, household localities and other available geographical features.

4.5.5
Training and support for Information Technology

In EFY 2003, capacity building programs were carried out for all RHBs and hospitals to enhance smooth running of the IT infrastructure. A total of 161 IT professionals were trained on networking (15), IT project management (55), network security (15), maintenance (15), GIS (33), EMR (10), and Microsoft Server 2008 (18).

Challenges

- Inadequate budget allocation to run and sustain eHealth initiatives; and
- Lack of harmonization among several eHealth initiatives.

Way forward

- Secure enough budget for the eHealth system including adequate running costs; and
- Finalize the eHealth policy as a national guideline for standardization, interoperability and harmonization of different eHealth projects.

4.6
Resource Mobilization and Utilization

Health services in Ethiopia are financed from the federal/regional governments, grants/loans from bilateral and multilateral donors, Non-Governmental Organizations (NGO) and private contributions. Although health financing has improved significantly over the years, it remains a major challenge for the health system. The basic objective of this component is to achieve a sustainable health care financing system through mobilization of increased resources to the health sector, promoting efficient allocation, effective expenditure management for allocative equity, and better utilization of available health resources.

The FMOH has initiated and implemented the Health Care Financing (HCF) reform for more than a decade ago now. The reform components include facility revenue retention and utilization, facility governance, systematization of fee waiver and exempted health services, user fee revision, out-sourcing of non-clinical services and establishment of private wing. These reforms have been undertaken with the objective of strengthening the supply side and delivering quality health services. In addition to the above reform components, the FMOH has recently initiated health insurance to address the demand side thereby to remove financial barriers to access health services. In both reform components significant achievements have been registered during the fiscal year.

The following section describes the progress made so far regarding resource mobilization and utilization.

4.6.1
Health Care Financing

Revenue Retention and Utilization

Currently 90 hospitals and 2,151 HCs (including Nucleus HCs) are retaining revenue and 87 hospitals and 1,738 HCs are using retained revenue for health service quality improvement. During the fiscal year, trainings and refresher trainings on HCF reform implementation were given to a total of 825 people drawn from RHB, ZHDs, WorHOs and health facilities in Amhara, Oromia, SNNP Regions and Addis Ababa City Administration. Improving the financial management at all levels is also another important factor in the implementation of revenue retention and utilization reform component. In this regard, several consultative workshops were undertaken to revise and update financial management manuals. Based on the adapted manuals and in collaboration with the regional Bureaus of Finance and Economic Development (BoFED), a total of 1,333 finance personnel drawn from hospitals and HCs were trained in Oromia, SNNP, Benshangul Gumuz, Amhara, Gambella, Tigray and Harari Regions and Addis Ababa and Dire Dawa City Administrations. Following the training, follow-up visits were made to assist the trainees in the application of the skills gained during the training.

Table 29: Number of Health Facilities Implementing Health Care Financing Reform (EFY 2003)

Region	Hospitals Implementation	Health Centers Implementation
Tigray	12	118
Afar	0	0
Amhara	16	358
Oromia	35	1053
Somali	0	0
Benishangul Gumuz	2	21
SNNPR	16	546
Gambella	1	1
Harari	2	8
Addis Ababa	5	31
Dire Dawa	1	15
National	90	2,151

Fee waiver, Exempted Health Services and User Fee Revision

To date, over 2.2 million indigents were selected and certified in eight regions (Amhara, Oromia, SNNP, Addis Ababa Tigray, Dire Dawa, Harari, and Benishangul Gumuz). Preparatory works are also in progress in Gambella, Afar and Somali Regions. Woreda Administrations have also allocated ETB 25.6 million which on average would come up to ETB 41,006 per woreda.

Implementation of the fee waiver system is the most difficult task among the reform components. It is implemented well in Amhara Region compared to other regions where the reform started during the same period. The challenge is mainly related to the selection of indigents who will benefit from the fee waiver system. To address the problem, fee waiver orientation workshops were organized in regions and city administrations.

Facility governance

The role of facility governing bodies both at hospital and HC level is critical in promoting and overseeing successful implementation of the HCF reform. As per the findings of quarterly supportive supervision, regional variations in implementation of HCF reform are mainly due to the strength and corresponding performance of the facility management boards and governing bodies. Based on this finding, in order to highlight and share experiences of the successful practices of governing bodies and other HCF reforms across regions, a two day experience sharing and networking workshop was conducted. This national level event was held in Addis Ababa and included 123 people drawn from health, finance and woreda administration from all regions, including Afar and Somali. This successful event served to enlighten the general public and relevant stakeholders about the HCF reform, and progress and achievements made to date. In addition, the standard two-day training for facility governing bodies and management boards were provided to a total of 1,775 board members in Tigray, Amhara, Benishangul Gumuz, SNNP and Oromia Regions and Addis Ababa City Administration.

Private Wing and Out-sourcing

To date, a total of 18 hospitals have established private wings. A study is being conducted on the implementation of private wing to inform the reform. During the fiscal year, the Benishangul Gumuz RHB endorsed the private wing/room directive, and hospitals in this region carried out preparatory activities to start the operation of private wing/room services.

Generally, HCF reforms are being implemented well in all regions except Somali and Afar. Somali Region has endorsed the legal framework and Afar Region is expected to endorse the legal framework in EFY 2004. The status of HCF implementation in the seven regions and two city administrations is described in Table 29.

4.6.2
Health Insurance

To address the financial barriers to access health services, the Government has initiated and is implementing two types of health insurance: Community Based Health Insurance (CBHI) for the rural population and urban informal sector and Social Health Insurance (SHI) for the formal sector. Significant progress has been observed in the implementation of both types of health insurance during the year.

4.6.2.1
Social Health Insurance

The Parliament of the Federal Democratic Republic of Ethiopia unanimously ratified the SHI Proclamation in EFY 2003. Two rounds of TOT workshops at federal and regional levels were organized and a total of 724 people were trained. Trainees served as facilitators of consultations on SHI proclamation and regulation in their respective institutions/organizations both at the federal and regional levels.

The feedbacks on SHI consultations held in the regions and at the federal level institutions were gathered and a refined SHI regulation has been prepared for subsequent endorsement by the Council of Ministers.

Furthermore, two short-term technical assistants for the development of Provider Payment Mechanism (PPM) were employed. The final report of the PPM study is being reviewed by the FMOH. A local consultant to undertake a study on job description, job grading, and salary scale for the SHI agency staff is employed and is expected to submit a draft report by the end of September.

4.6.2.2
Community Based Health Insurance

The FMoH endorsed the CBHI prototype directive in EFY 2003. With the exception of Tigray Region, all the three pilot regions adapted CBHI directive into their regional context. CBHI prototype by-laws were produced by the FMOH and pilot regions adapted it to their regional context.

Communication strategy and tools have also been produced to facilitate community sensitization and awareness creation activities at the community level and various training/orientation events at woreda, kebele, and community levels were organized. In EFY 2003, 5,373 people were trained on CBHI implementation. To further strengthen the CBHI sensitization and awareness creation activities in the community, training was provided for 52 HEW supervisors and 37 WorHO staff. Furthermore, 73 amateur artists were trained to enable them play a role in CBHI social mobilization events by disseminating locally appropriate messages. Subsequently, over 257 advocacy events in all CBHI pilot kebeles and woredas were organized; a total of 7,011 addressees (4,563 men and 2,448 women) were reached using interpersonal communication, community orientation and local mass media, and 454,384 people (305,604 men and 148,780 women) were contacted in twelve pilot woredas and 285 pilot kebeles.

RHB, Woreda Cabinet, WHISC, Kebele Cabinet and KHIIC members organized Kebele level CBHI consultation in four pilot regions. These consultative meetings were aimed at getting buy-in of the CBHI program and enable the community to decide whether to join the CBHI schemes. All the residents of 285 rural kebeles in all pilot Regions unanimously decided to join the schemes. Overall, a total of 1,064 people attended the meeting. The General Assembly heralded the establishment of CBHI schemes in all the 13 woredas. They endorsed the CBHI by-law, established the board of directors, decided on the amount of the registration fee and annual contribution, and fixed the timetable for the collection of contributions.

Following the establishment of the schemes, recruitment and training of CBHI woreda executive staff, opening of bank accounts, and CBHI scheme-health facility agreements were undertaken.

During the reporting period a total of 37,195 HHs were registered in all pilot regions and woredas. All

the schemes in thirteen CBHI pilot woredas generated a total of ETB 2,464,435.50 (ETB 0.135 million in Tigray, 0.430 million in SNNP, 0.644 million in Oromia, and 1.254 million in Amhara) from paying HHs. A total of 18,831, 12,339, 5,002, and 1,023 paying households are registered in Amhara, SNNP, Oromia and Tigray Regions respectively (Table 30).

An assessment on human resource, infrastructure, laboratory and medical equipment, and availability of drugs and medical supplies in HCs situated in the CBHI pilot woredas was undertaken and measures are being taken to strengthen health facilities that are operating in CBHI pilot woredas.

Table 30: Number of Paying Households, and Premium Collected from Paying Households by Region and Pilot Woreda (EFY 2003)

Region	Pilot Woreda	Paying Households	Premium Collected from Paying Households
Tigray	Tahitay Adiabo	414	54,648.00
	Ahferom	425	56,100.00
	Kilte Awlaelo	184	24,288.00
	Sub Total	1,023	135,036.00
Amhara	S/Achefer	4,116	346,150.00
	Fogera	5,373	272,368.00
	Tehuledere	9,342	635,700.50
	Sub Total	18,831	1,254,218.50
SNNP	Yirgalem	1,980	29,592.00
	Damot Woyde	6,304	295,875.00
	Damboya	4,055	105,430.00
	Sub Total	12,339	430,897.00
Oromia	Deder	3,024	287,280.00
	Gimbichu	1,650	308,054.00
	Kuyu	225	36,675.00
	Limmu Kossa	103	12,275.00
	Sub Total	5,002	644,284.00
Total		37,195	2,464,435.50

Evidence Generation

The project finalized two targeted studies (Fee-Waiver and User Fee Revision Assessments), and organized validation workshops in the SNNP, Amhara and Oromia Regions. A total of 70 people (12 in the SNNPR, 20 in Amhara Region, and 38 in Oromia Region) attended the workshops. Currently, the reports are being disseminated for stakeholders.

Challenges

- Slow identification of indigents; and
- Delay in implementation of the HCF reform in Somali and Afar Regions.

Way forward

- Share experience of Amhara Region on the fee waiver implementation to other regions;
- Implement the HCF reform in Somali and Afar Regions;
- Finalize preparatory activities and establishment of the Health Insurance Agency; and
- Enhance advocacy to increase resource mobilization from internal sources as well as DPs.

4.6.3
Financial/expenditure management and control

To improve and strengthen the financial management system, FMOH has taken four initiatives. These are introducing Integrated Financial Management Information System (IFMIS), establishing grant management system, hiring of financial technical assistants and contracting out of some of the accounting functions to accountancy firm. The performance of these initiatives in EFY 2003 is described below.

Grant Management System

FMOH has initiated this project to enhance efficient and effective grant management that ensures good stewardship of resources and enables proper accountability to stakeholders. A study team has been set up to make a detailed assessment of the existing system, benchmark other best practices with respect to grant management and come up with proposal of establishing the grant management system.

As per the approved work plan, a detailed process flow chart for grant management cycle focusing on the grant implementation phase and close out phase was prepared and shared to the Technical Working Group (TWG) formed for this purpose and to the management of FMOH. Furthermore, by interviewing the relevant staff of FMOH and other partner agencies, detailed assessment was conducted and the drawbacks in the existing system were compiled and submitted to the management.

Currently the final proposal is being prepared and there will also be a benchmarking visit to have additional insight on practical experiences of other countries that have better experience in this field. Development of the final proposal, manuals, working formats, staff recruitment and other preparatory works will be finalized soon and "The Grant Management Unit" is also expected to be operational within the coming six months.

As a result of implementing the grant management system, FMOH will be able to institute proper grant planning, monitoring and evaluation including timely close out of grants.

Integrated Financial Management Information System

The IFMIS is a web based and integrated financial information system which will provide a real time financial information across different levels of the government. Though FMOH had initiated its own FMIS, the process of establishing IFMIS at national level was also initiated by the Ministry of Finance and Economic Development (MOFED). Therefore FMOH decided to join the MOFED project to avoid duplication of efforts and FMOH became one the six pilot sectors/ministries in this project. MOFED IFMIS project will employ ORACLE e Business Suit (ORACLE Ebs) which is an internationally recognized Enterprise Resource Planning solution.

IFMIS incorporates nine modules namely General Ledger, Accounts Payable, Accounts Receivable, Fixed Asset, Cash Management, Inventories, Purchasing, Payroll and Public Sector Budgeting.

During the reporting period, 12 key users from FMOH were trained on the application of these

modules by ORACLE University. The first phase of designing the solution and testing it in a Conference Room Piloting (CRP) arrangement was completed and second phase is underway. The final designing and testing in the CRP and training of the end user will be finalized.

Hiring of Financial Technical Assistants and Contracting of Accountancy Firm

The accountancy firm has settled a long outstanding grant advance amounting ETB 38.6 million. Moreover, the capacity of woreda staff in the preparation of statement of expenditure and closing books of accounts has been strengthened.

The financial technical assistants have leading role in the establishment of the grant management system and implementing the quick fix tasks. They also provide technical advice to FMOH management in the designing of IFMIS. Therefore, based on the EFY 2003 quick fix plan, a huge recording back log was cleared and updated, recording of all grants was converted from Excel base to Peachtree accounting software, reconciliation of two records (i.e IBEX and Peachtree) was done, separate accounts were opened, revision of chart of accounts was made to be consistent with government rules and able to address donors' requirements. As a result, management and donors reports will become more informative with adequate supporting document and will also enable informed decision making. Furthermore continuous on the job training is being given to finance staff.

Challenges

- Lack of adequate staff; and
- Inadequate experience of the grant management system to be shared from domestic government agencies.

Way forward

- Hire technical staff as per the standard and requirements of the IFMIS; and
- Share experience of other countries/government organizations which have better grant management system.

4.6.4
Public Budget Allocation

This section reviews the allocation of public budget in EFY 2003. The source of data of this section is the MOFED. Besides, it shows only the regional block grant allocated for respective regions and the national average at the beginning of the fiscal year.

Percentage Share of the Health Budget Allocation from Total Budget

The regional block grant budget allocated to the health sector ranged from 4.7% in Addis Ababa to 14.5% in Dire Dawa in EFY 2003. An increase in the percentage share of health budget from EFY 2002 to EFY 2003 was observed in Amhara, Somali, Benishangul Gumuz, Addis Ababa and Dire Dawa, whereas the other regions showed a decrease. In EFY 2003, the national average of the percentage of total budget allocated in the health sector was 10.03%, which was slightly below the EFY 2002 level (10.4%) (Figure 46) In EFY 2003, the allocation on health per capita was ETB 49.01 which was higher than 39.82 in EFY 2002.

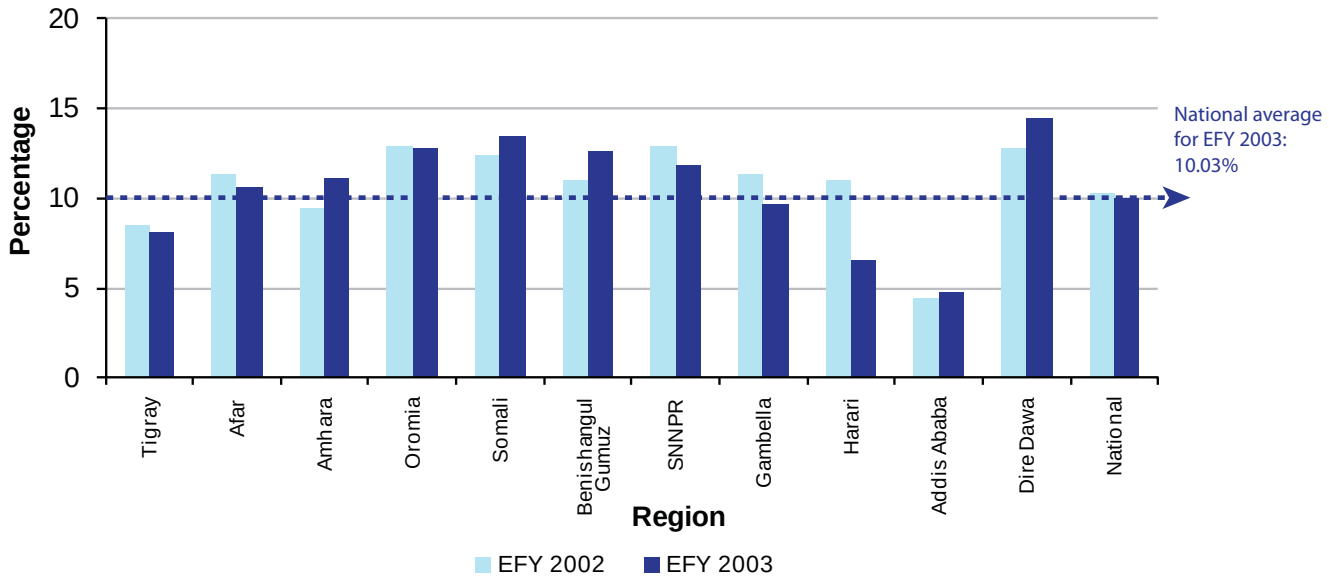


Figure 46: Distribution of the Percentage of Total Budget Allocated in the Health Sector by Region (EFY 2002 and 2003)

In general, this allocated budget for health is below the need of the sector for delivering quality care in the country. This calls for enhancing implementation of HCF reform and expansion of pre-payment schemes such as social and community based health insurances, as well as additional fund from DPs.

4.6.5
Development Partners' Contribution to the Health Sector

To ensure availability of responsive health care and the provision of quality health services is determined by many factors, the most significant of which is the availability of resources required to fund the necessary inputs. To this end, one of the sources of finance for the health sector is assistance from DPs. In EFY 2003 there has been a significant financial contribution from DPs for the achievement of the HSDP IV targets. The harmonization and alignment process, reinforced by the International Health Partnership (IHP) Compact and the Joint Financing Arrangement (JFA), has supported the overall program implementation, making financial support more effective and flexible. The key principle underpinning the process of harmonization and alignment is the establishment of "One-Plan, One-Budget and One-Report" to provide predictable funding in support of results-oriented national plans and strategies. A critical step towards "One Budget" is the establishment of the MDG Performance Package Fund to facilitate resource pooling in order to finance the priorities under the HSDP.

Commitment levels indicated below reflect amounts captured during the resource mapping exercise for EFY 2003. For EFY 2004, the resource mapping exercise has been expanded to capture planned spending in much greater detail and its results communicated to respective regions, woredas, and FMOH directorates. The higher definition and the inclusion of additional DPs in EFY 2003 resource mapping have greatly contributed to the usefulness of the exercise and represents significant progress towards IHP principles.

Comparison of Committed and Disbursed Funds by Development Partners

In EFY 2003 a total of USD 485.44 million was committed by DPs for public modalities, out of which USD 422.35 million (87%) was disbursed (Table 31). This represents an absolute increase in the amounts of funds committed and disbursed to public implementing agents in Ethiopia's health sector. However, the disbursement rate (87%) has decreased slightly from EFY 2002 (89%).

For EFY 2003, WHO reported that the disbursement was more than what was committed in the bi-annum agreement due to additional funding mobilized during the fiscal year. Low disbursement levels from the Centre for Disease Control (CDC) reflect the challenges in liquidating funds for a few select activities.

Table 31: Commitment and Disbursement of Funds by Development Partners (EFY 2003)

S.No	Source of Fund	Commitment (in USD) in 2003 EFY	Disbursement (in USD) in 2003 EFY	% Disbursement
1	**MDG Pooled Fund**			
	DFID	25,120,000	30,506,570	121.4
	WHO	300,969	300,969	100.0
	UNFPA	1,000,000	1,000,000	100.0
	Irish Aid	1,442,392	2,217,960	153.8
	AECID/Spanish Aid	6,416,510	6,416,510	100.0
	TOTAL	34,279,871	40,442,009	118.0
2	**Protection of Basic Services - Sub Program B**			
	World Bank	22,300,000	10,000,000	44.8
	Italian Cooperation	10,739,000	10,739,000	100.0
	Royal Netherlands Embassy	12,000,000	8,000,000	10.0
	CIDA Canada	19,078,000	19,078,000	100.0
	TOTAL	**64,117,000**	**47,817,000**	**74.6**
3	**Global Initiatives**			
	GAVI	23,496,345	19,600,000	83.4
	CSO	1,336,345	0	0.0
	ISS	2,560,000		
	TOTAL			
	Global Fund			
	Malaria	**71,153,810**	**32,793,810**	**46.1**
	HIV	143,000,000	129,700,000	90.7
	TB	9,522,399	5,494,887	57.7
	TOTAL	247,172,554	187,588,697	75.9
4	**UN Partners**			
	UNICEF	**103,979,859**	**111,444,578**	**107.2**
	UNFPA	14,244,663	11,395,730	80.0
	WHO	9,658,645	19,471,217	201.6
	TOTAL	127,883,167	142,311,525	111.3
5	**Bilateral Partners**			
	US CDC	**11,794,688**	**4,000,000**	**33.9**
	AECID/Spanish Aid	**192,495**	**192,495**	**100.0**
	TOTAL	**11,987,183**	**4,192,495**	**35.0**
	GRAND TOTAL	**485,439,775**	**422,351,726**	**87.0**

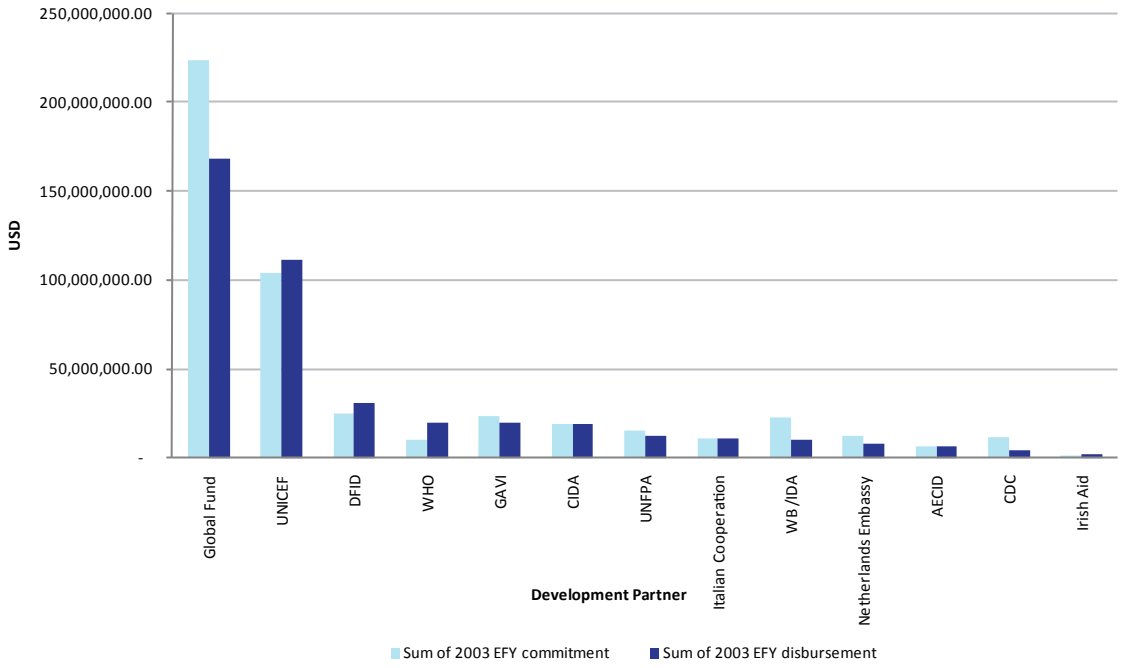


Figure 47: Percentage distribution of disbursement versus commitment by development partners (EFY 2003)

As a share of DPs disbursement, the Global Fund remains the largest contributor (40%), having had a substantial increase from EFY 2002 due to the increase in HIV funding (30.5% of all disbursed funding) (Figures 47 and Figure 48). This is followed by the United Nations Children's Fund (UNICEF) (26%) and UK's Department for International Development (DFID) (7%). Contributions by UNICEF and Global Alliance for Vaccines and Immunization (GAVI) also contain a substantial proportion of in-kind transfers.

Channel-3 contributors are not accounted for in the above mentioned text and illustration. However, USAID and CDC dedicated substantial resources through Channel-3 modality, amounting to USD 103.2 million and USD 75.6 million, respectively.

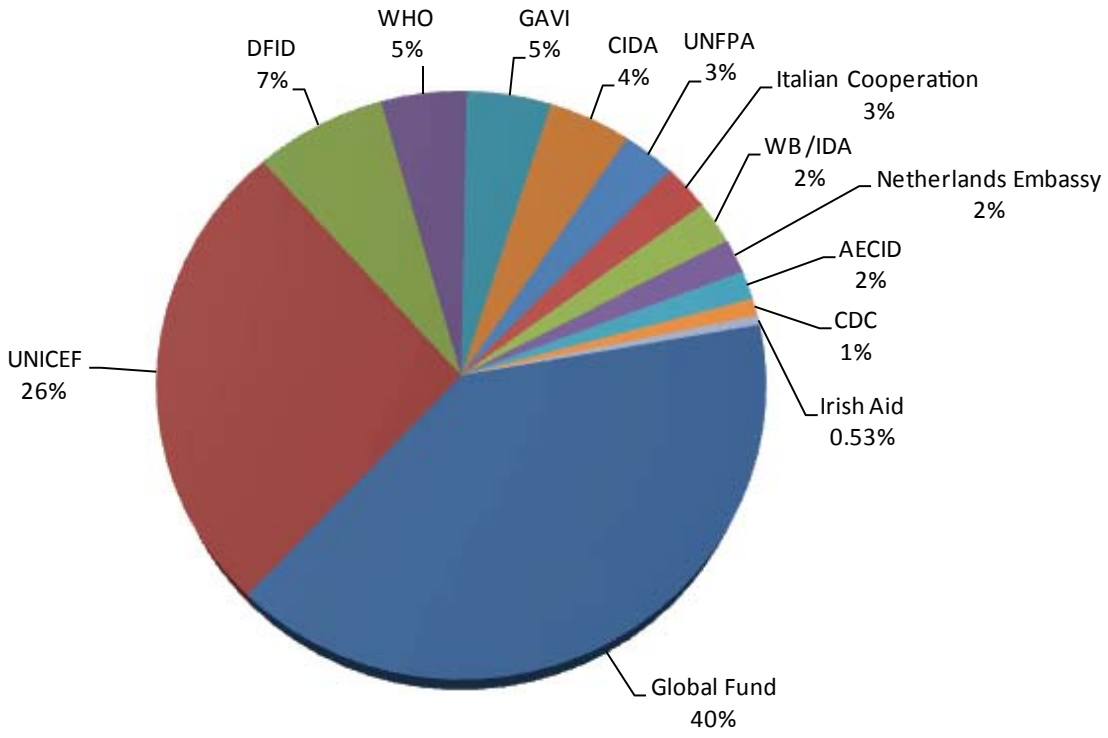
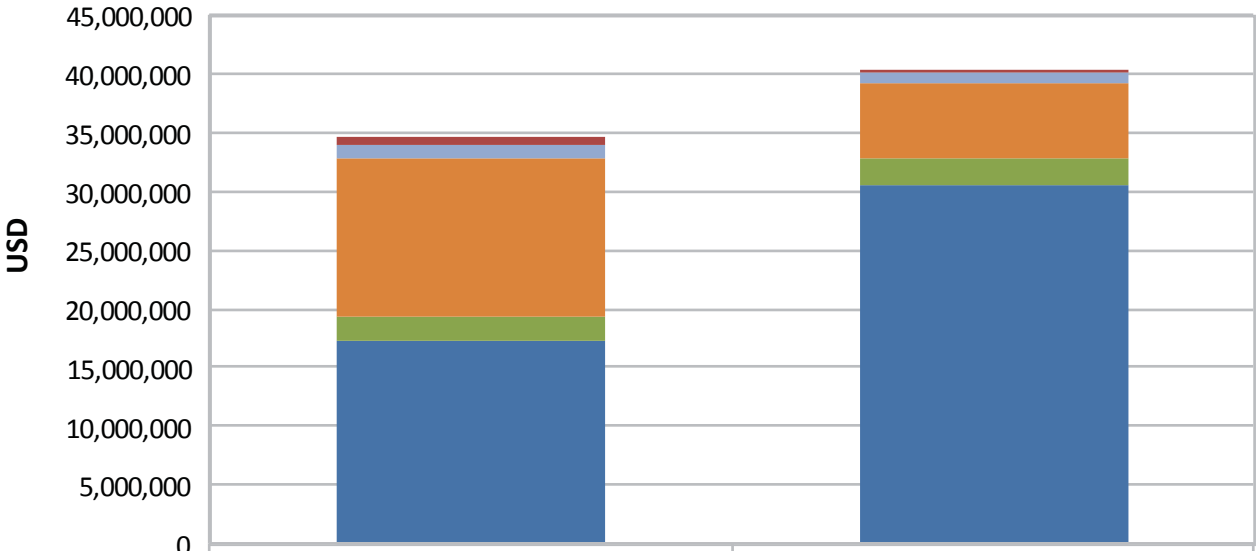


Figure 48: Percent Distribution by Development Partners (Out of the Total Disbursed) (EFY 2003)



	2002 EFY	2003 EFY
WHO	634,366	300,969
UNFPA	1,000,000	1,000,000
AECID/Spanish Aid	13,690,032	6,416,510
Irish Aid	1,924,669	2,217,960
DFID	17,292,678	30,506,570

Figure 49: MDG Pooled Fund Disbursement (EFY 2002 and 2003)

A total of USD 40.44 million was disbursed to the most preferred channel of disbursement – the MDG Pooled Fund. This represents 17% growth of USD 5.9 million from EFY 2002. The MDG Pooled Fund has also increased slightly as a proportion of total DP disbursements, having accounted for 9.6% of disbursed amounts in EFY 2003 as opposed to 9% in EFY 2002.

DFID remains the largest contributor to the MDG Pooled Fund, accounting for 75% of the EFY 2003 funding (Figure 49). DFID's EFY 2003 contribution also represents a substantial increase from the previous year. The apparent decrease from EFY 2002 to EFY 2003 of AECID's contribution is the artifact of the different fiscal calendars and disbursement schedules of the Ethiopian and the Spanish Governments, resulting in 2 calendar year's worth of disbursement falling on the EFY 2002.

As per the Ethiopia's IHP compact, it is expected that an increasing share of funding to the health sector should be channelled through the pooled funding mechanisms. For EFY 2004, there will be substantial growth to the MDG Pooled Fund, driven largely through the increase in DFID contributions. The Italian Cooperation (IC) will also disburse to the MDG Pooled Fund for the first time in EFY 2004 and both the Spanish Development Cooperation and Irish Aid have increased commitments to the MDG Pooled Fund in EFY 2004. The FMOH continues to approach new partners and actively mobilizes resources for this preferred funding modality.

The second Health Pooled Fund (HPF 2), which finances critical technical assistance, M&E, planning activities, as well as other capacity building operations, came to a close at the end of EFY 2003. In EFY 2003, a total of USD 1,410,036.76 was utilized. Cumulatively, USD 3,969,070.07 has been utilized out of a total of USD 4,509,661.63 in programmable funds by the closing of HPF 2. The remaining balance represents funds budgeted for TA contracts that extend beyond the close of the fund as well as a reserve for contingencies.

An independent review of the HPF 2 found that it was seen as effective, timely, responsive and demand-driven, with funds channelled towards the most urgent and critical needs of HSDP. UNICEF has provided valuable logistic support as the financial manager of the HPF and has filled critical funding gaps through its implementation. Discussions are in process to renew the HPF for the coming period.

Implementation Status of the MDG Pooled Fund

As per the JFA, the MDG Pooled Fund is used to fill the financial gap in four eligible funding areas: (i) Health Extension Program; (ii) Health Service Delivery; (iii) Procurement of Health Commodities; and (iv) Health System Strengthening. A financial plan for the MDG Pooled Fund was developed and agreed upon at the beginning of the fiscal year. The plan was based on gaps identified in the annual woreda-based planning exercise as well as other agreed to priorities. The implementation of the MDG Pooled Fund was reported to contributors quarterly.

All commodity procurement planned in EFY 2002 has been completed and items delivered. The exception is the USD 354,154 budgeted for cold chain spare parts which is now tendered for rebidding in combination with an additional USD 1,000,000 budgeted for under the EFY 2003 plan. The following section details the utilization status of the MDG Pooled Fund under the EFY 2003 plan.

Health Extension Programme

Health Extension Program is one of the four eligible funding areas, and for its implementation, the capacity of HEWs in the package programs needs to be strengthened in order to carry out their duties effectively. In this regard training of Implanon insertion, clean and safe delivery, refresher training on hygiene and sanitation and Integrated Refresher Training (IRT) has been conducted in various regions and is still being conducted. For this purpose, USD 384,058 were allocated from MDG Pooled Fund to cover the financial gap.

Health Service Delivery

In the Health Service Delivery area, budget was allocated to fill the gap for the implementation of maternal and child health activities and services. In particular, a total budget of USD 1,000,000 was allocated to improve the cold chain capacity for child immunization services (i.e., construction of cold rooms). Currently, the construction of cold rooms is underway. A total of USD 2,000,000 was also allocated for training and advocacy under maternal and child health programs (USD 1,000,000 respectively). An additional USD 1,000,000 allocated to support measles vaccination programs was transferred to six regions.

Procurement of Health Commodities

The MDG Pooled Fund helped to fill the financing gap for procurement of important health commodities. The planned commodities to be procured in EFY 2003 were vaccines, hospital medical equipments, EmONC equipments and ambulances.

Procurement of vaccines

A total of USD 3,000,000 was allocated from MDG Pooled Fund for the procurement of vaccines and syringes. Of this amount, USD 2,000,000 has been transferred to UNICEF for procurement.

EmONC drugs and supplies

A total of USD 1,700,000 was allocated for the procurement of drugs and supplies for EmONC services. Procurement is in process.

Procurement of ambulances

To reduce maternal mortality through strengthening referral system and availing ambulatory services, the FMOH has planned to procure 800 ambulances (i.e. one per woreda). The increased access it provides to rural mothers is necessary to reduce the second delay. Accordingly, a total of USD 11,000,000 was allocated for the procurement of ambulances, and the fund was transferred to United Nations Organization for Project Service (UNOPS). The procurement of 310 ambulances is underway and will be delivered within the next few months. The FMOH has signed Memorandum of Understanding with all regional government presidents to cover the operational and maintenance costs of the ambulances from regional budgets.

Procurement of Hospital Equipment

A total of USD 11,000,000 was allocated for the procurement of equipments for hospitals through PFSA. The package includes equipment for BEmONC, diagnostic imaging, newborn corners, and some equipment dedicated for specialized hospitals. Parts of the package are in different stages of procurement through PFSA. However, imaging equipment for 5 hospitals is currently being re-tendered.

Health System Strengthening

In terms of HSS, HC construction, and Community Based Health Insurance (CBHI) have been planned. Accordingly USD 7,000,000 million were allocated to fill the funding gap for HC construction. The allocated budget has been transferred to the regional Project Management Units (PMU). A total of USD 40,000 was allocated for the CBHI program to be used for establishing CBHI offices, and has been transferred to the regions. Currently all pilot woredas established the schemes and enrolled significant number of members including indigents. Furthermore, the trend shows that health service utilization in some of the pilot woredas has increased in EFY 2003.

Challenges

- Lack of timely utilization of funds mainly due to lengthy procurement processes and delayed liquidation; and
- Slow progress in terms of adhering to IHP principles.

Way forward

- Strengthen the grant management unit, and strictly implement the recommendations provided by the financial management assessment team;
- Pilot implementation of Integrated Financial Management Information System to improve financial management system; and
- Advocate for one budget and use of MDG-PP Fund as pooling arrangement of funds.

CHAPTER V

CONCLUSION



Conclusion

EFY 2003 is the first year of HSDP IV implementation and an overview of the planned activities, main achievements and key challenges encountered during the year has been presented in this performance report.

Concerning the performance in the implementation of MCH services, the findings were not uniform. While an increase in antenatal and postnatal care coverage was observed in EFY 2003, the percentage of deliveries attended by skilled health personnel was stable and the percentage of clean and safe deliveries (by HEWs) was even declining. Skilled attendance during delivery is considered as the single most important factor in reducing maternal mortality and further efforts have to be made to increase the number of deliveries assisted by skilled health personnel through measures articulated in HSDP IV, such as accelerated training of midwives and emergency surgery officers, equipping HCs to provide BEmONC, equipping all hospitals including primary hospitals to provide CEmONC, improving availability of safe blood and pharmaceutical supplies, and strengthening the referral system. Furthermore, innovative measures such as HEP and Health Development Army could make a difference to improve access to, and increase the demand of, maternity care.

Regarding child health, the U5MR and the IMR have declined rapidly from very high initial levels, with Ethiopia being on track to attain MDG4. Measles vaccine coverage provides a measure of the performance of the health care system and is considered as a proxy indicator for measuring progress towards the achievement of MDG4. The measles coverage rate in EFY 2003 (81.5%) is well above the average in sub-Saharan Africa of 73%, but the progress already achieved has to be secured and reversal averted.

In general, the performance was not uniform across programs. Interventions that can be routinely scheduled, such as antenatal care and immunization, had much higher coverage than those that rely on functional health systems and 24-hour availability of clinical services, such as skilled care at birth. Therefore increasing service coverage and strengthening health systems are interrelated, and cost-effective interventions that can avert much of the burden of maternal and child disease and death require functioning health system to have an impact at the population scale.

With respect to prevention and control of communicable diseases, encouraging results were achieved in HIV/AIDS control, with a combination of stable HIV prevalence, sustained prevention efforts and increased ART coverage, heralding the possibility of attaining of MDG6. However, PMTCT coverage was still low (9.3% in EFY 2003), highlighting the need for integration of maternal and PMTCT services.

Concerning malaria prevention and control, a three-pronged approach has been implemented, consisting of early diagnosis and effective treatment, selective vector control and epidemic prevention and control. With the distribution of over 4.2 million LLINs, the cumulative number reached 39,5 million in EFY 2003. A decrease in the number of malaria cases reported through PHEM surveillance system was observed from over 3 million in EFY 2002 to 2.6 million in EFY 2003.

Ethiopia ranks 8th among the 22 TB high-burden countries in the world and is the 3rd in Africa. In EFY 2003, the treatment success rate stood at 83% (target=85%), and the TB case detection rate slightly increased to 37%, far below the target set for the year (59%). Of note is the fact that TB detection rate was calculated from estimates of incidence rate of smear-positive TB derived from models produced by WHO. However, a TB prevalence survey was carried out in EFY 2003 to produce actual estimates in the country, with preliminary results showing an incidence rate of smear-positive TB which was lower than the WHO estimate. This will lead to an increase in TB case detection rate. For EFY 2003, WHO estimates were used waiting for final endorsement of the TB prevalence survey results.

Progress has been made in developing partnership and increasing resource mobilization and utilization.

Health has moved over the years from underinvestment, to single disease focus, and now to increased funding, harmonisation between FMOH and partners, and a systemic approach. The key principle underpinning the process of harmonization and alignment is the establishment of "One-Plan, One-Budget and One-Report" to provide coordinated and effective efforts and predictable funding in support of results-oriented national plans and strategies. While the "One Plan" component has been addressed by the HSDP IV as a single programme framework for coordinating health sector action, a critical step towards "One Budget" has been the establishment and the increasing funding of the MDG Performance Package Fund to facilitate resource pooling in order to finance the priorities under the HSDP. Concerning "One Report", the reform of the HMIS is underway, with a focus on the use of information for performance improvement at all levels of the health system.

We are at the beginning of the fourth phase of HSDP. During this period Ethiopia has made significant progress through decentralization and by putting relevant policies and institutions in place towards meeting the MDGs. However, there has been slow progress in some key health-related indicators, and, with four years left to the MDGs end-date, vigorous and concerted efforts are required on the part of the Government and its Development Partners to maintain the gains achieved so far and, at the same time, to scale up high impact interventions and implement innovative measures that will make a difference: this partnership is inherent in the MDG8 "Develop a global partnership for development".

This report tries to address the critical question of how to speed the pace of change observed in the past into dramatically faster progress during HSDP IV period, whose end in 2014/15 corresponds to the deadline of the quantitative, time-bound framework of accountability of MDGs. The past experience of achievements and challenges provides important hints to guide policies, strategies and programmes to be implemented in the next years with the support of all partners in order to achieve MDGs by 2015.

The participants at ARM 2011 are invited to examine this report in depth and come up with recommendations that will enhance implementation of initiatives designed to change the slow progress made with respect to the attainment of lagging HSDP IV targets and particularly those related to MDG5.

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