Annual Performance Report

of

HSDP-III

EFY 1999
(2006/2007)

October 2007

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ACRONYMS

AAU	Addis Ababa University
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ARM	Annual Review Meeting
ART	Antiretroviral therapy
AWD	Acute watery diarrhea
BCG	Bacille Calmette Guerin
BEOC	Basic Emergency Obstetric Care
BPR	Business Process Reengineering
CEO	Chief executive officer
CEOC	Comprehensive Emergency Obstetric Care
CPR	Contraceptive prevalence rate
CSA	Central Statistics Authority
CSRP	Civil Service Reform Program
DACA	Drug Administration and Control Authority
DHS	(Ethiopia) Demographic health survey
DOTS	Directly observed treatment – short course
DPT	Diphtheria pertussis tetanus vaccine
EFY	Ethiopian fiscal year
EHNRI	Ethiopian Health and Nutrition Research Institute
EOS	Expanded Outreach Service
EQA	External Quality Assurance
EPI	Expanded Program on Immunization
ETB	Ethiopian ETB
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
FP	Family planning
HC	Health Center
HCF	Health care financing
HEP	Health Extension Program
HEW	Health extension worker
HHM	HSDP Harmonization Manual
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Health officer
HP	Health post
HPN	Health, Population and Nutrition Donor Group
HRD	Human resource development
HRH	Human resource for health
HS	Health station
HSDP	Health Sector Development Program
IDSR	Integrated Disease Surveillance and Response
IEC	Information, education communication
IMCI	Integrated management of childhood illnesses
ITN	Insecticide treated net
IUD	Intrauterine device
LMP	Logistic master plan

MDG	Millennium Development Goals
NGO	Non-governmental organization
NHA	National Health Account
OPD	Outpatient department
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PBS	Protection of Basic Services
PHC	Primary health care
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of maternal to child transmission of HIV
PNC	Postnatal care
POA	Plan of action
PPH	Postpartum hemorrhage
RDT	Rapid diagnostic test
RHB	Regional Health Bureau
ROPA	Result Oriented Performance Appraisal
SD	Delivery attended by skilled health personnel
SSA	Sub Saharan Africa
TB	Tuberculosis
TBA	Traditional birth attendant
TOR	Terms of reference
TOT	Training of trainers
TVET	Technical and Vocational Education and Training Center
USD	United States Dollar
VCT	Voluntary counseling and testing

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EXECUTIVE SUMMARY

The Major achievements and challenges of the annual performance of the Health Sector Development Program III (HSDP-III) in 1999 EFY are summarized as follows.

1. The planning of EFY 1999 has been built upon the priorities of HSDP-III and the lessons learnt from the implementation of EFY1998 activities. It was developed and endorsed through a consultative process that involved Federal Ministry of Health (FMOH) staff and heads of Regional Health Bureau (RHB). As an extension of this effort, the preparation and proper use of a standardized weekly plan by all staff has been introduced at the FMOH. The plan is to gradually expand this to the RHBs.

2. Building the leadership capacity of the management team of the FMOH and RHBs was one of the priority activities planned for EFY 1999. This was accomplished through a series of trainings that exclusively focused on team building, conflict management, leadership competency, change leadership and self awareness. The Civil Service Reform Program (CSRP) has been a regular agenda of the management meeting at FMOH.

3. The Human Resource Development (HRD) Core Process and the Human Resource Administration sub process have been selected for redesign through Business Process Reengineering (BPR). HRD Core Process has been subjected to a redesign by a team of technical experts drawn from different partners and the FMOH. The redesign is expected to adequately address both the development (training) and retention of the health work force of the country. The best practices explored from other countries will be adapted to the Ethiopian context. The team has currently finalized the assessment and is working on design options. One of these strategies involves the accelerated production of key health professionals in greater numbers *i.e.* "flooding". Regulation has been passed to enforce that health workers graduating with first degree and above to serve a minimum of 2 years in the newly Emerging Regions and 4 years in the rest of the country before becoming eligible to leave the public sector.

4. As part of improving access and quality of health care, referral hospital sub-process (standard) has been designed. Blueprints have been developed and are being implemented in selected hospitals. The standards for health posts, health centers and primary hospitals are in process of finalization. Concurrently, alignment of all core processes with that of Access and Quality core process is underway.

5. Health Management Information System (HMIS) reform started with the assessment of the existing situation. The findings were shared with all stakeholders in the health sector. Indicators were selected that adequately address the monitoring requirement of various key health programs. This was followed by the designing of data recording and reporting tools that helped to generate the required indicators. In order to facilitate the proper utilization of the HMIS tools, training materials and guidelines have been developed. All these processes have been accomplished through a wide-ranging consultative process including all stakeholders from the Government, health development partners, NGOs and private sector. Subsequently, it was planned to pilot test the tools before scaling up at the national level. For the pilot testing, 11 Woredas in 7 Regional States were selected based on criteria formulated for this purpose. In June 2007, pilot testing was started in 6 Hospitals, 14 Health Centers, and 22 Health Posts.

6. In terms of harmonization and alignment, The HSDP Harmonization Manual (HHM) has been finalized through an extensive consultative process which has been endorsed by FMOH and HPN (Health, Population and Nutrition) Donor Group. The motto of HHM is "one-plan, one-budget, and one-report". The EFY 2000 health sector plan of action has been developed in line with the "one-plan" concept of the HHM. Initially, priorities and targets for the year have been agreed between FMOH and RHBs. Following this, planning tools were developed for FMOH, RHB and Woreda Health Office around the selected priorities and targets. Subsequently, planning workshops were organized at Regional levels to involve all Woredas and Zones to prepare EFY 2000 plan of action based on the nationally agreed priorities and targets while taking into account the local contexts and priorities.

7. Adherence evaluation on the Code of Conduct has been carried out as per the plan and the report is scheduled to be presented on Annual Review Meeting 2007 (ARM).

8. To improve the commodity supply and management system, the national Logistic Master Plan (LMP) was developed based on an overall assessment of the existing situation. As part of the implementation of the first year plan of action, a proclamation on drug supply and logistics management was developed and has been

discussed at the level of the Council of Ministers. The proclamation has been submitted to the Council of the People's Representative for endorsement. Challenges encountered with regard to the implementation of the Health Commodity Supply and Management System include inadequate capacity at the FMOH level to coordinate the activities of different partners and some difficulties in terms of aligning the interest of different partners with the master plan.

9. Reduction of Epidemic Occurrence has been one the seven BPR core processes. Relevant manuals, formats and standard operating procedures have been developed in order to facilitate its implementation. In addition, curriculum is also under development to start training of field epidemiologists at MSc level.

10. Among the explored options for the mobilization of additional resources, establishment of health insurance scheme has been among the major explored options and is considered as one of the effective sources of revenue for the financing of health care. As part of the process for deeper understanding of the scheme, the core process team has been able to make a study and experience sharing visits to various African and Latin American countries. The plan is to implement the social health insurance soon and pilot testing the community health insurance before it could be scaled up to the national level.

11. Implementation plan of the Ethiopian Health and Nutrition Research Institute (EHNRI) in the EFY 1999 involved major activities related to the strengthening of the National Quality Laboratory System and rendering support to ongoing programs. Regional and specialized hospital labs were supported financially to start implementing the National Laboratory Quality System operational plan, including training and referral linkage. The Institute has also finalized the alternative National Algorithm for rapid HIV testing based on new test kits. The report was endorsed by FMOH to be used nationally. A customized training module for National training for the scale-up of HIV Rapid Testing was prepared and is ready for training of laboratory personnel and lay counselors, keeping in mind the newly developed algorithm.

12. ART monitoring laboratories throughout the country were extensively supported by EHNRI for installation of equipment and by rendering preventive and curative maintenance to avoid interruptions of services. This was achieved through the combined efforts of maintenance personnel at EHNRI, 20 EHNRI trained regional personnel and contracted vendors. In addition, a national equipment maintenance database was developed.

13. The planned achievement in the implementation of the Health Extension Program (HEP) for EFY 1999 is encouragingly noteworthy. The target was surpassed by 3.4% showing a successful deployment of 7,753 Health Extension Workers (HEW). This additional figure brings the total sum of HEWs deployment so far to 17,653 HEWs accounting for about nearly 59% of the total national requirement of 30,000 HEWs.

14. Of the planned enrollment for traning of 7,500 HEWs in EFY 1999, nearly 7,095, or 95% have already started their class. It is to be noted that Tigray, Amhara, Harari, and Dire Dawa Regional States have already achieved 100% coverage with HEWs training. However, the newly emerging regions who have started the training late (Afar, Somali, and Gambella) will have to increase the training program which is now standing at coverage rate of only 24%-32% compared to what is expected from them. Special efforts and attention are needed in Oromia and emerging regions which are below the national average in the implementation of HEP.

15. During the reporting period, 2,659 health posts were constructed. The construction of an additional 1,064 health posts is under completion. This gives a total of 3,723 health posts or 87% achievement in EFY 1999. With such rate of construction at the national level, the availability of health posts will significantly increase to 9,914 accounting for 66% of the totally needed 15,000 health posts to reach universal health coverage in the rural areas of the country.

16. In order to build the capacity of HEW training centers in pastoral and semi-pastoral regions teaching materials and other supplies including a curriculum have been delivered. This will enable to train the planned number of HEW in these special areas. Furthermore, preparation of reference materials consisting of 16 packages and 4 main courses is 90% completed. In addition, HEP implementation manual customized to the life style and culture of the pastoral community has also been prepared. The 16 packages of HEP have been translated into Somali language and 3,000 copies were published and distributed.

17. The plan for EFY 1999 under environmental sanitation was to increase latrine use from 32% to 44% in areas where HEP is fully functional. Reports from three regions indicate that sanitation coverage increased from 20.5% to 28.1% (Oromia), from 6% to 8% (Gambella) and from 60% to 64.6% (Harari). However, due to under reporting from most the RHBs it has become a challenge to make a national estimation of sanitation coverage for this reporting year.

18. For the reporting year, the construction of 19 new health centers (HCs) was completed while an additional 25 HCs are under construction. Five HCs have undergone rehabilitation and 7 HCs were expanded. Moreover, the construction of 36 new, 192 ongoing and 228 up-grading of nucleus health centers were accomplished. The achievement figures indicate that the construction of 55 health institutions (health centers (HC) + Nucleus HC) has been completed in EFY 1999. The FMOH has successfully outsourced the upgrading work of 500 health stations (HSs) to Nucleus HCs for which the construction work has already commenced.

19. As part of Access and Quality of Care Core Process, a project that was designed based on the main strategic issues for improving hospital service has been implemented in 14 hospitals on a pilot basis. Subsequently, blueprints have been developed to rollout implementation to 40 hospitals in EFY 2000.

20. In addition to the existing training facilities in the Universities under the Federal Ministry of Education, the FMOH is making the necessary preparation to start training 50 general practitioners in St. Paulos Millennium Medical College beginning EFY 2000.

21. In EFY 1999, it was planned to train 2,000 health officers in 20 hospitals and currently 1,906 nurses are enrolled in the Accelerated Health Officers training in five universities. Currently, there are 3,278 students in the regular and Accelerated HOs trainings. When they complete their studies, the existing shortage of health professionals will be significantly alleviated.

22. There are 16 blood banks under construction in 6 regions. In EFY 1999, 25% of these constructions have been completed.

23. With the aim of enhancing the operational capability and durability of medical equipments, 65 trainees have started training at the Tegbare-Ed Technical and Vocational Training College in EFY 1999.

24. During the reporting period, 10.2 million children aged 6–59 months were given 46 million Vitamin A supplement capsules through the second round Expanded Outreach Service (EOS) campaign. This has increased the coverage of Vitamin A supplementation to 91% which is much higher than the 40% target set for EFY 1999.

25. The estimated national single point HIV prevalence estimate for EFY 1999 was 2.1%. Disaggregated prevalence rates were 1.7% for males and 2.6% for females; urban and rural prevalence rates were 7.7 % and 0.9%, respectively. The trend in the last four years suggests that with prevalence rates of 2.2% in EFY 1996 and 2.1% in EFY 1999, HIV/AIDS appear to have stabilized. A community mobilization manual has been developed through involvement of all concerned stakeholders. It has been designed to help the

transformation of the community conversations into action through the integration of HIV/AIDS prevention and control activities with the regular development plan of the Kebeles.

26. In EFY 1997 the number of health institutions that were providing VCT were 525, 801 in EFY 1998. In EFY 1999 VCT providing sites increased to 1,005. Currently 64% of the total health facilities (hospitals and health centers) provide VCT services. The number of people using the VCT service has also increased from 448,241 in EFY 1997 to 564,321 in EFY 1998 (26% increase), and to 1,898,191 (236% increase compared to EFY 1998). Social mobilization through the Millennium AIDS Campaign has contributed significantly resulting in doubling the number of VCT users in EFY 1999. The planned VCT coverage of the campaign was to enable 320,000 individuals to use VCT service.

27. In EFY 1999, there were 468,532 ANC clients that visited a PMTCT site. Among these, 204,266 or 43.6% received pretest counseling and 123,380 or 26.3% have been tested for HIV/AIDS. Out of those tested, there were 6,655 HIV positive deliveries out of which 3,967 mothers and 2,736 exposed babies received NVP.

28. The proportion of health facilities (hospitals, health centers, and private clinics) providing an ART service has increased significantly compared to the previous years. In EFY 1997, there were only three hospitals which were providing ART service. However, this figure was increased significantly to 222 in EFY 1998 and 271 health facilities in EFY1999 (153 HC and 118 hospitals). The number of PLWHA ever started on ART has increased sharply from 900 in EFY 1997 to 24,236 in EFY 1998 EFY and 97,299 in EFY 1999.

29. Environmental control and protection activities of malaria were implemented by the HEWs through community mobilization. Besides, 9.5 million ITNs (47.5%) were distributed in EFY 1998 and earlier. In EFY 1999, the plan was to distribute 10 million ITN of which and 8.7 million (87%) has been distributed to regions. The procurement for 2.3 million ITN is on process. Of the total requirement of 20 million ITNs, 18.2 million has been distributed so far. This brings a remarkable national target achievement of 90%. In general, due to the rigorous prevention and control measures taken, no epidemic of malaria occurred during the reporting fiscal year. Transmission of malaria has also been stable throughout the fiscal year as compared to the previous years.

30. Currently the national TB treatment success rate is 85%, which is equivalent to the international standard, improvements in percentages from 81% in EFY 1995 up to 85% in EFY 1999. The national TB case detection rate is 32% and the cure rate is 69%. The improvements in percentages of cure rate from EFY 1995 up to EFY 1999 were from 66% to 69%.

31. Emergency Operation Center was established in the FMOH in order to specifically deal with the international threat of Avian Human Influenza and other emergency situations.

32. Epidemic of Acute Watery Diarrhea (AWD) is one of the major health emergencies that occurred during this fiscal year. The outbreak was initially reported from Gambella in April 1998 and has been successfully controlled in two months time through a coordinated effort of both government sectors and partners. During the epidemic, 2,300 cases and 18 deaths were reported. A second bout of AWD occurred two months later, and was spread in 201 Woredas and 10 Sub-cities in 8 Regions affecting a total of 79,831 cases that led to 941 deaths between the periods from July 1998 to June 1999. Currently the outbreak is showing significant decline and vigorous efforts are being exerted to put it under complete control.

33. The coverage for DPT3, Measles, and fully immunized children showed consistent increase from 51%, 42%, and 30% in EFY 1994 to 73%, 65%, and 53% in EFY1999. The EFY 1999 coverage for all three antigens showed slight decline compared to what has been achieved in EFY 1998.

34. Improvements in the maternal indicators included ANC coverage increasing from 50% in EFY 1998 to 52% in EFY 1999, postnatal care coverage from 16% to 19% and proportion of deliveries attended by skilled health personnel from 15% to 16%.

35. There have been consistent increasing trend in the contraceptive acceptance rate for the years 1994 to 1998 from 14 to 36% with slight decrease in EFY 1999 to 33%. This is an indication of a sustained trend of achievement. However, the decline in EFY 1999 needs to be addressed appropriately in the coming planning year.

36. In 1998 EFY, OPD attendance per capita was 0.33 and in EFY 1999 stayed stable at 0.32. Underreporting appears to be the major reason for poor health service utilization rate figures as witnessed during the pilot implementation of HMIS. Hence it is expected to improve as HMIS reform expands across the country.

37. Since 1994 per capita public expenditure has been growing annually by 8%. In absolute terms it increased from 11.3 ETB in 1994 EFY to 19.6 ETB in 1999. The percentage of total regional budget allocated to the health sector ranged between 4.4% in SNNP to 28% in Gambella Regions, with a national average of 11.5%.

38. The governance structure between FMOH and HPN Donors are CJSC, FMOH-HPN Donors Group Joint Consultative Forum and the Joint Core Coordinating Committee (JCCC). During the reporting year, only two meetings of CJSC have been conducted. The FMOH-HPN Donors Group Joint Consultative meeting, however, has been conducted more or less on bimonthly basis. The ad-hoc meeting of the JCCC has been conducted almost on a weekly basis throughout most of the year.

39. Although some Regions have established partner fora, a lot of work remains to be done in terms of guiding these fora to the principle of *one-plan, one-budget and one-report* as per the HSDP Harmonization Manual. Regions are also expected to establish functional joint steering committees both at Regional and Woreda levels.

40. Some of the challenges faced during implementation of the fiscal year plan were

    40.1. Unnecessary delay in the selection of HMIS indicators mainly due to resistance from various vertical project managers to limit the information requirements and to use the new HMIS tools and system during the pilot phase,
    40.2. Inadequate institutionalization of HEP in the organizational structure of RHBs, Zonal Health Departments and Woreda Health Offices which is more prominent in the Newly Emerging Regions, inadequate supportive supervision at all levels of the health system, delay in the construction of HPs especially in Oromia region and delay in equipping and supplying these health posts.
    40.3. Rising cost of construction materials that contributed to the delaying of handover of the outsourced health centers to the contractors for timely commencement of the construction work, long delays in the procurement process of medical equipment, and long delays in the hiring of procurement agents.
    40.4. Poor financial liquidation and reporting by Regions.
    40.5. Occurrence of the AWD epidemic for prolonged period of time due to shortage of professionals to control the problem, incomplete and delayed reporting from regions, scarce resource at Woreda level, difficulty to coordinate partners working on the intervention, lack of information regarding the resource availability by partners.
    40.6. Failure to achieve the EPI targets are attributed to high turnover of staff, delay of reports, delay in liquidation of funds and diversion of attention to control of AWD.

40.7. Difficulty to coordinate the activities and aligning the interest of different partners with regard to the implementation of the Health Commodity Supply and Management System.
40.8. Inadequacy of essential equipment, supplies for EOC, additional workload on the already over-stretched medical staff and weak referral linkage among health facilities.
40.9. Underreporting appears to be the major reason for declining health service utilization rate
40.10. Multiple programmatic coordination fora creating administrative burden and lack of focus on the public sector.
40.11. A delay in undertaking the resource mapping of HSDP mainly due to lack of competent and willing firms to take up this important assignment.

The details of how the performance is compared to the target and the way forward in addressing the challenges are indicated in the report.

2

System Development and Capacity Building

The major goal in this regard is to build capacity in order to provide cost-effective, result oriented, equitable and customer focused services through effective institutional transformation. The Civil Service Reform Program (CSRP), Business Process Reengineering (BPR) and Result Oriented Performance Appraisal (ROPA) system are the major areas of focus under this goal.

2.1 Civil Service Reform Program activities

The Civil Service Reform Program has 5 sub-components.

2.1.1. Top Management Leadership Performance Improvement

One of the top management functions is planning. Accordingly, the planning of EFY 1999 has been built upon the priorities of HSDP-III and the lessons learnt from the implementation of EFY1998 activities. The plan for EFY 1999 was developed and endorsed through a consultative process that involved FMOH staff and heads of RHBs.

As an extension of this effort, the preparation and proper use of a standardized weekly plan by all staff has been introduced at the FMOH. The introduction of this innovative approach was to serve as a systematic follow-up and monitoring to ensure that health activities are focused on the priorities of the sector. The plan is to gradually expand this practice into RHBs.

Building the leadership capacity of the management team of the FMOH and RHBs was one of the priority activities planned for EFY 1999. This was accomplished through a series of trainings that exclusively focused on team building, conflict management, leadership competency,

change leadership and self awareness. As part of these trainings, the Ministry has revised its core values and beliefs with clear definitions to facilitate communication with the staff. In order to institutionalize and systematically monitor leadership skills a Leadership Competency Checklist is being developed.

The Civil Service Reform Program has been a regular agenda of the management meeting at FMOH. A team has also been setup to assess the implementation of the five civil service reform programs and currently a draft report has been submitted to the management for enrichment. A performance audit was conducted during the fiscal year and the results were discussed with the FMOH management and their recommendations implemented.

Eight top managers and change agents have been selected and assigned at the FMOH and hospitals under FMOH. This activity will be enhanced in order to effectively implement the new designs of the Business Process Reengineering (BPR).

2.1.2. Human Resource Development Reform

The Human Resource Development (HRD) Core Process and the Human Resource Administration sub process have been selected for redesign through BPR. HRD Core Process has been subjected to a redesign by a team of technical experts drawn from different partners and the FMOH. The redesign is expected to adequately address both the development (training) and retention of the health work force of the country. Best practices explored from other countries will be adapted to the Ethiopian context. The team has currently finalized the assessment and is working on design options.

While the design of HRD Core Process is underway, some crucial strategies of the HRD are also under implementation. One of these strategies involves the accelerated production of key health professionals in greater numbers *i.e.* "flooding". The "flooding" strategy in HRD has been implemented in the training of health extension workers and health officers with significant results. The other strategy is the legal enforcement of mandatory service years on health professionals after gradation and before eligibility to leave the public sector. Regulation has been passed to enforce that health workers graduating with first degree and above to serve a minimum of 2 years in the newly Emerging Regions and 4 years in the rest of the country before becoming eligible to leave the public sector. Since the passing of this regulation, 1783 degree graduate health workers have been assigned to nine Regional States and two city Administrative Councils.

Special consideration was given to the HRH requirement of the newly Emerging Regions before assignment of these newly graduating health professionals. Accordingly, 156 health professionals were assigned to

Benishangul-Gumuz, 53 to Somali, 46 to Gambella and 28 to Afar Regional States. In addition, Afar and Gambella Regional States were assigned one advisor each while the assignment of two advisors has taken place to Somali Region.

Whilst a comprehensive incentive package is under serious consideration in the HRD Core Process, improvements have been made on duty allowance payments for health workers. This is meant to relieve the serious shortage and de-motivation of human resource in health institutions. New salary scale is also under consideration for senior level health professionals. In an attempt to fill the prevailing short-term shortage in certain categories of health professionals, the FMOH is finalizing the necessary process to engage 32 health professionals from abroad.

2.1.3. Service provision performance improvement

A system of tracking clients' suggestions and complaints about services has been put in place to enable responsible departments of the FMOH to take appropriate and immediate action.

Different awareness raising activities are undertaken on malaria, Acute Watery Diarrhea, HIV/AIDS, including briefings on EFY1998 and 1999 plan and achievement reports.

It is to be recalled that Ethiopia has successfully hosted the 56th Session of WHO Regional Committee Meeting for Africa for the first time.

Improvement has been seen in the use of mass media in terms of creating public awareness on health issues such as The World AIDS day, the objectives and outcome of the World AIDS conference of Toronto, the Ethiopian Millennium AIDS campaign, on the newly developed guideline for Traditional Medical Practice, Health Extension program and community mobilization, Family Planning strategies, etc.

2.1.4. Financial management performance improvement

To improve the efficiency of the financial system, the management has taken an initiative to review the monthly expenditure report. To increase the efficiency of the financial system of the FMOH, salary payment and fuel management are now outsourced. This measure was taken to help the Ministry focus on important issues and continue making efficiency improvements. Guideline has also been developed to facilitate the process of selling unwanted equipment through which the ministry has been able to generate revenue amounting ETB 2,459,662.

2.1.5 Ethical performance improvement

Ethical performance improvement is one of the five sub-components of the CSRP. During the fiscal year, a total of 53 new employees attended orientation on the Ministry's activities and overall codes of conduct before initiating formal duties. In addition, a two-day training was given to 299 FMOH staff on the prevention of corruption. Moreover, the translation and explanation of the 12 codes of conduct will be finalized soon and ready for implementation in EFY 2000.

Problems associated with resource mobilization and utilization which predispose to exploitation and corruptions have been identified and corrective measures have been developed as part the overall plan of action.

2.2 Business Process Reengineering (BPR)

Seven Core Processes have been selected for BPR. These are:

- Human Resource Development (HRD),
- Improving Access and Quality of Health Service,
- Health Management Information System,
- Harmonization and Alignment,
- Health Commodity Supply and Management System,
- Reduction of Epidemic Occurrence,
- Finance Resource Mobilization and Utilization.

As the HRD Core Process has been discussed above, the status of the six core processes are presented below.

2.2.1. Improving Access and Quality of Health Service

The objective of this core process is to design a system that improves access and quality of health service to the population at different levels of health service delivery. It is a core process that lays down the basic framework for all other 6 core processes. The scope of the design ranges from household and community level to tertiary hospitals. The design of the system took into account experience of several countries and benchmarked those perceived to be practical in the Ethiopian context.

Referral hospital sub-process (standard) has been designed. Blueprints have been developed and are being implemented in selected hospitals. The standards for health posts, health centers and primary hospitals are in process of finalization. Concurrently, alignment of all core processes with that of Access and Quality core process is underway.

2.2.2. Health Management Information System

The objective of this core process is to design a system that will improve informed health decision making at different levels of the health system through the utilization of complete, timely and accurate heath information.

The plan during EFY 1999 was to implement HMIS in health facilities within 150 selected Woredas. This core process has been outsourced to a consulting firm through international competitive bidding. Technical assistance has also been mobilized from HSDP partners to expedite the design and implementation process. The process has been monitored by FMOH and HPN Donors Group through the establishment of a Joint Technical Working Group and National Advisory Committee that meet on regular basis to share information and discuss issues of common interest.

HMIS reform started with the assessment of the existing situation. The findings were shared with all stakeholders in the health sector. Subsequently, indicators were selected that adequately address the monitoring requirement of various key health programs. This was followed by the designing of data recording and reporting tools that helps to generate the required indicators. In order to facilitate the proper utilization of the HMIS tools, training materials and guidelines have been developed. All these processes have been accomplished through a wide-ranging consultative process including all stakeholders from the Government, health development partners, NGOs and private sector.

Subsequently, it was planned to pilot test the tools before scaling up at the national level, for the pilot testing, 11 Woredas in 7 Regional States were selected based on criteria formulated for this purpose. In EFY 1999, pilot testing was started in 6 Hospitals, 14 Health Centers, and 22 Health Posts.

As a precondition for pilot testing, commitment of the leadership both at the FMOH and RHBs was ensured at the FMOH-RHB Joint Steering Committee meeting. TOT and actual trainings were provided to Zonal Health Department, Woreda Health Department and health facility staff on the newly designed tools. FMOH has been able to mobilize a team of supervisors both from the Federal and Regional levels in order to provide hands on support to health workers during the implementation of HMIS in the pilot sites. In order to update key stakeholders on the status of implementation, daily electronic update has been sent to FMOH, RHBs and National Advisory Committee members from the field supervisors on the status of implementation at the facilitates. A mid term review of the pilot test was also done after 6 weeks of implementation. The review surfaced various challenges in terms of human resource, leadership commitment and utilization of the tools.

Preparations are underway to begin diploma level training on HMIS. This is expected to support the new system with a sustainable human resource base.

Out of the total 13.5 million USD required to implement HMIS, it was possible to generate 6.6 million dollar from various sources during the fiscal year. Implementation of the pilot HMIS reform is showing early sings of improvement in terms of enabling the facilities to record and understand the scope of services they provide. Moreover, integration of patient/client information at facility level has shown a positive impact on the quality of service by enabling easy access to patient/client information by health workers.

The FMOH website has been established and is now fully functional. Local Area Network (LAN) and internal message communication has been established at the main office. Internet connectivity has been hampered due to poor capacity of the broadband internet provided by the Ethiopian Telecommunication Agency.

Some of the challenges faced during the design and implementation of HMIS are:

- Unnecessary delay in the selection of indicators mainly due to resistance and the unwillingness to limit the information requirements to key indicators by various vertical project managers.
- Resistance from HIV/AIDS project managers and partners to use the new HMIS tools and system during the pilot phase,
- Resistance from some health workers in the health facilities to apply the new tools.
- Inadequate follow up of the pilot sites from some RHBs and Woreda Health Offices.

In order to alleviate these problems, the Ministry has used various mechanisms such as consultation and negotiations at NAC, FMOH-RHB Joint Steering Committee Meetings, *etc*. to clarify issues and create understanding and consensus. Preparation of legislation is also under way in order to enforce the implementation of the new system.

2.2.3. Harmonization and Alignment

The objective of harmonization and alignment is to focus on key priorities and reduce fragmentation of planning, implementation, financing and monitoring and evaluation of activities implemented by various stakeholders in the health sector.

The plan in EFY 1999 was to enhance harmonization and alignment and also ensure greater coordination of activities through the development of HSDP Harmonization Manual (HHM). The plan also

included conducting adherence evaluation on the code of conduct that was signed between the FMOH and its health development partners.

Accordingly, HHM has been finalized through extensive consultative process and endorsed by FMOH and HPN Donor Group. The motto of HHM is "one-plan, one-budget, and one-report". The EFY 2000 health sector plan of action has been developed in line with the "one-plan" concept of the HHM. Initially, priorities and targets of the year have been agreed between FMOH and RHBs. Following this, planning tools were developed for FMOH, RHB and Woreda Health Office planning around the selected priorities and targets. Subsequently, planning workshops were organized at Regional levels to involve all Woredas and Zones to prepare EFY 2000 plan of action based on the nationally agreed priorities and targets while taking into account the local contexts and priorities.

Adherence evaluation of the Code of Conduct has been carried out as per the plan and the report is scheduled to be presented on ARM 2007.

2.2.4. Health Commodity Supply and Management System

The Logistic Master Plan (LMP) was endorsed at the Annual Review Meeting that was held in October 1998 (ARM 1998). The design was based on the national revolving drug fund system which took account of best practices and experiences from other countries. As part of the implementation of the first year plan of action, a proclamation on drug supply and logistics management was developed and has been discussed at the level of the Council of Ministers. Currently, the proclamation has been submitted to the Council of the People's Representative for endorsement.

A support team for the implementation has been established at FMOH which is now working on the logistic sub process. As part of this process, relevant information is collected from RHBs, Woreda Health offices, and Health Facilities. Efforts are underway to integrate the LMP with the Pharmaceutical Master Plan which has been developed by the Ethiopian Drug Administration and Control Authority (DACA).

It is estimated that the full implementation of LMP would require the mobilization of around 200 million USD. Currently, the FMOH has been able to mobilize 15.14 million USD from different health partners.

Challenges encountered with regard to the implementation of the Health Commodity Supply and Management System include inadequate capacity at the FMOH level to coordinate the activities of different partners and some difficulties in terms of aligning the interest of different partners with the master plan.

2.2.5. Reduction of Epidemic Occurrence

As one the seven core processes, the situational analysis of Reduction of Epidemic Occurrence has been finalized, major areas of change identified and the new design developed by a team of experts. Implementation manuals, formats and standard operating procedures are being developed in order to facilitate implementation. Curriculum is also under development to commence production of field epidemiologists at MSc level.

2.2.6. Finance Resource Mobilization and Utilization

The other core process that has been subjected for the process of reengineering at the FMOH level is the mobilization and utilization of financial resources. The core process team has been able to critically examine the various sources of finance for the health sector. Among the major explored options, establishing of a health insurance scheme was considered as one of the effective sources of revenue for the financing of health care. As part of the process of deeper understanding of the scheme, the core process team has been able to make a study and experience sharing visits to various African and Latin American countries (Ghana, Mexico, Senegal and Rwanda) to see how health insurance schemes are functioning in practical terms. In addition, experience of countries such as Taiwan has been obtained. Subsequently, a background paper with justification of health insurance in Ethiopia, experiences in other countries and different options for Ethiopia has been developed and discussed with relevant stakeholders such as RHBs and the Social Security Agency. The paper identifies social health insurance and community health insurance as the major, perhaps the most feasible and implementable variety of the available health insurance schemes in the Ethiopian setting. The plan is to implement social health insurance soon and pilot testing the community health insurance before it could be scaled up to the national level. Currently the team is working on a strategic document and legal framework for health insurance.

2.3. Result Oriented Performance Appraisal (ROPA) System

The system for result oriented employees' performance evaluation has been in place since EFY 1998. To support the overall process of this system, a task force consisting of 33 members has been established. The team has so far made an overall assessment of the system and the finding indicates that there exists a problem on the recording of the evaluation. Based on this finding, training was offered to FMOH staff. ROPA has been used as a tool to solve problems of fund absorption by putting it as one of the evaluation criteria. A guideline is also in the process of finalization to facilitate appropriate recognition of outstanding performers.

2.4. Resources mobilized for the Implementation of HSDP

To strengthen the resource base for HSDP III, a plan has been put in place for the mobilization of resources from partner organizations and donors. Accordingly, a total of 387 million ETB has been secured for TB program, an additional 65 million ETB to support the Malaria prevention and control program. Moreover, an additional 654 million ETB has been pledged to be used for the construction of health facilities, for the procurement of medical equipment for health centers and health posts, for strengthening the capacity of health extension workers as well as for supporting the building of the new HMIS and Health Commodity Supply System.

Out of ETB 306 million that has been disbursed through Component two of PBS, ETB 272 million was used for the procurement of medical equipment and supplies. An agreement for ETB 240.7 million was signed to provide support to the health sector for 18 months.

The challenge with resource mobilization has been the long time delay in undertaking the resource mapping of HSDP mainly due to lack of competent and willing firms to take up this important assignment. The initial plan to undertake the resource mapping study was to appropriately identify and document the resource availability for HSDP-III from different stakeholders and then do a gap analysis in order to facilitate the mobilization of more resources. The other challenge was the unforeseen hesitation of the health development partners to come forward in support of the construction of the much needed health facilities and procurement of medical equipment.

2.5. National Laboratory System Strengthening and Programmatic Support

Ethiopian Health and Nutrition Research Institute (EHNRI) has been implementing the Five-year (2006-2010) master plan for the National Laboratory System in collaboration with RHBs and partners as per the mandate given by FMOH to strengthen and coordinate the National Laboratory System.

Cognizant of the fact that the success of HIV/AIDS prevention, treatment and care programs depends on the provision of quality laboratory service at all health facilities, the Institute has mobilized its resources and made a greater effort to implement all activities planned for the fiscal year. As part of the Five-Year Master Plan implementation for National Laboratory System, major undertakings of the Institute in the last twelve months were activities related to the strengthening of the National Quality Laboratory System and rendering support to ongoing programs. This has been demonstrated by trying to address the problems of insufficient qualified lab staff, lack of comprehensive

national Quality Assessment and Assurance Programs, absence of effective laboratory equipment maintenance and management system and lack of supply chain management system.

EHNRI has established the Regional Help Desk fully devoted for regional laboratory support. A detailed communication manual for this purpose was prepared, five laboratory liaison officers were employed and are currently working in Oromia, Amhara, SNNP, Tigray, and Addis Ababa. The desk facilitates regional laboratory support activities including distribution of VCT kits, general supplies and ART lab supplies in collaboration with PHARMID; coordinates standardized referral linkages services; quantification of VCT/ART lab supplies and the processes of purchase orders.

The National Laboratory Quality System Operational Plan was developed at the Institute which was approved through national and regional consensus. Regional and specialized hospital labs were supported financially to start implementing the National Laboratory Quality System operational plan, including training and referral linkage. With this financial support, Federal and Regional laboratories in Oromia, Amhara, SNNP, Tigray and Addis Ababa have begun implementation of referral linkages, as well as training rollout programs. Trainings given at a central level focused on TOTs mainly on HIV testing and ART monitoring. In addition, a five-day training workshop on "National Logistics system Design for Lab supplies" has been conducted to build up supply chain management capacity at central and regional levels.

EHNRI has enrolled twenty regional laboratories and ART monitoring laboratories in international and national External Quality Assurance (EQA) schemes. The laboratories participated in EQA for CD4, Chemistry and Hematology, as well as participation in national EQA for HIV rapid testing. The results are analyzed by EHNRI and feed back is prepared to be given to the laboratories. EHNRI itself successfully participated in international EQA schemes for HIV serology, CD4 testing, DNA PCR testing for infant diagnosis, for TB schemes and for malaria.

The Institute has finalized the alternative National Algorithm for rapid HIV testing based on new test kits. The report was endorsed by FMOH to be used nationally. A customized training module for National training for the scale-up of HIV Rapid Testing was prepared and is ready for training of laboratory personnel and lay counselors keeping in mind the newly developed algorithm.

In the reporting period, HIV rapid test kits and ART reagents have been distributed to all regions, specialized general referral hospitals and to other relevant health facilities. Moreover, general lab supplies have also been transported to each region. These supplies included refrigerators, centrifuges, balances, biohazard bags, syringes and tubes of different types that were found in the store of FMOH and which were highly required for VCT/ART activities.

ART monitoring laboratories throughout the country were extensively supported by installation of equipment and by rendering preventive and curative maintenance to avoid interruptions of services. This was achieved through the combined efforts of maintenance personnel at EHNRI, 20 EHNRI trained regional personnel, and contracted vendors. In addition, the national equipment maintenance database was developed.

Plans have been developed and implementation activities have been initiated to introduce accreditation for Ethiopian Clinical Laboratories with the primary focus on accreditation of laboratories in EHNRI, to be followed by other clinical laboratories

The National Laboratory Technical Working Group (NLTWG) was reorganized so that membership includes regional representatives and other relevant stakeholders. The main objective of the NLTWG is to serve as an advisory body to the Institute on matters pertinent to strengthening the provision of quality laboratory services nationwide. The NLTWG is regularly meeting to discuss on pertinent issues related to the National laboratory system.

The major challenges so far has been the weak communication between regional labs and EHNRI. This is crucial among others for planning and implementation and coordination purposes. RHBs also need to give emphasis to laboratory strengthening and empowerment in their respective regions.

The way forward is to work for full implementation of the five year laboratory master plan which addresses the major gaps identified in the National laboratory system. In line with this renovating, equipping of laboratories at different levels will continue. Central level TOTs and regional level training on different laboratory disciplines will also be strengthened. Laboratory information system will be started to be implemented in pilot sites. This is expected to alleviate the currently existing communication problems.

3 Health Extension Program (HEP)

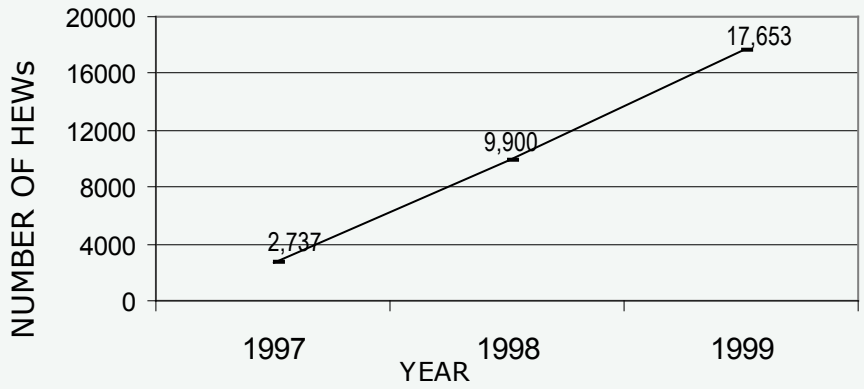
The Health Extension Program is an innovative health care delivery mechanism which forms the necessary linkages between the community and primary health care services. Since the launching of the program, female Health Extension Workers were assigned in each rural Kebele of the country to implement 16 health packages that are considered essential for improving health conditions of rural communities nearer to where they reside and work. The national implementation of the Health Extension Program (HEP) is supported by the rapid training of health extension workers, two per Kebele, and the construction and equipping of health posts (one per Kebele) through the Accelerated Expansion of PHC facilities. These health extension workers are trained to offer key health services such as personal and environmental hygiene, child immunization and family planning at each Kebele for an average population of 5,000 inhabitants. A community promotion program that is centered around volunteer/private sector community promoters/ TBAs who are providing services under the guidance of the health extension worker are undertaking useful health promotion tasks such as providing support to households with a major focus on behavioral change (e.g. breast feeding, complementary feeding, immunization, use of bed nets, clean delivery etc). This approach is considered as an additional and important strategy to achieve HSDPIII objectives and the Millennium Development Goals. The following sections provide the progresses that have been made in the implementation of the HEP for EFY 1999.

3.1 Training and deployment of Health Extension Workers

The FMOH has put in place a national plan for the expansion of HEP that would involve the accelerated training of 30,000 HEWs in order to reach universal coverage in all rural Kebeles of Ethiopia with the assignment of two HEWs per Kebele. The plan for the EFY 1999 was to deploy 7,500 trained HEWs and also enroll 7,500 trainees.

The achievement for the fiscal year as compared to the planned target was encouragingly noteworthy. In fact the target was surpassed by 3.4% providing a successful deployment of 7,753 HEWs to provide services for rural communities. This additional figure brings the total sum of HEWs deployment so far to 17,653 HEWs accounting for about nearly 59% of the total national requirement of 30,000 HEWs (Figure 1).

Figure 1: Trends in Number of Health Extension Workers Deployed in Health Posts, Ethiopia, 1997-1999 EFY.



On the training side, of planned enrollment of 7,500 HEWs nearly 95% or 7,095 have already started their class. The nationally planned enrollment of 7,500 HEWs was reduced to 7,207 HEWs in the Regional plans mainly due to reduction in Oromia. It is to be noted that Tigray, Amhara, Harari, and Dire Dawa Regional States have already achieved 100% coverage with HEWs training. However, the newly emerging regions who have started training late (Afar, Somali, and Gambella) will have to increase the training program which is now standing at coverage rate of only 24% -32% compared to what is expected from them.

Table 1: Training and Deployment of HEWs by Region, Ethiopia, 1999 EFY.

Region	Plan	Number trained and deployed 1999 EFY	Achievement (%)	Number of students attending 1999/2000 EFY	
				Plan	Number Attending
Tigray	1235	1235	100	100	0
Afar	200	64	32	50	154
Amhara	6650	5950	90	700	700
Oromia	13,000	5553	43	3000	2876
Somali	500	135	27	420	595
Benishangul-Gumuz	480	86	18	200	120
SNNP	7750	4465	58	2650	2650
Gambella	200	47	24	50	0
Harari	39	39	100	37	0
Dire Dawa	50	79	158	0	0
Total	**30,104**	**17653**	**58.8**	**7207**	**7095**

As shown in Table 1, Oromia Regional State has shown a performance rate of less than half of the planned number of HEW training uptake and deployment. This will mean that Oromia has to plan and execute more HEWs training in the coming fiscal years. The progress that has been made by the Amhara, Tigray, Harari, and Dire Dawa Regional States is promising. Other Regional States such as Somali, SNNP, and Afar are expected to achieve 100% training and deployment targets when currently their enrolled HEWs trainees complete their training by the EFY 2000.

Except for Tigray (100%), Amhara (93%), Harari (82%), and Dire Dawa (66%) the proportion of rural Kebeles where HEP is being implemented (two HEWs per Kebele) is reportedly low. Special effort is needed in Oromia and emerging regions which are below the national average.

Figure 2: Proportion of Regions with Rural Kebeles Implementing the Health Extension Program (with 2 HEW), Ethiopia, 1999 EFY.

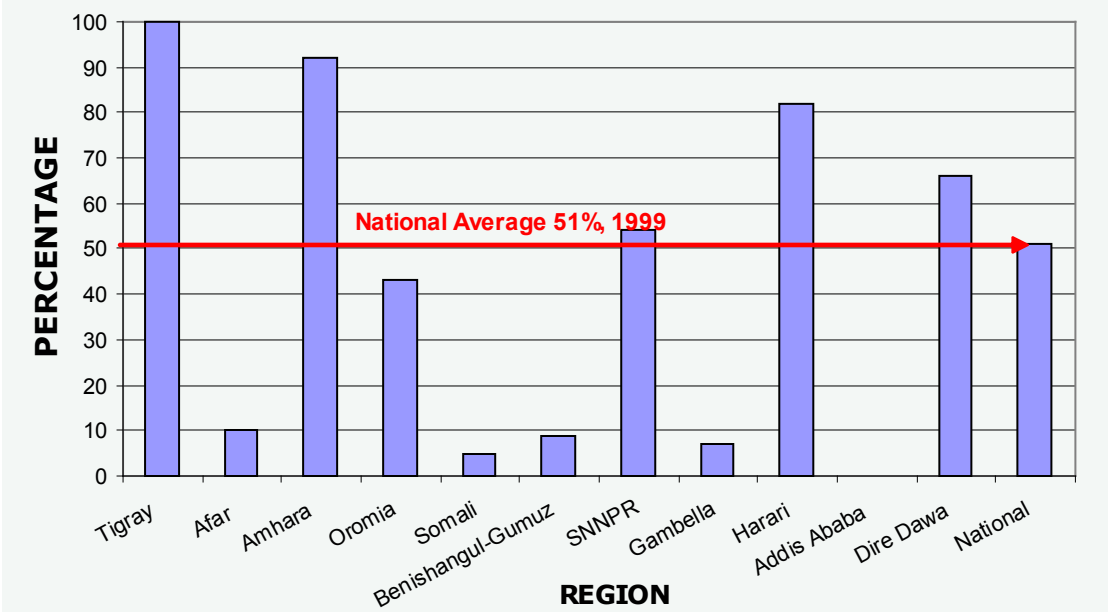
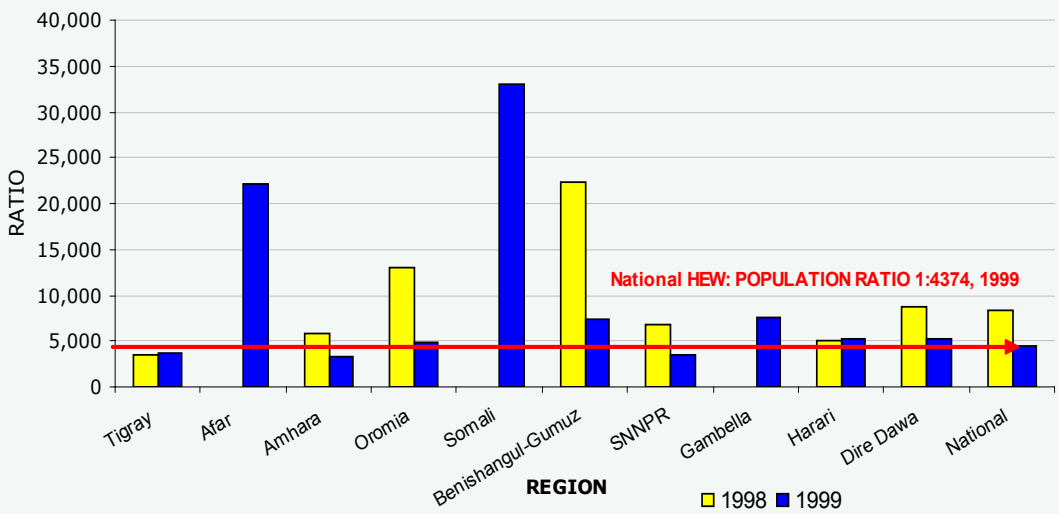


Figure 3: Distribution of HEW to Population Ratio by Region, Ethiopia, 1998, 1999 EFY



Health Extension Worker to population ratio showed a remarkable improvement from EFY 1998 to EFY 1999 as shown in figure 3. The relatively big gaps seen in such proportion in Somali, Afar, Gambella, and Benishangul-Gumuz Regional States will be addressed when all students complete their study in the coming fiscal year.

A total of 35 Technical and Vocational Education and Training (TVET) centers have been provided with the necessary teaching aids and materials that will be needed to achieve the planned training target of 30,000 HEWs. In order to implement HEP in a systematic way, HEP Implementation Guideline has been developed and more than 30,000 copies have been distributed to regions, health facilities, HEWs and non governmental organizations.

Integrated Refresher Training has been commenced based on assessed capacity gap. Training of Trainers (TOT) on Integrated Refresher Training to HEWs was organized for HEP supervisors and a total of 546 trainees were able to attend the training from 177 Woredas of the Amhara, Benishangul-Gumuz and Oromia Regional States. In EFY 1998, similar training was provided to 36 professionals from Tigray, 40 from Oromia, 35 from the 111 Woredas of SNNPR. Until now, a total of 856 trainees or nearly 47% were able to attend the planned training target compared to the total training need at the national level. Through the use the TOT in the Integrated Refresher Training it became possible to train a total 4,772 or 85% of the planned target of HEWs training for the fiscal year.

It is noteworthy that a guideline has been developed to facilitate the professional career development of HEWs. It is to be recalled that a National HEWs Day was celebrated with the participation of health partner organizations. In this colorful celebration, 37 HEWs who have shown better performance were given awards of recognition. Eleven (55% of the total) TVET centers which train HEWs were visited to conduct on-site evaluation focusing on the teaching and learning processes. In addition, 29 Health Posts (HP) were supervised to assess the overall implementation process of the program.

3.2 Community health post construction and equipping

Until EFY 1998, a total of 6,191 new health posts were constructed. The plan was to build an additional 4,263 health posts in EFY 1999. The report showed that the planned achievement in this regard has been 2,659 health posts. The construction of an additional 1,064 health posts is under completion. This gives a total of 3,723 health posts or 87% achievement compared the planned target for the just ended fiscal year. With such rate of construction at the national level, the availability of health posts will significantly increase to 9,914 accounting 66% of the totally needed 15,000 health posts to reach universal health coverage in the rural areas of the country.

Figure 4. Health Post Construction, Ethiopia, 1994-1998 EFY

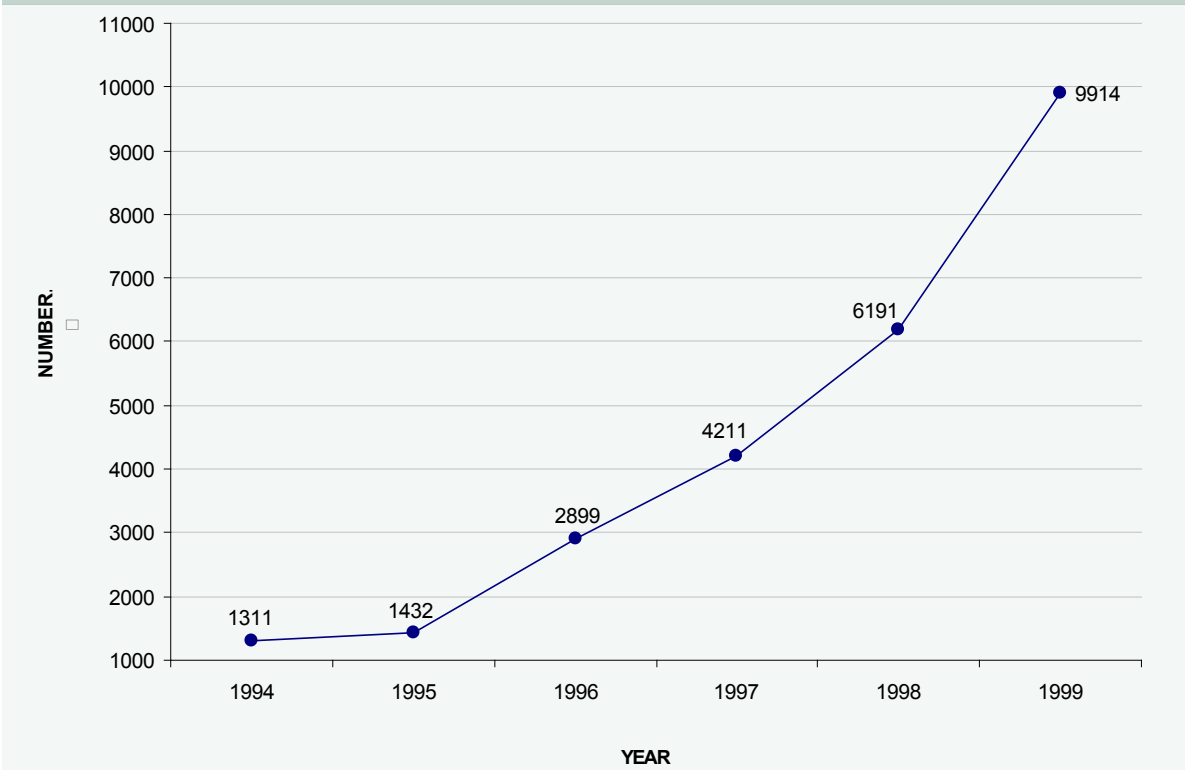


Table 2: Construction of Health Posts, Ethiopia, 1999 EFY			
Region	**Planned**	**Construction Completed**	**Under Construction**
Tigray	100	25	0
Afar	55	0	22
Amhara	539	208	327
Oromia	1103	407	336
Somali	137	0	0
Benishangul-Gumuz	17	14	3
SNNP	2272	1980	366
Gambela	35	25	10
Harari	0	0	0
Dire Dawa	5	0	0
Total	**4263**	**2659**	**1064**

Another priority plan for EFY 1999 was fulfilling the equipment and medical supplies requirement of 4,263 HPs. In this regard, distribution of supplies and equipments was made to 95 HPs including 1,050 bicycles purchased and distributed to HEWs in Amhara and Benishangul-Gumuz Regional States. Distribution of medical equipments to a further 1,105 HPs is in the pipeline and procurement is already under process for an additional 1,225 HPs. In addition, procurement of drugs and medical supplies is underway for 2,475 HPs and refrigerators and vaccine supplies were bought for a total of 2,498 HPs. Moreover, sufficient resources have been also secured for the procurement of equipment and supplies for 3,670 HPs.

In summary, of the total national requirement of 15,000 HPs, procurement and distribution of medical equipment and supplies have partially been done for 7,523 HPs and is under process for the remaining. Since funds have been secured to fulfill the equipment and medical supplies requirement for the remainder of the health posts, it will be possible to achieve 100% target by EFY 2000.

3.3. HEP for Pastoral and Semi-pastoral Areas

In order to build the capacity of HEW training centers in pastoral and semi-pastoral regions teaching materials and other supplies including a curriculum have been delivered. This will enable to train the planned number of HEWs in these special areas. Furthermore, preparation of reference materials consisting of the 16 packages and 4 main courses is 90% completed.

HEP implementation manual customized to the life style and culture of the pastoral community has also been prepared. The 16 packages of HEP have been translated into Somali language and 3,000 copies were published and distributed.

Using the formats and tools developed earlier, an assessment was conducted in three teaching and learning schools (Dupti, Arbaminch and Jijiga) of the Pastoral regions. Based on the findings of the assessment, technical, financial and material supports have been provided to these schools.

One of the challenges faced with regard the implementation of HEP in pastoral areas remains inability to secure sufficient funds to pay the salaries of teachers. Efforts are continuing to resolve this problem in consultation with RHBs.

Regarding the implementation of HEP in the urban areas, it was realized that such endeavor would require an appropriate benchmarking and the active involvement of various stakeholders to develop the health package and curriculum. The draft material was developed and has been reviewed by experts. Subsequently, package development and curriculum design will be conducted in the next fiscal year.

3.4. Information, Education, Communication

During the fiscal year it was planned to establish Audiovisual Information Centers in 1,943 Health Posts (HPs) out of the total 6,478 functional HPs. Accordingly, list of the necessary audiovisual materials and specification were identified. About half of these materials have been procured while development of a proposal is underway for the remainder HPs.

Basic health message cards have been prepared and distributed to HEWs with implementation guide cards. Reference material have also been prepared and distributed in 2000 copies to Amhara, Tigray, and SNNP regions and another 8,000 copies in Oromifa were distributed to Oromia Region State. Guideline has also been developed for Polio, Measles, and Neonatal Tetanus surveillance and this is already in use by HEWs.

To enrich HEWs knowledge and experience, 10,000 copies of health news magazine was published and distributed.

As a response to the Acute Watery Diarrhea epidemic, 80,000 leaflets with key messages in different languages and 1,850 health posters have been distributed to RHBs. Leaflet with key message on Relapsing Fever were also developed and distributed.

The plan to transmit messages using radio and other mass media about the importance and functions of HEP for 15 minutes per week using different languages was thoroughly discussed focusing on how to use the education media centers for the purpose of communicating key health messages. As part of the planned program of creating public awareness on the HEP, messages were transmitted through different radio programs in different local languages. Similarly, magazines were used for the publication of pertinent articles about the HEP.

Through the use of mobile vans, education campaigns were conducted in 203 Kebeles of 106 Woredas on HEP, HIV/AIDS, Acute Watery Diarrhea, Family Planning, Personal and Environmental Hygiene, and Harmful Tradition Practices. Television was also used for the transmission of key health messages and preparations are also in progress in collaboration with the Ministry of Education to transmit health messages using plasma televisions at schools. The plan on IEC also stipulated the production of two documentary films on HIV/AIDS and HEP implementation process with a completion rate of 80% and 10% respectively.

Challenge in the implementation of HEP

- Inadequate institutionalization of HEP in the organizational structure of RHBs, Zonal Health Departments and Woreda Health Offices. This problem appears to be more prominent in the Newly Emerging Regions.
- Inadequate supportive supervision at all levels of the health system.
- Delay in the construction of HPs especially in Oromia region.
- Delay in the fulfillment of equipment and supplies for health posts.

To alleviate these problems the following actions were taken:

- Institutionalization of HEP has been taken as an agenda of the regular FMOH-RHB Steering committee meeting. It has been discussed thoroughly and agreement has been reached to give it special attention.
- It is appreciated that the construction of HP needs the support of public administrations; hence, regions will give it attention to work with them.
- Resources have been mobilized from partners to fulfill medical equipment and supplies, for the existing and the health posts.

3.5. Environmental Sanitation

The plan for EFY 1999 under environmental sanitation was to increase latrine use from 32% to 44% in areas where HEP is fully functional.

The implementation of this activity commenced with the consideration and selection of different latrine designs and solid and liquid waste disposal facilities that were needed to be customized to the Ethiopian situation and also acceptable by the community. As part of this process, National Protocol for Hygiene and Onsite Sanitation has been translated into Amharic and was printed in 2,000 copies.

Similarly, a report on potable water quality control has been produced and 2,000 copies were distributed. Moreover, a quarterly National Sanitation Forum has been established for the first time with the aim of enhancing multi-sectoral coordination in order to achieve the national sanitation targets and the Millennium Development Goals. In addition to this, a national guideline has been developed in order to facilitate the utilization of dry waste materials as compost (natural fertilizer).

Reports from some RHBs on the implementation of environmental sanitation for the fiscal year showed that 191,446 private household and communal latrines were constructed out of which supervision and maintenance activities were carried out covering 608,685 private household latrines. As part of enhanced promotion of personal and environmental hygiene, health education with an exclusive focus on the construction and proper use of latrines was given to 904,388 community members.

Reports from three regions indicate that sanitation coverage increased from 20.5% to 28.1% (Oromia), from 6% to 8% (Gambella) and from 60% to 64.6% (Harari). Unfortunately, however, due to under reporting from most the RHBs it has become a challenge to make a national estimation of sanitation coverage for this reporting year.

Generally, annual activity report on hygiene and sanitation face lack of proper organization. One of the reasons was the inability to ensure the timely flow of information from Kebeles to Woredas and eventually to Regions, which has become a major challenge for the RHBs to compile quality report in a timely manner. The scaling up of the new HMIS is believed to alleviate this problem.

3.6. Strengthening Quarantine Services

The plan for EFY 1999 was to build the capacity of four quarantine sites in order to provide improved quarantine service. Accordingly, constructions of four quarantine sites (Moyale, Dewelle, Dire Dawa and Metema) were advertised for bidders. This attracted successful bidders who have already started construction works. Unfortunately,

the construction of the Metema quarantine site could not commence as planned because of the inability to secure a suitable construction site.

Moreover, office equipment including fax and computers has been provided to facilitate exchange of information in Dire Dawa and Moyale sites. Improvement to quarantine services also included the provision of two generators to sites where electric power is unavailable.

Supportive supervision has also been conducted in Dire Dawa, Moyale, and Metema quarantine centers including the four Internationally Certified Vaccination Centers (Black Lion, Paulos, Petros, and Dire Dawa). During the reporting fiscal year, food inspection and control was conducted on 48,519 tons of exported and 238,043 tons of imported food and drinks. In addition, insecticide spraying and inspection of aircrafts was done 5,784 times.

Using the Internationally Certified Vaccination Centers, a total of 55,551 and 42,076 people have received Yellow Fever and Meningitis Vaccines, respectively. Trainings have been given to health professionals in Bahir Dar, Desie, Jimma, and Awassa towns with the aim of further enhancing the decentralization of the vaccination services. Based on the finding of the client satisfaction survey conducted at Bole Airport and Black Lion Hospital, appropriate measures are taken to improve the quality of vaccination services.

4

Expansion and Equipping of Health Centers (HCs)

Expansion of health centers is a crucial component for achieving the planned universal primary health care coverage. In the Ethiopian health Care System, a HC plays an important role both in terms of supporting HEP and providing basic curative health care services. The target for HSDP-III is to put in place 3,200 HCs by 2009/10. As part the implementation, the plan for EFY 1999 was to construct 51 new HCs and upgrade 300 HSs to nucleus HCs.

For the reporting year, the construction of 19 new HCs was completed while an additional 25 HCs are under construction. Moreover, 5 HCs have undergone rehabilitation and 7 HCs were expanded. Moreover, construction of 36 new, 192 ongoing constructions and 228 up-grading of nucleus health centers were accomplished. The achievement figures indicate that the construction of 55 health institutions (HC+ Nucleus HC) has been completed in EFY 1999.

The FMOH has successfully outsourced the upgrading work of 500 HSs to Nucleus HCs for which the construction work has already commenced. The upgrading initiative is meant to enhance the expansion of VCT, PMTCT and ART services and to pursue the integration maternal and child health services, prevention and control of other diseases of public health importance.

In order to accelerate the expansion of health centers, FMOH proposed to regional governments that for every HC/HS construction/upgrading financed by RHBs, the FMOH will construct/upgrade a matching HC/HS including equipments. Almost all RHBs have agreed to this proposal. Hence, this is expected to accelerate the plan of putting in place 3,200 HCs by the end of HSDP-III.

The procurement of medical equipment for 351 HCs has been planned to materialize in EFY 1999. As of to date, medical equipment for 44 HCs has been distributed and the procurement for an additional 415 HCs is in progress.

Challenges encountered in the construction of health centers and procurement of medical equipment includes:

- Rising cost of construction materials that contributed to the delaying of handover of the outsourced health centers to the contractors for timely commencement of the construction work.
- Long delays in the procurement process of medical equipment,
- Long delays in the hiring of procurement agents as per the requirement of PBS2 arrangement.

In order to alleviate these problems, the cost of construction is being revised; different options are being explored to expedite the process. The FMOH is also undertaking continuous dialogue with partners to adopt a better and less bureaucratic approach to procurement of medical equipment while building its own capacity as per the Logistic Master Plan.

5

Strengthening and Expansion of Hospital Services

5.1. Hospital Management

An initiative for the improvement of hospital management for the improvement of quality medical care has started in EFY 1998. A team of expatriate experts has been deployed in 14 public hospitals. The team has started its work by identifying hospital management problems. Based on the assessment, a conceptual framework for improving hospital management has been developed and training was given to all medical directors in the Federal Hospitals during the previous year. In EFY 1999, hospital management has been fully integrated into the Access and Quality of Care BPR Core Process.

A project that was designed based on the main strategic issues for improving hospital service has been implemented in 14 hospitals on pilot basis. Subsequently, blueprints have been developed to rollout implementation to 40 hospitals in EFY 2000.

Based on experiences gained from other countries, a decision has been made to transfer the management of hospitals to Chief Executive Officers (CEOs) who are well trained in management skills. Implementation of this initiative has involved the selection of CEOs and assignment to hospitals. Preparation is also underway to provide training to these CEOs at Jimma University as of September 2007.

5.2. Outsourcing and Hospital Private Wings

Studies are completed to begin private wings and outsourcing of non-clinical services at government hospitals. Establishing private wings at government hospitals has the potential to generate additional income and can increase the ownership of the hospital services by health professionals. Outsourcing of non clinical services such as security, hygiene and sanitation, food catering etc. could be cost effective as long as the decision to outsource is evidence based.

5.3. Construction, Rehabilitation and Expansion of Hospitals

During the HSDP III period, the plan is to construct 5 new district hospitals, 2 zonal hospitals and also to renovate 37 hospitals. The expansion of eight hospitals was completed in Tigray (3) and Oromia (5) Regional States. Seven hospitals have been already rehabilitated in Somali (1), Addis Ababa (5), and Afar (1) Regional States. In addition, the construction of nine new hospitals, eight in Oromia and one in Tigray are already completed and five additional constructions are undergoing in Afar (1), Oromia (3), and Harari (1) Regional States. To strengthen the referral linkages, five ambulances were purchased and will be distributed to four hospitals and one University. In addition to this, the expansion of three specialized hospitals in Addis Ababa has been completed.

5.4. Training of Physicians

Within the HSDP III period, the plan is to make available (existing plus new) 2,200 general practitioners and 1,050 specialists. In addition to the existing training facilities in the Universities under the Federal Ministry of Education, the FMOH is making the necessary preparation to start training 50 general practitioners in St. Paulos Millennium Medical College beginning February 2000. To strengthen emergency obstetric care in areas where there are no Gynecologists and Obstetricians, 8 health professionals were trained on surgery and anesthesia.

Currently, the national average for a physician to population ratio stands at 1:61,603. In Addis Ababa this proportion is 1:4,817. This variation tends to indicate that there appears to be a concentration of large numbers of physicians in urban centers such as Addis Ababa, Dire Dawa and Harari.

5.5. Training of Health Officers

For the effective implementation of HSDP III, it would be essential to train and deploy the required number and type of health professionals to adequately staff the planned 3,200 health centers including those who will be capable of providing emergency surgical and obstetric care in order to combat maternal mortality particularly in rural areas. In EFY 1999, it was planned to train 2,000 health officers in 20 hospitals and currently 1,906 nurses are enrolled in the Accelerated Health Officers training in five universities. Beginning January EFY 1999, these trainees have been assigned in hospitals for practical training.

As a way of building the capacity of Health Officers training hospitals, 20 vehicles were procured and facility maintenances are undergoing. It is to be noted that more trainees have been recruited from Regions for the next round of HOs training. Moreover, evaluation on the overall

teaching and learning process has been conducted in collaboration with the Ministry of Education and the 5 Universities (Gondar, Jimma, Hawassa, Mekelle, and Haromaya). Currently, there are 3,278 students in the regular and Accelerated HOs trainings, and when they complete their studies the existing shortage of health professionals will be significantly alleviated.

Discussion on the developed curriculum has taken place with the Federal Ministry of Education to begin health officers training for two years in emergency obstetric and surgical skills at MSc level under universities. In addition to this, as part of the preparation to train 50 nurses in 10 hospitals on surgery for 2 years, a team consisting of 5 professionals has attended a workshop in Sweden. Based on the experience of the workshop, training materials will be developed and discussion will be carried out with responsible officials to start the training program in the next fiscal year. The current health officer to population ratio is 1:77,437 and nurse (all categories of nurses) to population ratio is 1:4,601, respectively.

5.6. Construction of Blood Banks

The aim of organizing an appropriate blood banking facility in Ethiopia is to ensure the supply of safe blood for transfusion and to prevent blood-borne diseases including HIV/AIDS. There are 16 blood banks under construction in 6 regions. In EFY1999, 25% of these constructions have been completed. The Ethiopian Red Cross Society is making a follow-up on the construction process and a task force regularly meets every 15 days to evaluate the progress. In addition, purchase of laboratory reagents and ambulances is under process.

Challenges faced in the construction work of blood banking were:

- Shortage of construction materials,
- Delay in settling payment obligation for the already executed constructions works.

5.7. Maintenance of Medical Equipments

With the aim of enhancing the operational capability and durability of medical equipments for improving the quality of health services, there is an undergoing training for professionals to enable them to maintain medical equipment. Preparation and selection of sites, development of curriculum and supply of appropriate teaching equipment has been put in place in collaboration with the Ministry of Education, Ethiopian Science and Technology Agency and National Center for Scientific Equipments. Based on adopted experience from other countries, educational standard and curriculum are developed and 65 trainees have started the training at the Tegbare-Ed Technical and Vocational Training College in EFY 1999.

6

National Nutrition Program

The targets for the National Nutrition Program in EFY 1999 were:

- Increase provision of Vitamin A from 30% to 40%
- Providing nutritional screening for 500,000 (18%) children aged 6-59 months of the total 2.4 million.
- Increase access to iodized salt to 50% households

The achievement for the planning year indicate that 10.2 million children aged 6–59 months were given 46 million Vitamin A supplement capsules through the second round EOS campaign. This has increased the coverage of Vitamin A supplementation to 91% which is much higher than the 40% target set for 1999 EFY. Nutrition screening has also been conducted concomitantly with EOS focusing in food insecure areas. Based on screening finding, children with sever acute malnutrition have received nutrition supplementation.

With regard to increasing access to iodized salt, a national operational plan on improving access to iodized salt has been already developed. Training on the quality control of iodized salt was given to 25 governmental and private salt producers in Afar Region. Efforts have been also made to organize and bring together different iodization machines.

One of the major challenges in the implementation of iodization of salt was the misunderstanding among salt producers on the distribution of iodization machines. This problem has been alleviated through consultation between MOH and the higher officials in the Afar Regional State. A taskforce composed of representatives from FMOH and Afar Region has been established to coordinate the implementation of the salt iodization program.

7

Prevention and Control of Communicable Diseases

7.1. HIV/AIDS Prevention and Control

HIV/AIDS continues to be the major public health challenge in Sub Saharan Africa. An estimated 2.8 million adults and children were infected with HIV in 2006, far greater than the combined figure of the rest of the regions in the world.

The targets from the strategic plan of HIV/AIDS in Ethiopia are summarized in table 3.

Table 3: HSDP and PASDEP Targets on HIV/AIDS Prevention, Care, Support and Treatment, Ethiopia, 1999 EFY

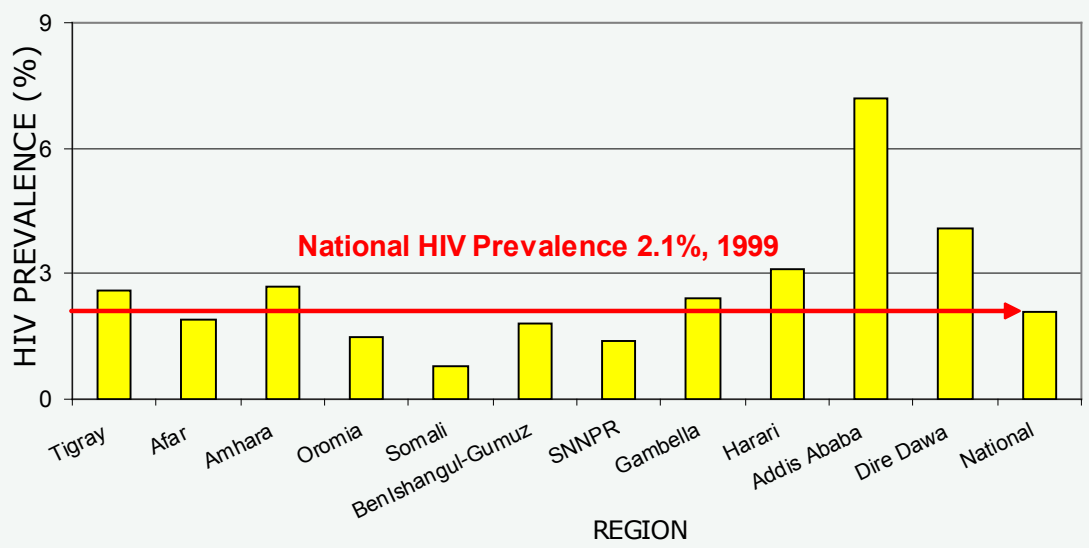
Major activities	**HSDP III / PASDEP Target 2002 EFY**
Proportion of hospitals and HCs providing PMTCT services	100% of hospitals and 70% HCs
Proportion of hospitals and HCs providing VCT services	100% Hospitals and HCs
Mothers/infants who get PMTCT services	72,167[1]
No. of PLWHA accessing ART	397,539[1]
Percentage of HIV positive pregnant women receiving complete course of ART	95%[1]
Incidence of HIV	0.28%[2]
Prevalence of HIV	2.1%[2]

[1] Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia: Road Map 2007-2010

[2] Single Point HIV Prevalence Estimate, June 2007

In EFY 1998, two types of HIV prevalence assessments were done in Ethiopia. The first assessment used population based method (DHS) and the second sentinel surveillance that was based on ANC services for pregnant women. The assessment report of these studies which was published in EFY 1999 indicated that the national HIV prevalence has been 1.4 % in EDHS study and 3.5% in the ANC surveillance study. Because of these differences, the Federal HIV/AIDS Control Office (FHAPCO) in EFY 1999 took initiative to establish a task force with a TOR to work out on the data from both studies and produce a single prevalence estimate. The finding of the taskforce showed that the estimated national single point HIV prevalence for EFY 1999 was 2.1%. Other disaggregated prevalence rates were 1.7% for males and 2.6% for females. Urban and rural prevalence rates were 7.7 % and 0.9%, respectively.

Figure 5. Distribution of HIV Prevalence by Region, Ethiopia, 1999 EFY



As shown in figure 5, Addis Ababa is the region with the highest HIV prevalence rate of 7.5% followed by Dire Dawa and Harari with 4.2 % and 3.2 %, respectively. With 0.8%, the lowest prevalence is in Somali region. The prevalence in SNNP, Tigray, Amhara, and Oromia is 1.4 %, 2.7 %, 2.7%, and 1.5%, respectively.

A careful assessment of the trends in the last four years suggests that with prevalence rates of 2.2% in EFY 1996 and 2.1% in EFY 1999, HIV/AIDS appear to be in a stabilizing pattern. A further analysis indicates that the total number of HIV positive population, HIV positive pregnant women, and annual HIV positive births are 977,394, 75,420, and 14,148, respectively. The progress being made to date in mobilizing the community for HIV testing, care, support, and treatment with ART and PMTCT programs are summarized in the next sections.

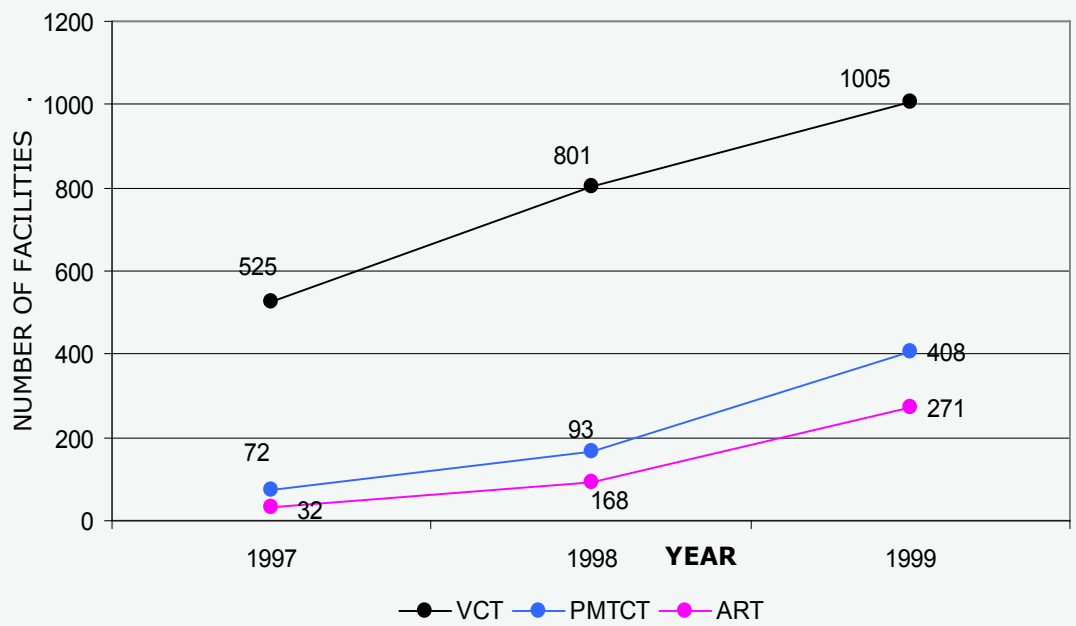
The targets set in EFY 1999 for the prevention and control of HIV/AIDS were:

- Enhancing the implementation of HIV/AIDS prevention and control program in HEP implementing 12,500 kebeles.
- Increasing the number of health centers providing VCT from 280 to 600.
- Increasing the number of health centers providing PMTCT to 267.
- Increasing the number of health centers providing ART to 111.
- Increasing the number of PLHA on ART to 105,000.

With regard to the community level interventions, the Strategic Plan specifies that establishing sustainable community involvement and ownership is the vital component towards an effective HIV/AIDS prevention and control. To implement this, it was planned to develop community mobilization manual in order to strengthen and sustain the already functional community conversation forums. The manual has been developed through involvement of all concerned stakeholders and designed to help the transformation of the community conversations into action through the integration of HIV/AIDS prevention and control activities with the regular development plan of the Kebeles.

As shown in figure 6, in EFY 1997 the number of health institutions that were providing VCT were 525. This figure has increased to 801 in EFY 1998 and to 1,005 in EFY 1999. Currently 64% of the total health facilities (hospitals and health centers) provide VCT services.

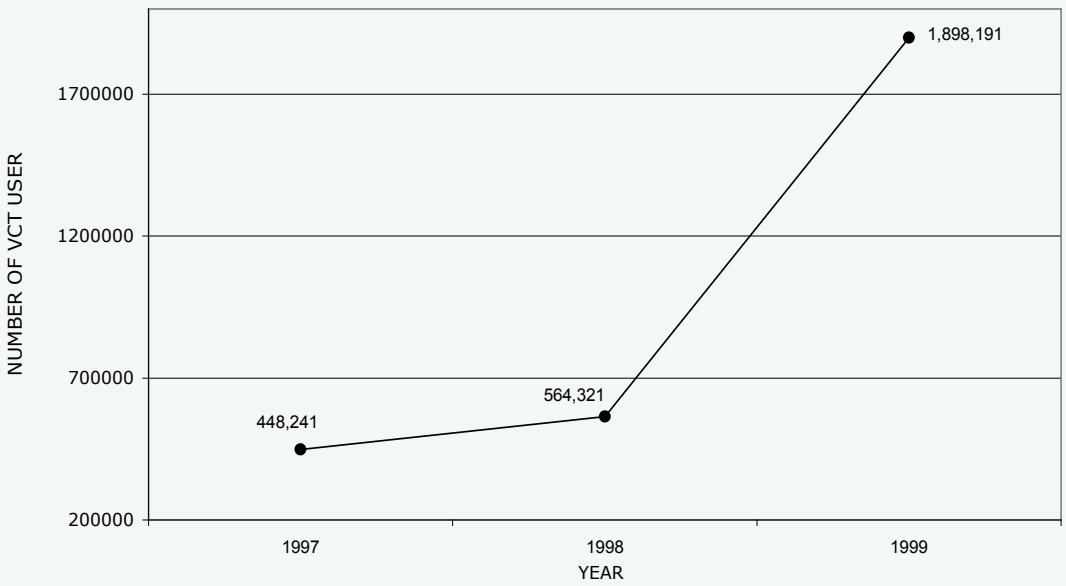
Figure 6. Trend in the Number of Facilities Providing VCT, PMTCT and ART Services, Ethiopia, 1997-1999 EFY



The number of people using the VCT service, as shown in figure 7, has also increased from 448,241 in EFY 1997 to 564,321 in EFY 1998 (26% increase), and to 1,898,191 (236% increase compared to EFY 1998). Social mobilization through the Millennium AIDS Campaign has contributed significantly resulting in more than doubling the number of VCT users in EFY 1999 as compared to EFY1998. The campaign has helped to get closer to the community, promote prevention, care and support services and encourage people to know their sero-status and enable them to use the next steps of service. The planned VCT coverage of the campaign was to enable 320,000 individuals to use VCT service.

It is important to note that before the campaign, an average of only 46,000 people per month avail themselves for HIV testing. But during the campaign, this figure has increased to 300,000 per month. Therefore, the campaign alone has been instrumental for achieving 87% of the planned target that made it possible to test a total of 605,903 people. In general, from June, 1997 to the end of this fiscal year, more than 2.9 million persons have been tested for HIV.

Figure 7. Trend in the Number of VCT Users, Ethiopia, 1997-1999 EFY



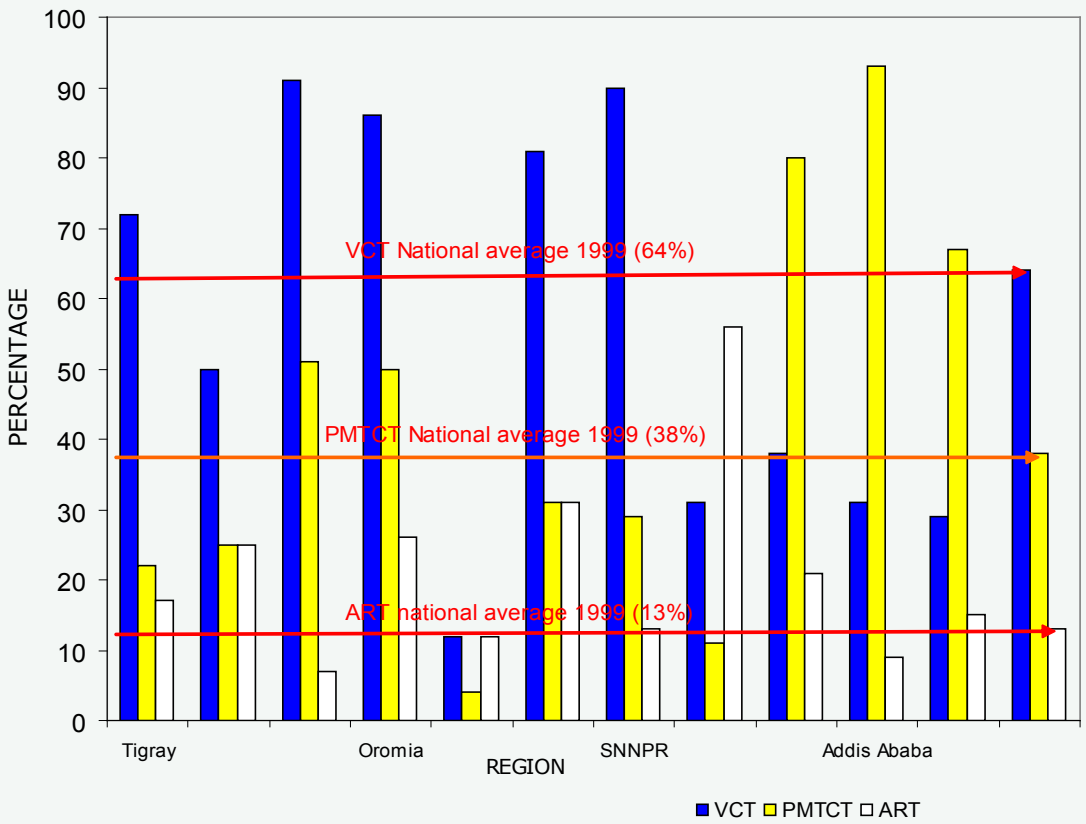
With regard to PMTCT, the number of facilities providing the service has also shown significant increase. PMTCT service providing facilities have increased from the low figures of 32 in EFY 1995, 37 in EFY 1996, and 72 in EFY 1997 to 93 in EFY 1998 and 408 in EFY 1999, respectively.

In EFY 1999, 468,532 ANC clients visited PMTCT sites. Among these, 204,266 or 43.6% received pretest counseling and 123,380 or 26.3% have been tested for HIV/AIDS. Out of those tested, there were 6,655 HIV positive deliveries out of which 3,967 mothers and 2,736 exposed babies received NVP. These achievements are considered significantly far better than the previous years and the expectation is that the service provision will increase with the expansion of the service to more health facilities.

With regard to ART, the proportion of health facilities (hospitals, health centers, and private clinics) providing ART services have increased significantly compared to the previous years (figure 6). In EFY 1997, there were 32 sites which were providing the ART service. However, this figure was increased significantly to 168 in EFY1998 and 271 health facilities in EFY 1999 (153 HC and 118 hospitals).

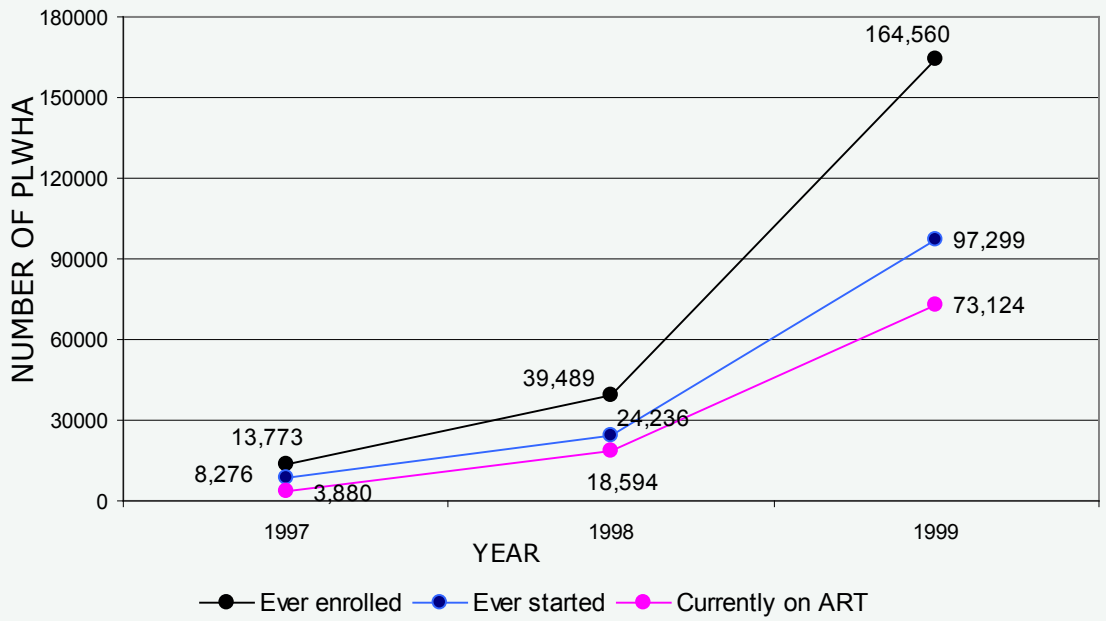
Out of the total available health institutions, 13% (hospitals and health Centers) are currently providing ART services, and 65% of these ART providing health facilities are in the Regional States. This is demonstrated in figure 8.

Figure 8. Proportion of Health Facilities (Hospitals and Health Centers) Providing ART, VCT and PMTCT Services by Region, Ethiopia, 1999 EFY



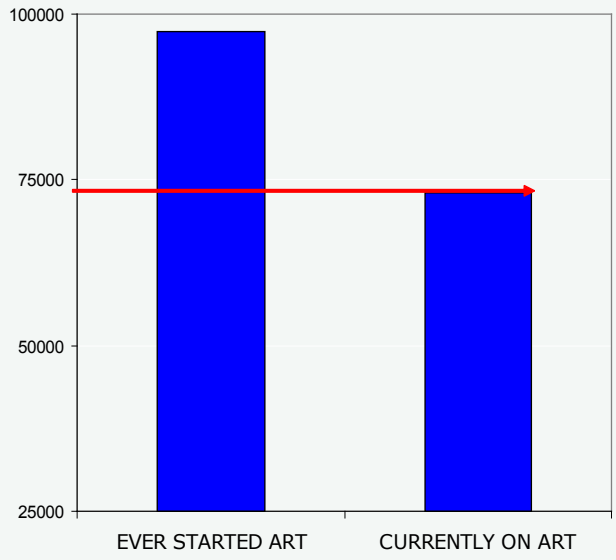
As shown in figure 9, the number of PLWHA ever started ART has increased sharply from 8,276 in EFY 1997 to 24,236 in EFY 1998 and 97,299 in EFY 1999.

Figure 9. Trend in Number of People Living with HIV/AIDS who Accessed Chronic HIV Care and ART, Ethiopia, 1997-1999 EFY



Until EFY 1999, a total of 164,560 PLWHA were enrolled for ART, and the number of clients ever started has been 97,299 and 73,124 are currently on ART. This is indicated in figure 10.

Figure 10. Number of ART Users; Ever Started and Currently on ART, Ethiopia, 1999 EFY



Initially, the number of female ART users was small (25%), but it has now increased significantly reaching 50%. Amongst the ART users, males and children constitute 46% and 4%, respectively.

Through the Millennium HIV/AIDS campaign the main objective of which was mobilizing the community for care and treatment services, a total of 605,903 persons were tested for HIV/AIDS of which 29,842 or 4.7% were sero-positive. Among these, 11,831 newly starters of ART treatment and the remainder 18,349 HIV positive persons were referred for care and support services. The campaign was a successful strategy which has made it possible to achieve more than the planned target for the EFY1999.

In general, the expansion of basic HIV/AIDS prevention, care, treatment and support services are encouragingly significant. This is mainly due to:

- An integrated Multi-sectoral response.
- The implementation of interventions from the household to higher level.
- Better political commitment.
- Active community participation and ownership in the efforts of HIV/AIDS prevention.

Support from International Organization (donors) for the HIV/AIDS prevention, treatment, care and support is growing; although this effort needs to be sustained in the future.

7.2. Malaria Prevention and Control

The malaria prevention and control program in Ethiopia is guided by a five year strategic plan that has been developed with the context of the Health Sector Development Plan (HSDP) and in line with the objectives of the international movement of Roll Back Malaria. Malaria prevention and control is an integral part of the national Accelerated and Sustainable Development to End Poverty (PASDEP) that feeds into the MDGs. The first five year strategic plan covering periods from 2001 – 2005 has been successfully completed and the second five year plan covering periods 2006 – 2010 is now in the implementation phase.

The three implementation approaches for the prevention and control of malaria consists of:

- Selective vector control including the use of long lasting insecticide treated nets, indoor residual spraying with insecticides (DDT) and environmental management.
- Early diagnosis and treatment of cases.
- Epidemic prevention and control.

Environmental control and protection activities were implemented by the HEWs through community mobilization. The HEWs have been provided with the necessary in-service training to build their capacity to undertake this task. The implementation for the EFY 1999 involved the procurement and spraying of 800 tons of DDT in areas where such spraying is needed. Of the total, 600 tons of DDT was procured by the Regional States while the remainder 200 tons became available through support from the FMOH. Of the areas that required DDT spraying, 30% has been completed in EFY 1999.

The second approach in the prevention and control of malaria is the use of ITNs. It is estimated that as many as ten million households reside in areas affected by Malaria in Ethiopia which puts a requirement of at least two ITNs for every household in order to effectively influence prevention. Based on this, the total requirement stands at 20 Million ITNs is to offer a blanket national coverage. Out of the total requirement, 9.5 million ITNs (47.5%) were distributed in EFY 1998 and earlier. In EFY 1999, the plan was to distribute 10 million ITN of which 8.7 million (87%) has been distributed to regions and the procurement for 2.3 million ITN is on process. Of the total requirement of 20 million ITNs, 18.2 million has been distributed so far (figure 11). Currently, the national coverage for the distribution of ITNs is at 90%. (figure 12)

Figure 11. Trend in Insecticide Treated Nets (ITNs) Distributed, Ethiopia, 1992-1999 EFY

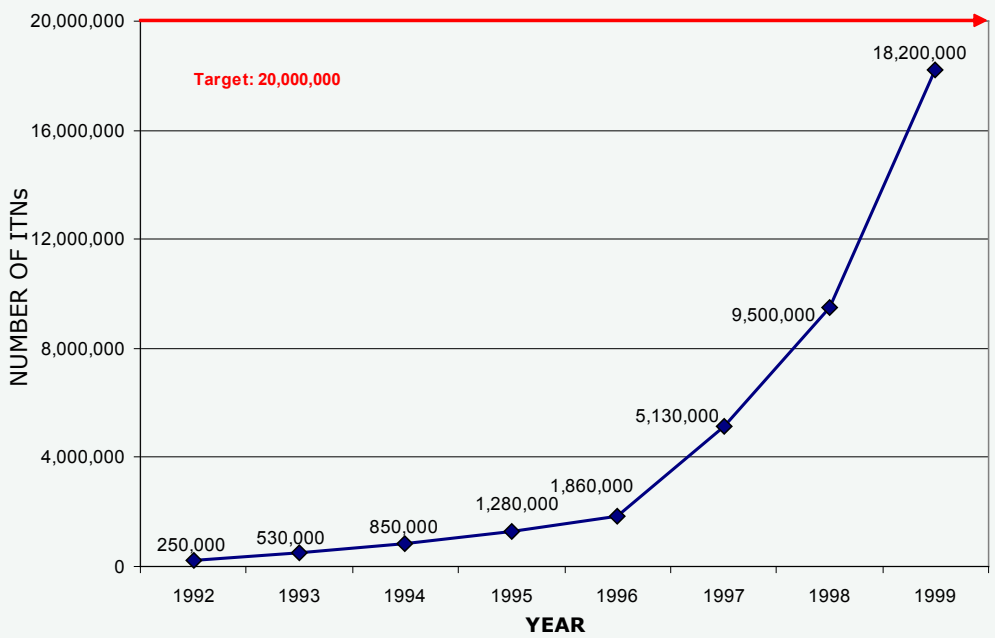
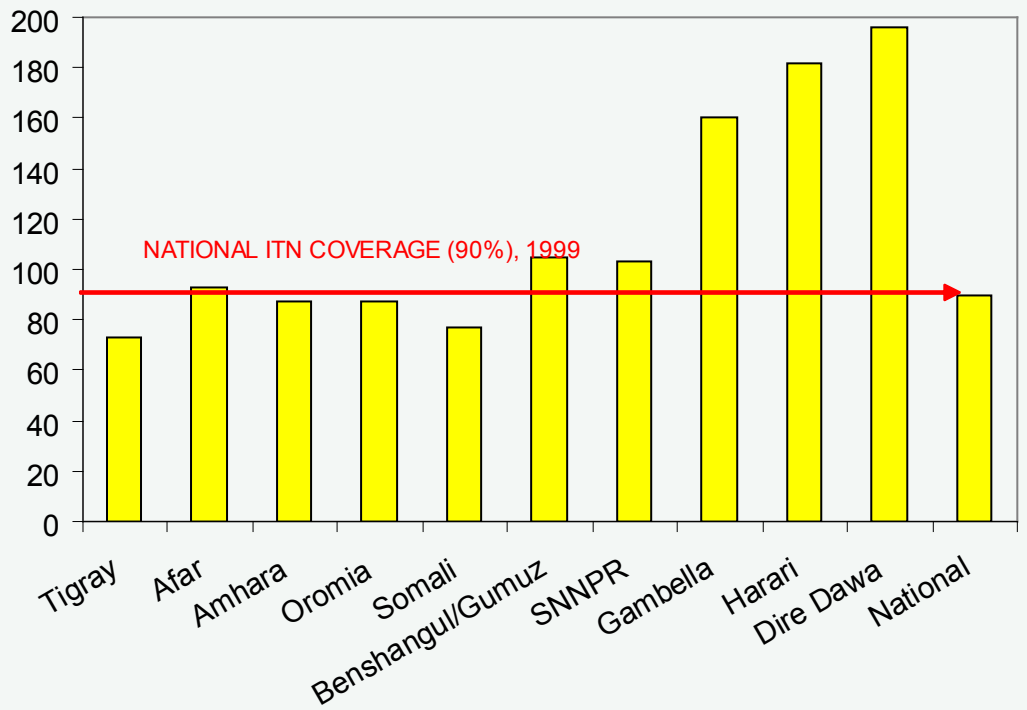
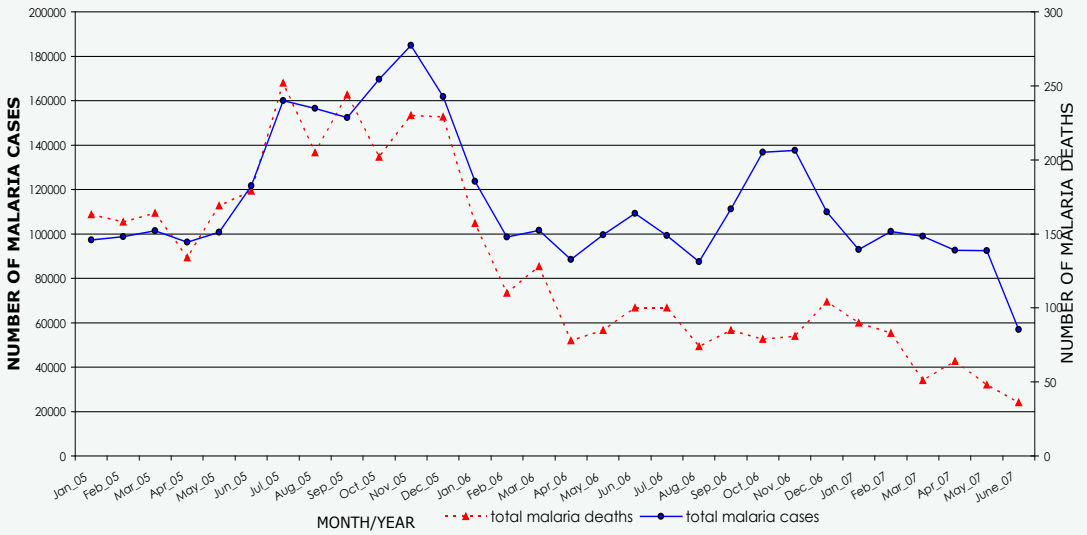


Figure 12. Coverage of ITN by Region (2ITN/HH), Ethiopia 1999 EFY



In terms of the implementation of early diagnosis and treatment of cases, the report showed that until June EFY 1998 adequate Coartem for treating 5.7 million malaria patients was distributed. Similarly, in EFY 1999, Coartem enough to treat 4.8 million malaria patients has been distributed. In addition, Rapid Diagnostic Test (RDT) enough to make diagnosis for 9.6 million patients has been purchased and distributed to strengthen laboratory tests in areas where there are no laboratory facilities.

Figure 13. Trend Analysis on Malaria Cases and Deaths, Ethiopia, January 2005-June 2007



In general, due to the rigorous prevention and control measures taken, no epidemic of malaria occurred during the reporting fiscal year. Transmission of malaria has also been stable throughout the fiscal year as compared to the previous years. This has been the result of the greater emphasis accorded to the promotion and increased use of bed nets, environmental control, and early diagnosis and treatment of malaria cases. The intensive malaria prevention and control activities are expected to alleviate the negative impact of malaria on human resource productivity.

7.3. Tuberculosis and Leprosy Prevention and Control

The target set for the fiscal year under TB control was to implement community DOTS in 110 pilot Kebeles. In this regard, accomplished activities are presented below.

With the aim of strengthening the prevention and control of TB and Leprosy, drugs estimated to be enough to provide treatment for 130,000 patients has been purchased and distributed on time. In addition, drug quantification has been completed and the procurement is in process to cover the estimated requirement for EFY 2000. IEC materials have been developed for HEP in the pastoral regions. A taskforce with a TOR to design a five-year social mobilization strategy for the prevention

and control of TB has been established. Moreover, media spots twice a week have been used for the creation of public awareness in 3 local languages. To integrate TB prevention and control with the millennium campaign, a five months accelerated action plan has been developed.

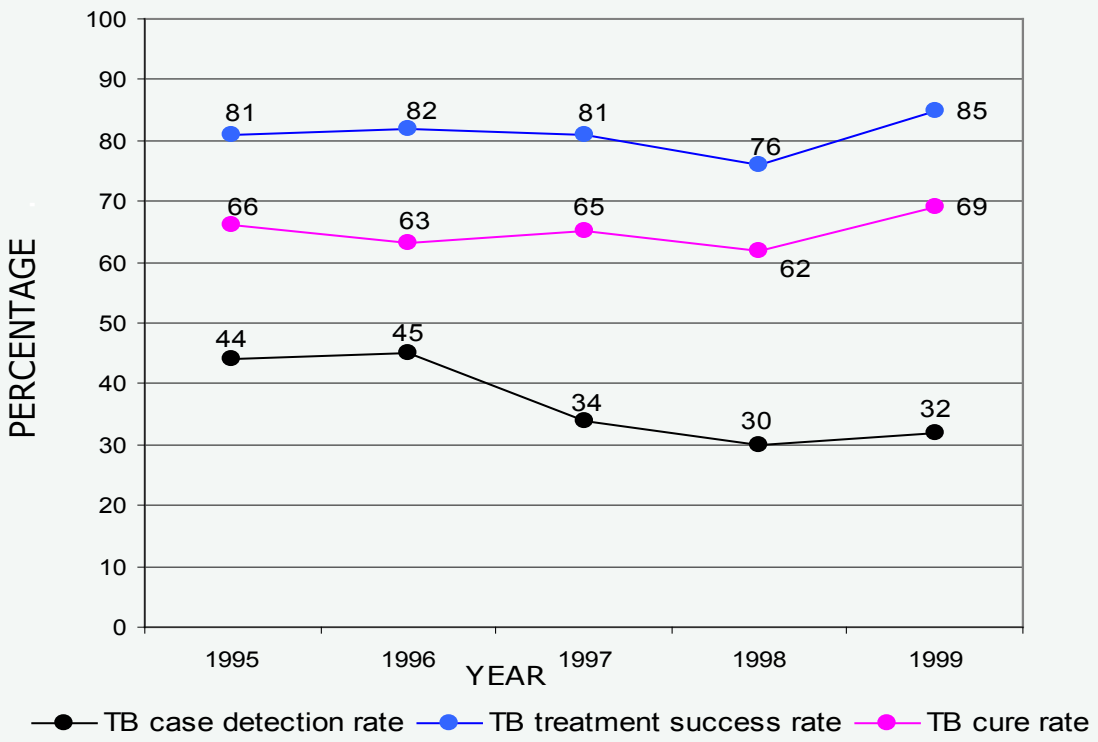
Three indicators are used to monitor and assess the overall TB prevention program. These are TB case detection rate, TB treatment success rate, and TB cure rate. TB case detection rate is defined as the percentage of new sputum positive cases detected versus the estimated number of new sputum smear positive TB cases. TB cure rate is the percentage of new sputum smear positive TB cases who were cured and who completed the treatment and who had negative sputum smear result in the last month versus total number of new sputum smear positive TB cases registered for treatment. TB treatment success rate is the number of new sputum smear positive cases who were cured plus the number of those who completed TB treatment versus the total number of new sputum smear positive TB case registered for treatment.

In this fiscal year a total of 37,441 new sputum smear positive cases were detected and 25,200 completed the treatment and were fully cured. The number of TB patients who were cured plus those who completed the treatment is 30,608.

The standard is to achieve a 70% case detection rate and an 85% cure rate. Currently the national case detection rate is 32% which is below the standard while the cure rate is 69% which is also 16% lower than the expected standard.

As shown in figure 14, the trend for TB treatment success rate and cure rates show that there have been improvements. TB treatment success rate is 85% which is equivalent to the international standard, an improvement from 81% in EFY 1995 to 85% in EFY 1999. TB Cure rate increased from 66% to 69% over the same period of time. Case detection rate also improved from the EFY 1998 level of 30% to 32% in EFY 1999. These figures are expected to continue improving with the scaling up of Community DOTS program from pilot areas to other Kebeles where HEP is operational.

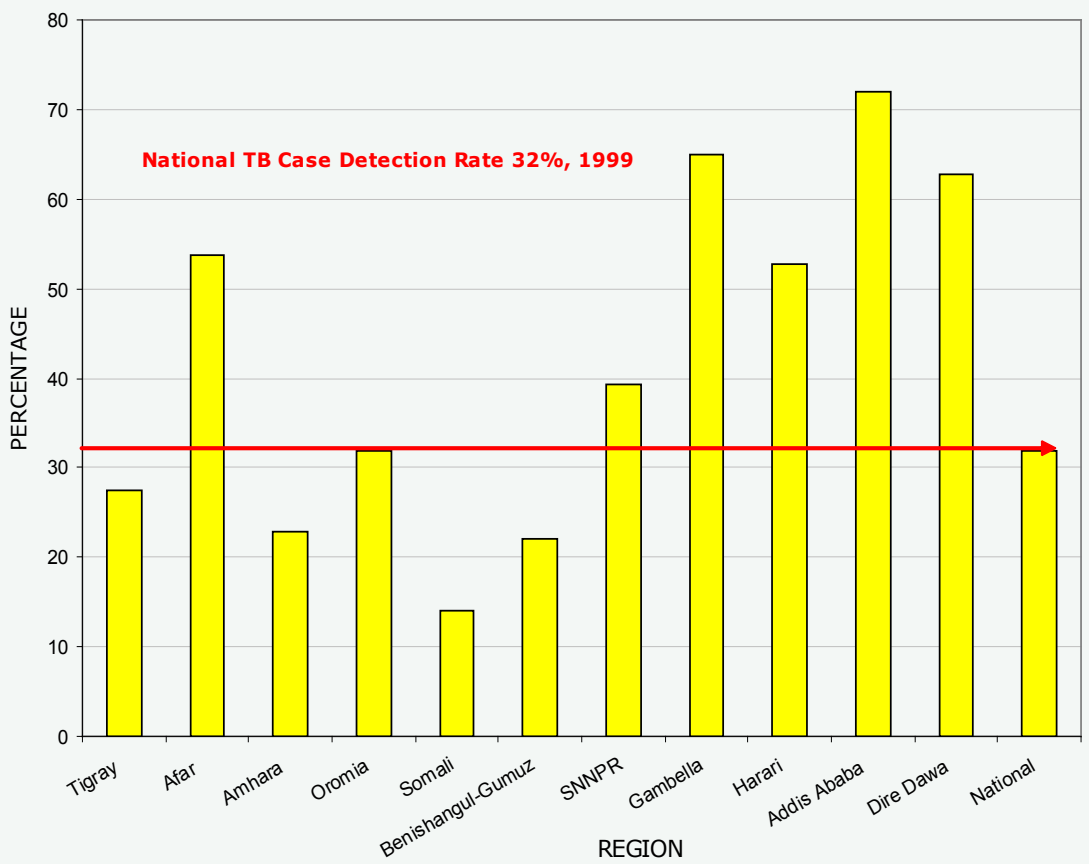
Figure 14. Trends in TB Case Detection, Treatment Success and Cure Rates, Ethiopia, 1995-1999 EFY



When we see the regional variations of case detection rate, it has decreased in seven regions from 1998 EFY to 1999 EFY but due to improvements in Amhara and Oromia regions the national average is more than the 1998 EFY achievement. As it is shown in figure 15 Somali region reported the lowest (14%) case detection rate.

All regions need to act vigorously through utilizing HEWs to improve the case detection rate which is behind the standard (70%).

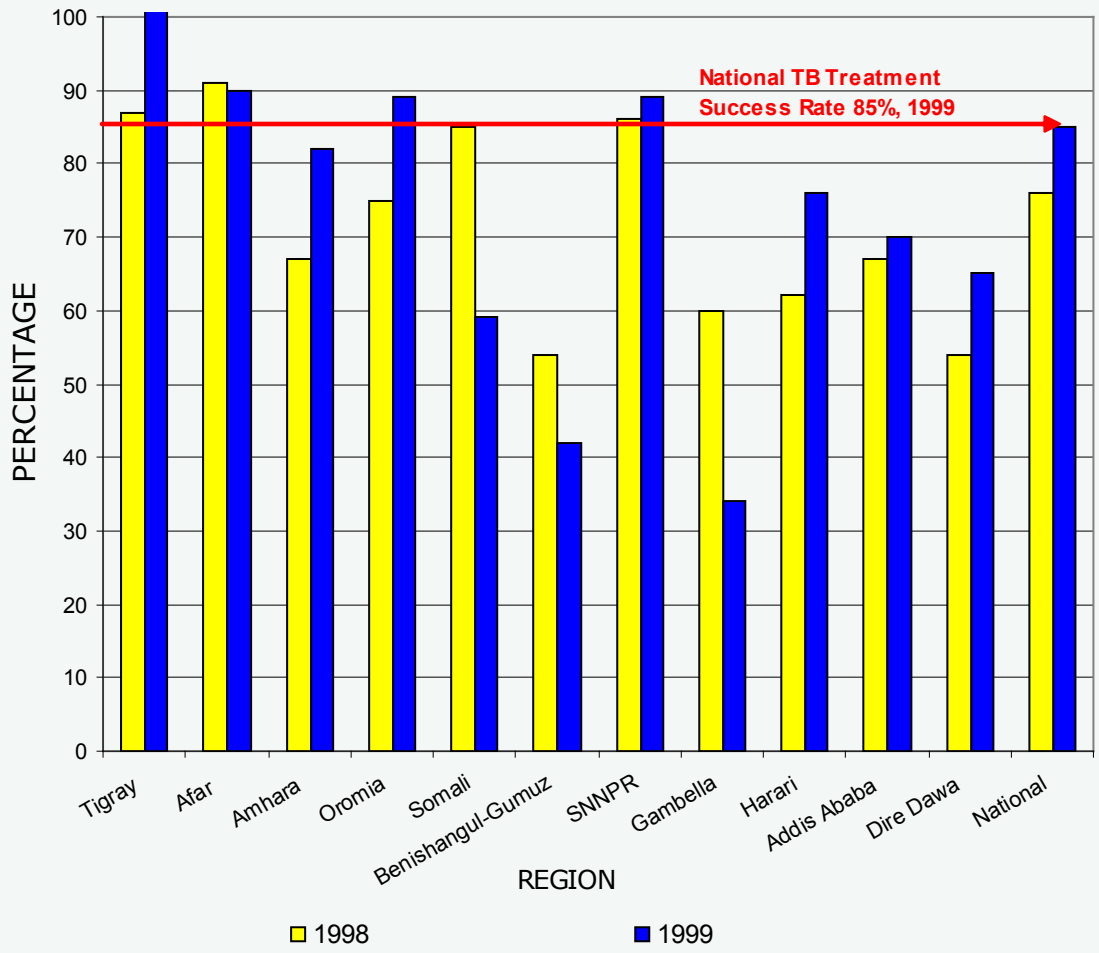
Figure 15. Distribution of TB Case Detection Rate by Region, Ethiopia, 1999 EFY



Treatment cure rate has shown very significant improvement from the EFY 1998 level of 62% to 69% in EFY 1999. This significant improvement is mainly attributable to the good implementation performance in Oromia region which has been able to increase from 62% to 74% and also Amhara with an increase from 66.5% to 71%. Gambella Regional State reported the lowest TB cure rate of 22% which needs special attention and follow up.

As it is shown in figure 16, treatment success rate is good in most of the regions but in Gambella (34%) and Benishangul-Gumuz (42%) Regions success rate is below 50% and their performance is much below than EFY 1998.

Figure 16. Distribution of TB Treatment Success Rate by Region, Ethiopia, 1998 and 1999 EFY



Except Gambella, Benishangul-Gumuz, Somali and Afar regions all other showed better TB treatment success rate in EFY 1999 than EFY 1998.

To make Community DOTS treatment in areas where HEP is implemented functional, one of the major areas of focus for the next fiscal year is to develop an implementation guideline and community mobilization strategies.

7.4. Oncocerciasis Prevention and Control

The plan for EFY 1999 was to provide treatment to 4.1 million oncocerciasis patients in ten Zones where oncocerciasis is prevalent. This treatment plan is to cover 84% of the total 4.9 million people who are in need of such treatment. To achieve this target, detailed implementation plan and project implementation guideline has been developed for nine oncocerciasis control projects that would help mobilize the necessary resources. Mectizan 11,845,488 drugs were imported and have been used for treating 4.1 million people seeking care. To strengthen the program, two teams have made visits to the project areas and provided supportive supervision. This helped to improve the record management system and also the link between projects and Regional Health Bureaus. Training is also given on record management and reporting systems.

7.5. Trachoma Prevention and Control

The plan for EFY 1999 was to expand Trachoma control program from 23 Woredas to 200 and also provide treatment to 8 million trachoma patients. Based on this, 4.3 million patients (54%) in 57 (28.5%) Woredas received the required treatment.

7.6. Kalazar Prevention and Control

Kalazar is becoming a serious problem in some regions of the country. As a response to the problem, it was planned to institute diagnostic and treatment facilities for kalazar prevention and control in all affected regions. To implement this, national Kalazar diagnosis and treatment guideline is developed and distributed to regions and training is also given to 33 health professionals for 5 days. The FMOH is intensifying the prevention and control activities and preparation is underway to establish a team of senior professionals and also make the necessary efforts to increase resources.

7.7. Epidemic Prevention and Control

In EFY 1999 the plan for epidemic prevention and control were:

- To establish Health Emergency Preparedness and Response Unit
- Develop Epidemic Preparedness and Response action plan
- Mobilize resources and avail essential materials
- Strengthen information communication system

The FMOH has been addressing health emergency issues through the IDSR team. Emergency Operation Center was established in order to specifically deal with the international threat of Avian Human Influenza and other emergency situations. Reduction of the Occurrence

of Epidemics has been identified as one of the selected seven core processes for Business Process Re-engineering. Currently, a team of experts from the FMOH, WHO and other partners are actively working on the design which is scheduled for discussion as one of the thematic areas for this year Annual Review Meeting.

Epidemic of Acute Watery Diarrhea (AWD) is one of the major health emergencies that occurred during this fiscal year. The outbreak was initially reported from Gambella in April 1998 and has been successfully controlled in two months time through a coordinated effort of both government sectors and partners. During the epidemic, 2,300 cases and 18 deaths were reported.

A second bout of AWD occurred two months later, and was spread in 201 Woredas and 10 Sub-cities in 8 Regions affecting a total of 79,831 cases that led to 941 deaths between the periods from July 1998 to June 1999.
Currently the outbreak is showing significant decline and vigorous efforts are being exerted to put it under complete control.

The approaches being followed are:

- Raise public awareness through various channels of communication
- Ensure sustainable availability of drugs and medical supplies
- Provide technical assistance
- Enhance surveillance and preventive activities
- Monitor and evaluate the overall situation

Figure 17. Areas Affected by Acute Watery Diarrhea, Ethiopia, 1999 EFY

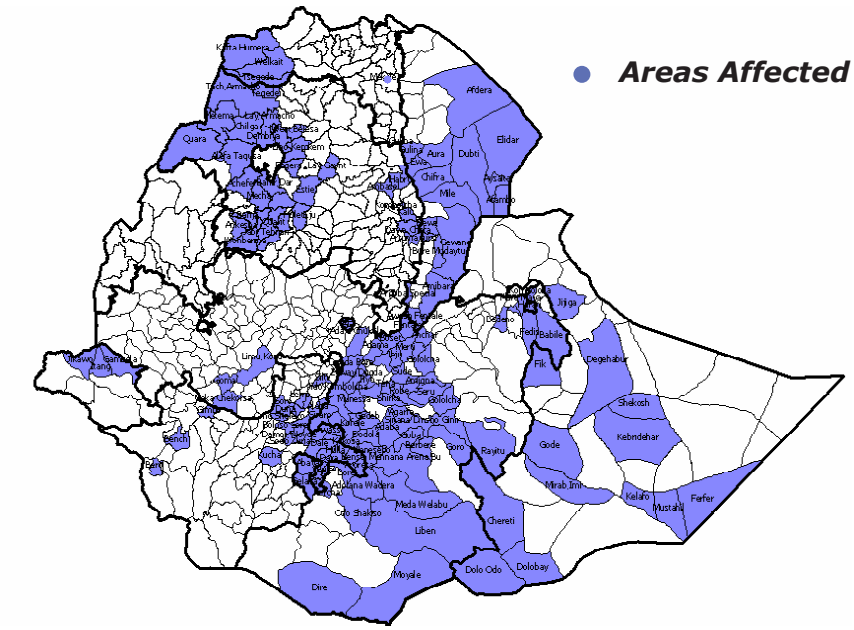
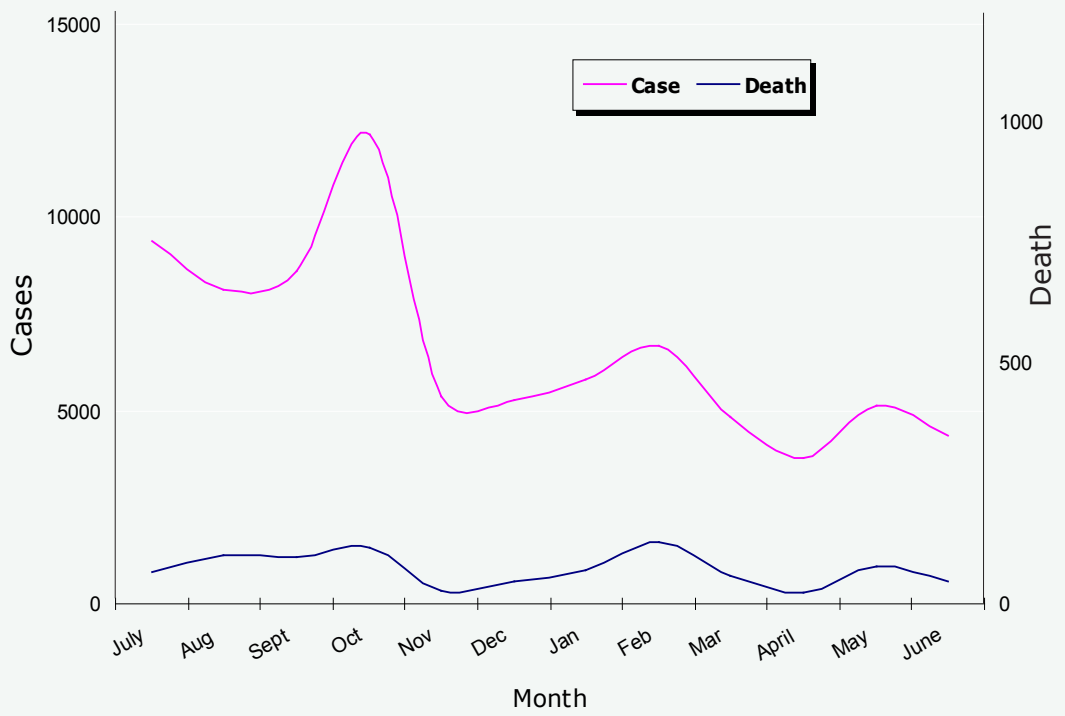


Table 4: Number of AWD Cases and Deaths Reported by Region, Ethiopia 1999 EFY		
Region	**Number of AWD cases**	**Number of Death due to AWD**
Oromia	32,822	288
Amhara	13,530	217
SNNP	16,407	119
Tigray	1,737	17
Afar	8,539	132
Somali	5,014	158
Addis Ababa	180	2
Gambella	85	3
Harari	1,517	5
Total	**79,831**	**941**

Figure 18. Trend in the Number of Acute Watery Diarrhea Cases, Ethiopia, 1999 EFY



Health epidemic preparedness and response taskforces at various levels (Federal, Regional, Woreda and Keble) were revitalized received back-up from higher levels. The support has enabled affected areas to benefit from Kebele based support which involved the community, HEWs, other categories of health workers, government sector and partners. Throughout the intervention period, drugs and supplies were available in adequate quantities.

To support the regions, a taskforce has been established within FMOH and pertinent messages are being communicated through the media and training manual is also developed to build capacity at all levels. In addition, treatment centers are opened in areas where cases have been reported, drugs and supplies worth of 19.4 million ETB has also been distributed to regions and an 8 million ETB worth of drug and supply has been mobilized from partners.

Challenges;

- Occurrence of the epidemic for prolonged period of time.
- Shortage of professionals to control the problem (because it emerged in many regions).
- Incomplete and delayed reporting from regions.
- Scarce resource at Woreda level.
- Difficulty to coordinate partners working on the intervention i.e. partners were not operating from one commanding center
- Lack of information regarding the resource availability by partners.
- Lack of information with regard to the supports that partners provided to the affected areas.

Different activities are being carried out to resolve these challenges through discussions held with regions.

In addition to this, as Ethiopia is located in the Meningitis Belt, epidemics of meningitis are normally expected to occur from the month of January onwards. However, this time the epidemic occurred earlier starting in September 1999 in three Zones of SNNPR (Wolayita, Derashe, and Omo) and in three Woredas (Damot, Woyede, and Derashie & Selamago). During the epidemic 619 cases and 10 deaths were reported.

To alleviate the problem of the meningitis epidemic, vaccine was purchased and distributed to affected areas where 57,000 people were vaccinated in SNNPR. There are no reported cases of meningitis in the last 7 months. Currently, there are 650,000 doses of meningitis vaccine available in stock and 1.11 million doses vaccines are already distributed to regions and hospitals, only 36% of the required 5 million doses.

8

Prevention and Control of Non - Communicable Diseases

In addition to vaccines, drugs and supplies were distributed using airlifts in order to control the flood emergency in Somali region.
In order to decrease the occurrence of non communicable diseases such as diabetes, hypertension, all forms of malignancies, etc. a task force consisting of representatives from Addis Ababa University, responsible governmental and nongovernmental organizations, and individual experts has been established. The task force is identifying key activities. In addition to this, the task force is designing strategies on ways and means of protecting the community from predisposing risk factors and improvement in the treatment and care of sick individuals.

Similarly, as a way to minimize health problems associated with accidents, a task force is created from governmental and nongovernmental organizations, Addis Ababa University including individual experts. The task force is now working on the designing of strategies that would help to make a continuous assessment on the severity and prevalence of the problem.

The strategy that has been developed for minimizing health problems associated with accident was reviewed in a workshop by the representatives from RHB, AAU Medical Faculty, and other government sectors. Based on the feedback from this workshop, the document was finalized by an ad-hoc team. This strategy has been endorsed by the higher officials of the FMOH. Based on this, a three years strategic plan has been developed.

In addition to this, collaboration is established with the National Coordination Office of Road Safety to build up Information, Education, and Communication materials focusing on road safety in order to raise public awareness.

9

Child Health Services

Since child health nutrition is treated under the nutrition section of this report, the report in this section will only deal with the implementation of child immunization and IMCI services.

Table 5: Child Health Indicators, Ethiopia, 1999 EFY

Indicators	HSDP III Target (EFY 2002)	1998 EFY	1999 EFY
DPT3 Coverage	80%	76%	73%
Measles Coverage	75%	66%	65%
Proportion of Fully Immunized Children	54%	54%	53%

9.1. Immunization

Improving child health is one of the priorities of HSDP III. It has set an explicit target for the reduction of under five mortality rate from 123 to 85 per 1000 live births and infant mortality rate from 77 to 45 per 1000 live births. One of the indicators used to monitor progress towards these targets is coverage of immunization. Child immunization is one of the most cost-effective public health interventions for reducing child morbidity and mortality. The goal of immunization programs is to reduce the incidence of vaccine-preventable diseases in children through high coverage of immunization with potent vaccines.

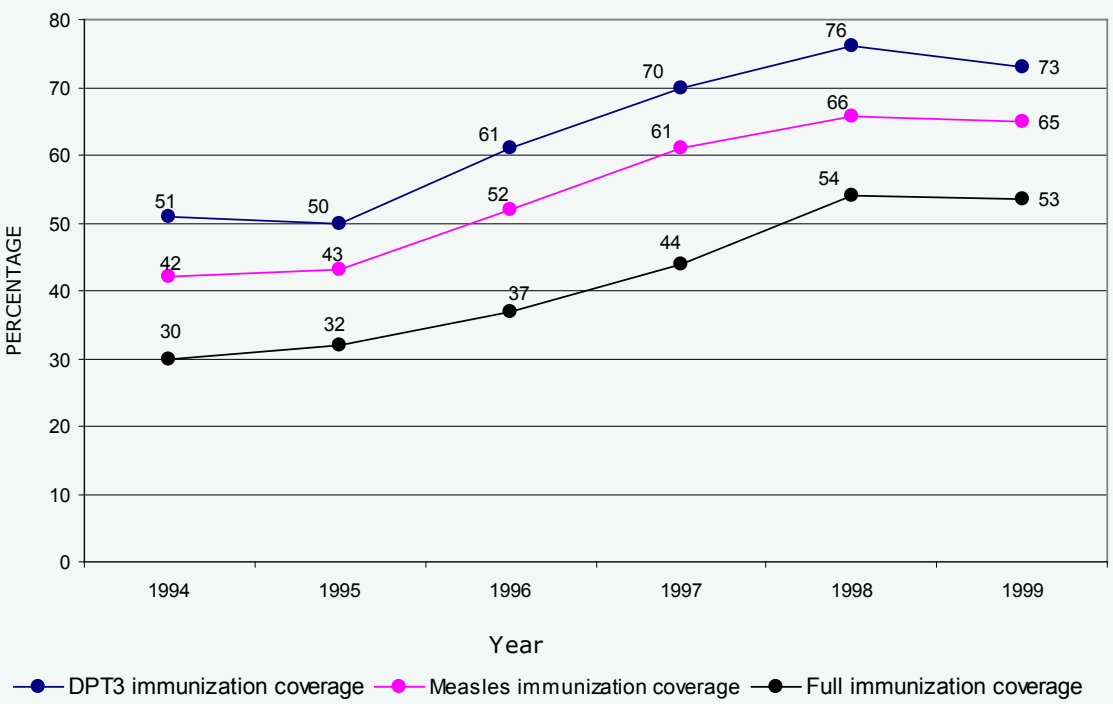
The target set for EFY 1999 was to increase DPT3 coverage from 70% to 80% by vaccinating 2.5 million children. In order to achieve this target, pentavalent vaccine enough to vaccinate 2.3 million children has been distributed to the regions. In addition, 4.8 million doses of

polio vaccine and 6.9 million doses of measles vaccines have been delivered to the regions. Moreover, the procurement of 1.7 million doses of measles and BCG vaccine for 3 million children is on process.

In order to build the capacity of health professionals, training was provided to trainers from 50 higher teaching institutes and 59 heads of program for EPI mid-level management. In addition, trainings were provided to 57 individuals on cold chain management, 277 persons on monitoring and evaluation, 25 on vaccine management and 86 persons (TOT) on the newly introduced pentavalent vaccine.

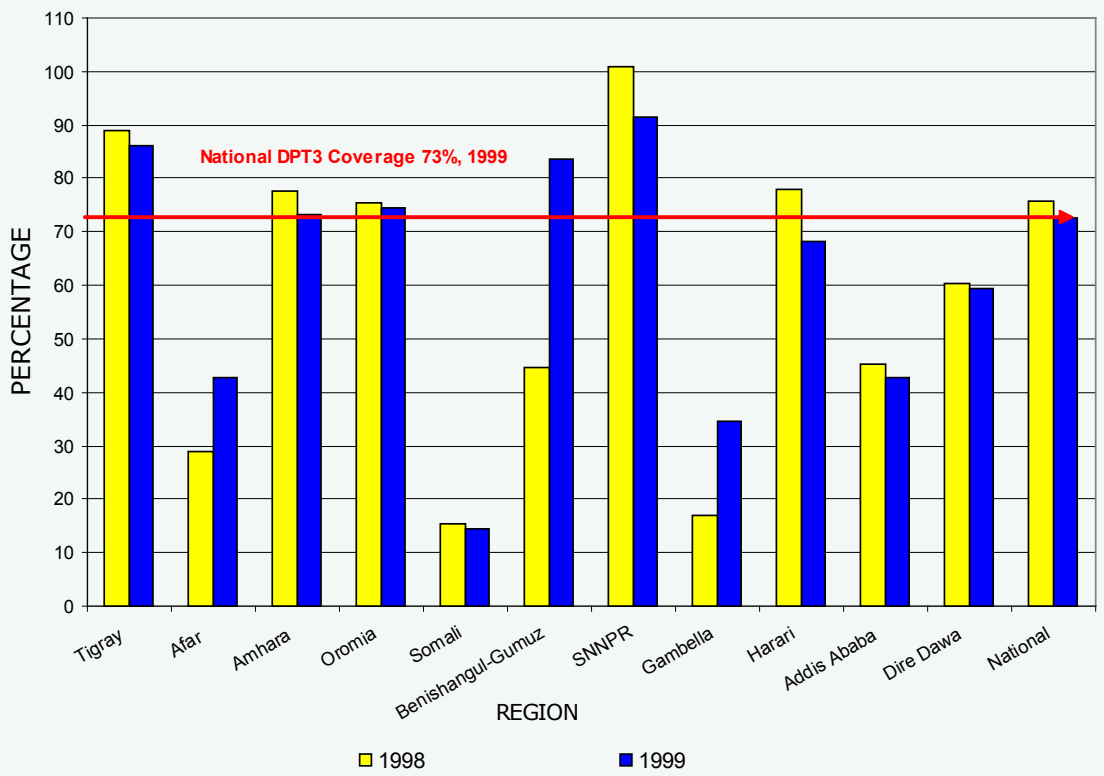
With these efforts, the EFY 1999 national DPT3/pentavalent immunization coverage has been 73%. This achievement is lower than the target set for the year EFY 1999 which was >80% and 2.4% lower than the achievement of EFY 1998 (75.6%). Figure 22 demonstrates the coverage of DPT3, Measles, and full immunization rates for the last six years.

Figure 19. Trend in DPT3, Measles and Full Immunization Coverage, Ethiopia, 1994-1999 EFY



The coverage for DPT3, Measles, and fully immunized children showed consistent increase from 51%, 42%, and 30% in EFY 1994 to 73%, 65%, and 53% in EFY1999. The EFY 1999 coverage for all three antigens showed slight decline compared to what has been achieved in EFY 1998.

Figure 20. Distribution of DPT3 Coverage by Region, Ethiopia, 1998 and 1999 EFY



Somali and Gambella Regional States reported the lowest DPT3 coverage, 15% and 35% respectively (figure 20). Challenges of setting proper population target and under reporting were presumed to be the causes for the declining of the indicators in Addis Ababa (42.8%). However, the lowest coverage rates in the two emerging regions need special consideration.

As indicated figure 22, Afar, Benishangul-Gumuz and Gambella regions showed remarkable increase in DPT3 coverage from 29% to 43% and 45% to 84%, and 17% to 35% in the years EFY 1998 and EFY 1999, respectively. This is an encouraging progress.

Measles is one of the major child killer diseases. Measles immunization coverage is one of the MDG indicators. The MDG report (2006, United Nations) showed that Sub-Saharan Africa achieved the largest reduction in deaths from measles: a decrease of nearly 60% between 1999 and 2000. Ethiopia's current measles coverage (65%) is not considered adequate to establish herd immunity (80%) within the community that can help to decrease the risk of measles outbreak.

Generally, in EFY 1999 regional and national DPT3, measles, and full immunization coverage have decreased from the EFY 1998 achievement levels. The decreasing coverage in SNNP and Amhara regions has contributed significantly to the lower national coverage. These are the regions with high number of un-immunized children. Hence, it is important to investigate the situation and take up proper measures.

Some of the challenges or constraints of the EPI program are the high turnover of staff, delay of reports, and delay in liquidation of funds.

9.2. The Integrated Management of Childhood Illnesses (IMCI)

IMCI is a strategy adopted by Ethiopia to improve the quality of the management of childhood illnesses. In EFY 1999, it was planned to expand IMCI to 96 health centers. The reported achievement has been 83 (87%) health centers. As part of this activity, trainings were given to 322 health professionals to provide IMCI service to 1.5 million children under five years of age. In order to insure the sustainability of the program through integrating the training of pre-service trainings, 46 teachers from higher institutes attended the IMCI case management training. In addition to this, 45 audiovisual materials and teaching aids are distributed to 13 teaching institutes.

In order to expand Community IMCI (C-IMCI) from 23 to 36 Woredas, sensitization workshop was held in 13 Woredas, training of trainers (TOT) was given to 148 health professionals, and 1,021 community volunteer who were selected by the community which received the C-IMCI training with the expected beneficiaries of 51,050 households. Based on the plan to train Health Extension Workers on C-IMCI in the Amhara region, TOT on C-IMCI was given to 328 professionals and they are expected to train 3,000 HEWs. The IMCI booklet has also been translated into Amharic.

Some of the challenges of implementing IMCI are high turnover of staff and other priorities like campaigns impeding implementation of activities as per the plan.

10

Maternal Health Services

Worldwide, every minute a woman dies from pregnancy and childbirth related complications. This means 1,500 deaths every day, and as many as over a half million deaths every year, with the highest proportion of these deaths occurring disproportionately in the developing world. In addition, for every woman who dies from childbirth complications, around 20 more women suffer injury, infection or diseases.

Provision of quality antenatal care is strongly associated with overall better pregnancy outcomes for both mothers and their infants. Antenatal care can foster rapport between the mother and the health care providers. It accords an opportunity to provide preventive care and health education, identify and treat illness, encourage skilled attendance at birth, prepare the mother and other members of the family including birth attendants for possible emergencies.

Unnecessary maternal deaths can be prevented if women have access to and make use of skilled care during pregnancy, childbirth and in the first month after delivery, or to quality family planning services and post-abortion care services. Reducing the number of women dying in childbirth by three-quarters by 2015 is one of the key goals of the Millennium Declaration.

This section presents the most common maternal health indicators. Comparisons are made between the regional/national performances against the targets sets both in the HSDP III and PASDEP.

Table 6: Maternal Health Indicators, Ethiopia, 1998-1999 EFY

Indicators	HSDP III Target (EFY 2002)	1998 EFY	1999 EFY
Contraceptive Acceptance Rate	45%	36%	34%
Antenatal Care Coverage	80%	50%	52%
Proportion of Deliveries Attended by Skilled Health Personnel	32%	15%	16%
Postnatal Care Coverage	31%	16%	19%
TT2 coverage for Pregnant Women	75%	52%	49%

10.1. Antenatal Care and Delivery Service

The HSDP III targets for achievement in the EFY 1999 with regard to antenatal care and clean delivery were to increase from 42.1% to 80% and 10% to 50%, respectively.

In order to achieve these targets, cost effective and home made delivery kits sufficient to service 15,500 mothers have been purchased and distributed to Oromia and SNNP Regions while 400 delivery kits were reserved at TVETS for practical training of HEWs. This distribution figure is a significant underperformance as compared to the target set to provide 1.8 million delivery kits for the reporting year.

The plan to prevent postpartum hemorrhage was to introduce the use of Misoprostol in 25 health centers and 140 health posts. This has been accomplished in 26 health centers and 96 health posts through the distribution of 50,000 Misoprostol. In addition, training was given to a total of 56 health workers and 96 HEWs on the administration of Misoprostol.

During the EFY 1999, except the contraceptive acceptor rate, all other maternal health indicators showed improvement as compared to the reported achievements of the previous year. Improvements in the indicators included ANC coverage increasing from 50% to 52%, postnatal care coverage from 16% to 19% and proportion of deliveries attended by skilled health personnel from 15% to 16%.

Although those improvements are encouragingly promising, they still leave a lot to be done in terms of achieving the HSDP-III and MDG targets. The greatest hope is that accelerating performance in the coming three years will make significant contribution towards decreasing the high maternal mortality in Ethiopia.

Figure 21. Trend in ANC Coverage, Percentage of Deliveries Attended by Skilled Health Personnel and PNC Coverage, Ethiopia, 1994-1999 EFY

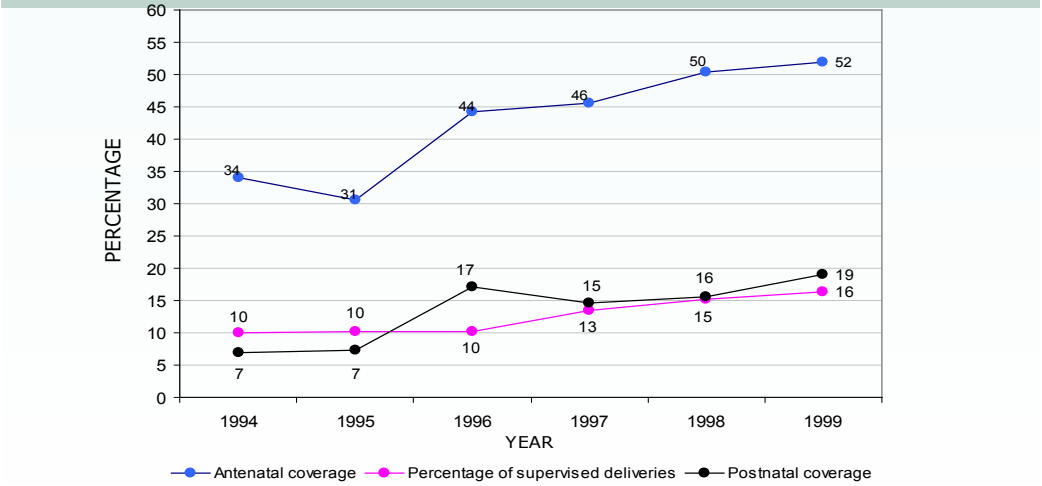


Figure 21 demonstrates that there has been a consistent increase in basic maternal health services for the last five years. Such increases were from 34% in EFY 1994 to 52% in EFY1999 for ANC coverage, from 10% to 16% in the proportion of deliveries attended by skilled health personnel and, from 7% to 19% in the postnatal care (PNC) coverage.

There have been wide variations in the performance of ANC coverage across regions ranging from the lowest of 6.6% in Somali Region to the highest of 89.5% in Tigray region. As can be seen in figure 22, Afar, Oromia, Benishangul-Gumuz, Somali, Amhara and Gambella reported coverage levels that are below the national average. However, Harari, Addis Ababa, and Dire Dawa regions have shown significant improvements in ANC coverage as compared to the achievements they had reported in EFY 1998. Amhara and Benishangul-Gumuz Regions experienced a decreased performance for the reporting year.

Figure 22. Distribution of ANC Coverage by Region, Ethiopia, 1998-1999 EFY

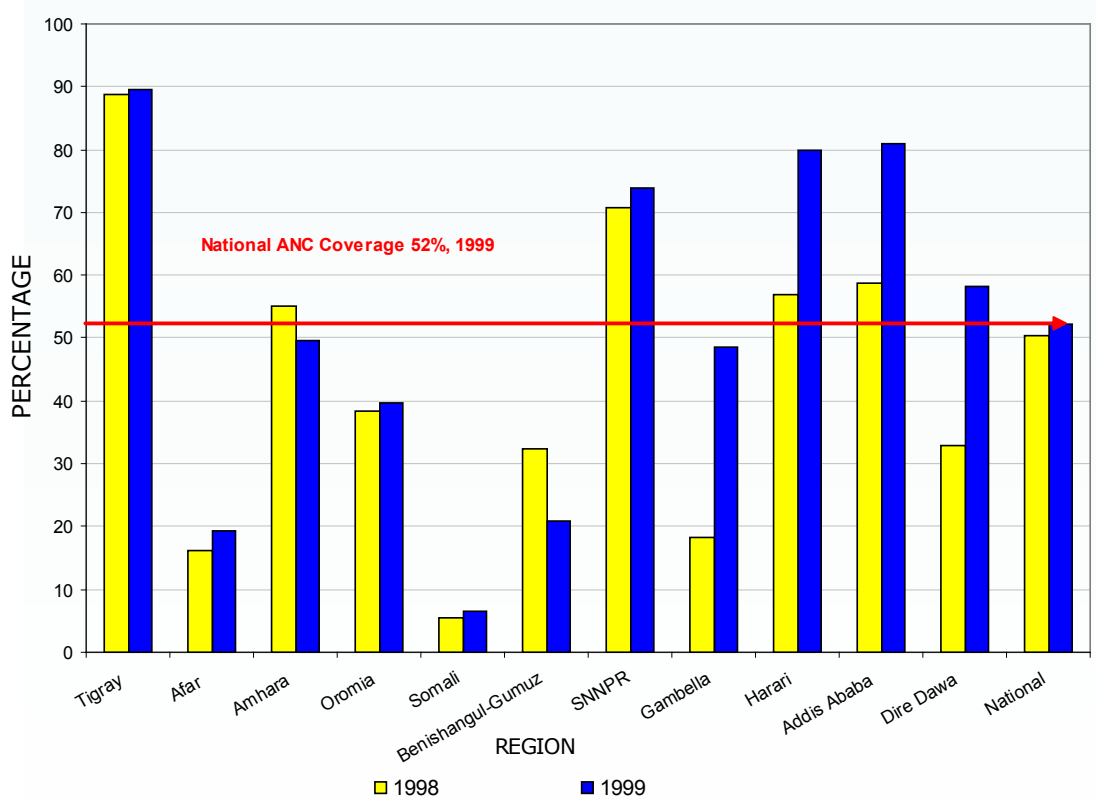
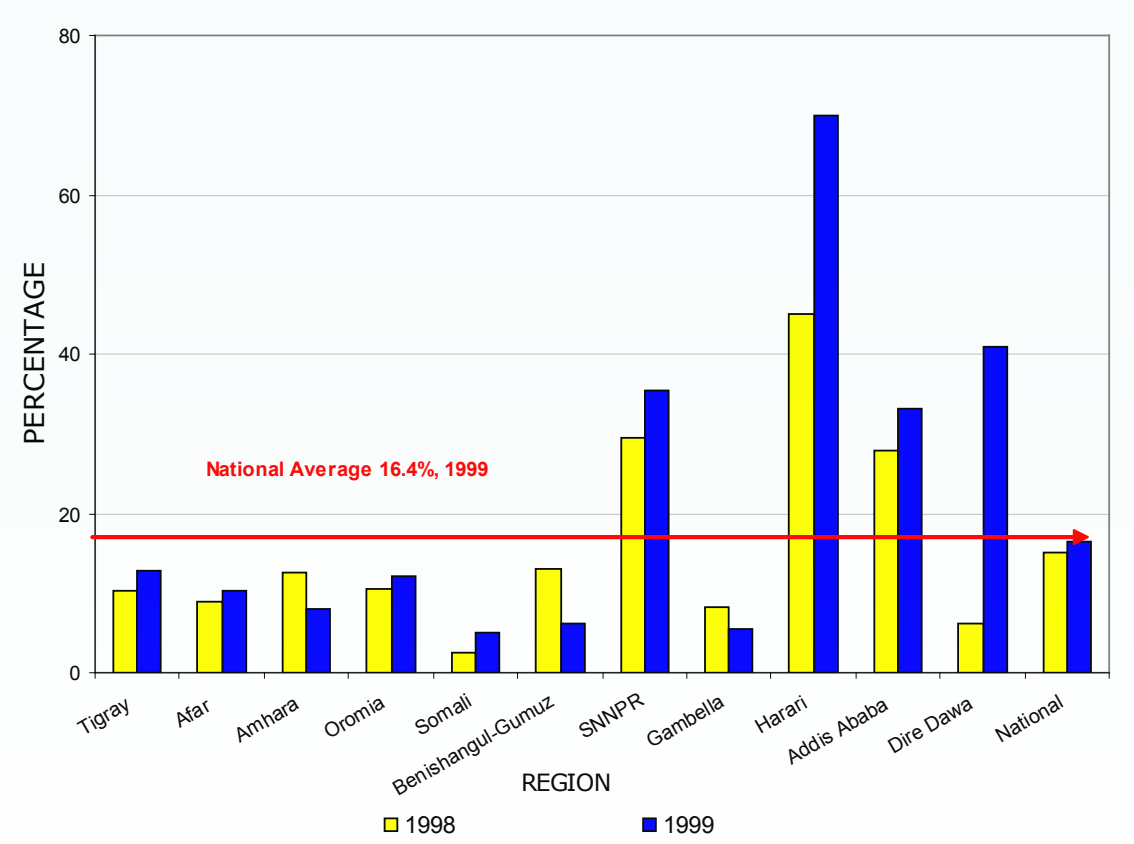
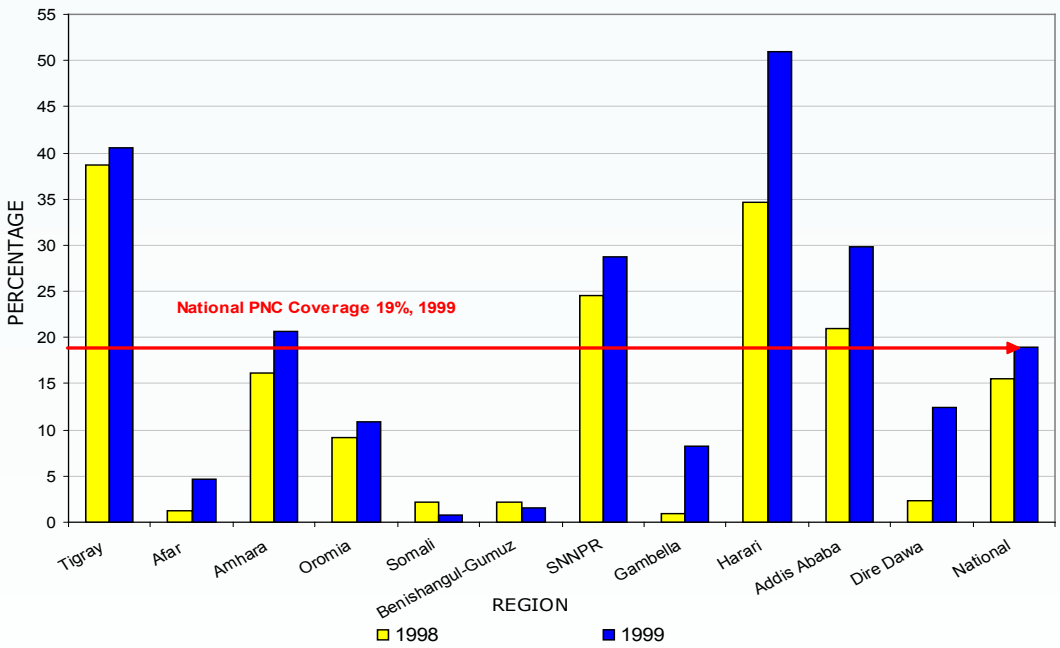


Figure 23. Comparison of Percentage of Deliveries Attended by Skilled Health Personnel by Region, Ethiopia, 1998 and 1999 EFY



As illustrated in figure 23, the highest SD coverage was reported from Harari (70%). Dire Dawa, SNNP, and Addis Ababa Regions achieved SD coverage rates in the order of 41%, 35.5%, and 33%, respectively. Three emerging Regions: Somali, Benishangul-Gumuz and Gambella reported the lowest SD coverage in the order of 5%, 6%, and 5.4%, respectively. Moreover, PNC coverage at 0.74% in Somali, 1.45% in Benishangul-Gumuz and 4.6% in Afar were the lowest achievements for the EFY 1999 (Figure 24). It is hoped that the expansion of HEP is expected to provide an opportunity to significantly increase PNC coverage across the country.

Figure 24. Comparison of Postnatal Coverage by Region, Ethiopia, 1998 and 1999 EFY



The reported sizeable coverage gap between ANC (52%) and PNC (19%) indicates the obvious weakness in the consistency of follow up in the delivery of basic maternal health services. The other major weak factor in the position of these indicators was the inadequacy in the proper recording and reporting of theses services by health facilities. Such operational problems will be expected to improve with the expansion of the new HMIS.

The other key health delivery program for the improvement of maternal health is the implementation of Basic and Comprehensive Emergency Obstetric Care (BEOC and CEOC). The target in the HSDP III is to cover all health centers with BEOC, 87% of Hospitals and 20% of the Health Centers with CEOC.

The targets in EFY 1999 plan were:

- To provide refresher training on BEOC for 320 health professionals and CEOC to 40 teams (one team consisting of three professionals; anesthetist, scrub nurse, and health officer or physician).
- To ensure the availability of equipment needed for basic emergency obstetrics care to 160 health facilities and for comprehensive obstetric care to 40 health facilities.
- To develop a guideline to facilitate the implementation of regulations for the prevention of complications associated with unwanted pregnancy,
- To initiate the implementation of BEOC in 160 Health Centers.

The reported achievement rates for the EFY 1999 in this regard have been encouraging. In terms of specifics, training on BEOC was given to 320 health professional (100%), CEOC training was provided to 68 teams (170%). Moreover, 16 health facilities were provided with equipment and medical supplies that are needed for the implementation of BEOC, and to date, BEOC is operational in 166 health facilities and CEOC in 79 health facilities (see table 7).

Table 7: Number of Health Facilities Providing BEOC and CEOC Service, Ethiopia, 1999 EFY

Region	Number of Health Centers (Govt)	Number of Hospitals (Govt)	Health Facilities providing BEOC	Number of Facilities providing CEOC
Tigray	12	42	15	16
Afar	14	2	5	2
Amhara	168	17	46	13
Oromia	192	22	20	12
Somali	22	6	6	2
Benishangul-Gumuz	14	2	14	2
SNNPR	161	16	24	7
Gambella	8	1	0	1
Harari	3	2	0	0
Addis Ababa	23	3	22	22
Dire Dawa	6	1	14	2
Total	**623**	**114**	**166**	**79**

A new guideline on the medically approved termination of pregnancy was prepared based on the revised Ethiopian penal codes. Appropriate training has been given to create awareness and facilitate implementation.

Challenges encountered in the implementation of these programs are:

- High turn-over of trained and skilled staff,
- Lack of essential equipment
- Additional workload on the already over-stretched medical staff,
- Weak referral linkage among health facilities.

The way forward:

- Ensure the adequate supply of the required equipments,
- Strengthen the referral linkage,
- Design a mechanism for the retention of trained professionals.

10.2. Family Planning

Enabling couples to decide when and whether they wanted to have children is vital for safe motherhood and child health. Limiting a closely spaced births or births to very young or old mothers can significantly reduce prenatal, infant, child, and maternal mortality.

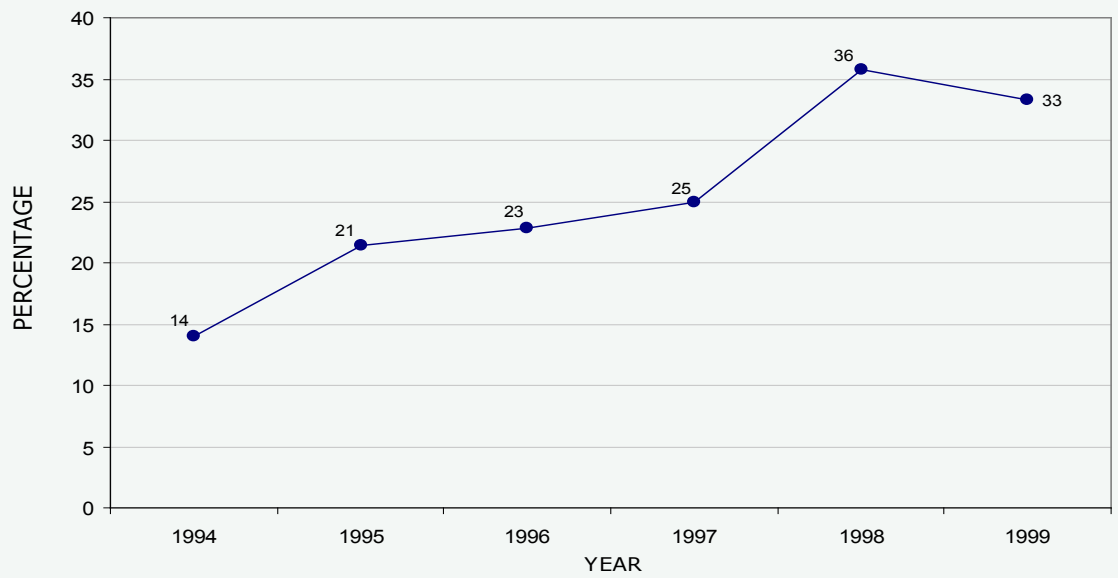
In the fiscal year under consideration, about 15.3 million of the total population are non-pregnant females who are in the reproductive age group. Among these, 11.9 million are expected to make use of FP services. Different types of contraceptives which will adequately fulfill the demand of 8.5 million women have been procured and distributed in the EFY 1999. In addition, 15,000 female condoms have been imported as a way of introducing the availability of the technology in selected regions of the country on which 356 HEW supervisors were trained on its appropriate use. In addition, the plan is to procure 300,000 female condoms to expand the implementation of the program.

In order to increase the family planning options through the availability of different types of contraceptives, the procurement of 1.6 million dose of injectable contraception, 160,000 dose of Norplant, 100,000 does of IUD and 400,000 doses of emergency contraceptives have been procured.

In addition, 60,000 dose of Implanon contraceptive is being imported and training will be given to 86 health professionals to facilitate its utilization. According to the recent study, there is 34% unmet need of contraception in the country. Hence, in addition to what the country is getting from development partners, the Federal and Regional governments of Ethiopia have secured funds to narrow the gap in the shortage of contraceptives.

There have been consistent increasing trend in the contraceptive acceptance rate for the years 1994 to 1998 with slight decrease in EFY 1999 (Figure 25). This is an indication of a sustained trend of achievement. However, the decline in EFY1999 needs to be addressed appropriately in the coming planning year.

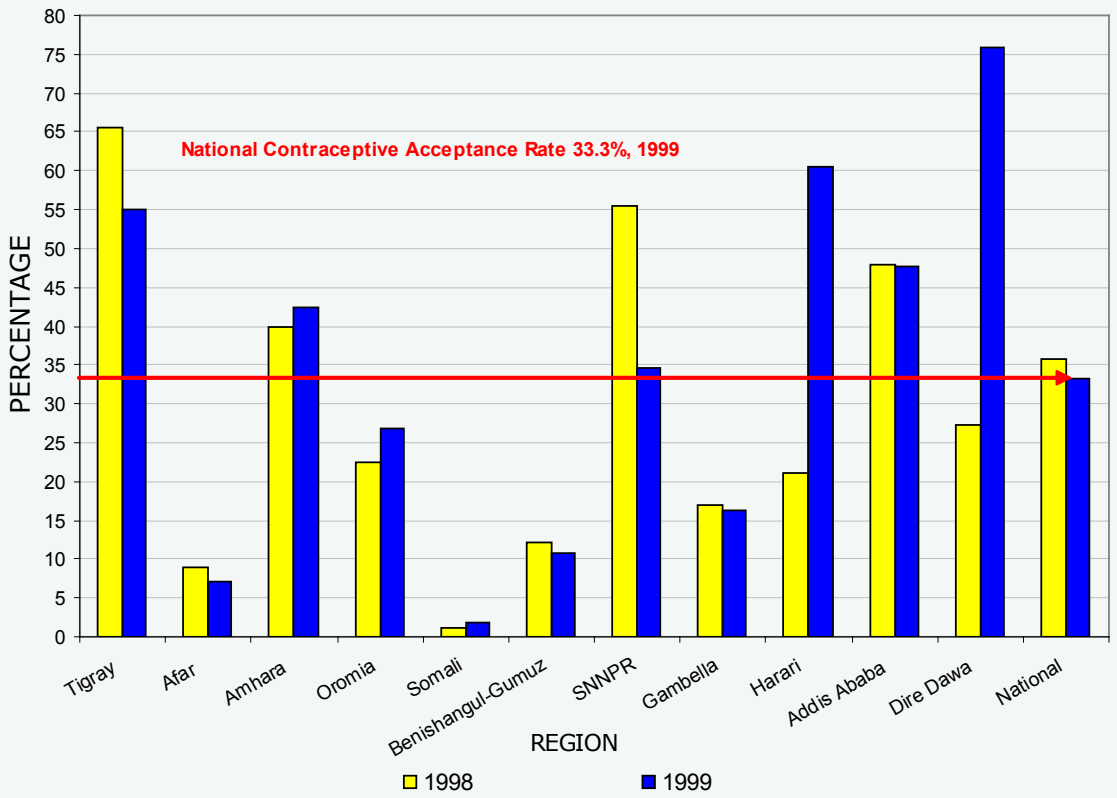
Figure 25. Trend in Contraceptive Acceptance Rate, Ethiopia, 1994-1999 EFY



There exists a wide regional variation in the reported contraceptive acceptance rate for EFY 1999. The variations ranges from as small as 1.84% in Somali, 7.9% in Afar, and 10% in Benishangul-Gumuz medium to encouragingly high rate in the order of 43% in Amhara, 55% in Tigray, 62% in Harari and 78% in Dire Dawa Regional States. Such gaps appears to be an indicative for considering the need for special focus in areas with low contraceptive acceptance rate through providing different choices of family planning methods.

The performance in contraceptive acceptance rate by region indicates that Afar, Tigray, Benishangul-Gumuz, Gambella and SNNP Regional States reported decline in EFY 1999 compared to what was reported in the EFY 1998. The decrease in percentage terms for SNNP and Tigray were very significant. However, as shown in figure 26, remarkable increases in the contraceptive acceptance rates were reported for Dire Dawa and Harari Regions.

Figure 26. Distribution of Contraceptive Acceptance Rate by Region, Ethiopia, 1998 and 1999 EFY



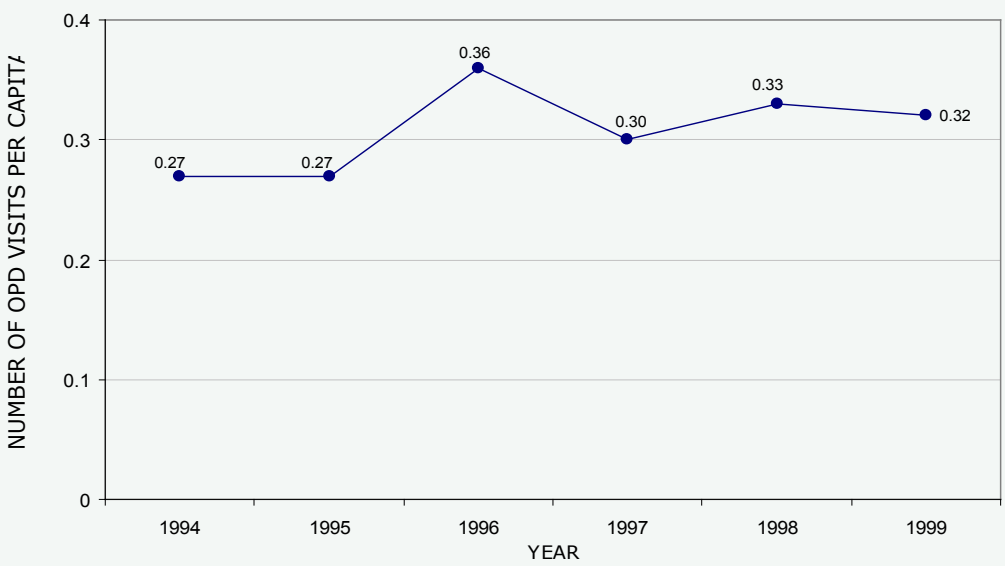
11

Utilization of Health Services

Four indicators are presented to show the utilization of the service by the community. Out Patient Department (OPD) attendance per capita is a measure of the number of first and repeat visits per total population. Inpatient admission rate is the number of inpatient admissions per total population, bed occupancy rate is the number of admission days or total length of stay per number of beds by 365 days, and average length of stay is the ratio of number of admission days or total length of stay and number of inpatient admissions. In addition to this the quality of service provided will be assessed using inpatient mortality rate which is the ratio of number of patients discharged dead and number of inpatient admission.

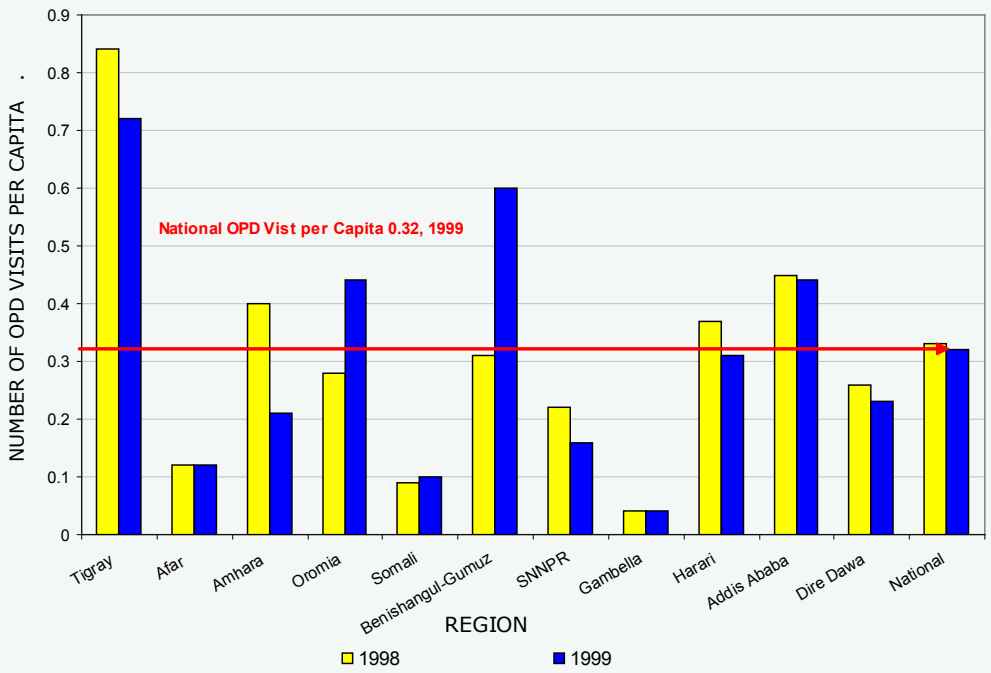
The HSDP III target for OPD attendance per capita is 0.66. In 1998 EFY, OPD attendance per capita was 0.33 and in EFY 1999 stayed stable at 0.32. As it is demonstrated in figure 27, trend of OPD attendance per capita for the last six years shows no significant change.

Figure 27. Trend in OPD Attendance per Capita, Ethiopia, 1994-1999 EFY



The highest per capita OPD attendance in EFY 1999 is observed in Tigray Region at 0.72 surpassing the HSDP target followed by Benishangul-Gumuz which has exhibited a significant improvement from 0.31 in EFY 1998 to 0.6 in EFY 1999. The lowest per capita visit is observed in the three emerging regions of Gambella, Somali, and Afar with 0.04, 0.10, and 0.12 respectively. This is indicated in figure 28.

Figure 28. Distribution of Outpatient Attendance per Capita by Region, Ethiopia, 1998 and 1999 EFY



Data reported from most regions especially from Afar and Somali have discrepancies on admission days, inpatient admissions, and hospital beds. This limitation does not allow calculating actual percentages of other indicators. Based on the report received from regions the national inpatient admission rate is 7.6/1000. The bed occupancy rate is also low. Only 35% of the total beds were occupied within the fiscal year. The average length of stay in the hospitals is 4.36 days.

Underreporting appears to be the major reason for declining health service utilization rate figures as witnessed during the pilot implementation of HMIS. Hence it is expected to improve as HMIS reform expands across the country.

12

Strengthening Operational Research and Related Activities

The main objective of any health operational research is to identify and study on priority public health concerns aimed to generate evidence that would help health decision-makers in their effort to improve the quality of health care in terms of maintaining acceptable clinical standards. In EFY 1999, operational researches were planned in areas of maternal and child health as well as on the surveillance of major public health problems (HIV/AIDS mainly on the prevalence among pregnant women, malaria and TB).

12.1. Operational Research on Maternal and Child Health

The maternal and child morbidity and mortality rates in the country are very high. Improving the status of maternal and child health are priority health intervention in the HSDP-III, and both are given due attention for operational research. In the EFY1999, four research areas were identified on Maternal and Child Health. These research topics are:

- Assessment on the causes of Maternal Mortality (Maternal death audit).
- Assessment on choice of Family Panning.
- National prevalence of cervical cancer.
- Coverage and impact of the Expanded Program of Immunization.

Accordingly, the following major researches have been carried out in the reporting year.

12.1.1. Assessment on the causes of Maternal Mortality (Maternal death audit): The studies on the prevalence of cervical cancer and the causes of maternal mortality (Maternal Death Audit) are outsourced to the Medical Faculty of Addis Ababa University. To facilitate the management of the study, relevant study protocol is developed and the required equipment for the investigation of cervical cancer has been purchased and being put in place.

12.1.2. Coverage and impact of the Expanded Program of Immunization: Data collection is completed for the study and the data analysis including report writing are in progress. It is expected that the study will bring about evidences and recommendations about the impact and coverage of EPI in Ethiopia.

12.1.3. A Study protocol on the effect of Misoprostol towards reducing maternal mortality associated with postpartum hemorrhage (PPH) has been developed. The draft protocol was shared among major partners who have been reviewed and endorsed. Preparation is underway to introduce the drug in health facilities and to start the study.

12.2. Surveillance of major public health problems (Malaria, TB, and HIV/AIDS)

The national HIV/AIDS prevalence survey among pregnant women is regularly carried out every other year. The latest survey on this has been successfully completed.

A study on the distribution and use of ITNs was carried out by the Pathobiology Institute of Aklilu Lema. The study report has been disseminated to relevant organizations and individuals.

13

Utilization of Financial Resources

The HSDP-III is a shared sector wide strategic plan document that has been developed through extensive discussion and reiterative consultative processes. Since the HSDP III planning document has been widely circulated, all relevant stakeholders are expected to make commitments to make available the required financial and non-financial resources for the effective implementation of the plan.

As a way forward, the FMOH and its health development partners are working in close collaboration and partnership to ensure the availability of the needed resources for the implementation of the annual plans as part of the HSDP-III. In a similar tone, all stakeholders of the Ethiopian health sector development convincingly believe that effective utilization of the available financial and material resources is equally important.

The Ethiopian Government has approved a Health Care financing strategy. The strategy aims at improving both allocative and utilization efficiencies in order to ameliorate the prevailing financial and non-financial resource gaps of the health sector.

Some Regional States (SNNPR, Amhara and Oromia) are progressing very well both in the development of the necessary legal framework and also in terms of embarking on the actual implementation of the reform. The legal frameworks in these regions have allowed retention and use of revenues collected in the health facilities. Health facilities (hospitals and health centers) in SNNPR, Amhara and Oromia reported that they have been able to generate substantial amount of revenues that would enable revenue collecting health facilities to invest for improving the quality and quantity of health care services. Some of these health facilities are already showing encouraging results in the proper and efficient use of the additional revenues for improving the quality of health care.

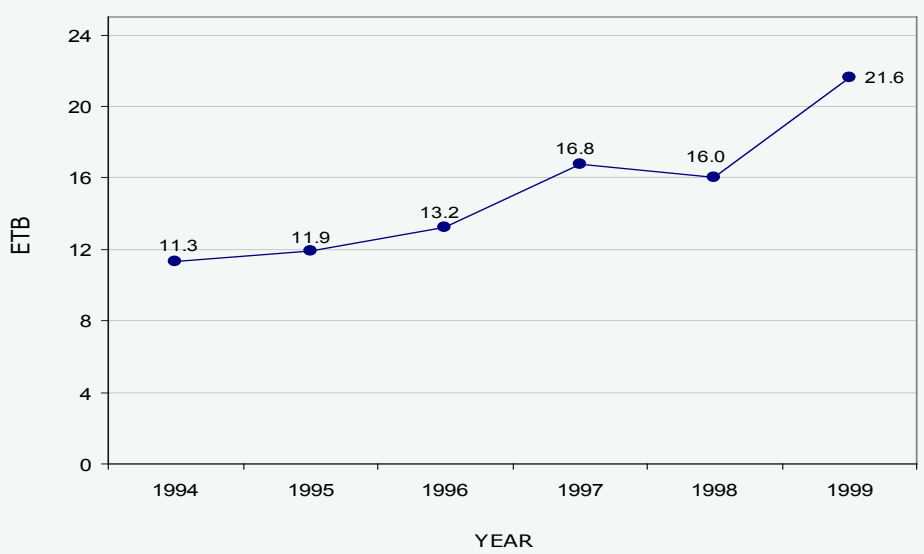
Overall, public spending on health both at the Federal, Regional and Woreda levels has been steadily growing over the years. The following section shows the per capita public expenditure at Federal and Regional levels

13.1. Per Capita Public Expenditure on Health

Public average health spending for each individual citizens and residents as shown by the per capita expenditure on health is an important indicator reflecting both governments' actual commitment for delivering quality health care as well as an indicator of resource availability for the sector. An upward trend in per capita public expenditure on health has been registered based on data provided by the Ministry of Finance and Economic Development over time.

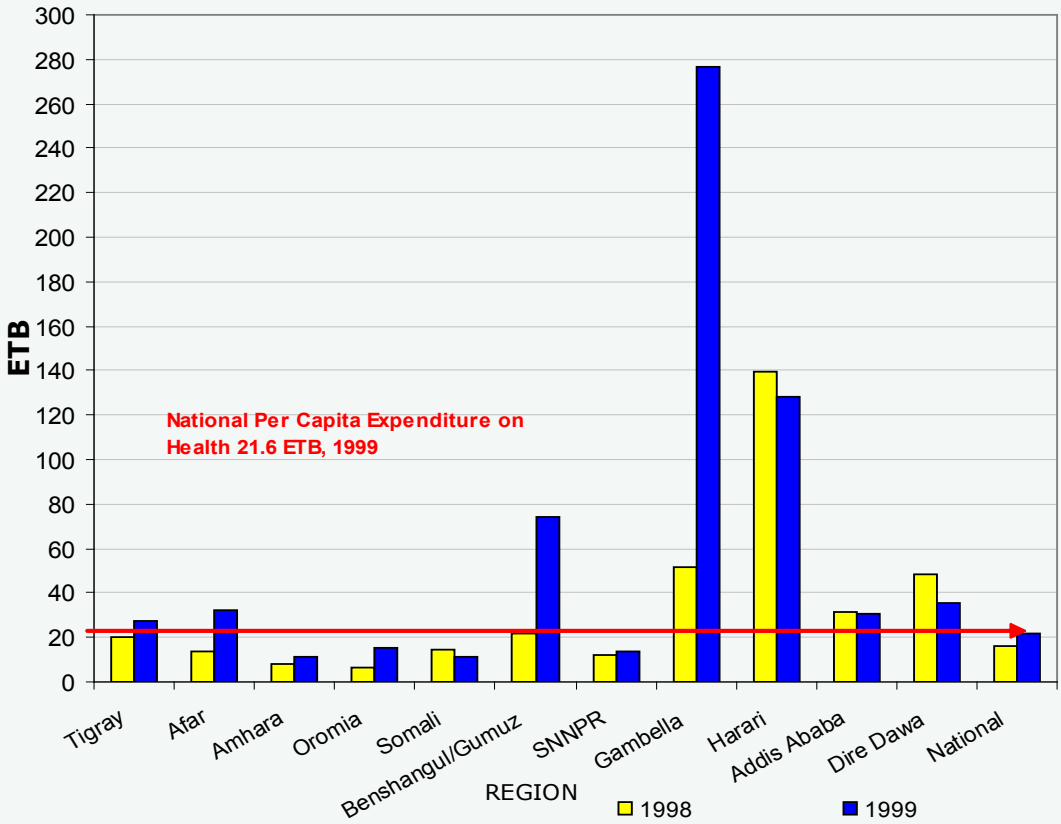
As it is demonstrated in figure 29, since 1994 per capita public expenditure has been growing annually by 8%. In absolute terms it increased from 11.3 ETB in 1994 EFY to 21.6 ETB in 1999. Given the annual population growth rate of 2.7%, the total spending on health has been substantially increasing. This continuous and consistent increment in per capita public expenditure indicates the due priority and attention given to the health sector. The absolute and per capita spending increment enables to avail more accessible and improved quality health care which in turn produces better and recognizable gains in health status of citizens.

Figure 29. Trend in per Capita Public Expenditure on Health (ETB), Ethiopia, 1994-1999 EFY



The level of per capita public expenditure of Regions in EFY 1999 shows wide variations, ranging between less than ETB 7 for Somali to ETB 277 for Gambella. The per capita public expenditure for Gambella, Harari, Benishangul-Gumuz, Dire Dawa, Afar, Addis Ababa and Tigray are above the national average. Expenditure per capita in Gambela, Harari, Benishangul-Gumuz and Dire Dawa is among the highest which could partly be due to the relatively small population size compared to the others. Similarly the Regions of Amhara, Oromiya, and SNNP that have large population size are below the national average. This is shown in figure 30.

Figure 30. Distribution of per Capita Public Expenditure on Health (ETB) by Region, Ethiopia, 1998-1999 EFY

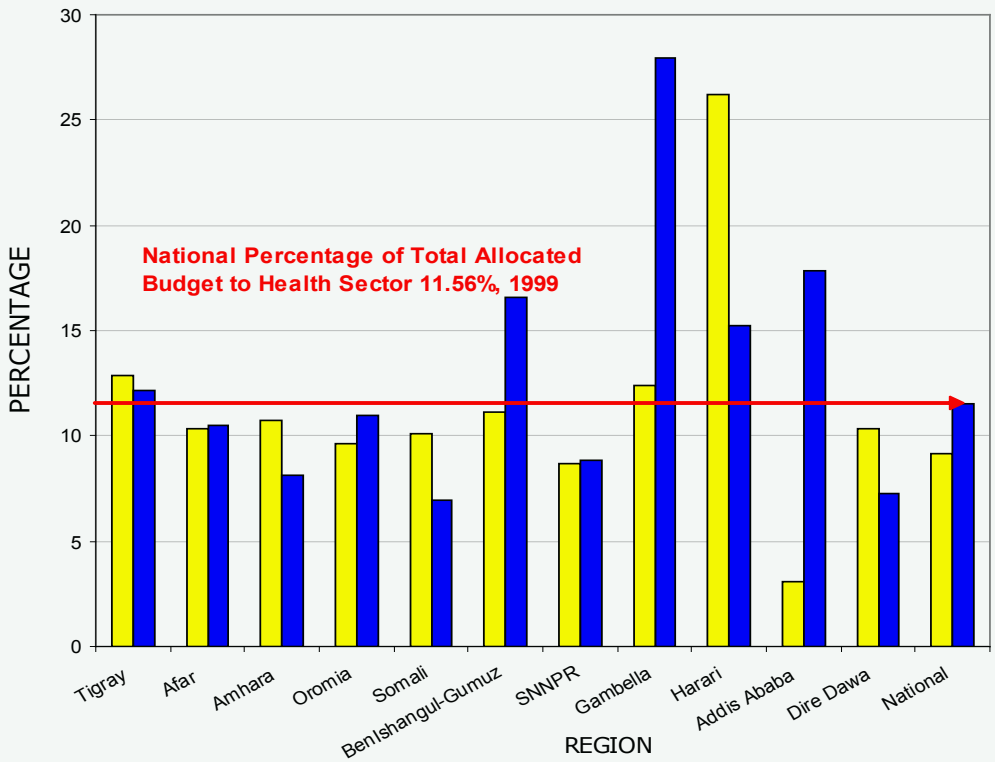


It should be noted that the comparison does not include resources flowing to the health sector from other financing sources such as out-of pocket spending by individuals, expenditure from private for profit and private-not-for-profit (NGOs) and from donors particularly channels 2 and 3, are not included in this estimation

13.2. Percentage Share of Health Budget to Total Budget

As it is indicated in figure 31, the percentage of total regional budget allocated to the health sector ranged between 11% in Somali and Amhara to 28% in Gambella Regions, with a national average of 11.56%. It is worth noting that, the national average allocation for health has increased from 9.1% in 1998 EFY. This increase is consistent with HSDP-III target to double the share of health as a proportion of total budget.

Figure 31. Distribution of the Percentage of Total Budget Allocated to the Health Sector by Region, Ethiopia, 1998 and 1999 EFY



Challenges:

Although the spending on health from public sector is increasing, the total and per capita spending on health is far below the sectors need for delivery of accessible and quality health care services in the country. The recent NHA showed that the per capita spending on health of USD $7.14 is on the lower side when compared to similar other SSA countries and far from the US $34 per capita spending recommended by WHO Macroeconomics and Health Commission. Thus, increasing the overall spending to the recommended level will be challenging. This will be particularly difficult for regions with current low per capita expenditure.

Way Forward:

- Advocate for better budget allocation to the health sector mainly in regions with very low level of per capita sending on health care.
- Strengthen implementation of the on-going HCF reform implementation such as health facility level revenue retention and use.
- Introduce social and community based health insurance.

14

Strengthening Coordination, Monitoring and Evaluation

14.1. Coordination within FMOH

Weekly management meeting is conducted at FMOH to monitor performance. The Civil Service Reform Program which is comprehensive in addressing both planning and monitoring and evaluation has been discussed as a regular management agenda. The same monitoring meetings have been conducted at departmental and team levels to follow up on implementation of plans.

14.2. Coordination between FMOH and RHBs

Bimonthly regular meetings have been conducted between the management of FMOH and Heads of RHBs throughout the year. Priorities of HSDP-III and other issues of common interest have been discussed and consensus reached between FMOH and RHBs. This has greatly facilitated common and agreed approaches to addressing key priorities of HSDP-III.

14.3. Coordination between the health sector and development partners

The governance structure between FMOH and HPN Donors are CJSC, FMOH-HPN Donors Group Joint Consultative Forum and the Joint Core Coordinating Committee (JCCC). During the reporting year, only two meetings of CJSC have been conducted. The FMOH-HPN Donors Group Joint Consultative meeting, however, has been conducted more or less on bimonthly basis. The ad-hoc meeting of the JCCC has been conducted almost on weekly basis throughout most of the year.

Moreover, some regions have established partner fora although a lot of work remains to be done in terms of guiding these fora to the principle of *one-plan, one-budget and one-report* as per the HSDP Harmonization Manual. Regions are also expected to establish functional joint steering committees both at regional and Woreda levels.

15

Conclusions

In the reporting year, remarkable achievements were made in the health sector which enabled increasing access, coverage and improved quality of health care. Encouraging achievements have also been observed in the area of health system strengthening.

This report has presented the major achievements, challenges and way forward. ARM 2007 is expected to look into the report very closely and provide recommendations that will help to improving on weaknesses and accelerate implementation to achieve HSDP-III target.