Federal Democratic Republic of Ethiopia
Ministry of Health

Annual Performance Report of HSDP-III

EFY2001
(2008/2009)

October 2009

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ACRONYMS

AAU	Addis Ababa University
ADB	African Development Bank
AHOTP	Accelerated Health Officers Training Program
ANC	Antenatal Care
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
AWD	Acute Watery Diarrhea
BEOC	Basic Emergency Obstetric Care
BPR	Business Process Re-engineering
BSC	Balanced Score Card
CBHI	Community-Based Health Insurance
CDC	Center for Disease Control
CEO	Chief Executive Officer
CEOC	Comprehensive Emergency Obstetric Care
CLSI	Clinical Laboratory Standard Institute
CPR	Contraceptive Prevalence Rate
CSA	Central Statistics Authority
CSRP	Civil Service Reform Program
EDHS	Ethiopia Demographic Health Survey
DFID	Department for International Development
DPs	Development Partners
EFY	Ethiopian Fiscal Year
EHMI	Ethiopian Hospital Management Initiative
EHNRI	Ethiopian Health and Nutrition Research Institute
EHR	Electronic Health Record
EOS	Expanded Outreach Service
EQA	External Quality Assurance
ETB	Ethiopian Birr
ETC	Ethiopian Telecommunication Corporation
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunization
GFTAM	Global Fund against AIDS, Tuberculosis and Malaria
GIS	Geographic Information System
JCCC	Joint Core Coordinating Committee
JFA	Joint Financing Arrangement
JRM	Joint Review Mission
HCF	Health Care Financing
HCT	HIV Counseling and Testing
HEP	Health Extension Program
HEW	Health Extension Worker
HHM	HSDP Harmonization Manual
HIT	Health Information Technicians
HMIS	Health Management Information System
HO	Health Officer

HPF	Health Pooled Fund
HPN	Health, Population and Nutrition
HRH	Human Resource for Health
HSDP	Health Sector Development Program
IDSR	Integrated Disease Surveillance and Response
ICT	Information Communication Technology
IEC	Information, Education, Communication
IHP	International Health Partnership
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
IUD	Intrauterine Device
LMP	Logistic Master Plan
LMIS	Logistics Management Information System
MDG	Millennium Development Goals
MOE	Ministry of Education
MOFED	Ministry of Finance and Economic Development
MOWR	Ministry of Water Resources
MoWUD	Ministry of Works and Urban Development
MTEF	Medium-Term Expenditure Framework
MTR	Mid-Term Review
NCD	Non-Communicable Disease
NCPB	National Committee for the Prevention of Blindness
NHA	National Health Account
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PBS	Protection of Basic Services
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund and Supply Agency
PHARMID	Pharmaceutical and Medical Supplies Import and Distribution
PHEM	Public Health Emergency Management
PLWA	People Living With AIDS
PMTCT	Prevention of Maternal to Child Transmission of HIV
PNC	Postnatal Care
PPP	Private-Public Partnership
RBI	Research-Based Initiative
RDF	Revolving Drug Fund
RDT	Rapid Diagnostic Test
RHB	Regional Health Bureau
SCMS	Supply Chain Management System
SHI	Social Health Insurance
SNNPR	Southern Nations, Nationalities and Peoples Region
SPM	Strategic Plan Management
SSA	Sub Saharan Africa
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Trachomatous Trichiasis
TVET	Technical and Vocational Education and Training Center
VCT	Voluntary Counseling and Testing

EXECUTIVE SUMMARY




EXECUTIVE SUMMARY

This report gives an overview of the annual performance of the health sector in EFY 2001 (2008/09) based on a set of selected indicators, along with the challenges encountered in the implementation of the Core Plan and actions taken to address the challenges.

In EFY2001, the major achievements and challenges of the sector include the following:-

1. EFY 2001 marks the finalization of the BPR core process design and start up of implementation. Accordingly:
    a. The leadership and top management at various levels of the health system has been provided with leadership development training, training on Government Policies and Strategies, implementation of BPR and Balanced Score Card. Implementation of the BPR has also been closely monitored at various levels.
    b. The organizational structure of the sector has been revised, personnel have been assigned, civil servants have been trained, legal frameworks have been drafted and some have been approved, and awareness creation activities for stakeholders have been undertaken.
    c. Health Care Delivery Core Process has created a customer centered organization of services at FMOH level to support rural, pastoralist and urban HEP following the one-stop-shopping principle.
    d. In order to improve the quality of hospital care, the hospital BPR is being implemented in all hospitals except those in emerging regions; and second degree level training is being given at Jimma University for a total of 80 Chief Executive Officers and Medical Directors. A document on opening of private wings in government health institutions has also been prepared in consultation with various partner organizations and is ready for printing.
    e. The BPR on Public Health Emergency Management has been completed and implementation is underway. Thirteen epidemic intelligence service officers are being trained at Master's Degree level. Eighteen diseases have been selected in the new design for surveillance and detection of public health emergencies has started.
    f. Research and Technology Transfer core process has drafted a strategic plan to prioritize research activities; and to lead its application in an integrated manner. The draft will be discussed and refined with stakeholders
    g. Pharmaceuticals Supply Core Process started EFY 2001 with the institutional transformation of the profit making PHARMID into service providing PFSA. The Agency has initiated activities towards building its capacity in terms of revolving drug funds, construction of hubs, transportation system, deployment of human resources and designing LMIS. It has also procured and distributed significant amount of essential drugs, medical equipment and supplies in the year under consideration.
    h. Resource Mobilization and Health Insurance Core process has started laying the backbone for establishing a sustainable financing system for the sector through deployment of staff as per the new design, mapping of resources and gap analysis. Implementations of the health care financing reforms activities in Oromia, Amhara and SNNP during the past fiscal year were geared towards strengthening capacity of implementers at regional, Woreda, and facility levels to implement components of the reforms. Out of 73 hospitals and 823 health centers collecting and retaining revenues, 90% have started retaining their revenues and 95% have utilized the funds to improve the quality of care.

i. Extensive consultation has been conducted on the draft Social Health Insurance Proclamation and regulation in EFY 2001. These documents have been resubmitted to the relevant body for endorsement.

j. Moreover, 12 Woreda have been selected in 4 regions for pilot testing of Community Based Health Insurance. Three year plan has been prepared, training manual has been developed for Regional and Woreda level CBHI leadership, regional feasibility studies have been finalized, and CBHI legal documents, and financial and management systems have been developed. Furthermore, Regional Steering Committees have been established, regional TOTs have been given for subsequent training of members of Woreda health insurance steering committee, Woreda health insurance board and management committee, Kebele health insurance mobilization committee, and Kebele health insurance management committee.

k. With regard to Health and Health Related Services and Product Regulation Core Process, policy documents have been refined and a new proclamation has been prepared. Drug manufacturing plants and factories have been inspected for good manufacturing practice. A unified Drug Quality Control Guideline is being finalized and a guideline on vaccine quality control has been prepared.

l. Health Infrastructure Expansion and Rehabilitation Core process has been established as a core process with the aim of construction and renovation of health and related facilities, the supply and utilization of inputs to health facilities, maintenance of medical equipment and computers and the expansion of health information technology. Currently, the necessary capacity is being built to start implementation of the core process at full scale.

m. As part of ensuring one-plan, the Policy, Planning and Monitoring and Evaluation Core process has developed the sector-wide, Woreda-based Core Plan for EFY 2002 through a bottom-up and top-down approach. Leadership at all levels of the health system has shown significant commitment, and development partners have also provided enhanced technical and financial support.

n. Implementation of one budget principle in the sector has also progressed through the signing of IHP+ compact and Joint Financing Arrangement to pool funds in the MDG Performance Fund. Seven Partners have pooled funds and procurement of commodities and capacity building activities have been implemented in a harmonized and aligned manner by using the funds.

o. One M&E is progressing throughout the sector by scaling up of HMIS. FMOH has printed and distributed HMIS forms and registers worth 20 million birr to health facilities that have met the necessary pre-requisites for implementing the new HMIS. Overall 7,779 health professionals have been trained and 44 hospitals, 82 health centers are currently implementing the new HMIS. It has been noted that health facilities that have implemented the HMIS have significant improvement in the level of data quality, in some instances by 50-60%. Encouraging results are being demonstrated in the level of data utilization and links with the use of the annual Woreda Plan.

p. In EFY 2001, the design of the Family Folder has been completed and initial implementation has begun. The design of the family folder enables close follow-up on the health status of each family with respect to preventive, promotive and high impact curative care that were incorporated in Health Extension Program. Moreover, the design incorporates a novel mechanism that enables health extension workers and program managers to closely monitor vital events (birth, death, cause of death). The Family Folder has been piloted and the necessary modifications have been made. Subsequently, the printing of around 14 million Family Folders has started and the necessary preparations

have been made to train health extension supervisors for the national scale up.

2. A laboratory that validates and monitors th e quality standards of RDT products has been established. This is a remarkable achievement as this laboratory meets international standards and is expected to give service to Africa Region. To undertake quality control at national level on HIV, TB and Malaria laboratories, guidelines and related documents which help to validate quality of HIV tests have been prepared at federal level and distributed to regions. In FY 2001 national HIV test quality control program has been implemented in three rounds. In all rounds, 500 laboratories and testing points as well as 130 VCT centers have participated and were able to register good results. The national HIV laboratory and six regional laboratories have participated in two rounds in the DNA-PCR international quality control program arranged by CDC Atlanta and have registered excellent results.

3. High performance was registered in the training and deployment of health extension workers, where over 100% of the total national requirement of HEWs was met. Regarding the urban HEP, preparatory activities have been undertaken to train and deploy HEWs that provide the packages on the basis of the life style and settlement pattern of the urban population. The Implementation Manual has been finalized and the 24 HEP packages have been prepared and distributed to the concerned urban administrations for implementation.

   The HEP in pastoral and semi-pastoral areas continues to be implemented; and the HEP Implementation Manual that was under preparation in EFY 2000 has been finalized and distributed in EFY 2001.

4. In EFY 2001, it was planned to train the cumulative number of 7,168,793 model families. The actual number of model families trained up to the end of EFY 2001 was 4,061,532, with a performance rate of 57%.

5. The cumulative number of health posts constructed up to end of EFY 2001 is 12,488. This constitutes 83.1% of the target. The performance in equipping new health posts is lower than the target in EFY 2001 (57.4%).

6. To achieve the planned Universal Primary Health Care coverage, the target of HSDP III is to put 3,200 health centers in place by 2009/10. The FMOH and RHBs have agreed in 2007 to share the responsibility of constructing health centers. As per their commitment, the FMOH is committed to build in EFY 2001 1,391 health centers while the RHBs are expected to build 838 health centers. Accordingly, 1,200 health centers have been contracted out, and site handover made for 1,192 health centers. Out of these, 1,135 are available or under construction, of which 326 have been already completed in EFY 2001.

7. On the part of RHBs, the plan for EFY 2001 was to construct 838 matching health centers. Accordingly, funds have been secured for 846 sites, 809 sites have been contracted out, and 806 are available or under construction, of which 368 have been already completed in EFY 2001. The national EFY 2001 baseline was 1,620 health centers; in addition to these baseline figures, 965 new health centers were constructed or under construction (by FMOH or RHBs) at the end of EFY 2001, therefore reaching the cumulative total of 2,585 health centers available or under construction in EFY 2001. A total of 365 new health centers are still to be constructed to reach the target of 2,950 set for EFY 2001.

8. With respect to equipment for health centers, equipment adequate for 1,023 health centers (79.3% of the target of 1,290) has been procured and has arrived at the port of Djibouti. Packing for 976 health centers has been completed and distribution of the medical equipment has commenced. The procurement of medical equipment for the remaining 300 health centers is underway and delivery is expected soon.

9. In EFY 2001, the construction of 23 new, the rehabilitation of 14, the expansion of 6 and the upgrading of 10 hospitals were started at regional level. There is an ongoing construction of 29 hospitals in 8 regions.

10. With respect to the construction of 16 blood banks in six regions, 95% of the work has been completed at Goba, Hawassa, Jimma and Harar and 70% at Axum, Mekelle and Wolisso. The performance rate in the construction of the 16 blood Banks is on an average 87%.

11. The coverage achieved in the distribution of two rounds of Vitamin A supplementation in EFY 2001 was 95% against the target of 98% set for the year.

12. Concerning the number of children de-wormed, the coverage of 98% has been achieved at the national level.

13. The number of people using the HCT service grew from 4,559,954 in EFY 2000 to 5,853,472 in EFY 2001, with an achievement rates of 88.8% compared to the target (6,588,497). Current estimates show that there are 79,184 HIV-positive pregnant mothers and 14,148 HIV-infected births within a year. In EFY 2001, 6,466 mothers received antiretroviral treatment and this amounted to only 8.2% of those eligible (79,184). Out of the planned number of mothers who need prophylaxis, it is only 16.2% who got the service. The number of PLWA ever enrolled in ART program increased from 266,507 in EFY 2000 to 376,772 in EFY 2001, while the number of those ever started ART increased from 150,136 to 208,784 and those currently on ART increased from 109,930 to 152,472 in the same period.

14. 20.5 million ITNs have been distributed in malarious areas up to EFY 2000 and 22.2 million up to EFY 2001 to maintain coverage at 100%. The planned new ITN distribution in EFY 2001 was 7.1 million and out of these, 1.7 million (23.7%) has been distributed during the reporting year.

15. TB indicators were quite stable in EFY 2001 with respect to EFY 2000, with TB case detection rate being at 34%, TB treatment success rate at 84% and a TB cure rate at 67%.

16. There have been outbreaks of epidemic diseases, such as AWD, meningitis, measles, and malaria; but an integrated and collaborative effort has been undertaken to control and prevent these epidemics and the necessary drugs and medical supplies have been distributed to regions affected by the epidemic.

17. Maternal health indicators showed increases in EFY 2001. ANC coverage increased from 61% in EFY 2000 to 66% in EFY 2001, and postnatal coverage increased from 26% to 34%. The proportion of deliveries attended by skilled health personnel increased from 21% in EFY 2000 to 25% in EFY 2001. The contraceptive acceptance rate increased from the 54% registered for EFY 2000 to 56 % in EFY 2001.

18. There were fluctuations in immunization coverage, with Pentavalent 3 vaccine coverage decreasing from 85 % in EFY 2000 to 82 % in EFY 2001, measles vaccine coverage slightly increasing from 76 % to 77 %, and full immunization coverage being stable around 66 % (66.4 % in EFY 2000 and 65.5 % in EFY 2001).

19. In EFY 2001, operations research was conducted in the areas of nutrition, traditional medicine, HIV/AIDS, TB and malaria, surveillance of major public health problems and health commodity tracking.

20. The percentage share of the health budget allocation from total budget was 10%. The per capita allocation on health increased from ETB 28.5 in EFY 2000 to ETB 38.0 in EFY 2001. The percentage of total regional block grant budget allocated to the health sector ranged from 2.7% in Addis Ababa to 19.8% in SNNPR.

    The per capita public expenditure on health has grown from ETB 16.0 in EFY 1998 to ETB 26.6 in EFY 2001.

21. Comparison between commitment and disbursement of donor's funds shows that 55.4% of the amount committed was disbursed in EFY 2001 with marked variation across Development Partners.

22. Monitoring and Evaluation has been an important area undertaken by the FMOH, Regions, Zones and Woredas in EFY 2001 .

23. Some of the major challenges encountered during implementation of the EFY 2001 core plan were as follows:
    - Delay and lack of uniformity in implementation of the BPR at all levels of the health system.
    - Slow implementation of the HMIS at sub-national levels, shortage of budget in some regions for training of health workers in HMIS and inability to hire health information technicians.
    - Delay in procurement, repacking, and distribution of medical equipment to health posts and health centers and low RDF capital.
    - Slow transfer of funds to the MDG pooled fund account by some development partners.
    - Inability to fully utilize funds and submit financial reports on time.
    - With respect to expansion of health centers, the major challenges include: Shortage of skilled personnel in relation to the construction through GTZ, shortage of qualified contractors, lack of willingness on the part of contractors to take up sites whose costs are estimated based on cost saving strategies, lack of commitment of contractors to complete construction as per agreed schedule, for PMU managed health centers slow progress in accessing funds and inability to get contractors for health centers situated in remote areas, the exacerbated escalation of construction prices and difficulty in taking construction materials to remote sites, shortage of allocated budget in the construction of health centers financed by RHBs, and the serious shortage of construction materials like iron and cement.
    - Lack of capacity and focus at regional level for coordinating programmatic interventions.

ARM 2009 is a forum to discuss these issues and provide recommendations to solve the challenges.

I

INTRODUCTION




INTRODUCTION

The end of EFY 2001 marks the conclusion of the fourth year of the Health Sector Development Program (HSDP III). Since its official launching in 1998, the HSDP has been continually reviewed through joint exercises as Mid-Term Reviews (MTRs), Final Evaluations, Joint Review Missions (JRMs) and Annual Review Meetings (ARMs). The present ARM is the eleventh in the series of annual review meetings that took place since the implementation of the HSDP I over a decade ago.

From the beginning, various monitoring and reporting mechanisms have been instituted as part of HSDP. One such mechanism is the regular reporting by Regions, FMOH departments and other stakeholders as an input to the Annual Performance Report which is presented at the ARM as one of the core agenda items.

Another equally important mechanism is the Joint Review Mission (JRM). The JRM is conducted prior to the Annual Review Meeting and focuses on assessing progress and identifying problems in the implementation of the sector. The report of JRMs is expected to shed light on the implementation status of the sector program, identify major constraints and recommend corrective measures. The JRM report supplements the annual performance report generated through the routine system and helps to strengthen and institutionalize the single monitoring framework. The JRM reports are also discussed at the annual review meetings.

Thus, the Annual Review Meeting is an important occasion which serves as a forum for discussion of progress of the HSDP and other issues raised by stakeholders, for experience sharing between Regions, central level institutions and other stakeholders; for the review and endorsement of the next plan and for deliberation of additional issues of sector-wide significance.

The Annual Review Meeting brings together a wide range of stakeholders that include Federal and Regional Government agencies, Woreda health offices, health extension agents, HPN Donors Group, NGOs, professional associations, institutions of higher learning, the private sector and international organizations.

According to the approved TOR, the objectives of the eleventh Annual Review Meeting are to:-

- Take stock of the progress made and problems encountered in the implementation of the EFY2001 plan based on the review of the consolidated implementation report;
- Look forward into the activities of the coming year by reviewing and endorsing the sector's Core Plan for EFY 2002;
- Provide the forum for the introduction or endorsement of new policy and program initiatives, for exchange of views on key topical issues and for forging common understanding/knowledge about current policy and technical trends.
- Strengthen the partnership between the Government, Donors and other stakeholders through joint work in preparing and conducting the review meeting.

The major inputs to the review meeting include: the EFY 2001 Performance Report, the Core Plan for EFY 2002, and the report of the Joint Review Mission for EFY 2001.

In EFY 2001 there has been steady progress in the development of evidence-based monitoring and evaluation and in the achievement of the harmonization vision of operating through one-plan, one-budget and one-report. Since the launching of the sector's HMIS reform, there is a unified reporting format, a sector-wide annual performance report based on standardized set of indicators including a sector-wide annual core plan. These are significant achievements; however, there are still a number of challenges to overcome. As noted by the JRM the scaling up effort of the HMIS system has to be implemented as per plan, and there is a need for re-strategizing the implementation of the scaling up process with all stakeholders.

In the preparation of this report, effort has been made to:-

- Assess the EFY 2001 performance of the sector against the set of selected indicators.
- Present highlights of performance against the Core Plan with the application of the national and regional level indicators.
- Analyze trends of achievements.
- Make comparisons among Regions.
- Present an overview of the health sector support system, and
- Provide a health sector financial report for EFY 2001.

The compilation of this report has relied heavily on the HMIS, the Joint Review Mission Report (EFY 2001), surveys and studies undertaken by various stakeholder institutions (e.g. CSA reports, Population Census, etc.) and reports by FMOH programs and other central level institutions.

One of the main data sources for this report is the recently released 2007 population census. Since the population based indicators are derived from the census figures, an understanding of the performance requires an explanation of the methodology used in the estimation of the population based indicators. To this end, a brief explanation of the methodology is presented as follows.

1.1 Methodology for the Estimation of Population-Based Indicators on the Basis of 2007 Census

We reviewed patterns and trends of population-based indicators for performance assessment in EFY 2001. Of note is the fact that, in the previous annual performance reports (including that for the EFY 2000), population-based indicators were estimated using the projections from 1994 census. Following the release of the population figures from 2007 census by the Central Statistical Authority (CSA), population estimates at the National and Regional levels are derived from this census and not from the 1994 census projections. This change has implications on the estimation of the denominators of the population-based indicators and, therefore, on the overall indicator estimates. For example, there are differences from the two sources not only in the total population in Ethiopia (i.e., 77,127,000 in 2007 from 1994 census projection, and 73,918,505 from 2007 census), but also in the Regional distribution, therefore affecting the values of the indicators at both National and Regional levels. Furthermore, it is worth noting that the Region-specific growth rates from 2007 census were applied for the estimation of the regional population over the years; however, other conversion factors have not yet been released by

CSA for the estimation of the different population groups (i.e. proportion of surviving infants, proportion of pregnant women etc…), and the previous conversion factors were applied for this purpose, according to the instructions from CSA. As soon as the new conversion factors are released by CSA, they will be used to update the population figures, with subsequent slight changes in the estimation of the indicators.

On this basis, retrospective analysis of the indicators was performed to ensure consistency over time for trend analysis purposes. The following graph provides an example on how the use of the new population figures affects the estimation of a population-based indicator (i.e. Contraceptive Acceptance Rate), showing that, using the figures from 2007 census, the values of the indicator are slightly higher compared to those derived from 1994 census projections (blue solid line and red solid line, respectively) (Figure 1). In fact, since the denominator of the indicator (number of non-pregnant women in reproductive age) is lower from 2007 census, the estimate of the indicator is consistently higher compared to the previous estimate based on 1994 census projections. The graph shows also that the use of population figures based on 2007 census affects the absolute levels of the indicator, but not the overall trend.

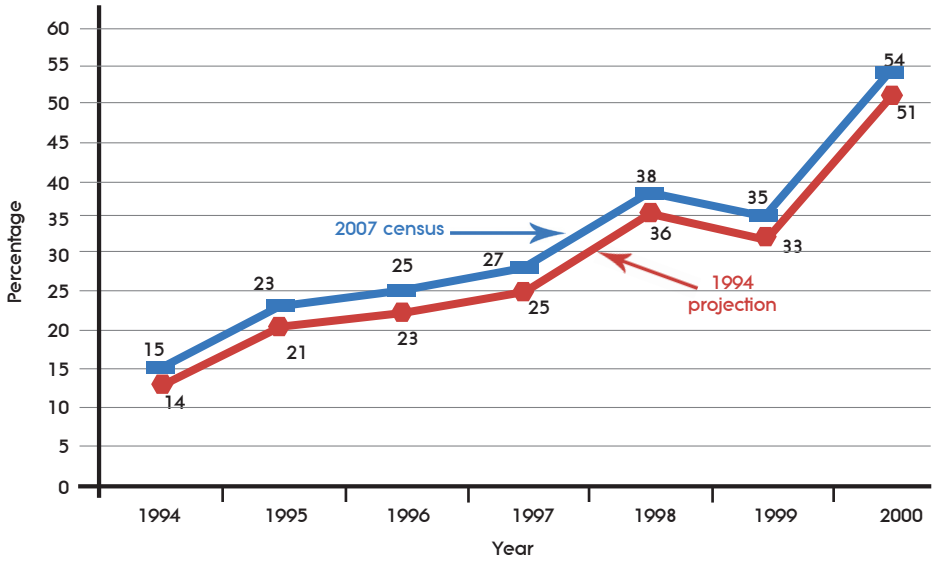

Figure 1: Comparison of the Trends of Contraceptive Acceptance Rate Based on the Population from 1994 Census Projection and 2007 Census (EFY 1994 - 2000)

Similar patterns are observed for the other population-based indicators. This justifies the slight differences in the values of these indicators presented in this Performance Report with respect to those presented in the previous years.

The report is made up of 20 sections and contains 20 tables and 50 figures used to illustrate progress, decline, comparison and trends over time. As in 2008, uniform structure of presentation has been followed in 2009 indicating background, plan, performance, challenges and way forward.

II

HEALTH SYSTEM DEVELOPMENT AND CAPACITY BUILDING




HEALTH SYSTEM DEVELOPMENT & CAPACITY BUILDING

The major goal of this program is to build capacity in order to provide cost-effective, result-oriented, equitable and customer-focused services through effective institutional transformation. The main areas of focus include the Civil Service Reform Program (CSRP) and the Business Process Re-engineering (BPR).

The performance of the sector in EFY 2001, with respect to this goal has been as follows:

2.1 Civil Service Reform Program Activities

2.1.1 Top Management Leadership Performance Improvement

Building the leadership capacity of the management team of the FMOH and RHBs was one of the priority activities during HSDP III. The target was to achieve strengthened implementation capacity by developing management skills and by establishing a monitoring system.

The major activities planned for EFY 2001 in terms of achieving the target included the following:- provide various types of training to top and mid-level management within the given fiscal year; give refresher training on national development strategies to all workers; undertake timely and regular monitoring of the plan for EFY 2001; give timely information on the sector plan to beneficiaries and the society at large; revise the Health Policy and Strategy and on the basis of the revised strategy establish various health sector advisory committees; strengthen the joint management forum of the FMOH and Regional Health Bureaus; and prepare the Woreda-Based Core Plan for EFY 2002.

The performance status with respect to the planned activities was as follows:

In accordance with the plan to provide training for top management, 3-days training on leadership development have been given in collaboration with the International Health Program for 37 heads of Regional Health Bureaus, members of the management committee at FMOH, directors and deputy directors of institutions as well as hospital chief executive officers and medical directors.

Based on the plan to provide refresher training to all workers, two rounds of training on Government Policies and Strategies was given for 12 days to professional personnel with basic and higher level degrees. In line with the plan to provide training on balanced scorecard, two rounds of training were given for 120 mid-level managers and professional personnel. Agencies accountable to the FMOH have participated in this training. In order to strengthen the capacity of the public sector at all levels to implement the balanced scorecard, George Washington University has been contracted. It is making the necessary preparations to strengthen the capacity of the public health sector.

Planning is a primary role of the leadership and of top management. A major planning activity undertaken in EFY 2001 was the preparation of a sector-wide, Woreda-based Core Plan for EFY 2002. The leadership of FMOH, RHBs and Woreda Health Offices have led and closely followed the planning process.

The Woreda-Based Health Sector Planning was exercised for the first time for the preparation of EFY 2000 annual plan. Since then, progressive improvements have been gained in terms of vertical and horizontal alignment of priorities and targets, improvements in the preparation of evidence-based implementation plan, ownership and partnership at all levels.

The EFY 2002 Woreda-based planning was based on the experiences and lessons learnt form prior experiences in EFY 2000 and 2001 and used the new BPR procedures and manuals.

The main challenges faced in the process of planning include:

- Incomplete resource mapping and unsatisfactory involvement of partners especially at Regional and Woreda level;
- Difficulty to get expenditure data at Woreda level for use as baseline for costing the plan.
- Inadequate commitment on the part of some managers, lack of empowerment, low level of awareness and lack of skills.

To address these challenges, it is necessary to improve the knowledge and skills of management through continuous training, to give decision-making authority at each level and to undertake continuous coaching in order to organize and mobilize change agents.

2.1.1.1 Service Provision Performance Improvement

The goal of this sub-program is to promote client satisfaction by providing efficient and cost-effective services; and by making health facility data and information available to the public on time.

Some of the activities indicated in the Core Plan include: preparing and implementing "quick wins" to implement results of performance improvement studies; prepare service standards based on the improved work process; examine complaints collected through the complaints management system and facilitate decision making by presenting recommended actions every week and implementing the decisions made on the reviewed complaints; present weekly implementation report to management; provide up to date information to the public about service provision and other current issues; undertake two assessment studies to understand and resolve problems encountered in service delivery; provide various types of training to governmental and non-governmental media networks; improve and implement the strategy of providing data by the information desk; and prepare and distribute leaflets to increase the awareness of workers about the nature of complaints and service delivery.

The performance of the sector in terms of this sub-program was as follows:-

By identifying quick wins which can facilitate the implementation of the BPR study results, efforts have been made to put in place user-friendly methods such as wearing badges and designating point of contact for clients.

In EFY 2001 170 complaints/suggestions have been received at the FMOH, of these 90 (53%) were complaints, while 79 (47%) were expressions of customer satisfaction. After review of the complaints, all concerned workers and sections of the Ministry were informed and made to take

corrective measures on time. In addition, feedback requested in writing about the complaint of administrative injustice at St. Paul Hospital was delayed. A committee established in consultation with the hospital management investigated the matter and appropriate disciplinary measures have been taken on the perpetrators of the injustice.

2.1.1.2 Financial Management Performance Improvement

The goal of this sub-program is to establish and implement an efficient and cost-effective resource management system. To meet this goal, some of the key activities of this sub-program incorporated in the Core Plan include: undertaking performance audit on the implementation of the annual plans of malaria, TB, HIV/AIDS and MCH programs; conduct financial audit on the quarterly financial statements prepared by the institution, perform audit on cash and property administration, implement fully the findings of the internal audit process study, collect on time receipts on funds and property transferred to RHBs and other organizations, prepare and implement the quarterly financial resource flows in EFY 2001 with relevant sections, implement program budgeting on a pilot basis, ensure that bulk procurement and distribution of supplies and vehicles is made properly and on schedule, dispose worn out property that is non-functional, and undertake study on modern financial management systems and replicate the results nationwide.

The performance of this sub-program in EFY 2001 was as follows:-

Based on the request of St. Peter TB Specialized Hospital to audit the utilization of the Abyssinia Fuel Card, audit confirmed the loss of Birr 11,338 which was retrieved and returned to Government treasury.

In accordance with the Civil Service Reform, to avoid piece-meal procurement of stationary, agreement has been signed with short listed suppliers for the procurement of two-years supply thereby saving working time and Government funds.

With respect to disposal of used properties such as vehicles, furniture, etc. at the end of EFY 2000, used vehicles were sold by bid for Birr 2,489,005 and this was transferred to Government treasury. Other used property was given freely to Regional Health Bureaus, Government schools, health facilities and Addis Ababa City Administration. In addition, bid process has been started by identifying materials to be sold to individuals or to smelting factories and spare parts to be disposed by burning or burying in the ground. A Disposal Committee had been established to sift through 40-year old documents and the work of selecting documents for disposal has been accomplished to the satisfaction of all concerned.

Inability to fully utilize the budget and submit financial reports on time; and difficulty to liquidate unused funds on schedule are some of the constraints encountered during implementation.

To address these challenges, an improved operational process document has been submitted to Regional Health Bureaus for comment.

2.1.1.3 Ethical Performance Improvement

The target of this sub-program was to prepare and implement an Ethics Guideline incorporating basic ethical principles that correspond with the basic functions and duties of the institution.

For the fulfillment of this target, the planned activities include: encouraging internal and external customers to indicate irregularities in operation and give suggestions based on transparency and good will, undertake continuous operational studies on work processes that could be exposed to corruption and red tape, prepare an "Ethics Forum" to create strong institutional linkages and culture of work discipline, give orientation training on ethics and corruption for 600 workers; prepare and implement an Ethics Guideline that comprises of basic ethical principles suitable for the institution. Other activities planned for implementation include conducting an assessment study on implementation of the Ethics Guideline, making quarterly monitoring visit and providing technical support to institutions.

The performance of this sub-program in EFY 2001 was as follows:-

Based on the objective conditions of the institution, an ethics guideline has been prepared and presented for comment. Concerning the strategy to prevent corruption, awareness raising training was given for 323 workers at the Head Office and for 329 workers at St. Peter Hospital. In addition, five professional staffs drawn from five sections have taken the TOT training provided by the Federal Ethics and Anti-corruption Commission.

To increase the awareness of workers about good ethics, four leaflets have been prepared and distributed to workers. Furthermore, articles that strengthen ethics have been selected and published in the internal newsletter. Similarly a 20 page document entitled "Ethics and Service Delivery" is being printed. By observing the experience of three institutions, work norms to be followed by workers during working hours or at the workplaces have been prepared and presented for discussion.

On the basis of the charges presented at St. Peter Hospital, follow-up is being made to facilitate decision on the case examined by special audit which was later transferred to Federal Ethics and Anti-corruption Commission. This practice has helped clients to present their views freely and the institution to improve its services. In order to rectify the irregularities seen in relation to utilization of vehicles and fuel and to make deployment of vehicles effective, an operational guideline on vehicle deployment has been prepared and is awaiting approval.

2.1.2 Business Process Reengineering (BPR)

The BPR includes the following eight core processes and five support processes:

1. Health Care Delivery
2. Public Health Emergency Management
3. Research and Technology Transfer
4. Pharmaceutical Supply
5. Resource Mobilization and Health Insurance
6. Health and Health Related Services and Product Regulation
7. Health Infrastructure, Expansion and Rehabilitation
8. Policy, Planning, Monitoring and Evaluation

The following are the five support processes in the BPR:

1. Human Resources Development /Management
2. Procurement, Finance, and General Service
3. Program-Based Audit
4. Public Relations, and
5. Legal Services.

The pre-implementation phase of the BPR included the accomplishment of several tasks such as the restructuring of the FMOH, assignment of personnel, setting up a grievance committee in connection with recruitment and assignment of personnel; providing various types of training to workers, provide offices and logistics support based on work processes, increase the awareness of stakeholders regularly, preparation of a legal framework on the structure and role of the organization and preparation of an implementation strategy and plan. Implementation of the BPR study started in March 2001. With respect to the restructuring, there are now three General Directorates, 13 Directorates, three offices, over 24 case teams and four agencies under the FMOH.

MOH staff discussing to bring radical, dramatic and fundamental change on the business process by redesigning and organizing

The next step was the implementation and change in organizational structure process. This included the follow-up and monitoring done by the Executive Committee chaired by the Minister of Health and comprising of General Directors of Agencies accountable to the FMOH. The FMOH has also set up a new Directorate of Health Sector Reform to follow up and monitor implementation of the BPR.

In accordance with the plan, a Council of Directors has been established at the FMOH level to oversee and monitor the implementation of BPR. The council meets twice a week and passed decisions whilst concurrently holding joint meetings with sponsors every15 days to discuss and make decisions on implementation issues that require joint decisions at the level of top management. Preparations are well underway for the fourth HSDP 5 year strategic plan which will be completed within the coming fiscal year.

In brief, the status of BPR implementation comprises of: process-based deployment of health workforce, provision of training on government policies and strategies for all health and non-health workers, provision of process-based training, and advocacy work for development partners with regard to new BPR design, process-based office layout, and establishment of Director's Council and development of BPR implementation strategy. The above description gives an overview of the general implementation process of the BPR.

In accordance with the plan to implement the organization and deployment of human resources based on the results of the BPR study, the study on eight core and five support processes has been completed and is under implementation. The status of implementation of the eight core and five support processes is presented below.

2.1.2.1 Health Care Delivery Core Process

The primary objective of this core process is to enable health facilities at all levels to provide equitable and quality health care to the population. This core process has two sub-processes:

i) Promotive and Preventive Sub-process ii) Curative and Rehabilitative Services Sub-process. The Promotive and Preventive Sub-process deals with all major health promotion and disease prevention activities whereas the Curative and Rehabilitative Services Sub-process addresses all facility-based curative and rehabilitative services. The new health care delivery process has been designed in a way that addresses process-related problems of the health care delivery system. The proper implementation of this core process is expected to bring dramatic improvements in access and quality of the Ethiopian health care delivery system.

The performance of this sub-program in EFY 2001 was as follows:-

Based on the BPR, a customer centered organization of services has been implemented at FMOH. The support to rural, pastoralist and urban communities follows the one-stop-shopping principle. The promotive and disease prevention service provided by the Health Extension Program covers most of the rural population and is geared towards implementation at the household level. This is to make model families benefit from this service within a short period. Accordingly, the number of model families taking care of their own health is now on the increase.

In accordance with the plan to identify and support general and specialized hospitals to conform to service standards, for the last two years, new operational standard is being implemented in Government hospitals located in Addis Ababa and in various Regions. However, this standard could not meet expectations with respect to quality and speed of implementation. Hence, to enable smooth implementation of the standard, attempts have been made to address constraints and fulfill the necessary preconditions.

In connection with the plan to prepare health service delivery and management proclamation including the necessary regulations and guidelines, the "Blue Print" that is intended to improve the medical care services is being implemented in all hospitals except those in the emerging Regions. Furthermore, to implement the new hospital standard, a hospital BPR document has been prepared and 10 hospitals in Addis Ababa have started implementation by integrating the two standards. The service has been organized into inpatient services, outpatient services and emergency medical care. All patients pass through screening/ triage and prioritize. In the case of an emergency case, the patient is referred directly to the emergency medical care case team and is enabled to get treatment immediately. A rapid emergency service is created through this core process. Graduate degree level training being provided at Jimma University for a total of 80 Chief Executive Officers and Medical Directors.

With respect to the plan to implement the new hospital standard in Regions, supportive supervision has been made by Regional Health Bureaus and a questionnaire has been sent to monitor the changes that have taken place.

In order to legally back the implementation of the core process, the first draft of the proclamation on Health Service Delivery and Management has been prepared and given to relevant bodies for comment. Parallel to this effort, a "Regulation on Hospital Administration" has been completed. The draft regulation has been submitted to the Council of Ministers; and feedback from the Council is being awaited.

A strategy to control ethical problems has been revised and included in the guideline. A document on "Ethics of Health Professionals" has been prepared in consultation with partners and is ready for printing.

A document on opening of private wings in Government health institutions has been prepared in consultation with various partner organizations and is ready for printing. This arrangement enables patients who can afford to pay to get alternative options for better care in public hospitals and has been considered as a health workers' retention strategy. The first draft of "Patient Referral System Implementation Guideline" has been completed and is ready for use. The implementation of the above measures has been incorporated into legal frameworks which are being applied in the bigger Regions. The regulation for Federal level hospitals has been approved by the Council of Ministers.

The Health Care Delivery system is constrained by major process-related problems such as dysfunctional referral system; delay in management of emergency cases, client-unfriendly environment, long and unjustified waiting time, neglected mental and rehabilitative services and compartmentalized intra-facility services.

The design and implementation of the Health Care Delivery Core Process and the two sub-processes under it are expected to solve these constraints.

2.1.2.2 Public Health Emergency Management (PHEM)

Epidemic-prone diseases and nutritional emergencies due to recurrent drought and the vulnerability of the country to the current threats of the H1N1 Influenza pandemic are major priorities for the health sector. The country is not adequately prepared to respond efficiently to these threats. Recognizing the country's poor capacity in this respect, Public Health Emergency Management, has been identified as one of the core processes to improve the effectiveness of the health sector response and to comply with Ethiopia's obligations under the new International Health Regulation.

Within this framework, the major plan for this financial year were completing and implementing the new design of the PHEM core process; to detect and respond to public health emergencies on time, preparing and distributing implementation manual on the new design to Regions and piloting the new design in 10% of the Woredas for country wide replication.

The achievements in EFY 2001 include the following:-

The study on the new PHEM core process has been completed and implementation is underway. The new design includes; functional early warning system, epidemic intelligence service, health alert network and epidemic information exchange, 100% timely and complete data flow, legal framework and a flat structure whereby workers are empowered to make decisions.

In order to build human capacity for implementation of the new design, 13 epidemic intelligence service officers are being trained at Master's Degree level in Addis Ababa University. Instead of the surveillance done earlier on 23 diseases, 18 diseases have been selected in the new design and surveillance and detection of public health emergencies has continued to be made in a satisfactory manner.

A new Forecasting, Early Warning, Response and Record System has been designed; in order to build capacity at national level to undertake effectively disease surveillance and forecasting activities; strengthen knowledge- based decision making, and enhance community participation in epidemic prevention and control activities.

Proclamation, guidelines and manual that enable the implementation of the new core process have been prepared and will be submitted to the appropriate authority for approval.

2.1.2.3 Research and Technology Transfer Core Process

The aim of this core process is to undertake research that addresses the health problems of the country. In the process of conducting research through technology transfer, it is intended to increase the capacity of the current system the current system from producing one vaccine to production of ten vaccines. To this end, contacts have been established with countries that have ample experience in vaccine production.

On this basis, draft strategic plan has been prepared to prioritize research that ought to be undertaken in the country and to lead its application in an integrated manner. The draft will be discussed and refined with stakeholders.

2.1.2.4 Pharmaceutical Supply Core Process

The major plan for FY 2001 were the reorganization of the PFSA through the establishment of its board, developing the working arrangements between the Agency and Regions, mapping of the necessary warehouses to be built in the future, and to strengthen its transport capacity. Furthermore, giving training to the staff on the proclamations, regulations and guidelines prepared to expedite the implementation of the Master Plan, designing operating system for the revolving fund, development of essential drug and medical supplies list and quantification and forecasting tools, conducting study on the logistics management information system (LMIS) were also planned.

The major achievement in this regard was the institutional transformation of the profit making PHARMID into service providing PFSA.

The following are the major achievements recorded.

Procurement Systems

The agency planned to procure health commodities worth of 550 million ETB using the revolving drug fund (RDF), including 300 million ETB worth of program commodities (vaccine, family planning commodities, etc.). The procurement of 2,299 health center equipment has been carried out by PFSA through international competitive bidding and consignment of goods is at different levels of delivery and distribution. The health post kits that were delivered (300 soft containers) are being repackaged into kits. These kits are going to be delivered directly to health posts.

It is reported that procurement of health commodities used to take 369 days. The business process re-engineering set a standard target of procuring such items within 120 days. PFSA reported to have procured anti-TB and HIV/AIDS testing kits within 90 days under normal Government procedures.

Another major contributing factor for improved supply of the health commodities is the capitalization of PFSA. PFSA inherited an institution with 23 million ETB negative cash balance. With the support of GAVI, GFTAM and PBS, it was able to mobilize 21.5 million USD for RDF. This contributed to its ability to procure the above mentioned amount of essential health commodities.

Despite these improvements, there remain serious problems, such as the delay in procurement and distribution of health center and health post equipment as per the procurement and distribution plan.

Storage and Warehousing Capacity

In EFY 2001, a cold room has been set up and that has increased the national capacity by five fold. Eighteen sites for construction of warehouses have been identified in different regions. These sites are secured, designs completed and resource mobilized to start the construction. It was reported that 5.3 million USD from PEPFAR, $4.7 from GAVI, and $1.6 million from GFTAM is available to start the construction of these warehouses.

As reported by PFSA, SCMS has rented warehouses in different areas to smooth PFSA's functions.

Transport and Distribution

Health commodities are delivered directly to health facilities. The Agency has 92 trucks for distributing these commodities and is on process of acquiring another 28 trucks, of which 8 have reached Djibouti. However, this capacity is not adequate for on time delivery to all health facilities. Hence, the necessary human resources are deployed both through PFSA and its major partners to ensure that distribution is carried out efficiently.

Drugs and medical equipment are distributed directly to health facilities especially HIV/AIDS test kits, drugs and reagents. Since it is intended to use this distribution channel to deliver other drugs and commodities especially the distribution of medical equipment to health centers and health posts, health facility mapping is being prepared in collaboration with various agencies.

The Revolving Drug Fund

A study on the operation of the RDF has been completed and is being implemented. The capital of the RDF will be raised by $10 million with the support of PBS Phase II. However, the low RDF capital (WHO recommended $2/capita requirement = $150 million for Ethiopia) has to be improved further.

Capacity Strengthening

PFSA is in the process of strengthening its organizational capacity. In this regard, the following are some of the achievements.

Ten procurement officers, biomedical engineers, two information specialists and 15 druggists have been recruited. Three seconded technical assistants (2 from SCMS and one from UNFPA) are supporting this process. In addition, TOR has been developed to recruit a procurement specialist to implement the action plan set in the Joint Financing Agreement to be funded by PBS.

The study of establishing LMIS that aims at linking health facilities to regional hubs and then to PFSA HQs has been completed. Support for software selection is in the process of being obtained. Attempts have been made to negotiate and influence PPA during the revision of the procurement law to ensure that the law addresses the specific nature of health commodity procurement. In addition, the revised PFSA proclamation to be submitted to government shall include provisions that allow PFSA to play role of promoting and strengthening the capacity of health facilities in the area of rational drug use.

Provision of Essential Drugs and Medical Equipment

In EFY 2001, the procurement of drugs worth 600 million Birr had been planned and drugs worth 602 million Birr have been bought and were distributed to health facilities. Drugs and medical equipment procured by various development partners worth 1.2 billion Birr have been distributed by PFSA to health facilities. In addition, drugs and medical equipment worth 321 million Birr procured outside the plan have been distributed to health facilities.

Challenges

The major challenges faced during plan implementation were as follows:-

- Delay in releasing committed funds by some development partners has affected construction of warehouses and delay in the finalization of the design has affected bringing contractors on board to start construction.
- Delay in procurement and distribution of health post and health center equipment as per the plan
- Improving the low RDF capital will remain one of the major challenges in the effort made to provide adequate health commodities in the country.
- There is delay in designing and implementing LMIS.

In order to tackle the above mentioned challenges, the following will be key activities for EFY 2002:

- Expedite the construction of hubs.
- Expedite design and implementation of LMIS.
- Mobilize additional funding to fill the significant gap in RDF capital.
- RHBs and HC construction project management unit to work together to provide the list of completed facilities to PFSA on timely basis.

- Strengthen the capacity of PFSA in procuring, packing and distributing medical equipment and supplies to facilities.

Implementation of the above mentioned activities require a strong collaboration of the Government and Development artners.

2.1.2.5 Health Care Financing Reform and Health Insurance

This part focuses on implementation of health care financing reforms and health insurance. Achievements in mobilization of financial resources from government and development partners have been elaborated in other sections of this report (Sections 13 and 14).

The financial resources pledged by various development partners for implementation of the EFY 2002 plan, have been mapped and used for the preparation of EFY 2002 health sector plan.

Consolidation and expansion of ongoing HCF reforms and introduction of Social and Community based Health Insurance are part of the Resource Mobilization Core Process which aims to address the critical and chronic problem of financial resources in the health sector.

In Regions where implementation of the financing reforms is already underway, namely Oromia, Amhara and SNNP; activities during the past fiscal year were geared towards strengthening capacity of implementers at Regional, Woreda, and facility levels to implement components of the reforms. These Regions have already put in place the necessary legal frameworks, operational guides, health facility governance, organizational structures and staffing. Reform components include: retention and utilization of revenue, administration of the fee waiver system and establishment of functioning facility governance bodies. Areas of geographic expansion during 2001 EFY include Addis Ababa city administration, Tigray, Benishangul-Gumuz and Gambella Regional States. The project supported these Regional Governments to adapt the prototype legal frameworks and operational guides as well as organization of various consultative, sensitization and capacity building activities.

With regard to insurance, the planned activities in EFY 2001 include: establishing a health insurance agency during the fiscal year, coverage of permanent Government employees with social health insurance, pilot implementation of community based health insurance in twelve selected Woredas, undertake awareness raising and sensitization activities on health insurance, implement alternative resource mobilization strategies for medical care in Federal health institutions, complete and implement study results on financial resource mobilization and utilization and complete and put to use the results of "National Health Accounts".

The performance of this sub-program has been as follows:

With respect to the retention and utilization of revenue the following table gives the summary of the health facilities (Hospitals and Health centers) collecting and utilizing revenue, as part of the HCF reform.

Table 1: Status of Health Facility Revenue Retention and Utilization in Ethiopia (EFY 2001)

Region	Collecting Revenue.		Utilizing Revenue.	
	Hospitals	Health Centers	Hospitals	Health Centers
Tigray	12	100	12	100
Afar	0	0	0	0
Amhara	16	140	16	140
Oromia	22	300	22	300
Somali	0	0	0	0
Benishangul-Gumuz	2	18	0	0
SNNPR	16	242	16	242
Gambella	0	0	0	0
Harari	0	0	0	0
Addis Ababa	5	23	0	0
Dire Dawa	0	0	0	0
TOTAL	**73**	**823**	**66**	**782**

As shown in the table above, out of 73 hospitals and 823 health centers 90% have started retaining revenue and 95% have utilized the revenue they have collected. Therefore, the utilization rate of revenue by these facilities is quite high.

Preparatory works have been intensively underway for establishment of both social health insurance and community based health insurance (CBHI). Development of these publicly managed health insurance schemes in Ethiopia is aimed at mitigating the risks of out of pocket health spending by employees of the formal and informal sectors as well as rural populations engaged in agriculture and pastoralism.

In this connection, the Social Health Insurance (SHI) design team drafted the SHI proclamation which has been reviewed, modified and endorsed by FMOH management and RHBs. The proclamation has subsequently been reviewed by the Council of Ministers, and using feedback from the Council the design team prepared an elaborated background document on SHI. The SHI background document which was produced in Amharic contains recommendations regarding premium levels, the benefits packages and the institutional structure of the Federal Insurance Agency. The design team also projected premium and benefits levels along with resource need of the insurance scheme program. As suggested by the Council, the next step was to involve stakeholders in the discussion of the draft and the background document.

Accordingly, the draft law and regulation have been revised and improved and presented for discussion to selected relevant stakeholders in two stages. During the first stage through four rounds of discussion, heads of institutions were sensitized on social health insurance and provided valuable feedback. In the second stage, continuing discussions have been made in over 15 discussion forums conducted in Addis Ababa and the Regions and around 2000 people have participated in these forums.

The legal framework has been improved based on the inputs from these discussion forums; and submitted to the Council of Ministers for the second time for its endorsement and subsequent ratification by the Federal Parliament.

Parallel to the work on social health insurance, various activities are being performed to pilot the Community-Based Health Insurance (CBHI) and based on the results in pilot areas, to replicate the experiences throughout the country. Twelve Woredas have been selected for this purpose in the four pilot regions (Tigray, Amhara, Oromia and SNNPR). A detailed three year plan has been prepared for implementation and evaluation of CBHI pilot, a technical background document has been prepared, training manual has been developed for Regional and Woreda level CBHI leadership. In addition, regional feasibility studies have been finalized, and CBHI legal documents,

and financial and management systems have been developed. A Regional Steering Committee has been established in three of the pilot regions, while adequate preparations have been made in Amhara Region to establish the committee. The Steering Committee is expected to oversee and support the implementation of the community-based health insurance scheme. The members of the committee have been briefed on the implementation plan of the community-based health insurance, the duties and responsibilities of the steering committee and about future activities.

As the community-based health insurance will be implemented by the community, it is necessary to build local capacity beforehand. In this regard, in SNNPR, TOT has been given for seven days for professional personnel drawn from various Regional Bureaus and the three selected pilot Woredas. These will in turn train members of Woreda health insurance steering committee, Woreda health insurance board and management committee, Kebele health insurance mobilization committee, and Kebele health insurance management committee. Accordingly, training has been given for members of Woreda health insurance steering committees established in the three Woredas in SNNPR.

In addition, to ensure the acceptability and sustainability of the community-based health insurance, feasibility study has been made in the four pilot regions and the report has been finalized by incorporating initial comments.

Based on these studies each Region will decide on the type of health services to be provided, premiums or contributions to be paid by members, and financial support to be given to these health insurance institutions.

Since it is appropriate for community-based health insurance schemes to be established at Woreda level to have their own internal regulations and establishment papers, draft papers and guideline that will enable them to get legal recognition have been prepared. In addition, draft guideline on financial administration has been prepared for use by the health insurance institutions.

The following were the key challenges /problems encountered during implementation.

- The discussion held with stakeholders on SHI legal framework has taken more time than expected.
- There was a delay in the establishment of CBHI Regional Steering Committees.

To address these challenges, higher management has so far extended support and encouragement to all concerned and will continue to do so for each level in the future.

The need for tracking the total magnitude and proportion of the health resources coming from different sources, the powers in making decision on these resources as well as the purposes of using these resources, makes National Health Accounts (NHA) an important exercise for Ethiopia to undertake on a regular basis.

To sum up the NHA helps to:

- Generate evidence on the relation between health sector priorities and spending on health care by level and types of health care services. NHA findings will be input for gauging financing level of the ongoing health sector development program by major components of the plan.
- Produce baseline data on health care financing for new health sector development plans (e.g. HSDP-IV), for the IHP Compact and financing reforms (scale-up of on-going

HCF reform, introduction of health insurance, etc);
- Provide evidence on financing sources and levels for selected areas of high disease and health service needy groups through conducting of subaccounts in areas of HIV/AIDS, Malaria, TB, CH and RH.
- Produce health expenditure data that will be internationally comparable and useful for designing, implementation and assessment of performance of country health sector initiatives.

During the fiscal year the fourth round National Health Accounts (NHA) has been launched along with six sub accounts: HIV/AIDS, Malaria, TB, Child Health, Maternal/Reproductive health and Health Information System (HIS). The institutional survey has been conducted successfully and data from these surveys have been analyzed and will be presented to the steering committee for validation before writing up the report. In order to obtain primary data on household level expenditure for health, a nationwide survey is being conducted on 10,020 randomly selected households. The household survey will capture data on general health expenditures, and will also inform the sub account calculations for child health, reproductive health, Malaria and TB. A separate, targeted survey is being conducted among sample of 4,000 individuals and families living with HIV/AIDS, in order to provide up to date information on expenditures related to diagnosis and treatment of the disease. Both surveys are underway with close oversight provided by the project's NHA experts. Data collection for both studies has been hampered by seasonal rains and analysis of the results will be completed within the coming quarter.

2.1.2.6 Health and Health Related Services and Product Regulatory Core Process

The goal of this Core Process is to undertake inspection and quality control of drugs, facilities, professional personnel and food products (one-stop service, 4Ps = Product, Premises, Professional Practice and Food Products) in an integrated manner and to make the approval procedure of drugs for the market efficient.

The performance of this sector in EFY 2001 has been as follows:-

The draft National Drug Policy has been revised and refined at a national workshop attended by relevant stakeholders. The policy will be modified based on the results of the BPR study and presented to the Government for approval. A new proclamation has been prepared taking the new organizational structure and responsibilities into account and has been presented to the Government for endorsement. The revision of the regulation has been partly accomplished.

Based on the ongoing BPR and to suit the design of the organization with its respective responsibilities, draft proclamation and five regulations have been prepared and presented to the Government.

A guideline on drug disposal has been prepared and is being printed. Post-market quality control tests have been made on Phase I samples of selected drugs to ensure efficacy while concept paper has been prepared to undertake tests on Phase II samples. Since implementation of the laboratory working standard is necessary for performing the laboratory activities fully,

implementation manual has been prepared and procurement of the necessary inputs is underway. A unified Drug Quality Control Guideline is being finalized and Guideline on Vaccine Quality control has been prepared.

In order to safeguard the well being of clients by ensuring the safety, efficacy, quality and proper and equitable distribution of drugs and pharmaceutical supplies; 373 drug retail enterprises, 156 drugs, medical equipment and supplies import and distribution firms, 63 hospitals and clinics have been inspected; while check on good manufacturing practice was made on106 registered and partly registered foreign manufacturing plants. Four thousand fifty six inspections have been performed at Addis Ababa Airport Customs, Railway Station Customs and Coli Post Customs.

Based on the plan to undertake supervision of existing and new drug manufacturing plants, 11 factories have been inspected for good manufacturing practice.

With respect to drugs sold within the country, a total of 1,060 types of quality control tests have been performed (372 physico-chemicals, 92 condoms, 235 microbiology, 354 toxicology and seven on pesticides). Ten medical facilities have been inspected for good clinical practices. Four clinical trial have been accepted out of eight proposals.

Work is underway to make the products of drug factories in the country to acquire drug registration certificate that meet the WHO criteria. Out of 20 drugs produced in the country, only four drug manufacturing plants received the certificate. In addition, certificates have been awarded for nine products of a single factory in the country and for nine products of six African countries. Enabling local drug factories to increase their capacity and supply the market with competitive and quality products has been given priority attention in the BPR. Accordingly, a team has been formed to follow-up and build their capacity.

Out of the diagnostic test kits presented for registration, quality assurance tests on seven kits have been done by selected facilities within the country and certificates have been given.

Based on the plan to start quality control tests within the country on traditional drugs, vaccines, medical equipment (Gloves, Diagnostic Test Kits, etc); the trial on 50% of the tests is being conducted by preparing necessary test documents and list of sample types for testing.

The construction of four zonal office buildings is being accelerated and these buildings are expected to be commissioned at the end of August 2009. The construction of the Drug Quality Control Laboratory and office buildings is proceeding as planned.

With respect to rational drug use, the performance status of activities in EFY 2001 include:-

- Training on rational drug use was given for 600 health workers drawn from 150 health centers and 50 district hospitals.
- The development of software for organizing and using the drug management information system is being finalized. Incoming and outgoing information is being collected on human and animal drugs and medical equipment of import and distribution firms.
- Baseline study on anti-microbial resistance has been made in 73 hospitals and health centers and the study report is under preparation.

2.1.2.7 Health Infrastructure, Expansion and Rehabilitation Core Process

The aim of this core process is the construction and renovation of health and related facilities, the supply and utilization of inputs to health facilities, maintenance of medical equipment and computers and the expansion of health information technology.

The distribution of health facilities in the country does not correspond with the population distribution and disease pattern. The few health facility buildings which have been constructed have remained for a long time without becoming operational; and due to the lack of proper use and maintenance of costly medical equipment it has been nearly impossible to provide timely and quality medical care. These factors had negative impact on the health and well being of the people.

In order to bring long lasting solutions to these problems, the following work processes are designed in the BPR and ought to be given priority during implementation:

- Make the construction of new health facilities or expansion of existing facilities dependent on the distribution pattern of diseases and population density; supported by the active involvement of the society and based on transparent data.
- Define the responsible implementing bodies at each level to ensure uniform procurement, utilization and maintenance of medical equipment.
- Train and deploy equipment maintenance technicians on a permanent basis, so that there is guideline on up keep of donated equipment.
- Satisfy the needs of clients by enhancing the broad application of health information technology in the health sector and by establishing modern and efficient system up to the grassroots level.

With this in view, the expansion and renovation of health centers and hospitals is being done on a large scale; in order to enable any member of society to get primary care in 30 minutes rather than 4 hours. Detailed description of construction of health facilities and procurement of medical equipment is presented in sections 3.2, 4.0 and 5.2 of this report.

2.1.2.8 Policy, Planning, Monitoring and Evaluation Core Process

Addressing the health service needs of the Ethiopian population necessitates the existence of a properly functioning health system. The FMOH has identified Policy, Planning and Monitoring and Evaluation as one of the core processes to strengthen the health care delivery system for addressing these needs. The Policy, Planning and Monitoring and Evaluation Core Process strives to address the need for informed decision-making based on an integrated and aligned planning monitoring and evaluation system.

The new core process includes policy analysis of the sector, developing woreda-based national planning and activity-based budget, and Monitoring and Evaluation. In the course of the BPR study, HMIS and harmonization and alignment have been included under the Policy, Planning, and Monitoring and Evaluation Core process. By making the planning system follow top-down and bottom-up approaches and ensuring horizontal integration, as well as coordinating the stakeholders in the health sector; the main target of this core process is to use resources for

achieving the development targets set by the Government. This core process is designed in a way that allows monitoring of resource utilization at each level in an organized manner.

The former Planning and Programming Department of the FMOH has been restructured along its main functions and new roles that effectively called for a transformation into a general Directorate of Policy, Planning and Finance with three directors. The three directorates are: 1) Policy & Planning and M&E, 2) Resource Mobilization and 3) Finance and Procurement Directorate. Currently 55% of the approved positions have been filled as prescribed by BPR.

Planning

Health sector planning in Ethiopia follows what is widely known as the top down – bottom up approach. An indicative health sector plan, that provides a national direction aligned at all levels with national priorities, was produced at Federal and Regional level which has reached the Woreda levels. Based on the indicative plan, Woreda Health Offices have a duty to prepare and finalize their health plans that are aggregated at the regional level which are eventually compiled at the FMOH level. The whole purpose of such planning process was to ensure that health issues at grass root level are sufficiently reflected at the national level and take account of the actual conditions existing at the grass root levels through effective horizontal and vertical integration, as well as relying on the coordination of the stakeholders at each level of the health care delivery system.

Based on the BPR design, one of the major planning activities that were undertaken in EFY 2001 was preparation of a sector-wide, Woreda-based Core Plan for EFY 2002. The Federal and Regional level indicative plan was prepared and dispatched to zones and Woredas. To support preparation of the plan, the FMOH has developed and distributed evidence-based planning and budgeting tool and planning guidelines.

Major steps undertaken to prepare the evidence-based Woreda-based annual plan of EFY 2002 include four stages: i) the preparation phase; ii) Woreda-level planning phase; iii) aggregation and reconciliation of Woreda plans to develop Federal & Regional Annual Core plan; and iv) comprehensive plan preparation. To this end, the EFY 2002 Evidence-Based Woreda-Based Annual Core Plan is prepared with continuous consultation of stakeholders at all levels improving on many aspects based on experiences gained in the previous years.

To support this process, the FMOH has trained180 mentors at Federal level for 12 days who in turn trained and coached 4100 Woreda staff and health professionals in the preparation of the health sector plan. One hundred and four Woreda level training & hands-on planning sessions have been conducted in 70 sites in two rounds, each session for an average of 5 Woredas for 6 days. Accordingly, all 801 Woredas in the 11 Regions and City Administrations have completed Woreda-based health sector plan for EFY 2002 with the participation of all stakeholders.

Training of Mentors on Woreda Based Health Sector Planning with the principle of "One Plan, One Budget and One Report"

Currently, detailed comprehensive annual plan of the sector for EFY 2002 is prepared; and based on the identified financial gap at woreda level; the financial requirement of the sector for the coming fiscal year has been estimated. This process also includes health resource mapping both at Federal and Regional levels.

Doing evidence based annual Planning at the Woreda level, Gambella

The new development in the EFY 2002 Woreda-based annual planning is the level at which the planning started. The lowest planning level in the preparation of the EFY 2002 core plan are health facilities like hospitals; and the Woreda plan has been based on the health facilities plan. A User-friendly excel-based planning and budgeting tool has been developed and used by mentors and Regions. The Plan has been costed using standard costing guideline and resource gaps have been clearly identified. This makes it different from previous years.

The strengths of the planning process include increased ownership at Regional and Woreda level, evidence-based planning; partnership specially at federal & regional level, technical and financial support from development partners, involvement of Woreda administration & finance; intensive consultation at federal and regional level, and commitment of mentors in supporting the Woredas.

Monitoring & Evaluation

Effective implementation of health services requires regular follow up of what a program accomplishes and achieves. The M&E BPR sub-process has four interlinked major tasks that were clearly identified and designed: Routine Data Collection and Aggregation (HMIS), Performance Monitoring and Quality Improvement, Integrated Supportive Supervision (ISS), Evaluation/ Operational Research and Inspection.

Routine Data Collection and Aggregation (HMIS)

In EFY 2001, it was planned to scale up the newly re-designed HMIS in all Regions. Detailed implementation plans have been prepared by Regional Health Bureaus but execution has been delayed. Four Regional Health Bureaus: Dire Dawa, Harari, Benishangul-Gumuz and Gambella have shown the required commitment and leadership to fully implement the designed HMIS. The other Regions have encountered multiple bottlenecks and challenges for the nationwide scale up including completing and implementing BPR, availing the necessary human resources for the process (hiring of health information technicians) as well as renovating and procurement of furniture to get medical record rooms up to standard.

HMIS Scale up Health Professionals Training at Benishangul Gumuz

The FMOH has printed and distributed HMIS forms and registers worth 20 million Birr to health facilities that have met the necessary pre-requisites for implementing the new HMIS. Overall 7,779 health professionals have been trained and 44 hospitals, 82 health centers are currently implementing the new HMIS. It has been noted that health facilities that have implemented the HMIS have significant improvement in the level of data quality, in some instances by 50-60%. Encouraging results are being demonstrated in the level of data utilization and establishing links with the annual Woreda Plan.

In EFY 2001, the design of the Family Folder has been completed and initial implementation has begun. The design of the family folder enables close follow-up on the health status of each family with respect to preventive, promotive and high impact curative care that were incorporated by the Government in the design of the Health Extension Program. The folder creates conditions that are conducive to the delivery of proper health care services and packages through provision of adequate data to the health care providers. Moreover, the design incorporates a novel mechanism that enables health extension workers and health service programs to closely monitor vital events (birth, death, cause of death) that are occurring in the society.

The Family Folders have been piloted in Dire Dawa Administrative Council and Harari Region and the necessary modifications have been made to the form and content of the Family Folder. Subsequently, the printing of around 15 million Family Folders has started and the necessary preparations have been made to train health extension supervisors for the national scale up. These supervisors will start implementation by providing on-the-job training to health extension workers. At the end of the next fiscal year, each graduating rural household will have its own family folder. Parallel to this effort, the family folder will be adapted for the Urban Health Extension Program.

In EFY 2001, besides the scale up for HMIS, the FMOH has drafted a "Regulation for HMIS". A draft document has been prepared that adequately addresses all the legal implications of recording, storage, security, right of access, use and disclosure and data reporting mechanisms. This legislative framework focuses on establishing legislative duties and the rights of patients, health professionals, health institutions and administrative offices. A consultative workshop was held where all relevant stakeholders participated and discussed on the draft document. The feedbacks have been incorporated and the final document will be submitted to the Council of Ministers in EFY 2002.

Training Health Information Technicians (HIT)

In EFY 2001, it was planned to train 200 HITs. The curriculum, Occupational Standard (OS), and educational aids for use in the training for these technicians have been prepared in collabortion with the Ministry of Education and Tulane University. Capacity assessment of the training institutions has been carried out. The HIT training, which is the first of its kind, has been promoted through orientation workshop held for the Regions, Health Science Colleges and TVET Agencies.

Harar Health Science College has been designated as the center for the training of HITs for the four emerging regions, Dire-Dawa City Administrative Council and Harari Region (Table 2). Currently, 84 trainees are enrolled by the Harari Regional Health Science College. As a capacity building measure, 50 computers and 10 printers have been provided to the college, and installation of a network has been completed.

The remaining 120 trainees will be recruited from Addis Ababa City Administration Health Bureau (extension program) and from hospitals throughout the country (regular day classes) and will start their training at ALERT training center. Delay in the recruitment of students is the main impediment to launch the program at ALERT.

Table 2: Training of Health Information Technicians at Harari Health Science College for Emerging Regions in EFY 2001

Region	HIT Enrolled
Afar	26
Benishangul-Gumuz	10
Somali	26
Gambella	9
Harari	10
Dire Dawa	3
Total	84

Fourteen additional health science training institutions are expected to initiate the HIT training program in 4 Regions. In EFY 2001, preparatory work has been completed to enroll 988 HIT students in EFY 2002. Familiarization workshops have been held and TOT training was provided for teachers based on the training needs of each Region.

Electronic Health Record

An electronic health record (EHR) system has been designed to enable better patient care and to make the reporting system effective from health facilities to the level of the Federal Ministry of Health. This EHR system will enable and empower the health care system to acquire accurate and timely patient information and also to enhance health information exchange. The system will improve patient care and will further provide accurate data for informed decision making at all levels.

In EFY 2001, this application has been fully institutionalized in Dire Dawa Administrative Region. Network Development has been completed for all health facilities in Harari Region and in selected hospitals in Addis Ababa. Early benefits of the EMR have already been demonstrated; the creation of a central repository of information has lead to better coordination between departments particularly between the health care provider and the laboratory and pharmacy. This electronic communication significantly reduces patient queuing and waiting time. Through the request of the RHB and based on BPR design, the EHR is now able to capture financial information at each service point reducing the number of times a patient/client has to go to a cashier. This has decreased patient frustration and significantly increased patient satisfaction. Through these systems health care providers staff, and other healthcare professionals get quick and easy access to critical patient and administrative information that helps them take timely, accurate and informed decisions.

Geographic Information Systems for Health

GIS is a system that will enable the collection, storage, management, analysis, retrieval, modeling and visualization of spatially referenced information. The use of GIS will build the capacity of the health sector to undertake the spatial tasks needed to improve monitoring of the spread of disease, modeling the future diffusion of the disease and planning of timely allocation of resources to improve public health conditions in a community. The Central Statistical Agency (CSA) has captured required spatial data during the Population & Housing Census, and the FMOH has provided the CSA with technical assistance and the necessary resources to finalize the data entry. In EFY 2001, the FMOH has continued with data cleaning and further incorporating the missing spatial data. Training on GIS has been provided to health workers in Regional Health Bureaus to link with the new HMIS in order to improve the quality of information for decision making in the Regions.

Telemedicine and Tele-education

The implementation of Telemedicine and Tele-education focuses on using ICT as support for health care delivery and training of health and medical professionals with activities around five universities and twenty hospitals. In EFY 2001, setting up telemedicine and tele-education has been carried out in one university and six hospitals (the Jimma University Network). Training was facilitated for a total of 43 physicians and specialists. So far, an encouraging 92 tele-consultations were resolved over the network.

It has been noted that this endeavor has been cost saving for patients involved by reducing transportation, use of a remote specialist skill for clients located in remote areas thereby reducing the need for referral. Enhanced skill development for participating physicians has been noted with greater appreciation of ICT use in health care delivery. Health care providers are also having access to reference materials for helping to resolve doubts and to update knowledge and skill.

Challenges experienced included the high turnover of trained specialists, frequent power interruption, and the internet network quality of service. To ensure connectivity at health facilities, the FMOH has negotiated with EITCDA and ETC to provide free broadband internet connection. In EFY 2001, connections were established for selected hospitals and Regional Health Bureaus. In FY 2002 the system will be further expanded whereby other hospitals and universities will be brought onboard.

Performance Monitoring and Quality Improvement

This is one of the sub processes included in Monitoring & Evaluation sub process. The sub-process helps in the effective implementation of program objectives and measures against the set standards. It is a means of joint problem identification, suggesting applicable solutions, joint planning, implementation and close follow-up (monitoring) of outputs and outcomes.

In EFY 2001, institutionalization of the sub-process has begun within the health sector with encouraging results. To strengthen the implementation of performance monitoring within the Health system the balanced scorecard (BSC) is selected as the measurement tool for the BPR for all processes. The BSC is directly linked to the comprehensive annual plan at all levels and will be guiding the weekly plan preparation. Weekly plan development has been fully institutionalized at the FMOH level and the BSC system has been implemented in the FMOH since EFY2000. Weekly plan is a systematic planning tool in which every employee in the FMOH devotes time in a given week for activities that can ensure that organizational goals are attained, enables employees for self evaluation of performance every week and used as a communication tool between staff and departments.

In EFY 2001, the FMOH has concluded the necessary preliminary work to scale up the BSC system throughout the health sector. To help the implementation of BSC in the health sector a firm, the Balanced Scorecard Institute, has been recruited and training for Federal Ministry of Health and Agency Officers and Regional Health Bureau experts is planned for EFY 2002.

Following are performance monitoring activities conducted in EFY 2001:

- FMOH has held regular meetings with RHBs on a bi-monthly basis to monitor and evaluate performance
- Mid-year performance evaluation conducted between FMOH and RHBs based in EFY 2001 Core Plan
- This year, All RHBs have undertaken their annual performance review meetings with Woredas and zones based on Core Plan 2001 and assessed the strengths/enablers and challenges in their own respective regions with their relevant stakeholders before the National Annual Review Meeting
- A Joint Review Mission (JRM) was conducted by Government and Development Partners
- Quarterly, semi-annual, 9-month and Annual reports were prepared and submitted to Parliament, Prime Minister's Office, MoFED etc

The main challenges faced in the process of plan implementation include;

- The long time taken by Regions in the preparation of the BPR has brought about delays in the implementation of the M&E process.
- Shortage of budget for training of health workers.
- Inability of some regions to hire health information technicians; and consequently the failure to perform other related HMIS scaling up activities.

To address these problems, there is a need for giving support to regions to complete the BPR studies and to start implementation; there is also a need to mobilize financial resources for undertaking the training of health professionals and to support regions to hire health information technicians in line with the agreement endorsed by the Regions.

Harmonization and Alignment

Based on the HSDP Harmonization Manual (HHM) 2007 and code of conduct (2005) developed and agreed upon early in the implementation of HSDP III, the IHP road map was finalized and its compact signed at the beginning of the year (August 2008). The compact serves as an over arching framework for aid coordination in Ethiopia and compliments more specific agreements relating to the Aid Policy of the GOE, the Harmonization Code of Conduct and the HHM.

The Harmonization and alignment activities in the sector have to be seen within the context of these global initiatives and implementation of the harmonization action plan adopted in 2005.

The performance status of the planned harmonization and alignment activities in EFY 2001 was as follows:-

The planned advocacy activities targeting health sector partners have been performed well. As noted in the JRM report (EFY 2001) some remarkable progress has been registered in EFY 2001 in terms of implementing key activities of the alignment and harmonization agenda. A Joint Financing Agreement (JFA) was prepared, agreed and signed by seven development partners. The total pledged resource to the MDG pool fund is about one billion ETB. When this is compared to the targets set both in HSDP III and IHP compact as well as the amount of resources that is being transferred using other channels, it is still insignificant.

As summarized by the JRM report, there was significant progress as the signing of the IHP+ compact and JFA took place in EFY 2001. The MDG pooled fund is now established and working. Many of the indicators set to measure alignment and harmonization (planning, budgeting and reporting frameworks) seem to have improved.

The JRM looked in to progress in implementation of the Joint Financial Agreement action plans, progress in using one plan and progress in using budgeting framework and one monitoring and reporting framework. According to JRM findings, the results were mixed.

There was improvement regarding involvement of Development Partners (DPs) in the annual planning process (78%) and fewer development partners (56%) are requesting separate planning document. None of the development partners conducted their own review missions. These are significant achievements, however there are also drawbacks. For example, in terms of using budgeting framework, there is no significant progress. Out of nine development partners reviewed, only 56% of all the support provided to the sector was channeled through government preferred modalities, and, of the total commitment indicated in their plan, only 30 % was disbursed during the year. Similarly, there was little progress in the use by development partners of a common reporting format.

To address challenges in relation to shortage of human resources and resource mobilization, a series of meetings are planned to be held with development partners to collect the committed funds during the next fiscal year (EFY 2002). At the same time efforts are being made to solve the human resources constraints which are given priority attention by the sector.

2.1.2.9Human Resource Development / Management Support Process

Human Resource for Health is one of the major strategic issues that the FMOH has been working to address since the first phase of HSDP. The FMOH with the involvement of RHBs and DPs has been working in the development of a comprehensive HRH Development Strategy for over a year; and the study is completed. The new HRH Strategy addresses both the supply and demand side of the HRH issues.

Target set in HSDP-III is to produce at least 5,000 health officers in 5 years. The trainees consist of both generic and post basic (nurse) health officers. Accordingly, at the end of the program year in EFY 2002, about 3,000 post basic and 2,000 generic students would be expected to graduate.

Nationally initiated by the FMOH, the Accelerated Health Officers Training Program (AHOTP) was launched in November 2005 in four of the health officers training Universities (Jimma, Haromaya, Hawassa and Mekelle). The 5th university, Gondar, started the program 4 months later in April 2006.

Twenty one hospitals located in 7 Regions of the country (6 in Oromia, 5 in SNNP, 4 in Amhara, 3 in Tigray, 1 each in Harari, Somali and Dire Dawa), were selected to conduct the training program affiliated with nearby universities. During the program period, there have been 3 intakes each to be trained for 3 years (the 1st year in the universities and the 2nd & the 3rd year in the training hospitals and neighboring health centers).

Currently the Accelerted Health Officers Training Program (AHOTP) is progressing as scheduled. All 3 batches of both post basic and generic students have been enrolled. The first batch of 1476 students (935 post basic and 541 generic) have already graduated in EFY 2001. This is in addition to the 1042 graduates (both post basic and generic (339 and 703 respectively) on training when AHOTP started in EFY 1998 together adding up to 2518 (1042 + 1476). The 2nd and 3rd batches are being trained in both the 5 AHOTP Universities and the 21 affeleated Hospitals. The summary of those on training and those who graduated is given in the following table.

Table 3: Summary of All AHOTP Students & Graduates by University, Type and Years of Training (EFY 2001)

Univ.	Post Basic				Generic			All Graduates			Grand Total (A+B+C+D+E+F+G)
	Yr I (A)	Yr II (B)	Yr III (C)	Total (A+B+C)	Yr II (D)	Yr III (E)	Total (D+E)	PBs (F)	Generics (G)	Total (F+G)	
Hawassa	---	295	214	509	93	65	158	357	276	633	1,300
Haromaya	---	249	207	456	125	190	315	194	463	657	1,328
Jimma	---	189	161	350	132	131	263	235	198	433	1,046
Gondar	242	---	197	439	110	100	210	318	262	580	1,229
Mekelle	---	123	90	213	4	8	12	170	45	215	440
Total	**242**	**856**	**869**	**1,967**	**464**	**494**	**958**	**1,274**	**1,244**	**2,518**	**5,443**

As shown in the table, total enrolled out of the 5000 planned are 2,925 and the total number of both post basic and generic students who graduated is 2,518 (50%).

In relation to the Innovative Physician Training Program initiated by the FMOH and undertaken by Addis Ababa, Mekelle, Haromaya and Jimma Universities; 80% of curriculum development has been finalized and actual training is expected to commence after the finalization of the curriculum.

Training of health officers in emergency obstetric care was initiated in Mekelle, Jimma and Hawassa Universities. Gondar and Haromaya Universities are also assessing their capacities to initiate this training. So far, 90 health officers have been enrolled for the two years Masters' program. This was one of the recommendations of the MTR which has started to be addressed in the implementation of the HRD reform.

Consultation has been initiated to scale up midwifery training and enroll 300 students per year. Concept paper was prepared and consultation on how to get the necessary preparatory works done is underway.

With regard to training and deployment of HEWs, out of a total of 6,215 HEWs planned to be trained and deployed in EFY 2001, 7,260 HEWs were actually trained and deployed, with an achievement rate of 117%. Additional 2,258 are under training.

In order to redress the serious shortage of health and non-health personnel in various occupational areas, different types of training are being conducted in EFY 2001. These are summarized in the following table.

Table 4: Type and Number of Training in Different Fields Undertaken in EFY 2001

Type of Training	Number Enrolled	Training Institution
Post Basic Anesthesiology	26	-
Radiography	93	-
Post Basic Ophthalmology-Nurses	25	ALERT
Post Basic training in Psychiatry- Nurses	50	Mekelle & Gondar Universities
Medical Equipment Maintenance Technicians	103	Addis Ababa
Post-graduate training in Hospital Administration – Hospital CEOs	28	Jimma University

With respect to the plan to deploy 3,000 health workers, 112 general practitioners and 2,486 other categories of health personnel have been deployed in different regions during the fiscal year. Hence, the performance rate of the deployment plan has been more than satisfactory (87%).

As reported by the JRM, aggressive communication campaign was initiated this financial year between the medical faculty graduates and FMOH; to develop a shared vision on the need to serve for some period before requesting release. According to the HRD department, the deployment of the 2000 graduates of Addis Ababa, Jimma and Gondar Universities was relatively smooth because of the better attitude created among the new graduates. The consultation between the top management of FMOH, medical school teachers and the graduates was reported to have had positive effect on retention.

The software for human resource information system has been developed. All the relevant information at the Federal level, Dire Dawa RHB and Harari RHB was collected and data entry has been performed. Preparation is underway to scale up this initiative to four hospitals and institutions that are accountable to the FMOH. The profile of all health workers is being collected, and this will help establish the human resource data base.

Some of the challenges/problems encountered during plan implementation include:-

- Slow finalization of the HRD Strategy
- Lack of demand-driven training,
- Difficulty to get employment by some graduates of health professions lacking demand;
- Inadequate budget for salary to employ some health Professionals;
- Inappropriate placement,
- Failure of Regional Health Bureaus to send to FMOH their human resource needs on time categorized by number and type of profession.

To solve these problems, the joint meeting of the FMOH and Regional Health Bureaus has decided that Regions should send their short-term human resource needs to FMOH in two weeks time and their long-term needs in detail; categorizing the data by health facility, Woreda, Zone and Region not later than October 25, 2009. Regional and Woreda administration will also be copied when HWs are sent from FMOH, in order to facilitate allocation of budget and employment. The HRD strategy will also be finalized though portions of it are already being implemented.

2.1.2.10 Procurement, Finance and General Service Support Process

The study on Finance and Procurement support process has been finalized and is being implemented. By using new experiences, operational systems and forms found during the re-designing study; it is implementing standards specified in the implementation plan.

Since procurement, finance and property administration are interlinked it was possible to differentiate by version and to categorize these two work processes. Key activities to be performed consecutively have been organized by sub-process; and procurement; property administration, income and payment; registration; finance and audit sub-processes have been organized in stages. It was possible to initiate efficient financial and procurement work by organizing these sub-processes in an inter-linked manner that does not affect the flow of the work process.

2.1.2.11 Program Based Audit Support Process

Audit and inspection support process has been designed to enhance efficient utilization of government resources towards the realization of the objectives of the institution and thereby contribute value added to the performance of the institution.

This support process contributes towards the achievement of the objectives of the institution; by starting from the Core Plan of the health sector and identifying beforehand challenges that hinder the full implementation of the plan. It also contributes to make work processes efficient, and to ensure the utilization of resources for its intended aims. Furthermore, it contributes by making inspections to ascertain the achievement of objectives by operational systems and by providing consultation to ascertain whether program implementation and resource utilization in the health sector are effective.

2.1.2.12 Public Relations Support Process

With respect to public relations and communication, actions have been taken to make the information system within the Ministry effective; and to design a system that allows development partners working in the health sector to get necessary data on time. Based on the results of the re-design study, a new communication strategy has been devised and when this is put into practice, effective information system will be developed to coordinate all information giving bodies.

Based on the planned activity to provide up-to-date information about service delivery and current affairs to clients and the public, information and data on the health sector, major communicable diseases and the Health Extension Program were transmitted through different media located at the center and in the Regions.

The FMOH website that was set up to raise public and client awareness about the mission and activities of the Ministry, as well as to receive and respond to questions and suggestions has been improved; and timely data and information is being provided to the public and to clients as well.

Consequently, the performance of the Ministry in EFY 2000 and the Core Plan of EFY 2001 have been aired on radio twice; as well as the implementation of the Health Extension Program. Media messages on HIV/AIDS and the current preparedness to prevent malaria epidemics have been disseminated several times.

In addition, to counter the negative reports given by various mass media and to give correct data and information on the new global epidemic of H1N1 Influenza; information and feed back were given on the distribution of the disease globally, its mode of transmission and how it was introduced into Ethiopia. Concerning BPR studies and the main achievements of the Ministry, the awareness of workers has been increased through publication and dissemination of ten issues of an internal newsletter.

The objectives and proceedings of 16 different meetings including the 10th Annual Review Meeting of HSDP organized by the FMOH have been disseminated through media reports. Reports on the implementation of the BPR have been made through electronic mass media as well as through print media. Training was given to workers about government policies and strategies, proclamations, regulations, guidelines, and strategies issued so far by the relevant authorities and also about pending new proclamations (e.g. health Insurance) to be issued in the future.

A media monitoring team has been established based on the new organizational structure. This team gathers data and information prepared at federal level, and will also transmit these data on the website of the Ministry of Health.

To create awareness on the work done around the reform process, and to enable leadership at any level to strengthen its implementation, in collaboration with ETV, Walta and Radio Fana, various discussion forums have been held and a lot of work has been done to promote the change.

2.1.2.13 Legal Services Support Process

This is one of the support processes designed at national level to facilitate the implementation of BPR in Government institutions.

The aim of this support process is to support the BPR of the institution with legal frameworks to enable institutional change based on firm legal basis. As a result since the start of the implementation, it is in the process of preparing various proclamations and regulations, refining and finalizing such documents and making follow-ups for the adoption of such documents by the relevant authority.

2.1.2.14 Chalenges

Some of the major constraints and challenges encountered during implementation of the BPR include the following:

- Inadequate human resources both in number and category
- Long time taken in some Regions for pre-implementation training; which delayed actual implementation
- Inability to implement the new design at lower levels
- Inadequate number of change agents
- Lack of standard checklist / questionnaire to measure customer satisfaction
- Slow pace of implementation in some regions due to the commencement of implementation without adequate understanding, and human resources
- Lack of knowledge of the new design at the level of Woredas
- Problem of logistics like supply of drugs
- Emerging regions not starting implementation along with the other regions, and
- Weak monitoring and follow-up of implementation.

2.1.3.15 Way forward

Various measures have been taken to address the above constraints such as recruiting additional workers, raising the awareness of management and workers, for purposes of regular follow-up and monitoring of the implementation process, conducting the FMOH and RHBs meeting every two months and tele-conference every fortnight, and efforts made to provide need based support to Regions that need special support. The main activities given priority for implementation in EFY 2002 include:

- Make efforts to empower management by increasing their commitment, changing their outlook and increasing their knowledge and skills.
- Make serious effort to strengthen the commitment, change the outlook and increase the knowledge and skills of professional personnel and workers.
- Improve the logistics supply system by establishing gradually a network at each health facility
- Provide adequate human resources based on the design and modifications on the work processes made during implementation
- Give priority to strengthening the implementation of the new design at Woreda level
- Scale up best practices
- Work to meet achievable targets by focusing on the implementation process of the new design

- Strengthen the practice of managing and monitoring change through planning and use of selected indicators, and
- Strengthen, on a sustainable basis, close working relations of Federal and Regional levels with development partners.

2.1.3 National Laboratory System Strengthening and Programmatic Support

Capacity building in terms of laboratory equipment and instruments is an essential component of the National Laboratory Master Plan. In accordance with the provisions of the master plan, to strengthen the capacity of regional and hospital laboratories, the following key activities were planned for implementation in EFY 2001.

The performance status of these planned activities in EFY 2001 was as follows:-
Fifty seven equipments have been procured and distributed to nine regional laboratories, to be used for training programs to be undertaken by regions. In addition, to the planned TOT for 40 laboratory technicians on laboratory monitoring of ART, TOT on CD4, clinical chemistry and haematology was given for 83 workers drawn from central level, Oromia, Jimma and Haromaya Universities. Furthermore, regular training was given for 30 laboratory technicians as well as TOT training on HIV testing for 30 laboratory technicians in SNNPR.

The plan to make Regional and ART hospital laboratories to participate on a permanent basis in global quality control work with respect to CD4, clinical chemistry, haematology and DNA-PCR, has been well accomplished. In terms of types of tests, the following laboratories have registered good results in three rounds i.e. 52 in clinical chemistry and haematology, 83 in CD4 and six in DNA-PCR programs.

The National HIV laboratory and six regional laboratories have participated in two rounds in the DNA-PCR international quality control program arranged by CDC Atlanta and have registered excellent results.

In accordance with the plan to undertake quality control at national level on HIV, TB and Malaria laboratories, guidelines and related documents which help to validate quality of HIV tests have been prepared at Federal level and distributed to Regions. In EFY 2001 national HIV test quality control program has been implemented in three rounds. In all rounds 500 laboratories and testing points as well as 130 VCT centers have participated and were able to register good results.

The laboratory quality assurance program is being implemented in all EHNRI laboratories and efforts are being made for the national HIV laboratory, to get international recognition in the quality of its laboratory services. Consequently in order to gauge the quality standard and identify their weaknesses; arrangements have been made for the institute laboratories, to be reviewed and evaluated by the American Clinical Laboratory Standards Institute (CLSI). Based on this activity, short term action plan has been prepared and is being implemented to fill the major gaps observed during the evaluation process. At the same time, the Adama and Addis Ababa Regional laboratories were evaluated by the American Clinical Laboratory Standards setting team.

Concerning the activities of TB quality control focal persons, monitoring and evaluation has been

done by professional workers sent by the center. In addition, 32 Regional and Federal health facility laboratories have participated for the first time in the TB national control program; while 57 laboratories, have participated in the two rounds of quality control work.

Panel test slides that help for quality control of TB laboratory tests have been prepared and distributed to 32 laboratories. The results of the quality control work have been compiled by the center. A five-day TOT training on microscopy and quality control of TB examinations has been given for 35 professional workers of regional referral laboratories and for TB coordinators.

In addition, quality control work of TB laboratories has been done on 52 laboratories in Regions and seven quality control inspectors of regional laboratories have been recruited for Amhara, SNNPR, and Harari Regional Health Bureaus. Training on pre-maintenance care of CD4, chemistry and haematology equipment has been given for 34 technicians at Hawassa, SNNPR.

In addition, guideline that helps to control work processes has been prepared. Quality control plan of action of national health laboratories has been prepared and according to the plan to prepare guideline on quality control, a national health laboratories quality control operational plan and schedule have been prepared and distributed to all regional laboratories and partner organizations.

At national level according to the plan to prepare ART laboratory equipment database to help in follow up of major equipment related with ART laboratory services, database showing the detailed situation of equipment in ART laboratories has been prepared and is being used.

To train 40 maintenance technicians drawn from Regions on major-equipment related with anti-HIV laboratory; and to give maintenance tools related with this work and according to the plan to organize laboratory equipment spare parts and maintenance service at central level; 80% of the procurement process of ART equipment and spare parts is completed and the arrival of these items is being awaited. With respect to the procurement of equipment to be used for TOT, 90% of the work is completed.

Based on the plan to give training for 20 laboratory technicians on epidemic diseases like meningitis and acute watery diarrhea, training has been given for 32 medical laboratory technicians drawn from all Regions.

Concerning quality control of malaria rapid diagnostic tests, according to the plan to establish a laboratory that meets international standards and gives service to Africa Region, such type of laboratory that validates and monitors the quality standards of RDT products has been established and chemicals and expendable supplies that enable the implementation of the quality control work have been procured. Working relations on quality control have been created with laboratories abroad and the work has been started by bringing a professional from abroad. Guideline that helps in quality control work has been prepared and sample necessary for immediate testing has been brought from abroad.

Opening Ceremony of Malaria RDT testing center, Global Lab

The main challenges/constraints faced during implementation were as follows:-

- The training of 40 maintenance technicians trained at strengthening the capacity of Regions to maintain laboratory equipment has not materialized due to the unwillingness of the foreign equipment manufacturing companies to cooperate and execute the program as scheduled.
- The plan to start viral load examinations in four hospitals has not been implemented.
- There was a plan to start in an additional four hospitals HIV/test on children using DNA/PCR. However, this was not possible since the development partner that has signed agreements with the institute did not supply the necessary equipment for the work on time.

In order to address these problems, the training of 40 maintenance technicians will be undertaken through discussion with external equipment manufacturers. Since it was found that it is necessary to build capacity of regional laboratories prior to starting viral load examination in hospitals; the necessary equipment and materials have been distributed to Addis Ababa, Adama, Hawassa, Mekelle, Dessie and Bahir Dar Regional laboratories. Installation of equipment and training activities are being performed. HIV test on children using DNA/PCR will be started in 2002 in 4 hospitals after discussion with the concerned partner organizations.

2.1.4 Institutionalization of Gender

Institutionalizing gender in the sector, to strengthen through capacity building the participation of women and thereby increase their benefits.

The performance of key activities in EFY 2001 included the following:-
In line with the plan, training manual on physical violence and analytic framework on gender and health has been prepared. In accordance with the plan to compile and analyze data on female workers and use the data for advocacy purposes, compilation and analysis of the data is already completed. The final version of the document will be published and distributed upon completion.

In order to prevent physical abuse on women and to provide adequate health services for the victims, rapid assessment was made and based on the results of the and identified gaps a draft training manual for use by health workers has been prepared and refined through a consultative workshop attended by all concerned stakeholders.

III

HEALTH EXTENSION PROGRAM




HEALTH EXTENSION PROGRAM

The Health Extension Program (HEP), which is extensively under implementation, is one of the major pillars of the health service delivery system in Ethiopia. It is getting momentum and global recognition as an effective strategy for substantially improving the health status and bringing about the required changes in both the rural (sedentary and pastoralist) population and socio-economically marginalized urban population. It is a family and community based intervention and considered as a major driving force for achieving the health-related Millennium Development Goals (MDGs), particularly MDG 4, 5, and 6.

HEP targets households to improve the health status of families and their members. It calls for the full participation of families and the use of technologies and the skills and wisdom of communities. The Program enables the communities to produce their own health as a commodity in a way that is similar to their experience in producing agricultural goods or products. This is realized when each family is trained on model family packages and the packages translated into action.

Since the Program aims at improving access and equity in the delivery of essential health services at village level and among the marginalized urban and pastoral population, it is now being expanded to urban and pastoral areas. The implementation of the urban HEP is based on the life style and settlement pattern of the urban population and the experiences acquired in implementing HEP in rural villages and communities.

HEP is composed of 16 packages of interventions broadly categorized into four areas as follows:

1 Hygiene and Environmental Sanitation
   - 1.1 Excreta disposal;
   - 1.2 Solid and liquid waste disposal;
   - 1.3 Water supply and safety measures;
   - 1.4 Food hygiene and safety measures;
   - 1.5 Healthy home environment;
   - 1.6 Control of insects and rodents,
   - 1.7 Personal hygiene.

2 Family Health
   - 2.1 Maternal and Child Health;
   - 2.2 Family planning;
   - 2.3 Immunization;
   - 2.4 Nutrition;
   - 2.5 Adolescent reproductive health.

3 Disease prevention and control
   - 3.1 HIV/AIDS, STI and TB prevention and control;
   - 3.2 Malaria prevention and control;
   - 3.3 First aid and emergency measures.

4 Health education and communication.

The following sections summarize the performances and the targets of the HEP in EFY 2001.

3.1 Training and Deployment of Health Extension Workers (HEWs)

A cumulative number of 31,831 HEWs were trained and deployed up to end of EFY 2001, which is above the target of 30,786 (103%) (Table 5). The number of HEWs newly trained and deployed in EFY 2001 was 7,260, above the target of 6,215 set for the year (117%). However, due to attrition of HEWs, the total number of HEWs actually available in EFY 2001 is 30,578, and it is for this reason that some Regions increased the number of HEWs to be trained in order to address the turn-over of HEWs and maintain the full coverage of HEWs in the country. This justifies the fact that the performance was largely above the target in some Regions.

Table 5: Training and Deployment of HEWs by Region (EFY 2001)

Region	Cumulative number of HEWs trained and deployed in EFY 2000 (A)	Number of HEWs newly trained and deployed in EFY 2001 (B)	Cumulative number of HEWs trained and deployed in EFY 2001 (A+B)	Number of HEWs currently available in EFY 2001 (C)	EFY 2001 target for number of HEWs newly trained and deployed (D)	Annual Performance (%) (B*100)/(D)	EFY 2001 target for cumulative number of HEWs trained and deployed (E)	Cumulative Performance (%) [(A+B)*100]/E
Tigray	1,235	134	1,369	1,259	0	-	1,235	111%
Afar	228	148	376	375	108	137%	336	112%
Amhara	6,630	382	7,012	6,415	20	1910%	6,650	105%
Oromia	8,437	4,526	12,963	12,875	4,563	99%	13,000	100%
Somali	555	545	1,100	1,100	445	122%	1,000	110%
B. Gumuz	206	315	521	499	286	110%	492	106%
SNNPR	7,115	800	7,915	7,492	635	126%	7,750	102%
Gambella	47	410	457	457	158	259%	205	223%
Harari	39	0	39	32	0	-	39	100%
D. Dawa	79	0	79	74	0	-	79	100%
TOTAL	24,571	7,260	31,831	30,578	6,215	117%	30,786	103%

With regard to the trend, there was a consistent increase in the cumulative number of HEWs trained and deployed during HSDP III, from 2,737 in EFY 1997 to 31,831 in EFY 2001 (Figure 2). The performance achieved in EFY 2001 was above the target of 30,786 HEWs set in the Core Plan.

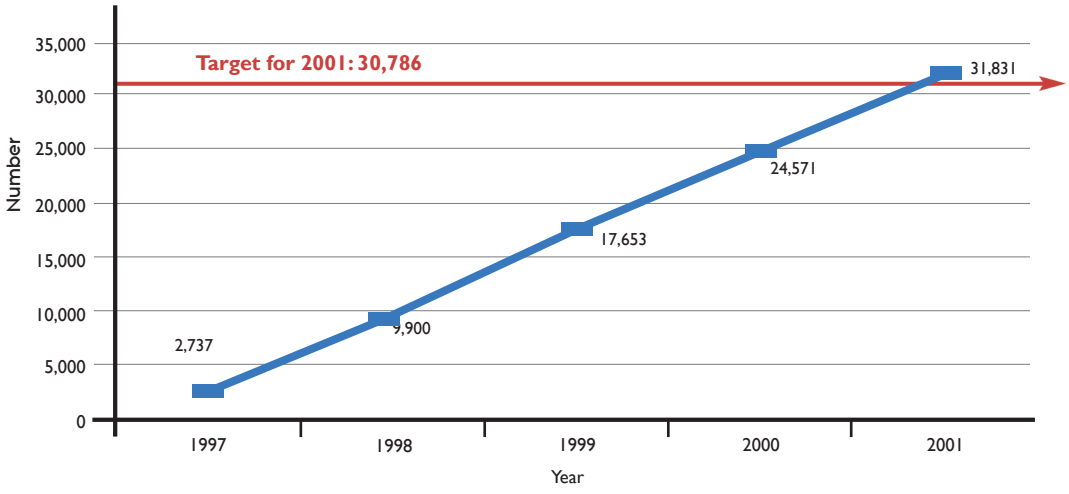

Figure 2: Trend in the Cumulative Number of HEWs Deployed in Health Posts (EFY 1997-2001)

Figure 3 below illustrates that all Regions achieved the target of the cumulative number of HEWs trained and deployed set for EFY 2001, with a performance ranging between 100% in Oromia, Harari, and Dire Dawa and 223% in Gambella.

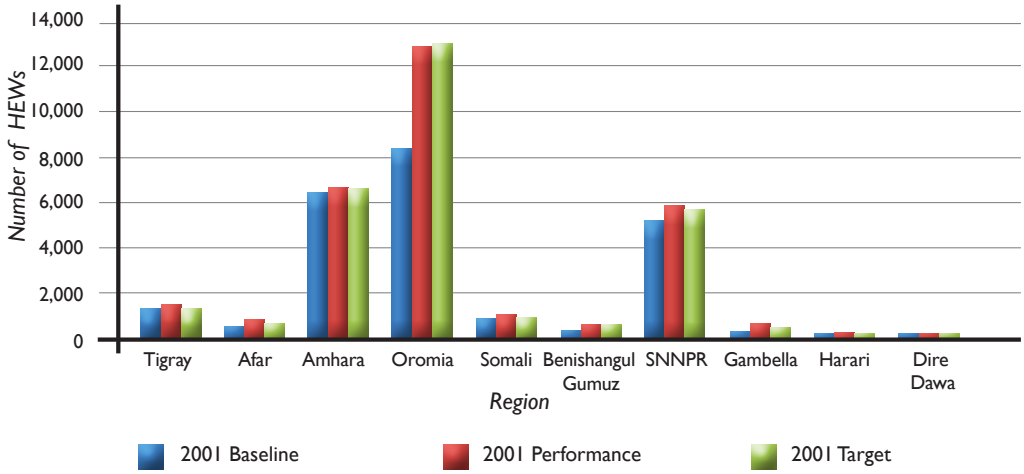

Figure 3: Comparison of Baseline, Performance and Target of the Cumulative Number of HEWs Trained and Deployed by Region (EFY 2001)

With regard to training and deployment of new HEWs in EFY 2001, as mentioned above, a total of 7,260 HEWs were newly trained and deployed in the year, which is above the target of 6,215 HEWs (117%) set in the Core Plan. Oromia Region accounted for most of this performance, with 4,526 HEWs being trained and deployed in the year. Of note is the fact that some Regions trained and deployed additional HEWs (above the target) to address the issue of the attrition of HEWs (Figure 4).

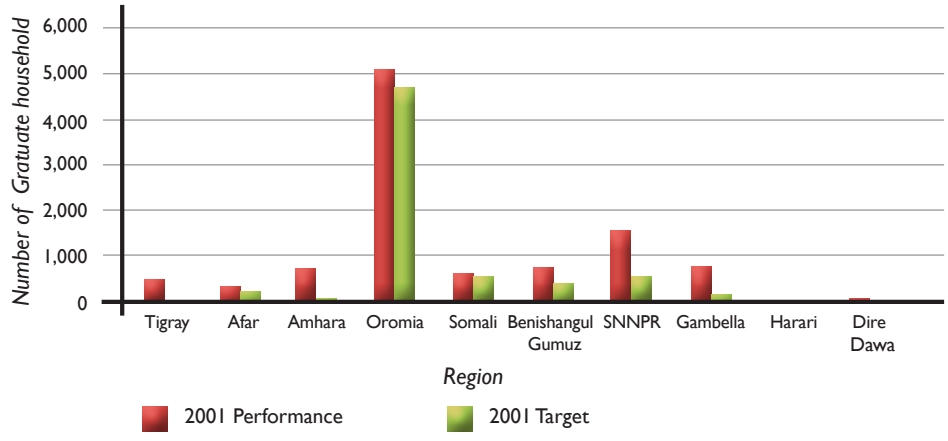

Figure 4: Comparison of Performance and Target of the Number of HEWs Newly Trained and Deployed by Region (EFY 2001)

Provision of Training materials

A target has been set for EFY 2001 to print and distribute 24,000 copies of HEP Implementation Guideline to Regions, health facilities, HEWs, and NGOs. However, 15,000 copies have been printed and distributed to new graduates (63% of the target). The number of Health Extension Newsletters distributed in the same year was 25,000, reaching the target set for EFY 2001.
Efforts have also been made to mobilize financial and material resources to fill the resource gap existing in the training centers.

Graduated Model Families

The selection and training of households has continued in EFY 2001. Basic training on the 16 packages of the Program has been expected to be given for 96 hours. As in the previous years, the households were selected based on the following criteria:

- Ability to easily follow and understand the envisaged training;
- Readiness to be model for other families;
- Readiness for change;
- Willingness and ability to convince and change others.

Clean and organized utility room of Model Family showing the effectiveness of health promotion for better health

The purpose of the training is to diffuse and communicate step by step innovations through appropriate channels over time among members of the social system in different communities.

In EFY 2001, it was planned to train 6,215,753 Model Households, while the actual number of Households graduated in the year was 2,932,356 (47% of the annual target). The cumulative baseline of households graduated at the end of EFY 2000 was 1,129,176; if we add the households graduated in EFY 2001 (2,932,356) to this cumulative baseline, we reach the cumulative total of 4,061,532 households graduated at the end of EFY 2001, a level of performance which is well below the target (57%) (Table 6). The achievement rate for the number of households newly graduated in EFY 2001 (47%) was even lower than the cumulative one (57%). The total coverage of the households graduated at the end of EFY 2001 was 26% of the total eligible households.

Table 6: Comparison of Baseline, Performance and Target for the Number of Model Households Graduated with Percentages of Target Achievement (EFY 2001)

Region	Cumulative number of Graduated Households at the end of EFY 2000 (A)	Number of Graduated Households in EFY 2001 (B)	Cumulative number of Graduated Households at the end of EFY 2001 (A+B)	EFY 2001 target for number of Graduated Households (C)	Annual Performance (%) (B*100)/C	EFY 2001 target for cumulative number of Graduated Households (D)	Cumulative Performance (%) (A+B)*100/ (D)	EFY 2001 eligible number of Households (E)	Coverage (%) (A+B)*100/(E)
Tigray	287,853	341,516	629,369	461,772	74%	587,680	107%	1,030,199	61%
Afar	0	0	0	38,150	0%	38,150	0%	258,572	0%
Amhara	252,935	1,010,008	1,262,943	1,595,221	63%	1,715,477	74%	4,209,129	30%
Oromia	31,798	671,958	703,756	2,358,014	28%	2,481,298	28%	6,011,967	12%
Somali	0	8,490	8,490	59,315	14%	59,315	14%	708,028	1%
B. Gumuz	9,476	1,126	10,602	78,533	1%	88,009	12%	158,156	7%
SNNPR	546,874	898,650	1,445,524	1,549,937	58%	2,121,906	68%	3,272,573	44%
Gambella	0	0	0	44,460	0%	44,460	0%	72,304	0%
Harari	0	428	428	13,851	3%	15,758	3%	49,488	1%
D. Dawa	240	180	420	16,500	1%	16,740	3%	80,041	1%
TOTAL	1,129,176	2,932,356	4,061,532	6,215,753	47%	7,168,793	57%	15,850,457	26%

The Regional distribution of the 2001 baseline, performance, and target of the cumulative number of graduated households shows that Tigray was the only region performing above the target (107%) set for EFY 2001, with 629,369 model families having graduated against the target of 587,680 (Figure 5). Amhara showed the second best performance with 1,262,943 model families being graduated (74% of the target), followed by SNNPR (68%) and Oromia (28%). Lower achievements were found in Somali (14%), Benishangul-Gumuz (12%), Harari (3%), and Dire Dawa (3%). No graduation was reported in Afar and Gambella.

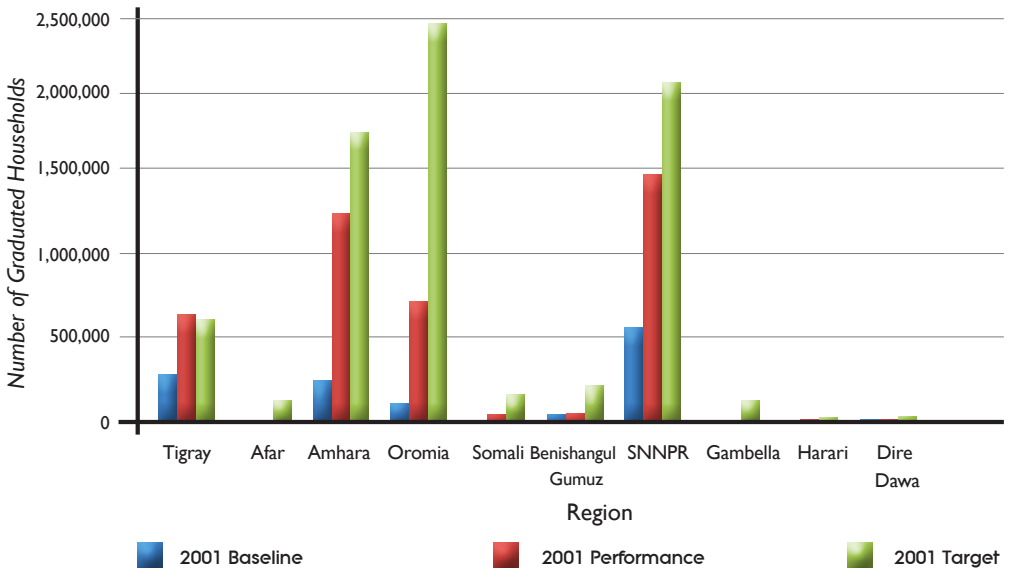

Figure 5: Comparison of Baseline, Performance and Target of the Cumulative Number of Graduated Households by Region (EFY 2001)

The standards established in HEP concerning the graduation of Model Households are as follows:

- Each HEW is expected to train 40 to 60 Households at once for 96 Hours every three months, with 4 batches per year and a total of 160 to 240 Model Households to be graduated per year (40 to 60*4);
- 10-15% of the graduated model households (called innovators) are also expected to train and graduate at least 40 to 60 Households per year.

In order to make a conservative estimate of the number of Model Households expected to be graduated in EFY 2001 according to the HEP standards, we can take into consideration the minimum number in the range above (160 households graduated per year) and we can also exclude those households to be trained by already graduated households ("innovators") that are not under the direct control of HEWs. Therefore, we can estimate the expected number of graduated Model Households by multiplying the number of HEWs already deployed at the beginning of EFY 2001 (24,571) and the minimum number of Model Households graduated per year (160). We can then compare the expected and actual number of new Model Households graduated in EFY 2001 to assess performance (Table 7).

Table 7: Comparison of Expected and Actual Number of New Model Households Graduated (EFY 2001)

Region	Number of HEWs deployed at the beginning of EFY 2001 (A)	Expected number of new Model House-holds to graduate in EFY 2001 (A*160)	Actual Number of New Model Households Graduated in EFY 2001 (B)	Difference between actual and expected number of Model Households graduated in EFY 2001 (B)-(A*160)	Percentage of achievement (B*100)/(A*160)
Tigray	1,235	197,600	341,516	+143,916	173%
Afar	228	36,480	0	-36,480	0%
Amhara	6,630	1,060,800	1,010,008	-50,792	95%
Oromia	8,437	1,349,920	671,958	-677,962	50%
Somali	555	88,800	8,490	-80,310	10%
Benishangul- Gumuz	206	32,960	1,126	-31,834	3%
SNNPR	7,115	1,138,400	898,650	-239,750	79%
Gambella	47	7,520	0	-7,520	0%
Harari	39	6,240	428	-5,812	7%
Dire Dawa	79	12,640	180	-12,460	1%
TOTAL	**24,571**	**3,931,360**	**2,932,356**	**-999,004**	**75%**

A large gap (999,004) was observed at the National level between the expected and actual number of new Model Households graduated in EFY 2001. At the National level, the level of achievement was 75% of the expected number of new Model Households to graduate in EFY 2001. The Regional comparison shows that Tigray had the best performance (173%); among the other Regions, the comparison between expected and actual performance shows that Amhara achieved 95% of the expected performance, followed by SNNPR (79%), and Oromia (50%). All the other Regions performed below 50%, with Afar and Gambella not reporting any Model Household for graduation during the year (Figure 6).

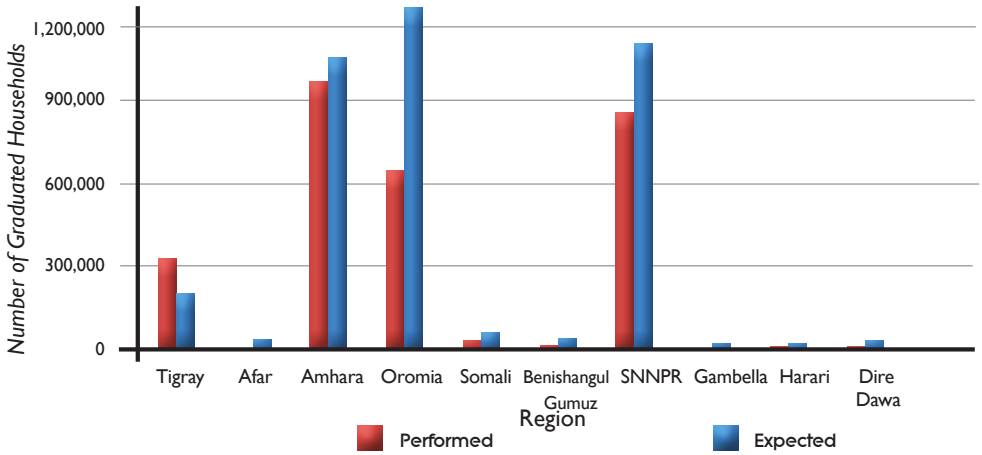

Figure 6: Comparison of the Actual and Expected Number of New Model Households Graduated (EFY 2001)

HEP Supervision

Supportive supervision, which addresses the quality, technical and other constraints that HEWs encounter in implementing the packages, is critical in the process of HEP implementation.

Therefore, targets have been set for EFY 2001. Performances with regard to achieving these targets are as follows:

- An HEP supervision technical guideline, four types of rural HEP reference books and a school health program manual which were prepared in the past have been reviewed and adopted in light of the BPR. All the manuals and guidelines have been made ready for printing;
- Out of 615 HEP supervisors planned to be trained on supportive supervision, 452 were trained, with a performance of 73.5%. Table 8 illustrates the activities planned against the achievements. Due to lack of complete data, the number of HEWs who received refresher training is not reported;
- Preparations have been completed to conduct the planned 15 days training to 60 HEP coordinators and other health professionals at Federal and Regional levels on health education material preparation, production and distribution.

Table 8: Training of HEP Supervisors (EFY 2001)

Region	Cumulative number of HEP supervisors trained and deployed in EFY 2000	EFY 2001		Cumulative number of HEP supervisors trained and deployed in EFY 2001	Total target	Percentage of Achievement
		Plan	Graduated and deployed			
Tigray	176	-	0	176	240	73.3
Afar	0	-	54	54	110	49.1
Amhara	458	332	153	611	765	79.9
Oromia	951	-	0	951	1,050	90.6
Somali	0	-	0	0	190	0.0
Benishangul-Gumuz	38	38	0	38	75	50.7
SNNPR	403	245	245	648	640	101.3
Gambella	47	-	0	47	50	94.0
Harari	20	-	0	20	30	66.7
Dire Dawa	21	-	0	21	50	42.0
TOTAL	**2,114**	**615**	**452**	**2,566**	**3,200**	**80.2**

As can be seen from the above table, the highest performing Region in EFY 2001 was SNNPR with 100% achievement of the target, followed by Amhara with a performance rate of 46.1%. Tigray, Afar, Oromia, Somali, Gambella, Harari and Dire Dawa had no target for the year. Although there has been no target set for the year, Afar has trained 54 supervisors.

Comparison of Regional performances with targets set for the cumulative number of HEP supervisors trained and deployed in EFY 2001 again shows that SNNPR was the only Region whose performance was above the target (101%), while Gambella and Oromia registered coverage of 94% and 91%, respectively. Afar, Benishangul Gumuz and Dire Dawa showed low performance rates between 42% and 51%.

3.2 Construction and Equipping Community Health Posts (HPs)

3.2.1 Construction of Health Posts

There was a steady increase in the number of HPs constructed over the past years, from 6,191 in EFY 1998 to 12,488 in EFY 2001 (Figure 7). According to HSDP III, the plan was to construct and make operational a total of 15,022 during the period of the program; therefore, the performance at the end of EFY 2001 was 83.1% of the overall HSDP III target. This implies that 2,534 (16.9%) more HPs will have to be constructed in EFY 2002.

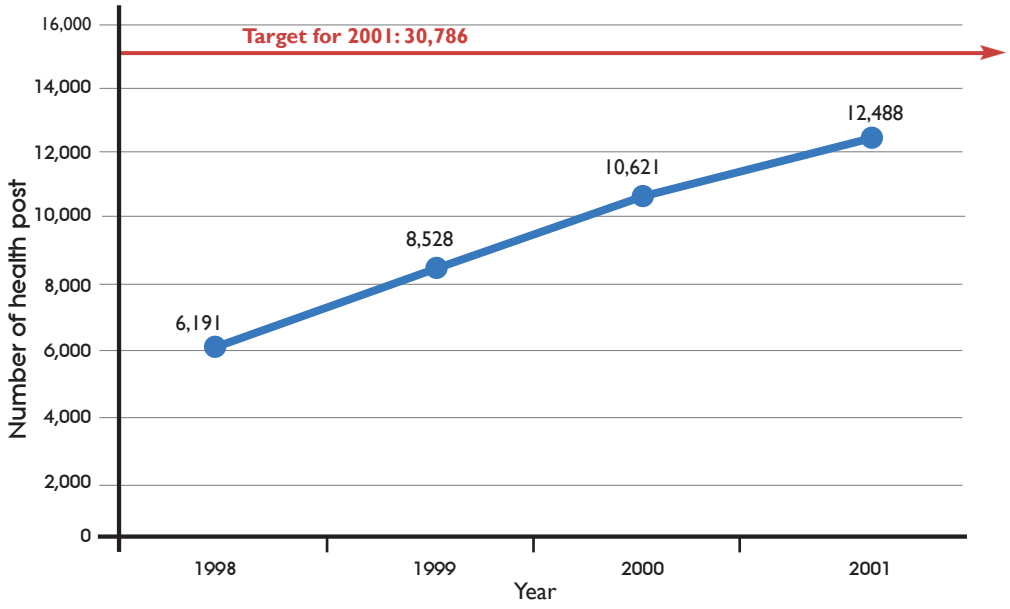

Figure 7: Trend in the Cumulative Number of Health Posts Constructed (EFY 1998-2001)

As can be observed from Table 9 below, large variations in performance were observed across Regions, ranging between 68.4% in Tigray and 97.9% in Benishangul-Gumuz. Afar (93.0%) and Oromia (89.6%) have almost reached their Regional target.

A functional Health Post is the backbone of the Health Extension Program

Table 9: Construction of Health Posts (EFY 2001)

Region	HSDP Target	Cumulative number of HPs available in EFY 2000	EFY 2001		Cumulative number of HPs available in EFY 2001	Perfor-mance in %
			Plan	Completed		
Tigray	786	614	172	0	538	68.4%
Afar	256	112	144	126	238	93.0%
Amhara	3,853	2,664	1,189	192	2,856	74.1%
Oromia	5,227	3,758	1,469	927	4,685	89.6%
Somali	740	290	450	257	547	73.9%
Benishangul-Gumuz	240	166	74	69	235	97.9%
SNNPR	3,729	2,904	0	334	3,238	86.8%
Gambella	124	51	73	48	99	79.8%
Harari	25	23	2	0	19	76.0%
Dire Dawa	42	39	3	0	33	78.6%
TOTAL	**15,022**	**10,621**	**3,576**	**1,953**	**12,488**	**83.1%**

The highest increase in the number of HPs constructed in EFY 2001 was found in Oromia (+927), followed by SNNPR (+334). Of note is the fact that three Regions (Tigray, Harari, and Dire Dawa) upgraded some HPs to HCs, therefore showing a lower number of HPs at the end of EFY 2001 with respect to the be beginning of the year (Figure 8).

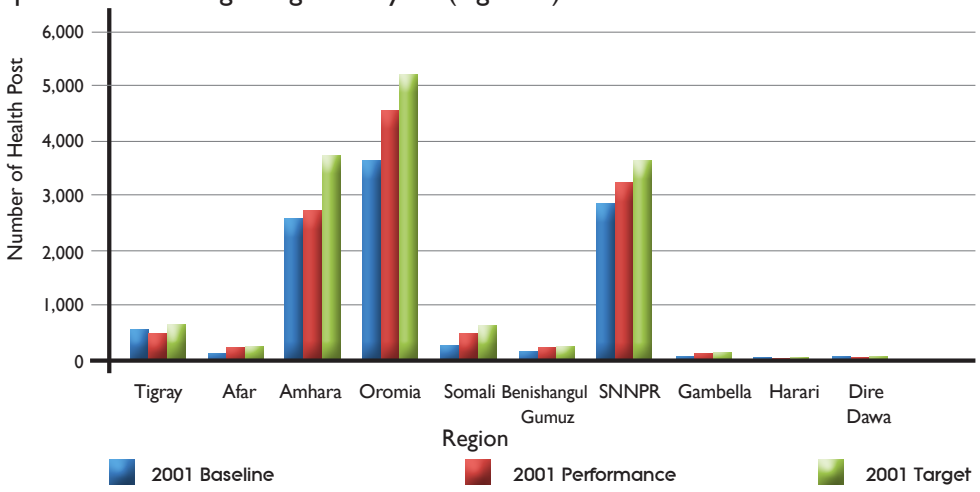

Figure 8: Comparison of Baseline, Performance and Target of the Cumulative Number of Health Posts Constructed by Region (EFY 2001)

3.2.2 Equipping Health Posts

Providing Health Posts with equipment, materials and supplies is a pre-condition for delivering the different packages of HEP. Hence, equipping 9,916 Health Posts with medical kits was a major target for EFY 2001. Reports received from UNICEF and ADB show that 5,691 Health Posts were equipped in EFY 2001 (57.4% of the target). The cumulative total of HPs equipped at the end of EFY 2001 reached 10,797 (71.9% of the cumulative target of equipping 15,022 HPs).

Comparison of EFY 2001 baseline, performance and target of the HPs newly equipped during EFY 2001 across Regions is shown in Figure 9. With the exception of Tigray (performing above the target), all Regions were found below their Regional target. The highest number of HPs equipped was in Oromia (1,960), followed by Amhara (1,766), and SNNPR (1,139).

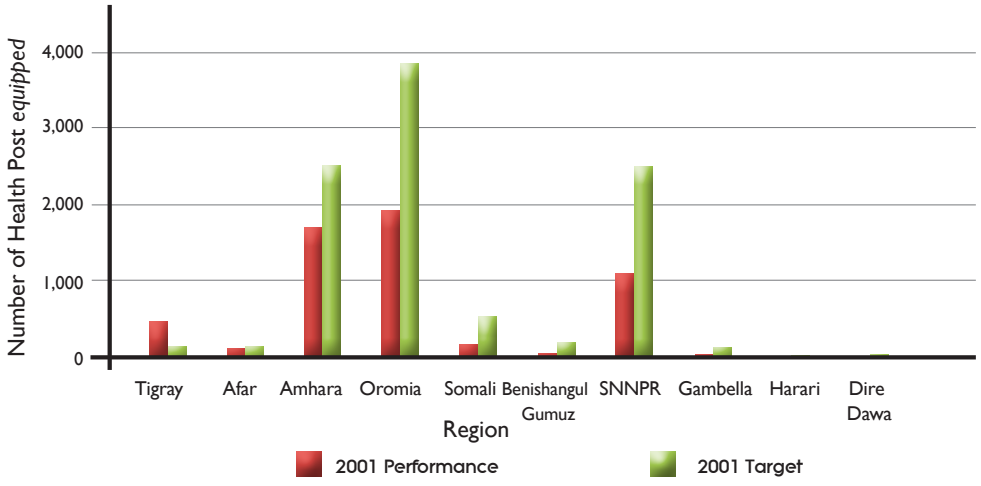

Figure 9: Comparison of Performance and Target of the Number of Health Posts Newly Equipped by Region (EFY 2001)

In addition to the medical kits distributed, 7,000 kits with an estimated cost of Birr 65.06 million, are procured and ready for distribution. They will be distributed to the Regions as soon as the work of packing is completed. Of note is the fact that 2,346 kits for HPs provided in EFY 1998 (before the standard for kits was set) will be replaced with standard kits in EFY 2002.

Medical Equipments and Supplies ready for Distribution

3.3 Health Extension Program in Pastoral and Semi Pastoral Areas

The HEP Implementation Manual that was under preparation in EFY 2000 has been refined, finalized and under distribution in EFY 2001, 10,000 copies of the manual have already been distributed to the concerned Regions during the year.

3.4 Health Extension Program for the Urban Areas

Expansion of the HEP in the urban areas of the country has started in EFY 2001, and it is planned to be implemented in seven Regions. The activities undertaken in EFY 2001 are summarized as follows.

Preparatory activities have been undertaken to train and deploy HEWs who provide the packages on the basis of the life style and settlement pattern of the urban population.

The task force that was established to look into the experiences of the other Regions and countries and to develop an appropriate implementation manual for the urban areas based on the experiences gained has completed its task. The Implementation Manual has been finalized and the 24 HEP packages have been prepared and distributed to the concerned urban administrations for implementation.

Training of Trainers for Urban Health Extension Program: theoretical and practical sessions

Since the Program requires intersectoral collaboration, a sensitization and awareness creation conference has been conducted. Over 200 representatives of Government entities, heads of sectoral bureaus and offices, professional associations and NGOs have participated in the conference. A press release has been also given to 100 public and private media professionals to enlist their commitment and for support in the implementation of the program. The recruitment of HEW trainees has been also undertaken during the year. The preparatory activities undertaken in EFY 2001 are shown in Table 10.

Table 10: Preparatory Activities on the Expansion of the HEP in Urban Areas (EFY 2001)

Description of activity	2001 Target	2001 Performance	% achieved
Strengthen HEP training centers	25	15	60.0
Prepare and distribute copies of 24 HEP Packages	24,000	15,000	62.5
Prepare and distribute copies of TOT manuals	1,000	1,000	100.0
Prepare and distribute copies of urban HEP Implementation Manual	10,000	10,000	100.0
Conduct training of trainers	100	100	100.0
Distribute copies of the 24 HEP packages to HEWs	5,000	5,000	100.0
Follow up and monitoring of the recruitment of urban HEWs in regions	7	7	100.0

3.5 Information, Education and Communication (IEC)

A number of IEC activities on HEP have been planned and implemented in EFY 2001. The core target was to sensitize and raise the awareness of heads of offices, experts and professionals on HEP. In order to achieve this target, the following activities were undertaken.

About 100,000 copies of a sensitization and awareness creation document that will assist heads of offices, experts and professionals on the HEP have been prepared and distributed to Federal and Regional level heads of offices, other professionals and partners. The implementation rate for this has been 100%.

The two days sensitization and awareness creation workshop which was planned for 200 heads of sector offices was conducted for 320 participants. This constitutes an implementation rate above the target. In addition to this, familiarization of the experiences, best practices and results of the HEP has been started in SNNPR, Tigray, Harari and Dire Dawa Regions involving the model families, health extension and other health workers.

A two days sensitization and awareness creation workshop on the 24 HEP was conducted for 120 heads of sector offices. This was accomplished according to plan. Similarly, a five days training on HEP was given to 40 federal and 60 regional level media professionals.

HEP centered leaflets/pamphlets that are expected to bring about sustained behavioral change were prepared in different languages and communicated to the public. Copies of 120,000 Health Newsletters have been also prepared and distributed for HEP Day for raising the knowledge and skills of 30,000 HEWs.

A total of 208 health programs were transmitted in four languages through Radio Fana, and 260 health programs in five languages through the Ethiopian Radio, while 48 articles were published on Addis Zemen Daily Newspaper, and 48 health messages on Abyotawi Democracy Newspaper. Mobile van was used in 40 Woredas. The number of messages communicated through Ethiopian Television were 18 in Amharic, 16 in Oromifa and 18 in Tigrigna. Radio spots that focused on malaria, maternal and child health care were also aired.

A total of 516 audio and 69 video messages on different communicable diseases, maternal and child health, hygiene and environmental health were reproduced and sent to Regions, and a total of 25,000 copies of health newsletters that focused on different health topics were distributed to health workers to strengthen their knowledge and skills.

A symposium and festival on HEP was conducted in Hawassa to acknowledge, encourage and award prizes to individuals and institutions that contributed to the success of the HEP. Preparation for a second festival in Adama is completed. A five days awareness creation training workshop for community conversation coordinators from health, education, water, agriculture sectors and women's affairs was conducted.

A documentary film on HEP success stories and experiences in SNNPR, Amhara, Tigray, Harari and Dire Dawa RHBs, selected Woredas, kebeles, model families has been transmitted and shown at the symposium conducted in Hawassa. Similarly, a documentary film on the results of the HEP has been started with Walta Information Center.

In order to bring about health behavioral changes, the transmission of health messages on HIV/AIDS, malaria, TB, acute watery diarrhea (AWD), hygiene and environmental health, reproductive health, Regional level mobilization on health related issues in different languages is critical. Therefore, messages on these critical and acute health problems have been transmitted through the Federal and Regional mass media. Messages on AWD and related health problems have been also transmitted using mobile vans and educational films at Kebele and Woreda levels.

3.6 Strengthening organizational structure

The FMOH and the Regional Health Bureaus jointly decided to integrate the HEP at the different levels of the health system. Based on this decision, RHBs have continued to create HEP departments at the Regional level and teams at Zonal and Woreda levels. All Regions, Zones and Woredas have completed the process of strengthening HEP structurally by assigning qualified and committed professionals.

3.7 Hygiene and Environmental Sanitation

The plan for EFY 2001 was to increase the number of households with latrines from 37% to 86% but the performance achieved in the year (60%) was below the target.

Comparison across Regions shows that Addis Ababa, SNNPR and Tigray Regions had better performances than other Regions, with performance rates of 76%, 75% and 71% respectively. The lowest performers were Somali, Afar, and Gambella Regions, showing performance rates of only 3%, 7% and 10%, respectively (Figure 10).

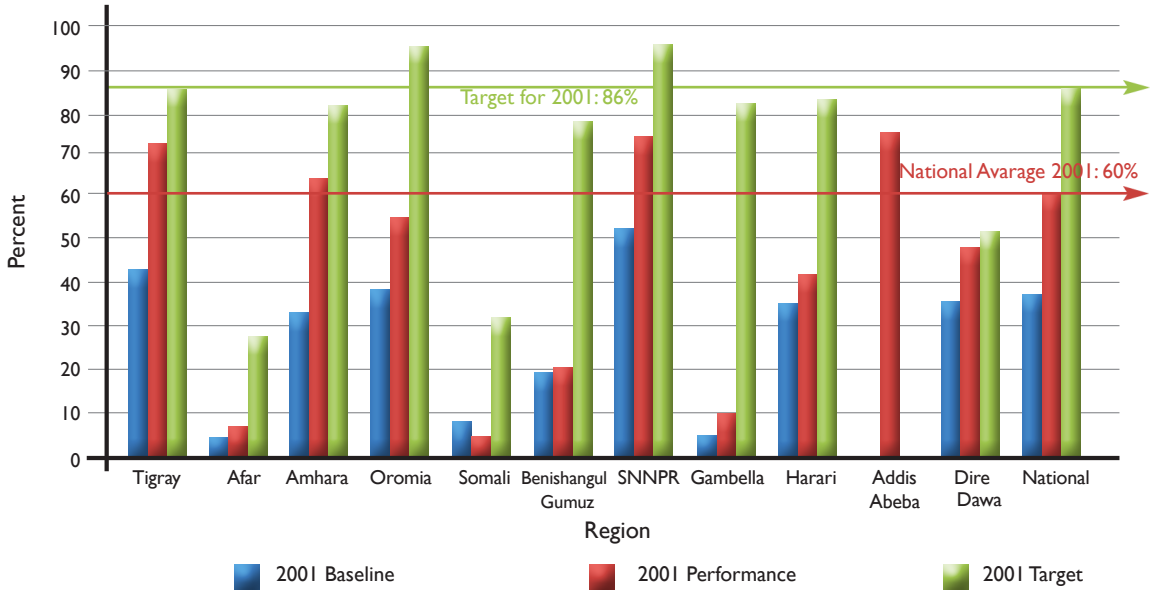

Figure 10: Comparison of Baseline, Performance and Target of the Latrine Coverage by Region (EFY 2001)

With regard to environmental sanitation in HEP areas, the plan for EFY 2001 was to prepare and distribute to Regions 15,000 copies of a manual on the prevention of open field defecation, provide TOT for 200 HEP supervisors and coordinators and plan and conduct experience sharing visits in two selected regions for 500 HEP supervisors and other related professionals.

Activities related to this plan include the following:

- Education on proper use of latrines was given through the mass media and 20,000 leaflets were printed on this subject for distribution in the rural areas.
- A five days TOT on low cost latrine construction has been given to 28 participants coming from all Regions and selected micro-enterprises. A training manual and design on the construction of improved latrines has been prepared.
- A TOT on community-led total sanitation (CLTS) has been given to 45 participants drawn from RHBs and partner agencies. Experience sharing visits were organized and undertaken in selected sites in Oromia Region for health workers involved in environmental hygiene and sanitation.
- To improve the quality of water, sanitation and personal hygiene in elementary schools, a manual on environmental health requirements and a guideline on environmental health have been prepared for use by elementary schools. Trainings on the manual and guideline have been given to professionals from health, education and water resources sectors.

Many of the following challenges and constraints were raised at the joint meeting of the FMOH and the RHBs. They were extensively discussed and a number of action points have been noted to overcome the challenges and constraints.

Challenges and constraints with regard to HEP implementation:

- Delay in translating the package in the local language;
- Failure to recruit the HEP supervisors as per the criteria;

- High cost of training the HEWs on clean and safe water;
- Issues related to incentive mechanisms for HEWs, such as promotion, transfer, separation/resignation, and educational opportunities;
- Absence of the HEWs from their catchments areas due to uncoordinated refresher trainings;
- Delay in procurement, repacking and distribution of HP kits to the Regions;
- Shortage and high cost of construction materials for HPs, delaying their construction as per the plan;
- Delay in the finalization of the urban HEP package;
- Incompleteness of the urban HEP package manual;
- Low performance in the training and deployment of model families due to poor follow-up in some Regions.

The review on EFY 2001 plan implementation and past performances on the various aspects of the HEP illustrates that the training and deployment HEWs and the construction and equipping of HPs have continued vigorously, with achievement of the target set for deployment of HEWs. However, delays have been observed in the training of model families.

Recommendations are as follows:

- The construction of HPs has to be accelerated, and close monitoring and support is necessary;
- The training and deployment of model families has to be monitored and necessary support has to be provided to HEWs by Woreda Health Offices in order to reach planned target;
- Recruit and deploy HEP supervisors as per the criteria to increase the number of graduating households;
- Necessary IEC materials and equipment have to be provided to HPs without delay;
- Provision of refresher trainings to HEWs in an integrated manner led by RHBs;
- The actual implementation of urban and pastoral HEP has to be started as there has been sufficient experience to tune the Program on the basis of the local conditions in the respective areas.

IV

EXPANSION AND EQUIPPING OF HEALTH CENTERS




EXPANSION AND EQUIPPING OF HEALTH CENTERS

Expansion of health centers is one critical component necessary for the achievement of the planned universal primary health care coverage. In the Ethiopian context, a health center plays a crucial role both in terms of providing curative health care services and supporting HEP by acting as referral and technical assistance centers for HEWs.

4.1 Progress in Construction and Renovation of Health Centers

To achieve the planned universal primary health care coverage, the target of HSDP III is to put in place 3,200 health centers by 2009/10.

To achieve this target, the FMOH and RHBs had concluded an agreement at ARM 2007, whereby for every health center to be constructed by a RHB, the FMOH will construct one matching health center and supply the equipment for both health centers. This agreement is expected to accelerate the plan of putting 3,200 health centers in place by the end of HSDP III.

Table 11: Status of Health Center Construction (EFY 2001).

Breakdown FMoH/RHB	HSDP III Target (A)	EFY 2001 Baseline for HCs available (B)	HCs available at the end of EFY 2001 (C)	EFY 2001 Baseline for HCs available plus under construction (D)	HCs available plus under construction at the end of EFY 2001 (E)	EFY 2001 Target for HCs available plus under construction (F)	Gap between 2001 performance and 2001 target (E-F)	Gap between 2001 performance and HSDP III target (E-A)
	3,200	721	1,338	1,620	2,635	2,950	315	565
FMoH					1,135	1,391	256	
RHB					806	838	32	

In summary, the status of HCs construction is as follows:

- The cumulative number of HCs available at the beginning of EFY 2001 was 721;
- The cumulative number of HCs available at the end of EFY 2001 was 1,338;
- The number of new HCs completed during EFY 2001 was 617; and
- The number of HCs under construction at the end of EFY 2001 was 1,297.

The targets for EFY 2001 are set in the Core Plan. Note that the contribution by the FMoH towards the HC construction has changed from a 50% share to a 75% share, leaving 25% for the emerging Regions. This change was formulated in early EFY 2002 and is not reflected in the targets for EFY 2001.

Of note is also the fact that the above table excludes the HCs from Addis Ababa in line with the "Accelerated Expansion to Primary Health Care Coverage in Ethiopia". The numbers for Addis Ababa are significant: the EFY 2001 cumulative target is 39 HCs to be available of which 24 HCs were already available in EFY 2000. Since 49 HC were available or under construction at the end of EFY 2001, the performance surpassed the target set for EFY 2001.

The national EFY 2001 baseline was 1,620 health centers available plus under construction; in addition to these baseline figures, the construction for 1,015 new health centers started (by FMOH or RHB) in 2001, therefore reaching the cumulative total of 2,635 health centers available plus under construction at EFY 2001 (excluding Addis Ababa). If we add Addis Ababa, the cumulative total is 2,684. The highest number of health centers available plus under construction was in Oromia (1,018), Amhara (631), and SNNPR (592) (Figure 11). With the exception of Addis Ababa, no Region reached the target set for EFY 2001. However, Oromia Region showed a performance (1,018 HCs) almost reaching the target (1,047 HCs), with an achievement rate of 97.2%.

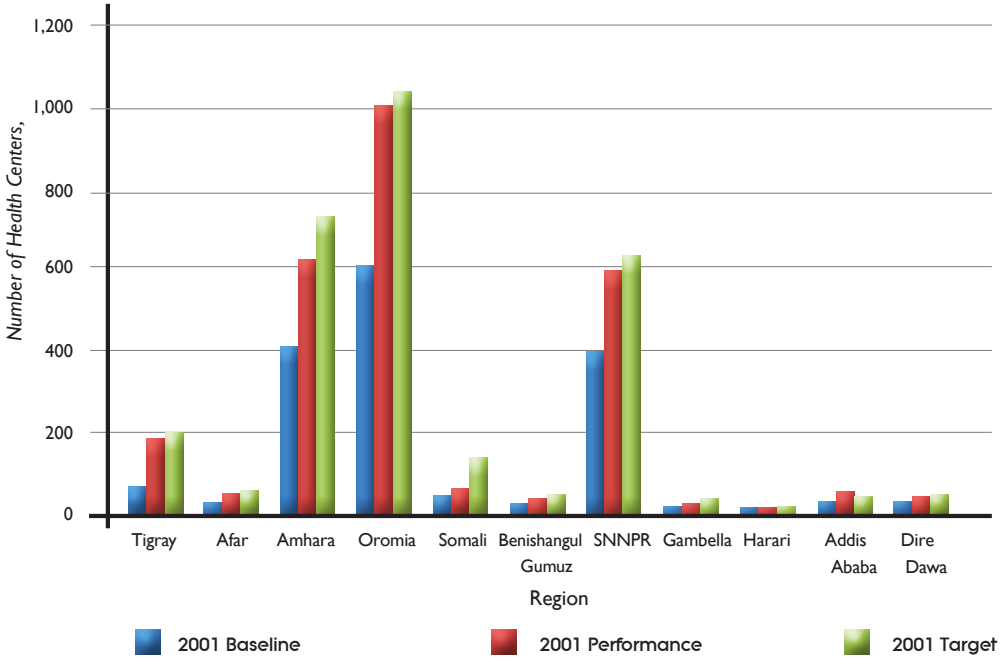

Figure 11: Comparison of Baseline, Performance and Target of the Number of Health Centers, Constructed and Under Construction by Region (EFY 2001)

Construction of Health Centers removes geographic barrier to accessing health care

Nationally, the HCs available went up from 721 (EFY 2000) to 1,338 (EFY 2001), with an increase of 85.5 %. Concerning the number of HCs available at EFY 2001 (excluding those under construction), the highest number was found in Oromia (548), Amhara (378), and SNNPR (244) (Figure 12).

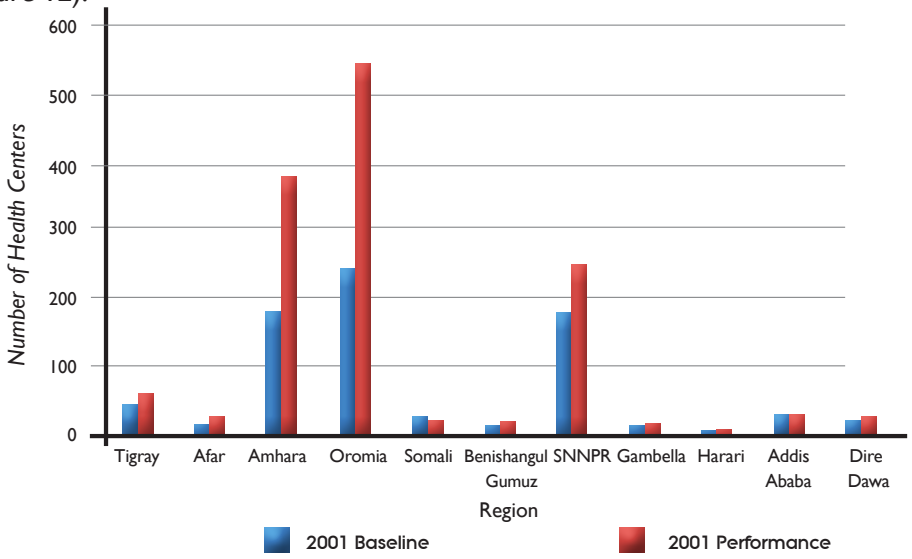

Figure 12: Comparison of Baseline and Performance of the Number of Health Centers Available by Region (EFY 2001)

4.1.1 Construction of Health Centers by FMOH

In this regard, the plan for EFY 2001 was to construct 1,391 health centers, conduct weekly follow-up of the construction process and monthly monitor the work and resolve problems jointly with regional representatives, prepare and implement design of health centers for urban areas and provide solar electric lights for 50 health centers.

Accordingly, the number of sites under contract is 1,200, site hand over has taken place for 1,192 health centers; 1,135 health centers are currently available plus under construction, of which 326 have been completed in EFY 2001 (Table 12).

Table 12: Status of Health Center Construction supported by FMOH Across Regions (EFY 2001)

Region	Total sites	Number of sites assessed	Sites under contract and active	% of sites under contract and active	Number of sites handed over	% of sites handed over	Number of sites available plus under construction	% of sites available plus under construction	Number of sites completed in EFY 2001	% of sites completed
Tigray	86	86	84	98%	82	95%	79	92%	30	35%
Afar	43	43	43	100%	43	100%	42	98%	9	21%
Amhara	341	337	285	84%	281	82%	265	78%	88	26%
Oromia	517	517	454	88%	453	88%	447	86%	114	22%
Somali	96	94	61	64%	60	63%	46	48%	5	5%
Benishangul- Gumuz	15	15	14	93%	14	93%	14	93%	8	53%
SNNPR	264	231	231	88%	231	88%	214	81%	59	22%
Gambella	15	15	15	100%	15	100%	15	100%	1	7%%
Harari	5	5	5	100%	5	100%	5	100%	5	100%
Dire Dawa	9	9	8	89%	8	89%	8	89%	7	78%
TOTAL	**1,391**	**1,352**	**1,200**	**86%**	**1,192**	**86%**	**1,135**	**82%**	**326**	**23%**

Again, it is worth noting that these targets do not reflect the recent changes made as a result of an increased contribution by the FMoH for the emerging regions (Afar, Somali, Benishangul Gumuz, and Gambella).

4.1.2 Construction of Matching Health Centers

The plan for EFY 2001 was to have 838 matching health centers available or under construction by Regions. Regions have reported that 806 health centers are available or under construction, of which 368 have been completed. They secured the budget for 846 health centers for EFY 2001.

Table 13: Status of Health Center Construction by Regions (EFY 2001)

Region	Regional HSDP Target	Fund Secured EFY 2001	Number of sites contracted out	Number of sites available plus under construction	Number of sites completed by EFY 2001
Tigray	72	74	71	71	0
Afar	39	0	0	0	0
Amhara	288	197	175	175	99
Oromia	441	379	379	379	242
Somali	80	19	7	7	0
Benishangul-Gumuz	10	2	2	2	0
SNNPR	221	167	167	167	24
Gambella	12	7	7	4	2
Harari	1	0	0	0	0
Dire Dawa	1	1	1	1	1
TOTAL	**1,165**	**846**	**809**	**806**	**368**

4.1.3 Renovation of Health Centers

This has been an ongoing activity started in EFY 2000. The plan in EFY 2000 has been to undertake the study of the functions of the health center, finalize the master plan, and undertake renovation of 41 health centers. Accordingly, the renovation of 41 health centers, started in EFY 2000, has been completed and provisional acceptance made in EFY 2001.

4.1.4 Installation of Solar Power for Health Centers

In accordance with the agreement made by the FMOH with GTZ-AMESE, the plan was to install solar power for 50 health centers lacking hydroelectric supply. Project sites have been selected for this purpose, and solar panels generating electricity from sun light have been installed for ten health centers, five in Oromia, three in SNNPR and two in Harari. The installation work in the remaining 40 health centers is in progress and could be completed at the beginning of EFY 2002.

The following were the main challenges faced during the implementation phase with respect to the construction of health centers:

- Shortage of skilled personnel in relation to the construction through GTZ;
- Shortage of qualified contractors;
- Lack of willingness on the part of contractors to take up sites whose costs are estimated based on cost saving strategies;
- Lack of commitment of contractors to complete construction as per agreed schedule;
- For PMU managed health centers, slow progress in accessing funds and inability to get contractors for health centers situated in remote areas;
- The exacerbated escalation of construction prices and difficulty in taking construction materials to remote sites;
- Shortage of allocated budget in the construction of health centers financed by RHBs;
- The serious shortage of construction materials like iron and cement due to the closure of respective factories.

To address these challenges, actions have been taken by the FMOH and RHBs. The actions taken include:

- Providing follow-up support to GTZ and revising the unit prices to reflect market trends;
- Engaging new contractors trained by Ministry of Works and Urban Development;
- Engaging experienced contractors in places that are unsuitable for the new contractors; and
- Importing iron bar and cement from abroad.

4.2 Equipments for Health Centers

The plan in EFY 2001 was to procure and distribute medical equipment for 1,290 health centers and secure financial resources for procuring medical equipment for 1,189 health centers.

With regard to performance in this respect, the Pharmaceutical Fund and Supply Agency (PFSA), has procured equipment worth 506.29 million Birr for 2,299 health centers. The kit packing for 976 health centers has been completed and distribution of the medical equipment has commenced. Out of 2,299 health centers, equipment adequate for 1,023 (79.3%) of the target of 1,290 health centers has been procured and has arrived at the port of Djibouti. Procurement of medical equipment for the remaining 300 health centers is underway and delivery is expected soon.

The main challenge observed in relation to medical equipment is delay in procurement and distribution to the health facilities. As a result, a number of completed health centers and health posts are waiting for equipment as reported by RHB heads. Therefore, urgent action is called for and next steps have been set for PFSA, RHBs and PMU to expedite the distribution of equipment.

Besides, RHBs are not providing the list of completed health facilities and contact persons on time to facilitate the distribution of the equipment.

V

STRENGTHENING AND EXPANSION OF HOSPITAL SERVICES




STRENGTHENING AND EXPANSION OF HOSPITAL SERVICES

5.1 Hospital Management

In recent years, there has been substantial investment for strengthening hospital management in order to promote efficiency and effectiveness in health care delivery. The Ethiopian Hospital Management Initiative (EHMI) is one of the programs launched by the FMOH in collaboration with the Clinton Foundation with the aim of promoting efficiency and effectiveness in health care delivery. The goal of EHMI is to enhance the management capacity of hospitals in Ethiopia using a system-based approach. This program has developed a set of guidelines for key areas of hospital management. Implementation status of the Blue Print was briefly presented in the last performance report (ARM 2008), whereas the Performance of in improving the hospital management system in 2001 E.C has been as follows.

With respect to the number of hospitals implementing the reform, 42 hospitals in Addis Ababa, Amhara, Tigray, SNNPR, Oromia, Dire Dawa, and Harari continued to implement the "Blue Print" standards and guidelines.

With regards to the BPR, 16 hospitals in Amhara (out of 17), all 21 hospitals in Oromia, all 12 Hospitals in Tigray and five hospitals in Addis Ababa have been implementing the BPR (Data was unavailable for SNNP and other Regions).

With regard to training activities, 25 CEOs are participating in a Masters Degree program in hospital administration in Jimma University. The second batch enrolled is 30 CEOs.

Generally, significant achievements have been registered in terms of improvement of hospital services. For example, in Tigray, in a recently held review meeting, the following achievements were reported:

Table 14: Achievements in Improving Hospital Services in Tigray (EFY 2001)

Stretch objective	Achievement
Complete out patient service within 2 hours	100% (in 10 hospitals)
Working time expected to provide care for 7 days a week and 24 hours a day	100%
Completeness of services	82%
Client satisfaction	85-100%

Emergency patients are able to get emergency care within 5 minutes after arrival.

In EFY 2001, for demonstration purposes, an analytical framework for hospital performance assessment was made by using routinely collected data in a sample of 13 hospitals. The analytical framework shows that few data elements available from routine sources are useful to estimate basic indicators and relational measures for performance monitoring purposes.

The analysis of service indicators showed that the average performance in the period 1998-2000 EFY was as follows: 65.9% of bed occupancy rate (BOR), 28.8 inpatients per bed per year as bed turnover rate (BTR) and 8.4 days of average length of stay (ALOS). This performance is above the national average (i.e. BOR around 35% in recent years), but below the international standard. In fact, health facilities are designed to operate most efficiently at a level of about 80-90% of bed occupancy; however, only two hospitals out of 13 showed such level of performance.

The variability across individual facilities was higher than expected, and this may have resulted not only from differences in bed availability, staffing pattern and case mix but also from the relative efficiency of input use, highlighting the fact that a number of factors subject to management intervention may contribute to low or high efficiency.

The combination of high expenditures and/or low service utilization is a common cause of inefficiency because overhead costs and other fixed inputs are spread over a smaller number of outputs. According to this assessment, improving efficiency in hospital care delivery has wide implications. For example, increasing bed occupancy with short average length of stay enables turnover rates to increase and thus allows hospital benefits to be extended to a greater number of patients. This increases the cost-efficiency by reducing the average cost per admission.

In general, there was understaffing. Of note is the fact that staffing ratios may reflect the quality in health care delivery; however, training and skill levels, supporting technology, productivity, teamwork, and the organization of services are all essential complementary co-determinants of quality.

The above analysis was made before the implementation of the BPR which includes restructuring of patient flow, implementation of case teams for outpatient, inpatient, emergency, and community outreach services, governing boards, and private wings. It is expected that this restructuring will have effects in the near future in terms of improvement of efficiency and effectiveness in hospital care delivery.

One of the serious challenges observed even in hospitals implementing EHMI is poor recording, analysis and use of data for improving quality of care. This issue has been taken up with Clinton Foundation and Medical Services Directorate to come up with a quick strategy of implementing the HMIS.

5.2 Construction, Rehabilitation and Expansion of Hospitals

5.2.1 Federal Hospitals

Emanuel Psychiatry Specialized Hospital

To mitigate some problems encountered on existing buildings of female and male wards, it was possible to identify the problems of the buildings by hiring a consultant. Final designs were completed after series of reviews by technical steering committee and professionals of the Ministry.

The design work of the expansion of the hospital is completed with approval from Ministry of Works and Urban Development. Site acquisition process for the new Psychiatry hospital by corresponding with different bodies of the city administration of the city of Addis Ababa was

successful. A new 13 hectare site was secured in Yeka-sub city for the already completed new design of the hospital. Necessary negotiations are being done with the consultant who did the design for site adaptation design works.

Because the existing kitchen of the hospital is in a dilapidated condition, complete design process for a new kitchen for the existing hospital is completed by the Ministry's professionals. It is now ready for tender process and eventual award for a winning contractor.

St. Peter TB Specialized Hospital

Provisional acceptance of the HIV wing of the hospital is completed and fully functional. Since the provisional acceptance, the contractor has done some corrective constructions as per the remarks given.

Renovation construction of a female ward to start MDR TB treatment is under way and it is more than 80% complete. After the completion of the construction the facility will have a capacity of treating 50 inpatients. This facility is the first of its kind comprising of an OPD, patient recreation block and two inpatient blocks.

To avoid the inconvenience of the differing locations of two campuses of the hospital, expansion design of OPD and Emergency is on the process of development. Preliminary design is completed and presented to the steering committee of the hospital and professionals of the ministry. Budget for the consultant fee, surveying and soil test was secured through the Global Fund.

St. Paul Specialized Hospital

Construction of the Emergency department is completed and its provisional acceptance is to be conducted soon. The department is a two storey building with semi basement auditorium and ground floor emergency facilities.

St. Paul Millennium Medical College and MCH complete design is finished after passing through rigorous revisions of every design step by the steering committee of the hospital and professionals of the Ministry. The design is also approved by MoWUD. The complete document is now ready for construction bid process.

ALERT

Nearly 100% of the planned expansion and rehabilitation works at the hospital are completed and provisional acceptance of the facility is also done with remarks to be repaired and improved within the one year guarantee period. Eighty percent of the construction of the library and office buildings is also complete. Supplementary agreement is also signed between the hospital and the contractor to accommodate works that are not part of the main contract. In addition, the expansion of the library for the HMIS center and the construction of the building for a research center are completed and provisional acceptance was also made.

Cardiac Center Building

Construction of the center has started providing the much needed medical treatment that is lacking in the country and thereby avoiding the high cost of getting treatment abroad.

The following are challenges faced and measures taken in the construction, rehabilitation and expansion of Federal level hospitals.

- The long time it took to approve the supplementary work at ALERT hospital that was not incorporated in the main contract delayed completion of the construction of library and office buildings. Effort was exerted to resume the construction by signing supplementary agreement with the contractor.
- Delay in the design preparation of OPD and Emergency of St. Peter TB Specialized Hospital by ACME designers and consultants due to the disagreement between the Ministry's professionals and the consultant on where to locate the new facilities within the premise of the Shiromeda campus of the hospital. Apart from this problem, lack of budget for soil test and surveying for the project site has contributed to the delay. To mitigate this problem series of efforts through correspondence to various funding organizations were made. Finally it was possible to get the fund for consultancy, soil testing and surveying.
- Site selection for new facility of Emanuel hospital also took duration far longer than expected and planned due to lack of appropriate vacant land suitable for the hospital. Akaki sub city was the first choice for location of the new hospital but after two optional sites were offered, it was found out that the sites were not convenient. It was finally possible to find appropriate site in Yeka sub city.

5.2.2 Regional Hospitals

In EFY 2001, the construction of 23 new hospitals, rehabilitation of 14, expansion of 6 and the upgrading of 10 hospitals have been reported by Regions. Out of the 23 new hospitals under construction in Oromia, 7 will start service in September 2009, 8 after three months and the remaining 8 at the end of EFY 2002. There is an ongoing construction of 29 hospitals in 8 regions (Tigray, Afar, Amhara, Oromia, Somali, SNNPR, Dire Dawa and Addis Ababa). The distribution of these hospitals is shown in Table 15.

Table 15: Status of Hospital Construction / Upgrading by Region, Ethiopia (EFY 2001)

Region	New	Ongoing	Rehabilitation	Expansion	Upgrading
Tigray	-	1	-	-	1
Afar	-	1	-	1	2
Amhara	-	7	1	2	-
Oromia	23	15	5	-	6
Somali	-	1	2	1	1
Benishangul-Gumuz	-	-	-	-	-
SNNPR	-	1	-	-	-
Gambella	-	-	-	-	-
Harari	-	-	2	-	-
Addis Ababa	-	2	3	2	-
Dire Dawa	-	1	1	-	-
TOTAL	**23**	**29**	**14**	**6**	**10**

The challenges faced in the construction, rehabilitation and expansion of hospitals were:-

- Lengthy supplementary work approval process for ALERT Hospital that delayed the completion of the construction of the library and office buildings.
- Delay in the design preparation of the OPD and inpatient wards of St. Peter's Specialized TB Hospital, by FMOH and ACME designers and consultants who were unable to complete the design in EFY 2001 as planned.
- Lack of budget for design preparation at St. Peter's Hospital.
- The long time it took to select another suitable site for the expansion of Emanuel Hospital.

To address these challenges actions have been taken by the FMOH and the respective hospitals. The actions taken include, continuation of the construction work at ALERT hospital by signing a supplementary agreement with the contractor, based on the suggestion of the consultant engineer; change of construction site to a suitable location within St. Peter's Hospital and the continuation of surveying and soil tests, and measures to access budget for design preparation at St.Peter's Hospital and ensuring availability of suitable site for expansion of Emanuel Hospital at Yeka Sub-City.

5.3 Construction of Blood Banks

In EFY 2001, the plan was to meet 80% of the needs of hospitals for blood and blood products, and to increase the number of volunteer blood donors from the present 35% to 70%.

Accordingly, out of the construction of 16 blood banks in six Regions 95% of the work has been completed at Goba, Hawassa, Jimma and Harar and 70% at Axum, Mekelle and Wolisso. The performance rate in the construction of the 16 blood Banks is on an average 87%.

Challenges faced in the construction of blood banks were the low performance of the construction process and inability to complete the construction of the blood banks, despite the significant financial support provided to the Red Cross Society which oversees the construction work.

To solve this problem caused partly by the shortage of cement, the Red Cross has been allowed to take the required cement from the Project Monitoring Units in the nearest towns.

5.4 Traditional Medicine

In EFY 2001, the plan was to provide support for the establishment of offices and advisory councils on traditional medicine at Federal and Regional levels; register and give license to allied and alternative medicine practitioners and as a capacity building measure to give training to practitioners of traditional medicine.

In accordance with the plan, the regulation on traditional and alternative medicine has been discussed in the presence of members drawn from traditional medical practitioners and all stakeholders, and submitted for approval to the concerned agency. Three practitioners have been trained in China to develop their knowledge and skills in preparation for taking over and running the office when the regulation is approved.

In general, by integrating the effort to develop traditional medicine with the experience drawn from other countries and aligning it with the regulation on traditional and alternative medicine and incorporating it into the BPR process, a new organizational and operational system is being developed.

5.5 Role of Professional Associations

In order to enable professional associations to play a significant role on the quality of health service delivery system, key activities were planned for implementation in EFY 2001.

The performance in this respect has been as follows:-
An ethics guideline for professional associations has been prepared in collaboration with representatives of various professional associations and NGOs.
To provide surgical treatments for 500 patients through a mobile team of volunteer surgeons; hospitals have been selected, and implementation arrangements have been revised to align costs of service delivery with the ability of the selected hospitals to cover such costs.

With respect to the plan to revise the guideline on licensing of private clinics, technical working group has been established and zero draft prepared and transmitted to the Regional Health Bureau. In addition, a consultant has been recruited to help design the "Public-Private Partnership Policy Framework and Guideline" document.

To address the shortage of health workers in rural areas and in pastoralist and semi-pastoralist Regions which need special support, the Ethiopian Medical Association along with the FMOH has designed a project entitled "Research Based Incentive" for physicians. This project aims to encourage physicians to stay rural areas. The project has opened branch offices at Mekelle, Gondar, Jimma and Haromaya Universities. Supportive supervision has been made to Mekelle and Gondar universities and the necessary adjustments have been made to the project. Furthermore, based on the training on "Research Methodology and Proposal Writing" given in 2000 E.C, memorandum of understanding has been signed with 19 physicians in four hospitals in emerging Regions; and with six physicians who took similar training in 2001 E.C. The study and research work is underway.

To strengthen the capacity of hospitals in these Regions based on the results of study and research, various medical equipment have been sent in 2000 E.C. while the remaining medical equipments are being distributed. In general, for the research based incentive (RBI) project undertaken by the Ethiopian Medical Association with coordination tasks handled by the FMOH, the necessary follow-up has been made and 1,080,111 Birr has been utilized for project implementation purposes.

With regard to the plan to organize an association of private hospital owners in collaboration with the Addis Ababa City Administration, agreement has been made in the presence of the provisional committee of private hospital owners. Based on the agreement, TOR has been prepared and work has started with the provisional committee.

Preparatory arrangements have been completed by the FMOH in collaboration with Ethiopian Surgeons' Association to conduct campaign with volunteer surgeons in Bahir Dar, Felege Hiwot Hospital, to provide surgical treatment for patients who have spent a long time waiting for such treatment.

Work is underway to develop policy framework for public-private partnership (PPP) in health. The key activities undertaken in this respect include the following.

- Desk top review of policies, strategies etc. at national and international level have been made.
- Brainstorming session has been held with internal and external stakeholders such as the Medical Services Directorate, civil society, NGOs, and health professional's associations.
- Semi-structured questionnaire has been distributed to health professional's associations, FMOH Directorates, RHBs, for-profit private hospitals, and NGOs. The returns are being collected.
- Two-days Consultative Workshop of critical stakeholders was held in June 2009 and the Concept Note prepared after the workshop has been submitted to concerned FMOH Directorates.

VI

NATIONAL NUTRITION PROGRAM




In order to mitigate the malnutrition problem in Ethiopia, the National Nutrition Strategy has been developed. The objective of the Strategy is to ensure that all Ethiopians secure adequate nutritional status in a sustainable manner, which is an essential requirement for a healthy and productive life. According to the Core Plan, two of the major targets to be achieved in EFY 2001 are the following:

- Increase the coverage of vitamin A supplementation for children 6-59 months from 94.0% to 98.2% and
- Ensure the de-worming coverage for children 2-5 years of age at 99.0%.

Vitamin A Supplementation (VAS)

Out of the eligible population of 6-59 months children, the coverage of those with two rounds of VAS in EFY 2001 was 95% against the target of 98.2% set in the Core Plan. Variations were observed across Regions, ranging between 72% in Dire Dawa to 100% in Afar and Gambella Regions. Three regions (Afar, Somali, and Gambella) performed above their Regional target.

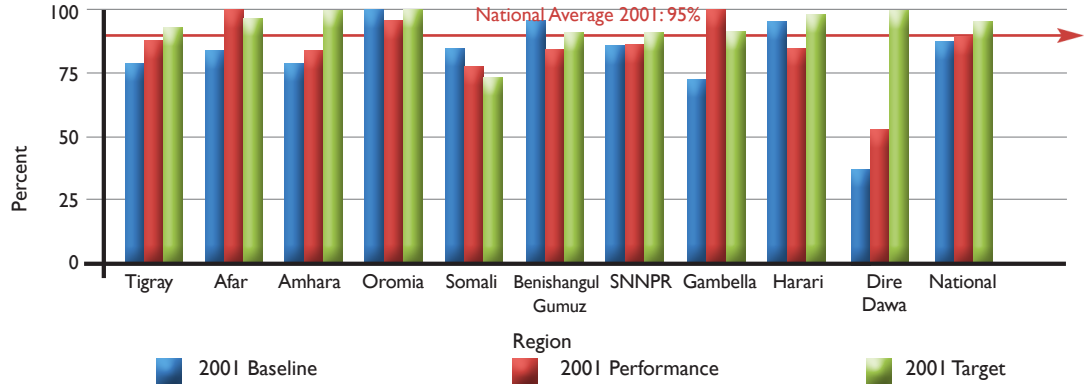

Figure 13: Comparison of Baseline, Performance and Target of Coverage of 6-59 Months Children Supplemented with Two Doses of Vitamin A by Region (EFY 2001)

De-worming

Out of the eligible population of 2-5 years children, the de-worming coverage in EFY 2001 was 98%, slightly lower than the target (99%) set for EFY 2001. Variations were observed across Regions, ranging between 79% in Afar to 99% in Amhara and Harari Regions. Two Regions (Benishangul-Gumuz and Gambella) reached their regional target.

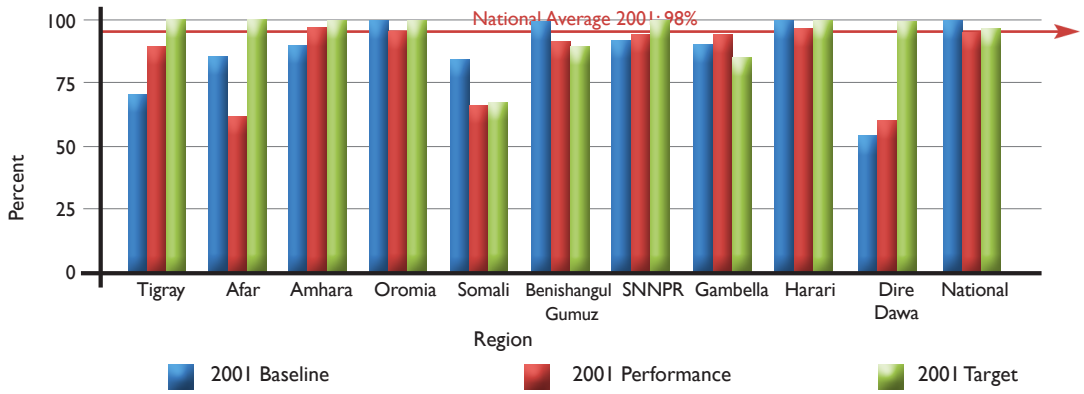

Figure 14: Comparison of EFY 2001 Baseline, Performance and Target of Coverage of 2-5 years Children De-Wormed by Region (EFY 2001)

VII

PREVENTION AND CONTROL OF COMMUNICABLE DISEASES




PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

7.1 HIV AIDS Prevention and Control

HIV/AIDS continues to be a major public health challenge for countries in Sub-Saharan Africa. To address this challenge the UN General Assembly approved on June 2, 2006 the Declaration on HIV/AIDS referred to as Resolution 60/262, which includes a commitment by UN member states to move towards the goal of universal access to HIV prevention, treatment, care and support services by 2010 and to work with partners at country level in order to overcome barriers that block access to prevention, care and treatment. Ethiopia has approved the Resolution 60/262 and has developed and implemented a Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support (2007–2010). This development has been guided by the HIV Strategic Plan for Multisectoral Response (SPM), Ethiopia's universal access commitment, and the "Three Ones" (One HIV/AIDS Action Framework one National AIDS Coordinating Authority and one Monitoring and Evaluation System) principles.

The Ethiopian Government has been implementing the SPM for the period of the last five years. It was envisaged to enhance implementation capacity, coordination and networking, leadership and mainstreaming, social mobilization and community empowerment, integration of services and targeting responses in order to alleviate the health, social and economic impact of HIV/AIDS. The SPM has been the lead document in organizing and implementing responses in Ethiopia.

Since then Ethiopia has updated its planning framework with ambitious targets to achieve universal access and it has also launched a Millennium AIDS Campaign that has catalyzed more rapid scale up of key prevention and treatment programs.

Concerning the status of the epidemic in Ethiopia, the adult HIV prevalence was estimated at 2.1% in 2007/08. Urban and rural prevalence rates are estimated at 7.7% and 0.9% respectively. Gender wise, the prevalence rates were 1.7% for males and 2.6% for females.

According to the single point estimate, there are around 1,030,000 people living with HIV/ADIS and of these 289,732 need ART. The total number of HIV positive pregnant women and annual HIV positive births are 75,000 and 14,000 respectively.

The Multisectoral Response to HIV/AIDS has been guided by strategic plans and based on these plans a number of activities have been performed during the past years. Commendable progresses have been seen in creating enabling environment and institutional strengthening in terms of governance and mainstreaming, partnership and networking, resource mobilization, Multisectoral approach, and HIV and gender issue. The achievements being made to date in HIV testing, PMTCT and ART programs is summarized in the following sections.

Trend in the Number of Facilities Providing HCT, PMTCT and ART Services

A total of 1,596 health facilities were providing HCT service in EFY 2001, while 843 were providing PMTCT services, and 511 were providing ART services (Figure 15). There was a marked increase in the number of sites providing HCT, PMTCT and ART during the HSDP III period: from 801 to 1,596 sites for HCT, from 93 to 843 for PMTCT and from 168 to 511 for ART.

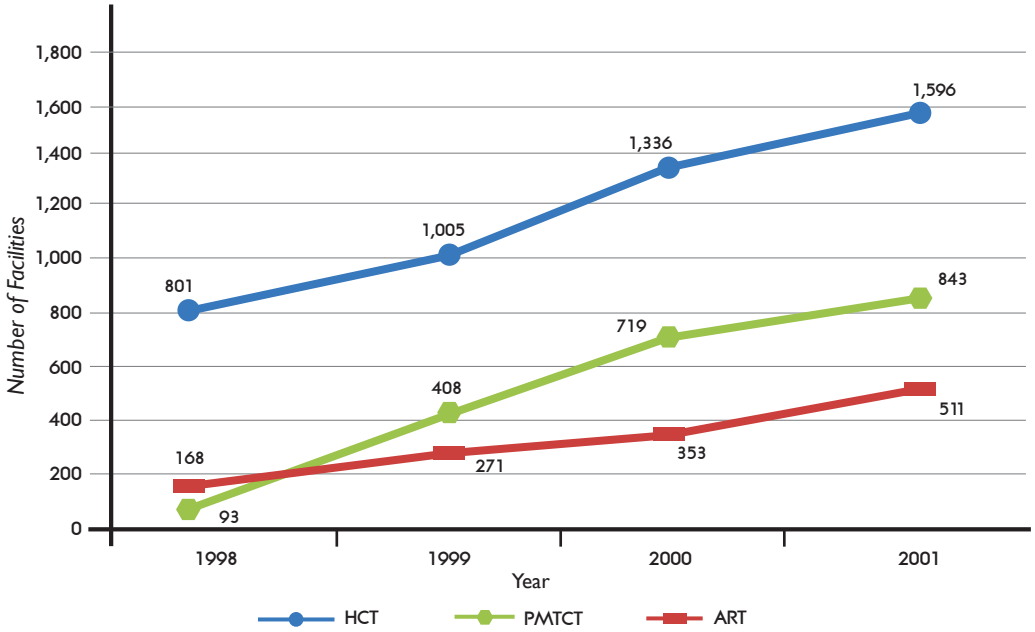

Figure 15:Trend in the Number of Facilities Providing HCT, PMTCT, and ART (EFY 1998-2001)

HCT services

Concerning the trend in the number of clients using HCT services, the number of users has increased substantially from 4,559,954 in EFY 2000 to 5,853,472 in EFY 2001. The target for EFY 2001 was to provide HCT services to 6,588,497 clients, with an achievement (88.8%) slightly below the target (Figure 16).

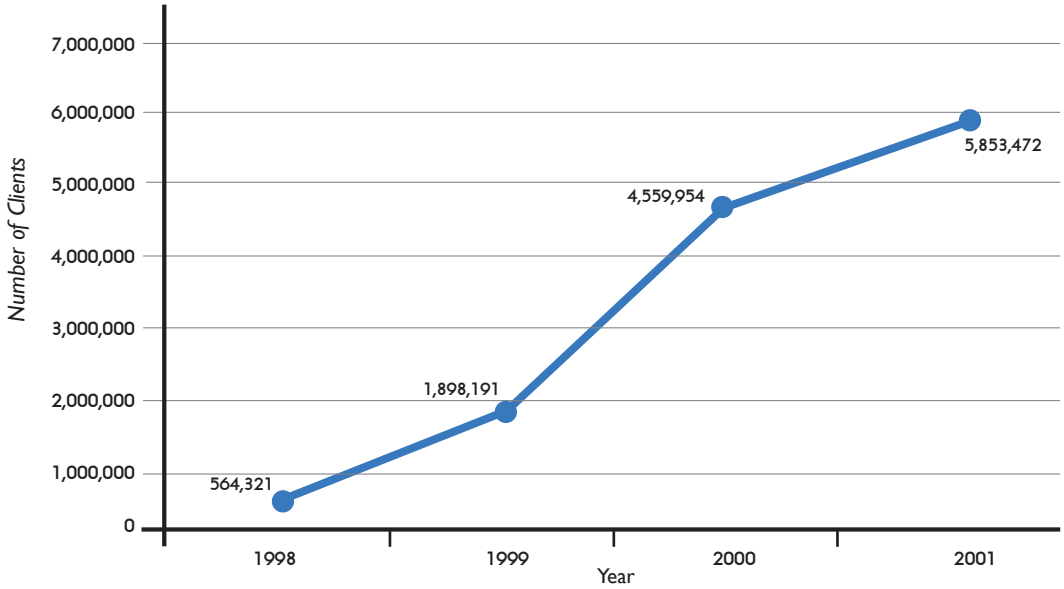

Figure 16:Trend in the Number of Clients Using HCT (EFY 1998-2001)

Wide variations have been observed across Regions in the number of clients using HCT. Seven Regions (Afar, Amhara, Oromia, Benishangul-Gumuz, SNNP, Gambella, and Harari) improved their performance in EFY 2001 with respect to EFY 2000, with the highest increase being found in

Oromia Region (+660,552), while four Regions decreased their performance (Tigray, Somali, Addis Ababa, and Dire Dawa) (Figure 17).

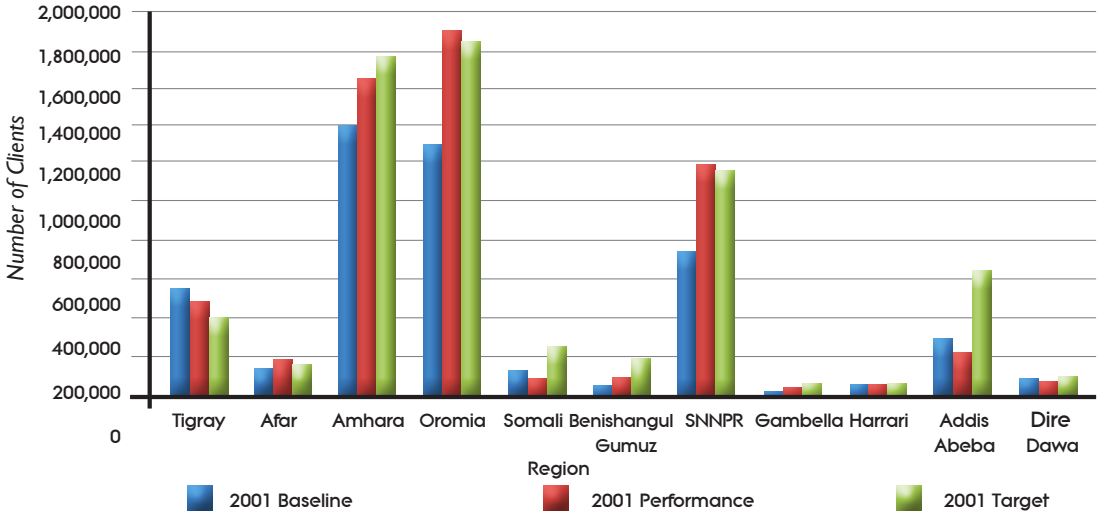

Figure 17: Comparison of Baseline, Performance and Target of the Number of Clients Using HCT by Region (EFY 2001)

Prevention of Mother to Child Transmission (PMTCT) of HIV

A total of 6,466 HIV-positive mothers received PMTCT prophylaxis in EFY 2001, a performance which is above the achievement of EFY 2000 (4,411), but far below the target set for EFY 2001 (39,869): therefore, only 16.2% of the target was achieved in EFY 2001 (Figure 18). No Region achieved the target set for PMTCT services in EFY 2001. The highest number of HIV-positive mothers provided with PMTCT prophylaxis was in Amhara Region (1,726), followed by Addis Ababa (1,337) and Oromia (1,331).

According to current estimates, there are 79,184 HIV-positive pregnant mothers and 14,148 HIV-infected births within a year. In EFY 2001, 6,466 mothers received antiretroviral treatment and this amounted to only 8.2% of those eligible (79,184) and (5,025 out of 14,148) infants, only 35.5% received PMTCT prophylaxis. Compared to 89% in Botswana, 67% in Zimbabwe, 66 % in South Africa, 52% in Kenya in 2007, PMTCT coverage for HIV-positive mothers in Ethiopia (8.2%) is extremely low exceeding only that of Nigeria (5%).

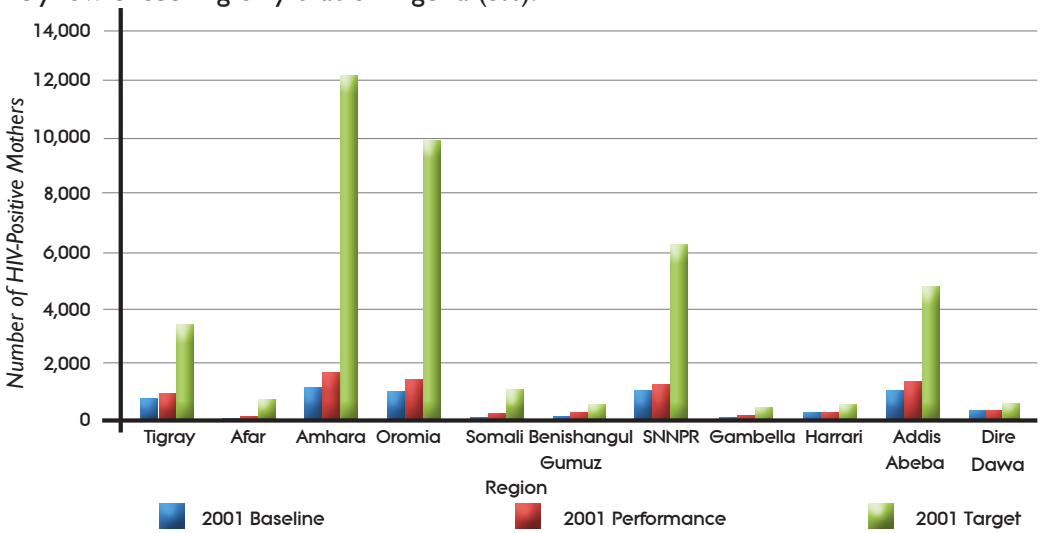

Figure 18: Comparison of Baseline, Performance and Target of the Number of HIV-Positive Mothers Provided with PMTCT Prophylaxis by Region (EFY 2001)

Antiretroviral Treatment

The number of health facilities (hospitals, health centers and private clinics) providing ART services has increased from 168 in EFY 1998 to 271 in EFY 1999 to 353 in EFY 2000 and 511 in EFY 2001. Thus, 83% of the hospitals and 51% of the health centers are currently providing the service.

The number of PLWA ever enrolled in ART program increased from 266,507 in EFY 2000 to 376,772 in EFY 2001, while the number of those ever started ART increased from 150,136 to 208,784 and those currently on ART increased from 109,930 to 152,472 in the same period (Figure 19). Out of the 208,784 ever started on ART, 52% were women, 43% men and 5% were children less than 14 years of age.

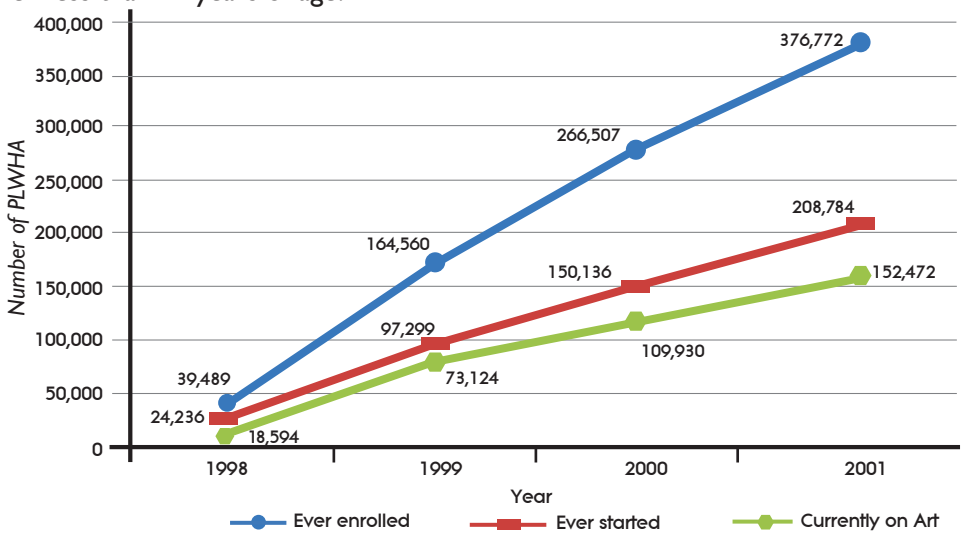

Figure 19: Trend in the Number of PLWHA who Accessed HIV Chronic Care (EFY 1998- 2001)

The highest number of PLWHA who ever started ART was found in Amhara (55,647) and in Addis Ababa (47,753). Only Harari (with 2,504 PLWHA who ever started ART) showed a performance above the target (1,404) set for EFY 2001, while the other ten Regions performed below their regional targets (Figure 19).

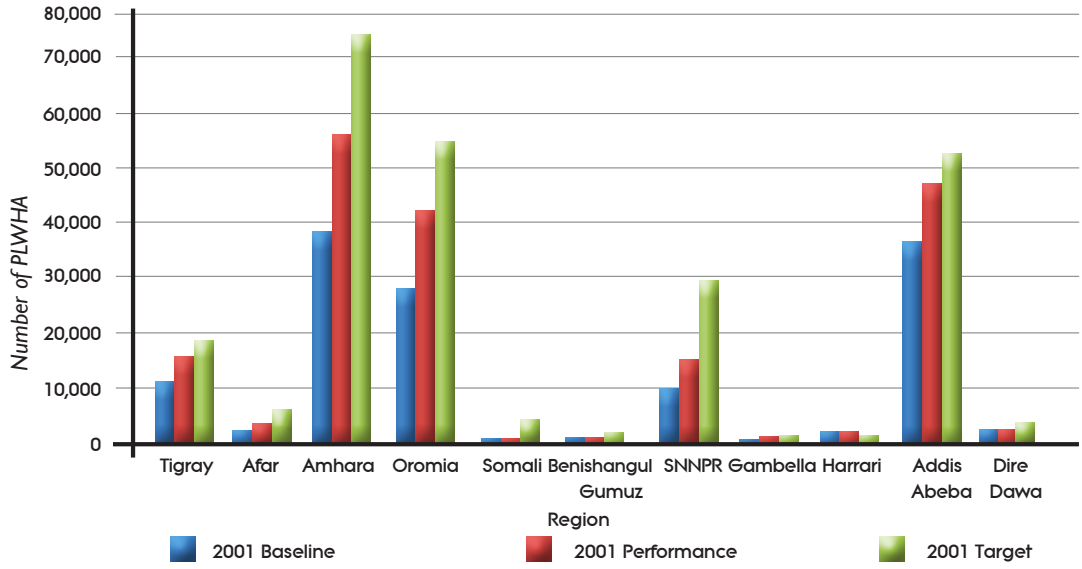

Figure 20: Comparison of Baseline, Performance and Target of the Number of PLWHA who Ever Started ART by Region (EFY 2001)

ART is given free of charge in all Regions. The target for EFY 2001 was to reach a cumulative number of ever-starting PLWHA of 256,542, with an achievement rate of 81% during the year, but only 72% coverage of those eligible for treatment was achievied.

ART coverage (percentage of PLWHA currently on ART out of the total eligible) was 52.6% in EFY 2001. Compared with the achievements in other selected African countries (2007 data), the performance in Ethiopia is increasing. For example, the coverage with ART is 83% in Botswana, 51% in Zambia, 42% each in Kenya and South Africa, and only 17% in Nigeria.

As in previous years, the performance in the provision of PMTCT services in EFY 2001 has shown very slow progress and the coverage has been extremely low. The major gaps and challenges identified in the implementation of PMTCT in the country include:

- Limited expansion of the service;
- Inadequate use of PMTCT service even where it is available;
- Poor integration of PMTCT with ANC services;
- Low percentage of deliveries attended by skilled health personnel;
- Limited number of skilled and motivated human resources; and
- Weak M&E system.

Other challenges faced by the HIV/AIDS prevention and control program include:

- Inadequate leadership and commitment at all levels;
- Poor reporting;
- Inadequate settlements (liquidation) of advances made to Regions and different sectors;
- Weak documentation of data at all levels.

To address these challenges, it is necessary to:

- Strengthen the integrated multi-sectoral response at all levels;
- Provide capacity building support to sector offices so that they are able to strengthen their HIV/AIDS mainstreaming efforts;
- Increase number of health facilities (both public and private) providing PMTCT services;
- Increase in number of clients; and
- Enhance the integration of counseling, testing and PMTCT in antenatal clinics as per the new BPR to increase the uptake of the service.

7.2 Malaria Prevention and Control

Malaria is one of the major public health problems in Ethiopia. Approximately 68% of the population lives in malarious areas covering almost 75% of the country's land mass. Malaria prevention and control program in Ethiopia is guided by the National Five-year Strategic Plan for Malaria Prevention and Control (2006-2010) developed in line with the goals of the HSDP. A three-pronged approach has been implemented, consisting of early diagnosis and effective treatment, selective vector control and epidemic prevention and control. In particular, Arthemisin Combination Therapy (ACT) has been used as first line treatment for falciparum malaria, complemented with the distribution of a cumulative total of 22.2 million ITNs to provide each household in malarious areas with two ITNs.

Planned targets in EFY 2001 are as follows:

1. Spray 6.7 million unit structures with insecticide to protect 21.3 million inhabitants living in malaria endemic areas;
2. Distribute 7,118,319 new Insecticide-Treated Nets (ITN) to maintain ITN coverage at100%;
3. Provide anti-malaria treatment to malaria cases in 13,425 kebeles where HEP services are provided.

Concerning IRS, the following activities were performed in EFY 2001:

- 3.5 million unit structures have been sprayed with insecticide to protect 10.9 million people from having malaria (52,2% of the target);
- About 1,600 tons of DDT with an estimated cost of 17 million birr are under production in Adama Tulu Insecticide Production Factory; Regions have started to directly transport their share from this factory.

According to the Core Plan, 7,118,319 new ITNs were planned to be distributed to maintain ITN coverage at 100%, while 1,685,101 were actually distributed in EFY 2001 (23.7% of the target); this was due to delay in the procurement and delivery of the nets.

The cumulative number of ITN distributed increased from 20,492,318 in EFY 2000 to 22,177,419 in EFY 2001 (Figure 21).

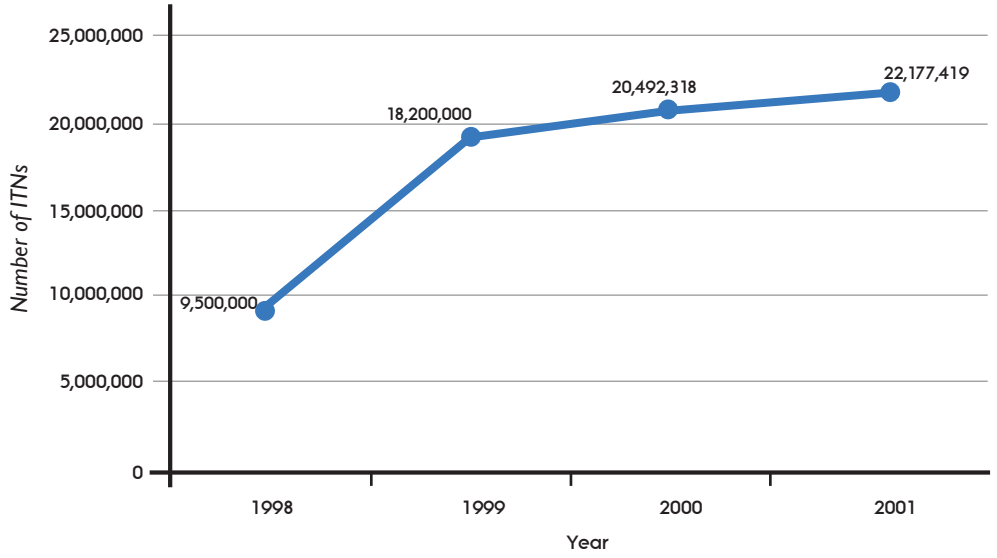

Figure 21:Trend in the Cumulative Number of Insecticide-Treated-Nets (ITNs) Distributed (EFY 1998-2001)

The comparison between 2001 performance and target shows that no Region achieved its regional target, with the highest number of ITNs being distributed in SNNPR (458,770), Oromia (405,315), and Amhara (317,389) (Figure 22).

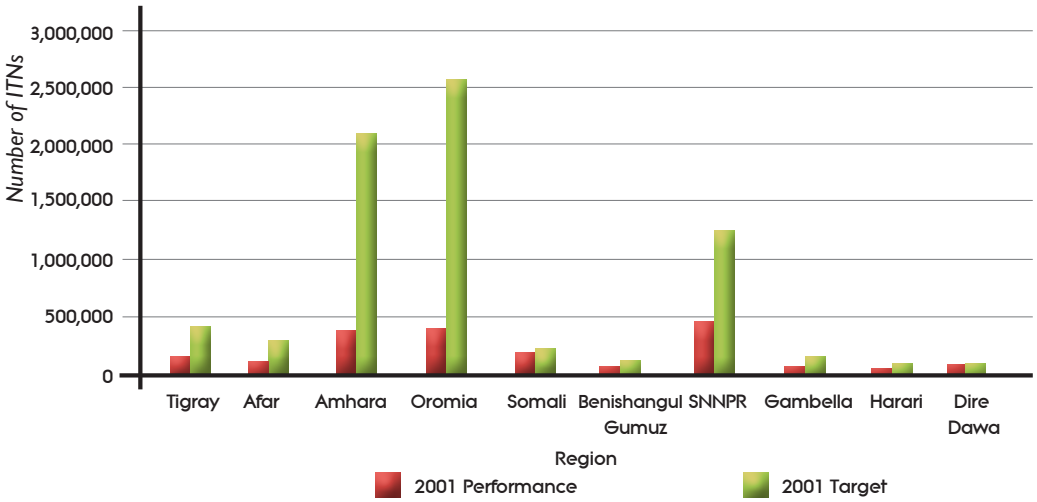

Figure 22: Comparison of Performance and Target of the Number of Insecticide-Treated-Nets (ITNs) Newly Distributed in the Year (EFY 2001)

In order to raise the effective utilization of the 22.2 million ITNs that have been distributed up to the end of EFY 2001, educational messages have been prepared and transmitted through the radio in five languages (Amharic, Tigrigna, Oromifa, Afaregna and Somaligna). Training has been also given on the effective utilization of ITNs to 22 media professionals. The media people are expected to play a major role in educating the public on the effective utilization of ITNs.

The main strategy to strengthen malaria prevention and control is the use of HEP, with encouraging early results.

The Malaria Indicators Survey (MIS) conducted in December 2007 was published in 2008, showing a steep rise in ITN coverage and use in the previous two years, in particular:

- In malarious areas, 66% of households were protected by at least one ITN;
- In malarious areas, ITN use by children under five years and pregnant women increased to nearly 42% and to over 60%, respectively, in those households that own at least one net.

Other results confirm the remarkable progress the country has made in the last two years in its fight against malaria:

- Over 95% of the nets in Ethiopia are long-lasting insecticidal nets;
- At the time of the survey, parasite prevalence was very low (0.7% in malarious areas) and similar across age groups.

Teaching how ITN is utilized

One of the approaches to malaria control is early diagnosis and effective treatment. In this context, HEWs play a major role. In order to undertake these activities, 6.1 million doses of Coartem® have been procured and 614,880 doses have been already distributed to Regions. Furthermore, 4.1 million Rapid Diagnostic Tests (RDTs) have been already procured and distributed.

The above mentioned Malaria Indicators Survey showed that there has been only a slight increase in malaria-seeking behavior, but 43% of children under five years who took an anti-malarial in the two weeks preceding the survey have been given the recommended ACT. This percentage is higher than the average proportion of children treated with ACT in other African countries. According to the 2008 UN MDG Report, it is estimated that, in Sub-Saharan Africa, the proportion of children with fever who received anti-malarial medicines dropped from 41% in 2000 to 34% in 2005, of whom only 6% got ACT.

As to malaria epidemics, there were outbreaks of malaria in 18 Woredas of SNNP, Tigray and Oromia Regions, with 19,736 malaria cases. Technical support and provision of medical equipment and drugs have been given to those Regions affected by the epidemic to assist them in undertaking control measures.

The major challenges include low IRS coverage, environmental management for vector control, mosquitos' resistance to DDT, low usage of ITNs by households in some areas, and lack of sufficient information on the anti-malaria drugs storage. Furthermore, "El Niño", may occur in EFY 2002 with meteorological forecasts suggesting high risk of malaria epidemic starting in September 2009; it is therefore necessary to undertake urgent preparedness measures for this purpose.

The following measures have been agreed between FMOH and RHBs:

- Involve the leadership at all levels of the system;
- Start daily epidemic briefing at all levels;
- Identify hot –spots, train professionals and start aggressive implementation of prevention and control measures based on micro plans;
- Ensure focus on environmental management;
- Make available the necessary supplies on time.

7.3 Tuberculosis and Leprosy Prevention and Control

Targets for TB control have been set within the framework of the MDGs. MDG 6 target for TB is to have halted, and begun to reverse, TB incidence by 2015. The Stop TB Partnership has set two additional impact targets which are to halve prevalence and death rates by 2015, compared with their level in 1990. The outcome targets first set by the World Health Assembly in 1991 are to detect at least 70% of new smear-positive cases in DOTS programs and to successfully treat at least 85% of detected cases. All five targets have been adopted by the Stop TB Partnership, and in 2007 were recognized by the World Health Assembly Resolution -WHA 60.19.

The Stop TB Strategy launched by WHO in 2006 is designed to achieve the 2015 impact targets as well as the targets for case detection and treatment success. It has six major components: (i) Expanding and enhancing DOTS; (ii) Addressing TB/HIV, MDR-TB and other challenges; (iii) Contributing to health system strengthening; (iv) Engaging all care providers; (v) Empowering patients and communities; and (vi) Enabling and promoting research.

The objective of the TB Control Program is to reduce morbidity, disability and mortality caused by TB. The target set for TB control in the Woreda Plan for EFY 2001 is to increase TB case detection rate from 33.9% to 67.8% percent, while keeping TB treatment success rate high (from 84.0% in EFY 2000 to 84.5% in EFY 2001). These targets were to be achieved through: (1) Provision of TB drugs for 244,944 patients; (ii) Provision of reagents and laboratory equipment adequate for 816,480 suspected TB cases; (iii) Improved communication and community mobilization; (iv) Expansion of TB/HIV integrated prevention and control activities in 288 health facilities; (vi) Provision of TOT training to workers drawn from Regions; (vii) Revision/preparation and dissemination of printed copies of pocket size reference booklet for HEWs, and implementation guideline on integrated HIV/TB treatment and on MDR TB treatment; and (viii) Implementation of country-wide TB prevalence survey.

The achievements of the TB and Leprosy Program are summarized as follows:

- In accordance with the targets set in the Core Plan for EFY 2001, 45 million Birr have been transferred to PFSA for the procurement of reagents adequate for an estimated 816,480 suspected TB cases and drugs adequate for the treatment of 244,944 TB cases.
- Drugs adequate for six months for 77,932 TB patients and reagents adequate for 235,851 suspected TB cases have been distributed to Regions.
- TOT training on expanding TB control services in private health facilities (PPM DOT) has been given to 30 professional personnel drawn from Regional Government Institutions and private health facilities. A total of 45 health workers (10 abroad) have taken training on MDR-TB.
- Similarly, TOT training has been given to 30 health workers drawn from all Regional and Federal hospitals, and to 40 health workers drawn from all regions on TB/HIV and on TB/HIV data management, respectively. Training on operational research methodology was also given to 30 health workers drawn from regional and central levels.
- To help HEWs in the provision of public education on TB and Leprosy, and enable them to identify and refer suspected TB cases to health facilities, preparation of a pocket size reference booklet has been completed and is being printed.
- Program manual on TB-leprosy and TB-HIV has been printed and disseminated to all partner organizations and regions.
- Guideline on service delivery has been printed and distributed to regions, while training manual is being printed. Draft proposal on undertaking a nation-wide TB prevalence survey in collaboration with WHO has been prepared. A steering committee comprising of representatives from various governmental and non-governmental organizations has been established and has started the survey activities.
- EHNRI and Regional laboratories have conducted assessment and gap analysis on the quality of 525 laboratories working on TB case detection.

Trend in TB case detection rate, TB treatment success rate and TB cure rate

TB indicators were quite stable in EFY 2001 with respect to EFY 2000 (Figure 23), with TB case detection rate being at 34%, TB treatment success rate at 84% and a TB cure rate at 67%. Overall, upward fluctuations were observed during HSDP III, with an increase of the TB case detection rate from 30% in EFY 1998 to 34% in EFY 2001, TB treatment success rate from 76% to 84%, and TB cure rate from 62% to 67% in the same period.

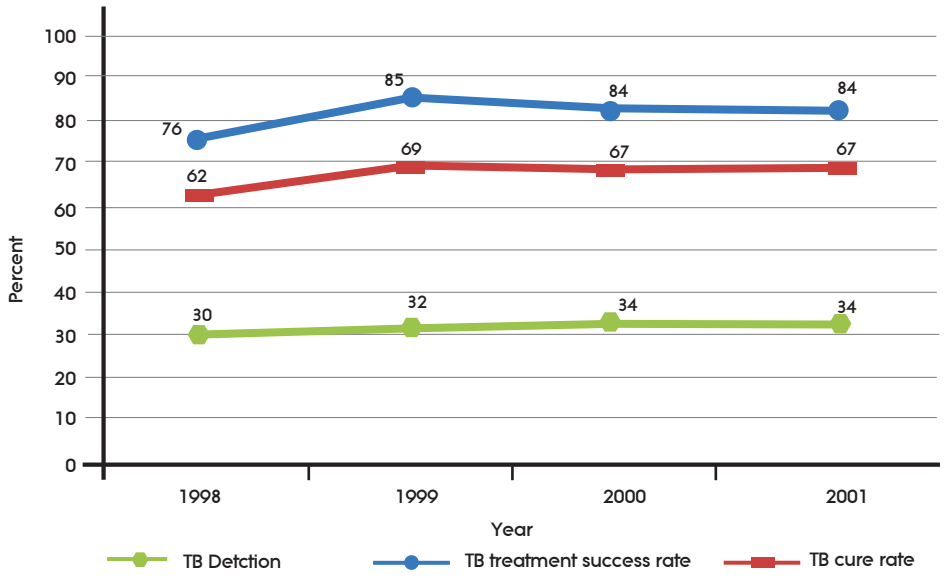

Figure 23: Trend in TB Case Detection Rate, TB Treatment Success Rate and TB Cure Rate (EFY 1998-2001)

TB Case Detection Rate

TB case detection rate is defined as the percentage of new sputum smear positive TB cases detected out of the estimated number of new sputum smear positive TB cases. In EFY 2001, 33,069 new sputum smear positive TB cases were detected. The national target has been to achieve a 67.8% TB case detection rate. However, since the current rate stands at 34.0%, the performance is still way below the planned target.

Large variations were observed across Regions, ranging between 19% in Somali Region and 95% in Harari. An increase was observed in EFY 2001 in five Regions (Amhara, Oromia, Benishangul-Gumuz, Harari, and Dire Dawa), while a decrease was observed in the other six regions. No Region achieved the target set for EFY 2001 (Figure 24).

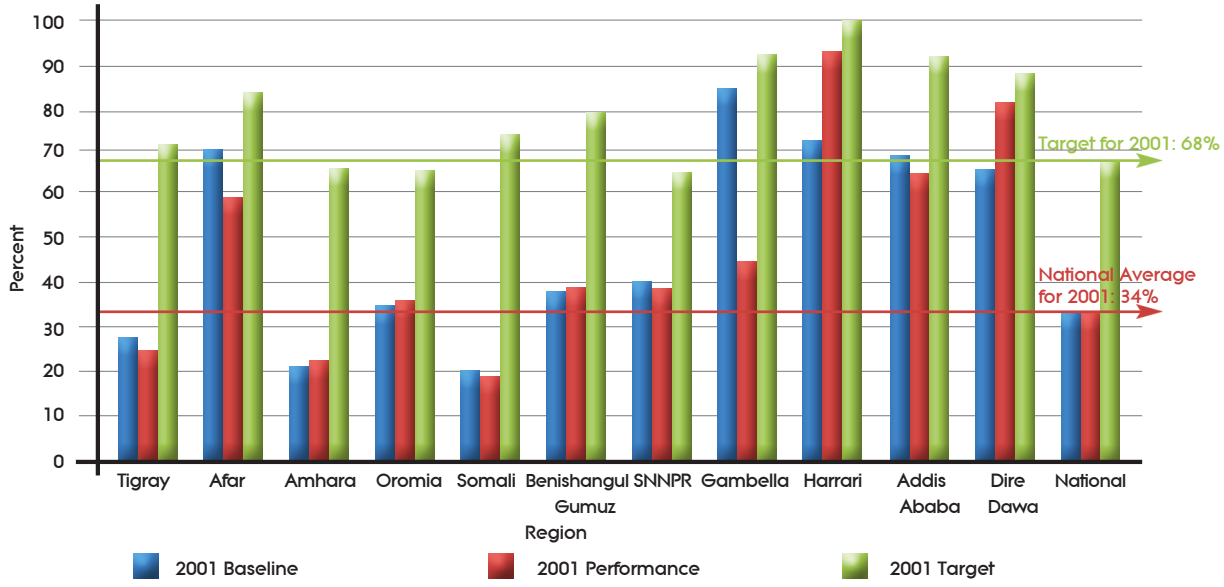

Figure 24: Comparison of Baseline, Performance and Target of the TB Case Detection Rate By Region (EFY 2001)

Increasing TB detection rate remains a major challenge. As observed by the JRM (EFY 2001), even an operational research in a Woreda of SNNPR, with strong support for strengthening TB case detection capacity, managed to improve the rate up to 70% only. The main reason reported for lack of progress is inability of the sector to exploit potential areas for improving detection rate, including: (i) Lack of integration of TB case detection in all OPDs as part of the provider initiative counseling and testing (PICT); (ii) Inadequate involvement of health extension workers to refer those with signs of the disease to health facilities; (iii) Lack of provision of services by some health facilities, (iv) Focus of training and supervision on improvement of TB success rate with less emphasis on detection rate, (v) Lack of functional laboratories in many of the visited health facilities; and (vi) Inadequate skill in some of the laboratory technicians on how to do proper microscopic examination using the AFB staining. According to the JRM report, the potential of the HEP on creating awareness about TB at all levels and creating demand for the service needs to be further exploited. There may be a need to empower HEWs to play active role in bringing the service closer to the community and it is necessary to train them on detecting signs of TB suspects in the community. The other challenge will continue to be the lack of capacity and focus at Regional level for coordinating programmatic interventions.

Furthermore, there is the possibility that TB incidence applied to estimate the denominator of TB detection rate may be overestimated in the Ethiopian context, leading to the underestimation of the indicator; this issue will be addressed by the TB prevalence survey already under way.

TB Treatment Success Rate

In EFY 2001, the TB treatment success rate was 84% which is near the international standard (85%). Large variations were observed across Regions, ranging from 54% in Harari to 92% in Afar. An increase was observed in 6 regions (Amhara, Somali, Benishangul-Gumuz, SNNPR, Gambella, and Dire Dawa), with a decrease being observed in the other 5 Regions with respect to their 2001 baseline (Figure 25). Five Regions (Amhara, Somali, Benishangul-Gumuz, SNNPR and Gambella) performed above their own regional target.

The main reason for success in improving this rate is attributed to the fact that the sector has focused on improving treatment at TB clinics through training and supervision, with subsequent strengthening of clinical services.

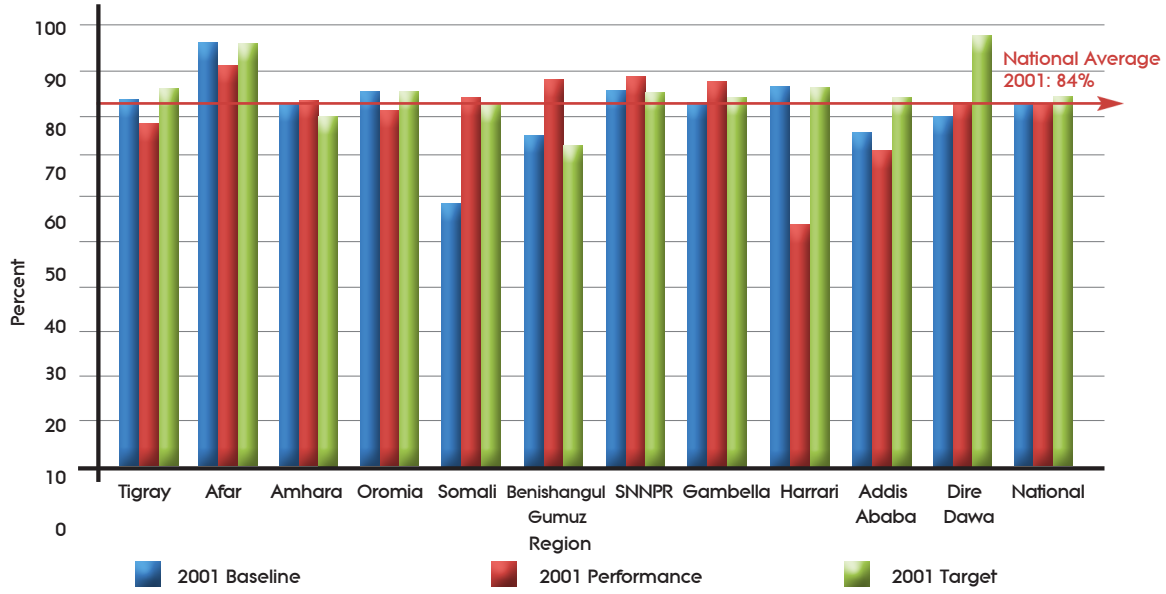

Figure 25: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2001)

TB Cure Rate

In EFY 2001, TB cure rate has shown no change (67%) with respect to the EFY 2000 level; since this indicator is not included in the Woreda Plan, its target is not set for the year. The best performance was achieved in Benishangul-Gumuz (82%), while the lowest cure rate was found in Afar (37%). An increase was observed in EFY 2001 in five Regions (Oromia, Somali, Benishangul-Gumuz, SNNPR, and Gambella), with a decrease being observed in the other six Regions (Figure 26).

The lack of improvement indicates the presence of problems related to the lack of capacity at the grass roots level. This issue requires extensive review and the taking of appropriate measures based on the results of the review. The low participation of Regions with respect to the expansion of the service, inadequate laboratory capacity, turnover of trained health workers, the inability to give fully integrated TB and HIV prevention and control service, and the lack of complete and timely reports were the major problems faced during the implementation process.

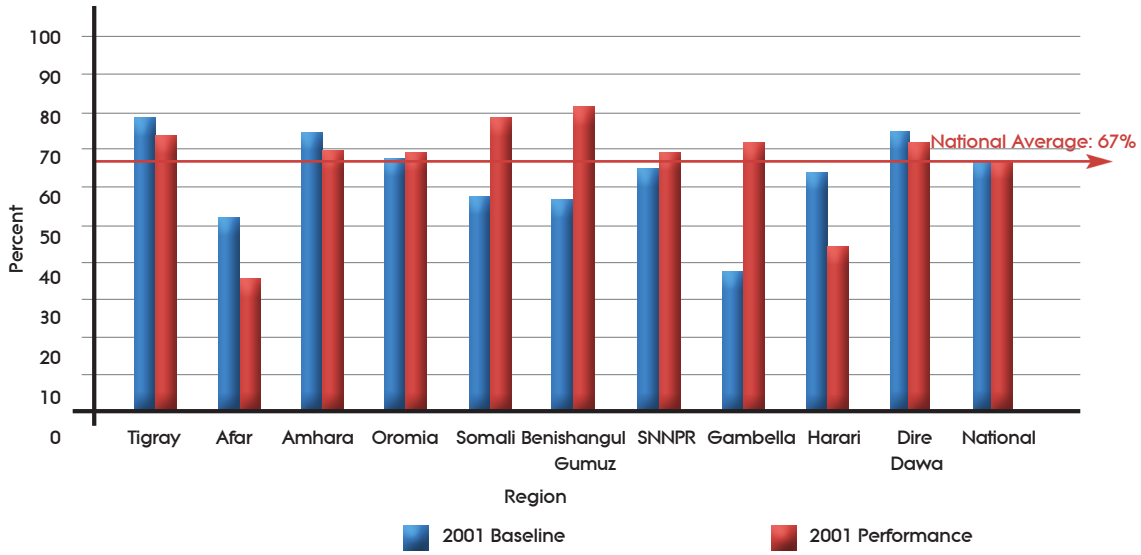

Figure 26: Comparison of Baseline and Performance of the TB Cure Rate by Region (EFY 2001)

7.4 Kalazar / Leishmaniasis control

Leishmaniasis control activities were undertaken at the Federal level and, mainly in Amhara and Tigray Regions.

At the Federal level, a working group to revise and update the National Guideline for Visceral Leishmaniasis (VL) was established. A technical working group that comprises of collaborative partners was also established for the preparation of standard training curriculum for VL.

The procurement of 16,000 rk39 tests, 2,500 ampoules of SSG and 1,900 ampoules of AmBisome was completed.

Discussions have been undertaken between MOH of Ethiopia and Sudan to include Leishmaniasis as part of the diseases that require cross border activities. Special emphasis will be given to active surveillance and capacity building for proper case management and referral in cross border areas.

In Amhara Region, support was given for the diagnostic and treatment centers in the region, with services being now provided in five centers (i.e. Bahir Dar Hospital, Addis Zemen Health Center, Metema Hospital, Gondar Hospital and Abdurafi Health Center). Further decentralization of the diagnostic service has been undertaken and, as a result, the service is being provided in 12 Health Centers located in the endemic districts of the region. A total of 6,800 ampoules of Meglumine antimoniate (Glucantime®) and 4,000 rk39 tests have been donated by WHO and distributed to the Region.

Two rounds of training were conducted for 56 health staff, including physicians, health officers, nurses and laboratory technicians who are working in the endemic districts of the Region, and three rounds of supportive supervision were undertaken in the facilities and districts of the Region.

Discussions have been undertaken with RHB and different NGOs and institutions on identification of the most convenient mechanism for undertaking outreach activities for active case detection, active surveillance and support.

In Tigray Region, support was given to the handover of the Leishmaniasis Control Program in Humera from Medecins Sans Frontières (MSF) to the RHB. Financial and technical support was given to Tigray Health Bureau for the smooth handover and continuation of control activities.

Risk factors study was conducted for the residents of Kafta-Humera and T/Adiabo districts.

Discussion is under way with the RHB and Mekelle University-College of Health Science for the involvement of outreach or mobile teams to do active case detection of Leishmaniasis.

7.5 Trachoma prevention and control

Blindness is one of the major public health problems of the country with a national prevalence of 1.6%. There are more than 1.2 million people with blindness (all causes) and 2.8 million people with low vision. Cataract and trachoma constitute more than 60% of all blindness cases. Around 90% of blindness cases in Ethiopia are avoidable (i.e. preventable and/or treatable). Despite the efforts made so far, lack of adequate resources (shortage of trained personnel, budget and infrastructure/equipment) is still among the major challenges for the implementation of the National Five-Year Strategic Plan (2006-2010) for Eye Care in Ethiopia. The broad strategic approaches of the Plan are disease control, human resource development and infrastructure/equipment development. These are being implemented in the country in line with the HSDP-III targets.

The major achievements in EFY 2001 are the following:

- The number of woredas implementing the WHO recommended SAFE (Surgery, Antibiotics, Facial cleanliness, and Environmental improvement) strategy for trachoma control, increased from 82 to 124 (out of 281 targeted Woredas) and 15,439,275

people were treated with Azithromycin and Tetracycline eye ointment in Woreda campaigns;
- Around 37,000 cataract surgeries (92.5% of the target for 2001) were performed;
- A total of 369 Trachomatous Trichiasis (TT) Kits were distributed to eye units in the country for eye-lid correction/TT surgery;
- The National Five-Year Strategic Plan for Eye Care Mid-Term Review (MTR) was conducted in collaboration with the National Committee for the Prevention of Blindness (NCPB) and results of the MTR were disseminated.
- Training of trainers (TOT) was given to 22 health professionals from Regional Health Bureaus on the National Guideline for mass antibiotic treatment (Azithromycin and Tetracycline eye ointment).
- Integration, partnership and coordination for prevention of blindness were strengthened through the NCPB and National Taskforce for Trachoma Control (NTTC) meetings.

7.6 Epidemic Prevention and Control

Acute Watery Diarrhea (AWD)

An outbreak of Acute Watery Diarrhea (AWD) epidemic occurred in 70 woredas of seven regions and in one urban administration, with 9,485 cases and 193 deaths (case fatality rate=2.0%). The Regional distribution shows that the highest number of cases (2,988) occurred in Afar, followed by Oromia (2,272), Amhara (1,953), Somali (1,309), SNNPR (810), Tigray (96), Harari (45), and Addis Ababa (12) (Figure 27).

An integrated and collaborative effort has been undertaken to control and prevent the epidemic, and drugs and medical supplies with a value of Birr 1,599,262.30 have been distributed to Regions affected by the epidemic. Technical assistance has been also provided to the same Regions.

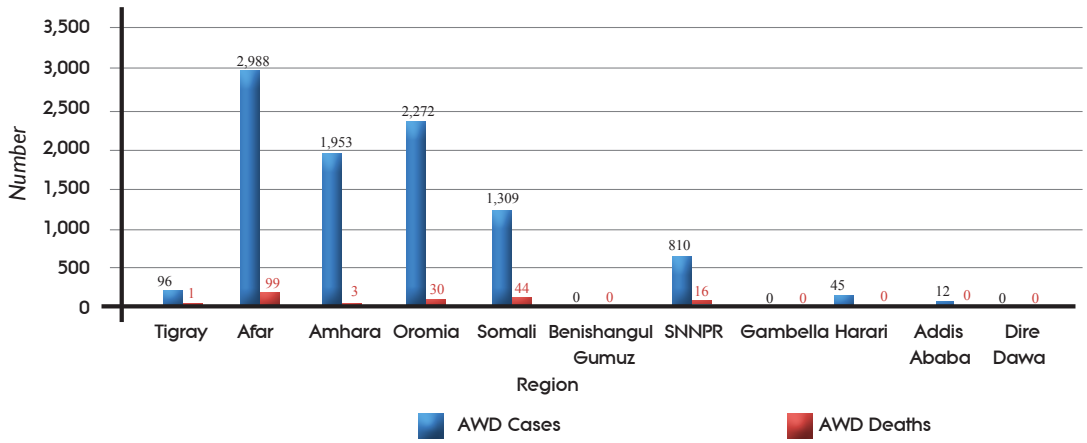

Figure 27 Distribution of the Number of Acute Watery Diarrhea Cases and Deaths by Region (EFY 2001)

The average case fatality rate was 2.0% at the national level, ranging between 3.4% in Somali Region and 0% in Harari and Addis Ababa. The highest number of deaths occurred in Afar (99), followed by Somali (44), Oromia (30), SNNPR (16), Amhara (3), and Tigray (1).

Figure 28 shows that there were two peaks in AWD cases, the first being in Nehassie 2000, while the second high peak occurred in Sene 2001, highlighting that the highest number of cases occurred during the rainy season.

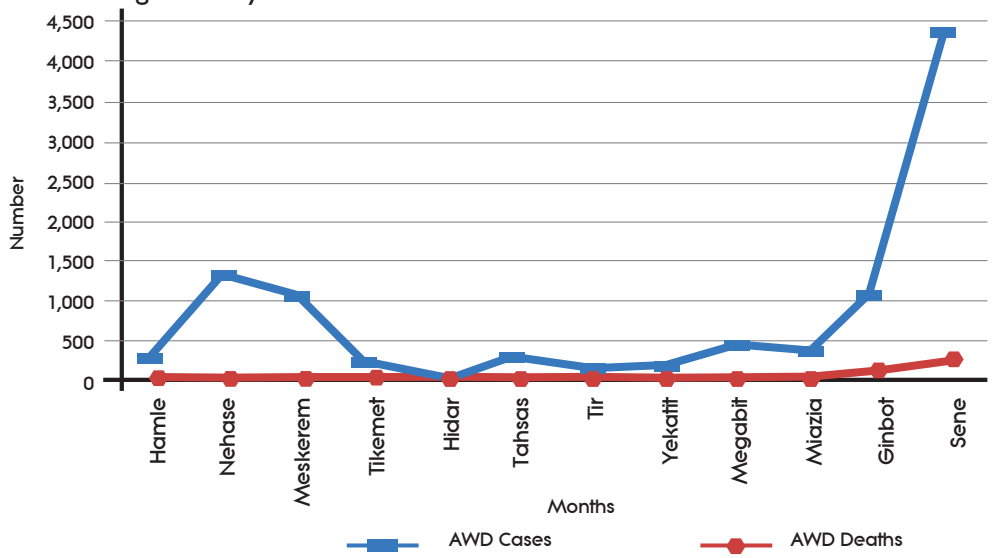

Figure 28: Trend of Acute Watery Diarrhea Cases and Deaths by Month (EFY 2001)

The following strategies have been implemented to contain the epidemic:

- Raising the level of awareness of the public on the disease;
- Educating the public on personal hygiene and environmental sanitation;
- Providing medical care;
- Ensuring the availability of drugs and medical equipment; and
- Providing technical assistance and making follow up on prevention and control activities.

Challenges and constraints with regard to the AWD epidemic are as follows:

- High burden on already busy health personnel working in health facilities to control AWD epidemic;
- Irregular and incomplete submission of reports from Regions affected by the epidemic;
- Lack of attention and preparedness on the epidemic by some Regions;
- Resurgence of the epidemic due to weak and slow prevention and control activities; and
- Low hygiene and sanitation coverage.

Measures taken include:

- Provision of technical support to Regions on gathering information required for monitoring the distribution of the disease;
- Provision of technical support to Regions on the prevention and control of the epidemic; and
- Communication alerting the Regions on the occurrence of the epidemic.

The way forward is as follows:

- Have a comprehensive strategy on AWD;
- Take collaborative actions with partner organizations to effectively respond to the epidemic and bring the epidemic under control;
- Bring behavioral change in the society by raising awareness using various media;

- Assist Regions to start implementing the new BPR;
- Strengthen the capacity, and use HEP for prevention of AWD;
- Conduct a comprehensive multisectoral study on AWD, the results of which feed into the national strategy on AWD; and
- Initiate inter-regional collaboration.

Meningococcal Meningitis

The outbreak of Meningitis occurred in 22 woredas of SNNPR, Amhara, Tigray, Oromia, and Addis Ababa Regions, with 89 cases and 12 deaths (case fatality rate=13.5%). The highest number of cases occurred in SNNPR (42, with 2 deaths), followed by Amhara (22 cases, 10 deaths). No deaths were reported from other Regions: Tigray (17 cases), Oromia (7 cases), and Addis Ababa (1 case) (Figure 29).

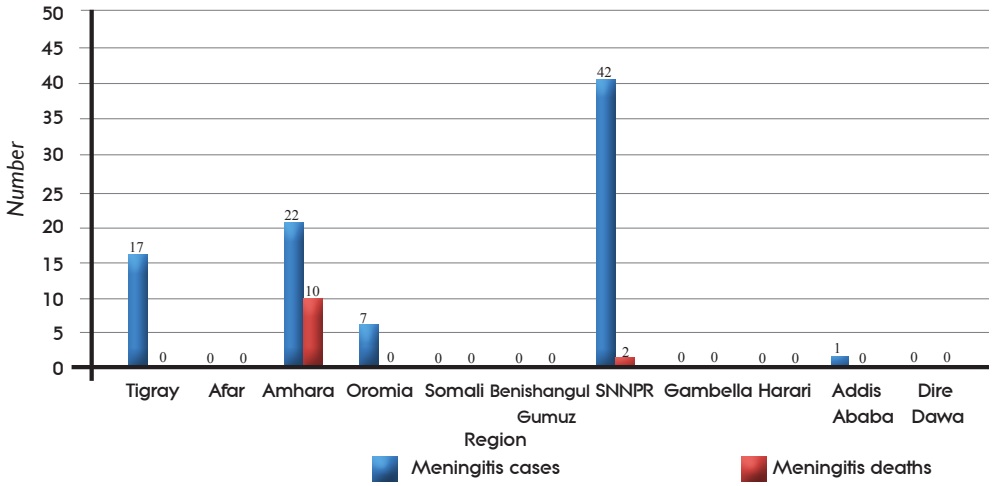

Figure 29 Distribution of the Number of Meningitis Cases and Deaths by Region (EFY 2001)

There were two peaks, the first in Tikimt 2001, while the second high peak was in Yekatit 2001. A relatively high number of deaths was observed in the months of Tir, Yekatit and Sene 2001.

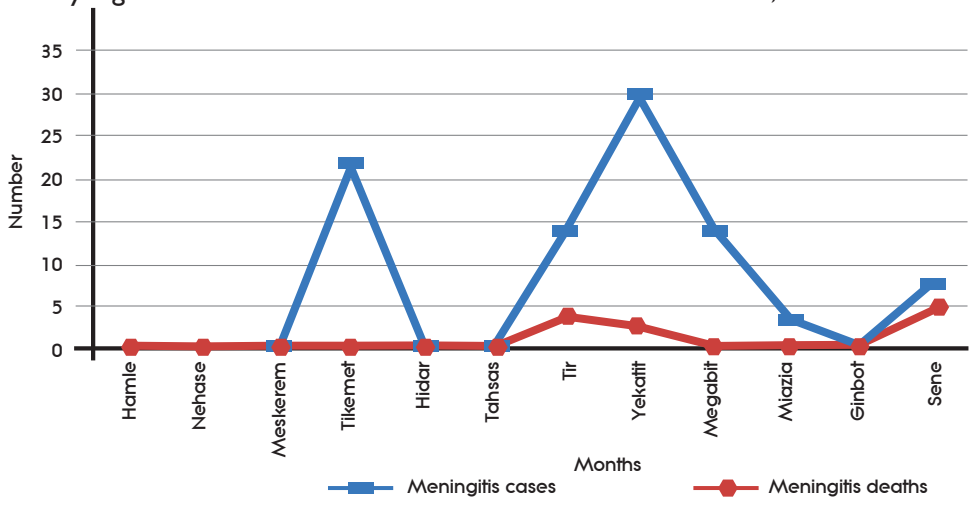

Figure 30: Trend of Meningitis Cases and Deaths by Month (EFY 2001)

In order to prevent the epidemic, two preparedness guidelines were developed, and vaccines adequate for 1.6 million people were distributed to Regions. Other medical supplies were also procured and distributed.

Training on preparedness and response has been given to professionals from all Regions. The epidemic is now fully under control.

Measles

Despite the national measles immunization coverage of 76.6%, measles epidemic occurred in 33 Woredas of Afar, Amhara, Gambella, Oromia, SNNPR, Addis Ababa, Dire Dawa and Somali Regions, with 3,976 cases and 43 deaths. The highest number of cases was seen in Oromia (2,084), SNNPR (1,290), Somali (213), Afar (153), and Amhara (114). Gambella, Addis Ababa, and Dire Dawa had cases between 30 and 59. The other Regions did not report any case. The highest number of deaths (17) was observed in Afar Region, followed by Amhara (13), Somali (8), Oromia (3), and SNNPR (2). There has been no death reported from Tigray, Benishangul-Gumuz, Gambella, Harari, Addis Ababa and Dire Dawa (Figure 31).

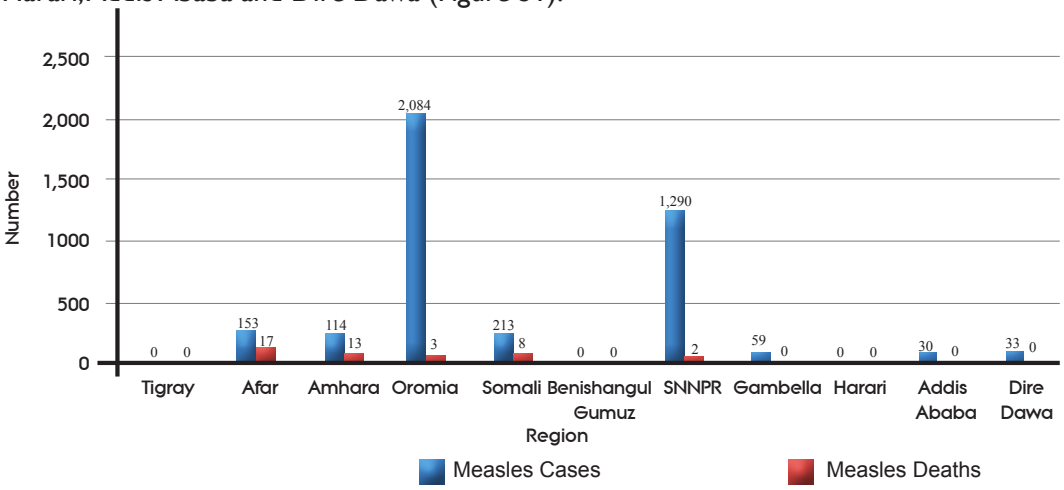

Figure 31: Distribution of the Number of Measles Cases and Deaths by Region (EFY 2001)

As can be observed in Figure 32, the incidence of the disease gradually increased from the month of Tikmet 2001 and reached the peak in the month of Tir 2001. It then sharply declined in the month of Yekatit, with fluctuations in the following months.

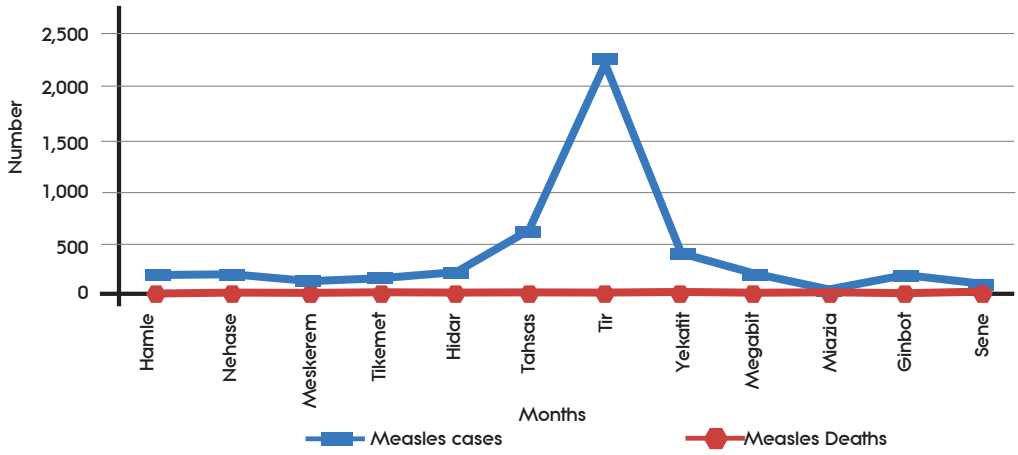

Figure 32:Trends of Measles Cases and Deaths by Month (EFY 2001)

Poliomyelitis

Two confirmed polio cases have been reported in Abobo Woreda of Gambella Region. The following actions have been undertaken to control the cases in the Woreda:

- A team comprising of members from Ethiopia and Sudan has been formed in the Woreda to undertake surveillance activities that include tracing the origin of the disease, which was found to be in Abobo Zone, Teregol (Kuchar) Kebele. Two rounds of polio vaccination have been given to children in the Kebele.
- In order to control the transmission of the polio virus, the exchange of information and surveillance activities was undertaken in the area where the cases occurred. An agreement has been also reached to conduct an inter-border meeting with Sudan.
- As per the recommendation of the international evaluation mission for polio and measles, two professionals have been employed to work in the Gambella area.

Relapsing Fever

Relapsing fever epidemics have occurred in Adama town and prison, and in Addis Ababa, Kolfe Keranio prison, with 454 cases. Since the cause of the disease is overcrowding and poor personal and environmental hygiene, FMOH has agreed with the concerned Regions on the control measures to be undertaken. The disease is now under control.

Bloody Diarrhea

A bloody diarrhea epidemic occurred in Tigray and SNNP Regions. A total of 393 cases have been identified, of which 319 were from Tigray and 74 from SNNPR. There has been no death from the disease. Water treatment chemicals have been sent to Regions through donor organizations and Ministry of Water Resources. The disease is now under control with a relentless effort from the concerned regions.

Rift Valley Fever

Since Rift Valley Fever epidemic has been repeatedly reported in neighboring countries (Sudan and Kenya), close surveillance has been undertaken in Ethiopia. The committee that comprises the Ministries of Health and Agriculture of Ethiopia, Sudan, and Kenya have made the necessary follow up on the disease. There has been so far neither rumor nor outbreak of the disease in the country.

Rabies

A total of 140 people from Hargele Woreda of Somali Region and 11 people in Addis Ababa have been bitten by dogs carrying the rabies virus. Nevertheless, there has been no death from the disease in both regions. Although there has been no report received from the Region, the disease is known to occur in Amhara Region. Vaccination has been given to all the people bitten by rabid dogs.

Influenza

Influenza pandemics are unpredictable but recurring events that can have severe consequences on societies worldwide. Since the 16th century, influenza pandemics have been described at intervals ranging between 10 and 50 years with varying severity and impact.

Avian Influenza

Ethiopia has continued to undertake intensified surveillance activities on Avian Influenza. In order to strengthen the influenza sentinels surveillance system, 25 professionals have been trained and two health facilities have started surveillance activities. A total of Birr 997,669 assistance has been secured and, out of this, a total of Birr 845,000 (84.7%) has been transferred to strengthen the Ethiopian Health and Nutrition Research Institute (EHNRI). Computers and refrigerators have been procured for selected health facilities with this fund.

H1N1 Influenza

The first cases of Influenza A (H1N1) was reported in Ethiopia the cases were reported in June 2009 when two Ethiopians returned from abroad were suspected and laboratory investigation was performed.

To date, laboratory investigation was carried out for 45 people who were suspected of influenza A (H1N1) infection out of which 7 were turned positive for A/H1N1, and the rest are negative. There are no deaths due to H1N1. All the positive individuals were traveling to and from a country where confirmed cases were reported.

In response to this particular pandemic and with the objective of strengthening the early warning system to reduce possibilities for human infection, to contain or delay spread at the source, reduce morbidity, mortality, economic and social disruption due to the pandemic the Government has alerted its existing systems. One of such actions includes the reactivation of the existing National Council on Zoonoses, chaired by the Minister of Health and co-chaired by the Minister of Agriculture & Rural Development. Arrangements have been made at Bole Airport to screen and quarantine suspected cases of the disease, while the procurement of drugs and supplies has been completed.

To contain the epidemic, in collaboration with partners, a Plan of Action was prepared and shared among the key actors. An isolation and quarantine system was also activated both at the airport and ports of entry and strengthened the surveillance system. An additional isolation center for intensive care of suspected/confirmed cases was opened at St Peter Hospital. Advocacy as well as health educations on prevention and control methods were widely disseminated.

Trainings were given to health workers from more than 30 private and public health facilities. Drugs and supplies were procured and distributed to all Regions.

VIII

PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES




PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

Globally Non-Communicable Diseases (NCDs) and injuries constitute a growing public health problem. Chronic diseases are often thought to be a public health problem in high income countries only. In reality, only 20% of chronic disease deaths occur in high-income countries. On the other hand, more than 85% of deaths from all types of injuries occur in developing countries.

In Ethiopia, NCDs and injuries are among the major contributors to the high level of mortality and morbidity. The Federal Ministry of Health has conducted a situational assessment on NCDs in the country in the year 2008. The report concluded that cardiovascular diseases, diabetes mellitus and cancers are among the leading chronic diseases with marked contributions to the overall morbidity and mortality burden in the country. Their risk factors are widely prevalent in urban and rural populations of the country.

The burden of chronic diseases, including cancers and chronic kidney diseases, might have been obscured due to the lack of complete and reliable data and the lack of disease registration systems such as cancer registry or chronic kidney disease registry.

One of the key steps for prevention and control of NCDs is to design and develop a national strategy to guide control activities at all levels. To this end, the draft strategy has been developed and being enriched by all stakeholders including regions for finalization.

Assessment of pattern of injuries in Addis Ababa in 2007 has shown that injuries accounted for 27% of all emergency visits and 3% of all other visits, 5% of all hospitalizations, and 3% of deaths. Road traffic injury is the main burden on health facilities contributing to 61% of injury-related admissions and 52% of injury-related deaths, being also the leading cause of repeated visits. As injuries have multiple causes so should be the approach towards their prevention and response. Accordingly, multi-sectoral national strategy on prevention of injuries and strengthening emergency medical services has been drafted and expected to be finalized by EFY 2002.

A strategy for expansion of mental health services is under development. A process for decentralization and integration of mental health services through provision of psychiatric training to mid and low level professionals is showing encouraging development.

The planned situational analysis to identify non-communicable diseases and their etiology has been finalized in EFY 2001.

The preparation of a strategy document on prevention and control of major non-communicable diseases has been contracted out.

The draft three-year strategic plan on issues related with accidents and medical emergencies prepared in EFY 2000 has been printed and distributed in the reporting year.

IX

MATERNAL HEALTH SERVICES




MATERNAL HEALTH SERVICES

Ethiopia is committed to achieve MDG5 to improve maternal health, with a target of reducing maternal mortality ratio (MMR) by three-quarters over the period 1990-2015. HEP and accelerated expansion of health centers and blood banks are the major strategies that have been designed to meet this target. Despite the decline in MMR from 871 deaths per 100,000 live births in 2000 EDHS to 673 deaths per 100,000 live births in 2005 EDHS, maternal mortality is still unacceptably high in Ethiopia. It is expected that through the implementation of the HEP packages and the provision of basic and comprehensive emergency obstetrics care (BOEC and CEOC) services at health center and hospital levels, maternal mortality will be further reduced in the next years.

Five major HMIS indicators have been selected to measure the progress towards the achievement of MDG5: antenatal care coverage, percentage of deliveries attended by skilled health personnel, clean and safe delivery service coverage (percentage of deliveries attended by HEWs), post natal care coverage, and contraceptive acceptance rate. Table 16 shows 2001 baseline, performance and target for these indicators, as well as the overall HSDP target set for EFY 2002.

Table 16: Maternal Health Indicators (2001 Baseline, Performance and Target and HSDP Target for EFY 2002)

INDICATOR	EFY 2001 Baseline	EFY 2001 Performance	EFY 2001 Target	HSDP Target
Antenatal Care Coverage	61.2%	67.7%	80.5%	80%
Percentage of Deliveries Attended by Skilled Health Personnel	20.7%	18.4%	37.1%	32%
Clean and Safe Delivery Service Coverage (Percentage of Deliveries Attended by Health Extension Workers)	9.4%	12.3%	29.3%	-
Postnatal Care Coverage	25.9%	34.3%	-	31%
Contraceptive Acceptance Rate	53.8%	56.2%	64.5%	-

Trend in Antenatal Care Coverage, Percentage of Deliveries Assisted by Skilled Health Personnel and Postnatal Care Coverage

Maternal health indicators showed an overall improvement compared to EFY 2000 (Figure 33). Antenatal care coverage increased from 61.2% in EFY 2000 to 67.7% in EFY 2001 and postnatal coverage from 25.9% to 34.3%. The proportion of deliveries with skilled health attendants rose from 20.7% in EFY 2000 to 24.9% in EFY 2001. Despite this upward trend, the coverage of maternal health services is still low in Ethiopia, and the national targets set for EFY 2001 were not achieved (80.5% for ANC coverage and 37.1% for proportion of deliveries with skilled health attendants).

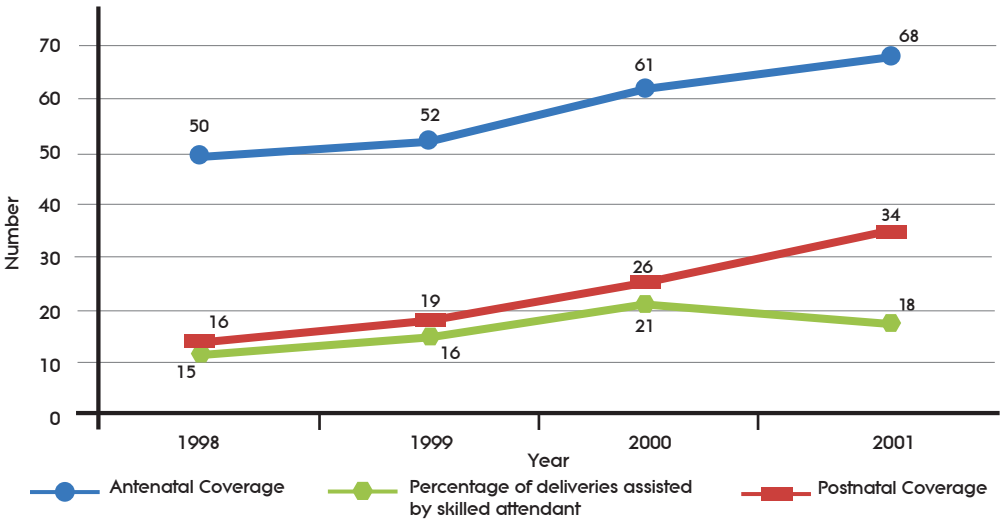

Figure 33: Trend in Antenatal Coverage, Percentage of Deliveries Assisted by Skilled Health Personnel and Postnatal Coverage (EFY 1998-2001)

Regional Distribution of Antenatal Care Coverage

Concerning the regional distribution of the antenatal care coverage, there were wide variations across Regions ranging from 27.1% in Afar Region and 28.8% in Somali Region to about 100% in Tigray and Addis Ababa. An increase was observed in seven Regions (Tigray, Amhara, Oromia, Somali, Gambella, Addis Ababa and Dire Dawa), with the highest increase being observed in Tigray (+17.3%), while there was a decrease in the other four Regions. Two Regions (Tigray and Addis Ababa) performed above the target (Figure 34). These regional performances resulted in a national increase in antenatal coverage from 61.2% in EFY 2000 to 67.7% in EFY 2001 (+6.5%), still below the target set for EFY 2001 (80.5%).

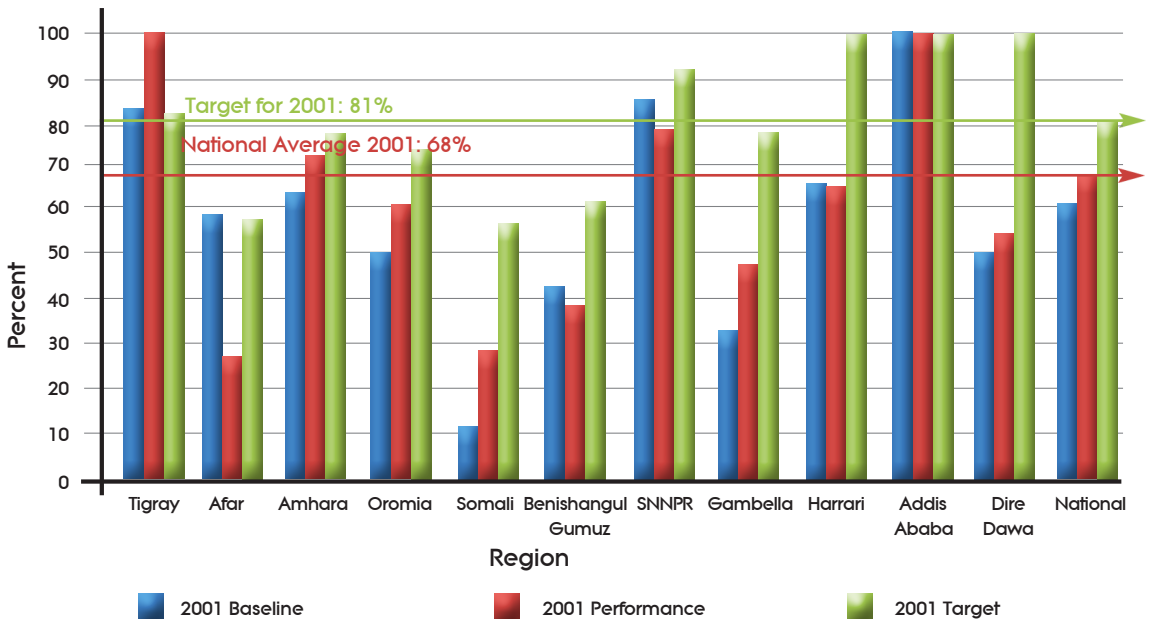

Figure 34: Comparison of Baseline, Performance and Target of the Antenatal Care Coverage by Region (EFY 2001)

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

A decrease was observed in the percentage of deliveries assisted by skilled health personnel from 20.7% in EFY 2000 to 18.4% in EFY 2001 (below the target of 37.1% set for EFY 2001), with wide variations across Regions ranging from 5.6% in Benishangul-Gumuz and 6.2% in Afar to 62.5% in Addis Ababa. An increase was observed in four Regions (Tigray, Gambella, Addis Ababa and Dire Dawa), while there was a decrease in the other seven Regions (Figure 35).

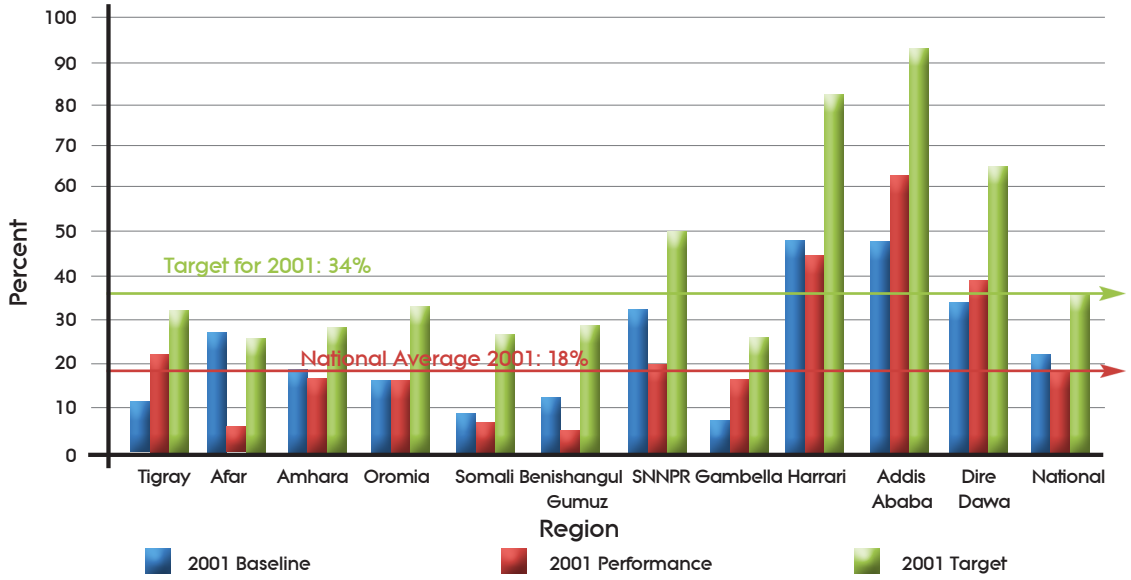

Figure 35: Comparison of Baseline, Performance and Target of the Percentage of Deliveries Assisted by Skilled Health Personnel by Region (EFY 2001)

Regional Distribution of Clean and Safe Delivery Service Coverage (Percentage of Deliveries Attended by Health Extension Workers)

An increase was observed in the clean and safe delivery service coverage, reaching 12.3% in EFY 2001, a level which is still below the target set for the year (29.3%). Wide variations were observed across Regions ranging from 0% in Somali Region and 0.8% in Harari Region to 11.2% in Tigray and 32.0% in SNNPR. There was a general pattern of performance increase across Regions (Tigray, Afar, Amhara, Oromia, Benishangul-Gumuz, Gambella, Harari, and Dire Dawa), with the exception of SNNPR, where the highest performance was achieved, but with a decrease from 36.2% in EFY 2000 to 24.1% in EFY 2001. No Region achieved its regional target (Figure 36).

Of note is the fact that almost one third (30.7%) of the total deliveries were attended either by skilled health attendant (18.4%) or HEW (12.3%). These are encouraging results towards decreasing the burden of maternal morbidity and mortality.

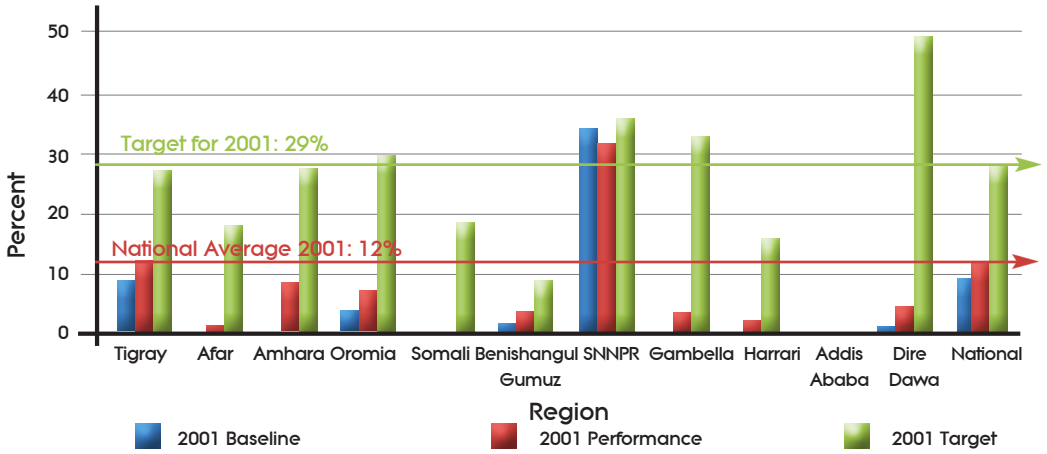

Figure 36: Comparison of Baseline, Performance and Target of the Clean and Safe Service Delivery Coverage (EFY 2001)

The following activities were performed in EFY 2001:

- Clean and safe delivery kits sufficient enough to provide delivery service for 862,568 pregnant mothers were procured and distributed to Regions;
- TOT for 513 trainers of HEWs was conducted to improve the quality of clean and safe delivery service to mothers;
- A training manual that focuses on clean and safe delivery skills by HEWs has been prepared and sent for printing;
- 4,000,000 tablets of Mesoprostol, which helps to reduce maternal deaths due to post delivery hemorrhages and can be prescribed by HEWs, have been imported and distributed to Regions.

Regional Distribution of Postnatal Care Coverage

Concerning the Regional distribution of the postnatal care services, the highest coverage was observed, as for antenatal care, in Tigray and Addis Ababa (51.2% and 48.3%, respectively), while the lowest one was found in Somali Region (2.7%) (Figure 37). There was an increase in seven regions (Tigray, Amhara, Oromia, Benishangul-Gumuz, SNNPR, Harari and Addis Ababa), with the highest improvement being found in Tigray (+12.8%), while a decrease was observed in the other four Regions. This indicator was not included in the Woreda plan, therefore there was no target set for EFY 2001. Of note is the fact that, with the increase in postnatal coverage from 25.9% to 34.3% observed in EFY 2001, the overall HSDP III target (31%) set for EFY 2002 has been already achieved.

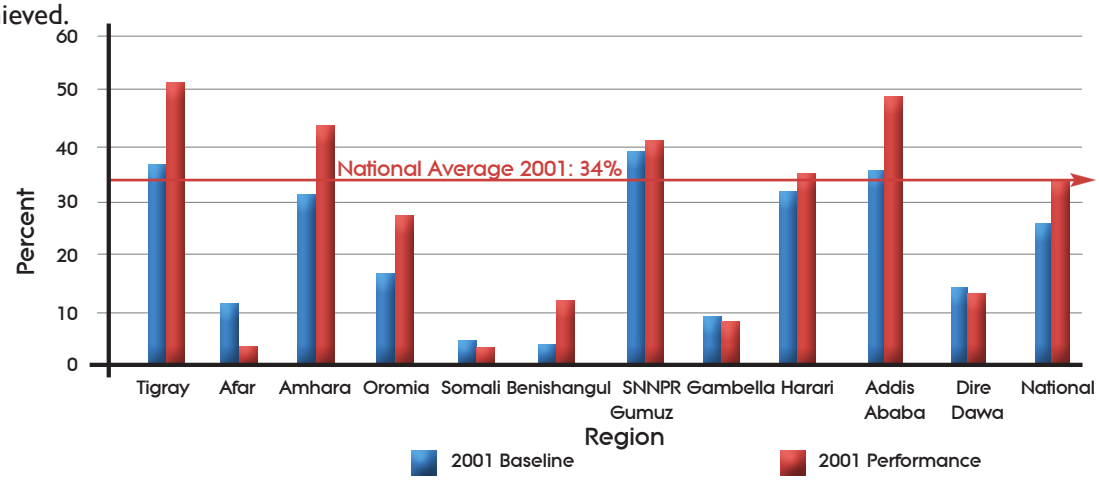

Figure 37: Comparison of Baseline and Performance of Postnatal Care Coverage by Region (EFY 2001)

The following activities were performed in EFY 2001:

- Equipment such as resuscitation kit, weighing scales and heater that help to strengthen the provision of essential newborn care have been procured to be distributed to 200 hospitals and 60 health centers;
- In order to improve the quality and expand service delivery, the delivery service manual (Management Protocol) has been prepared and submitted for adoption.

Male Involvement is crucial for Family Planning

Trend in Contraceptive Acceptance Rate

Contraceptive Acceptance Rate (CAR) is the proportion of women of reproductive age (15-49 years) who are not pregnant and are accepting a modern contraceptive method (new and repeat acceptors). Each acceptor is counted only once, the first time s/he receives contraceptive services in the calendar year. Appropriate supervision is needed to ensure that the number of acceptors (not the number of consultations) is included in the numerator of CAR. CAR increased from 53.8% in EFY 2000 to 56.2% in EFY 2001, short of the target (64.5%) set for the year (Figure 38).

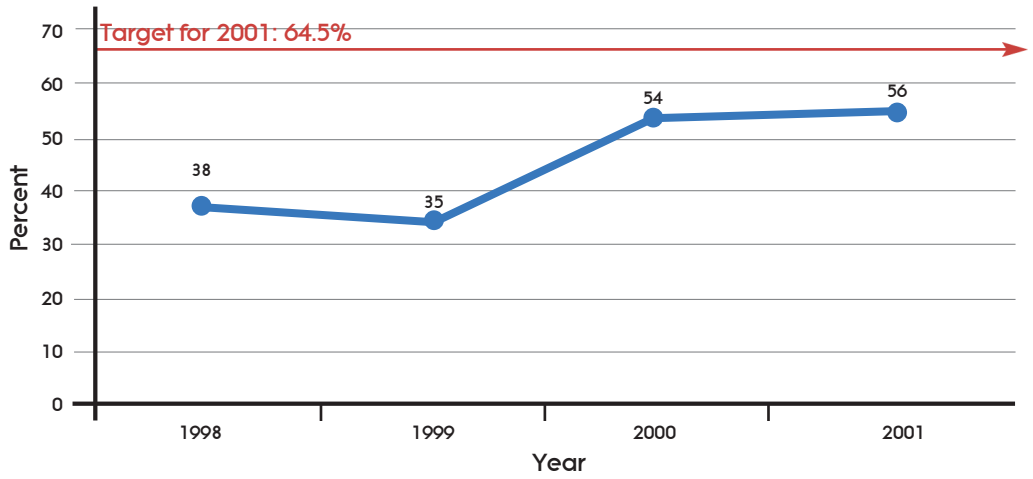

Figure 38: Trend in Contraceptive Acceptance Rate (EFY 1998-2001)

Concerning the procurement and distribution of contraceptives, 9.6 million injectables and 230,000 Implant are already in the country and available for services. A total of 4.4 million injectables, 100,000 implant and 2 million oral contraceptives are expected to arrive in the country within a short period of time. The total number of contraceptives distributed or under procurement is 14 million injectables, 330,000 Implant, 1 million emergency contraceptives, and 6.5 million oral contraceptives.

Regional Distribution of Contraceptive Acceptance Rate

There were wide variations among Regions (Figure 39). The lowest rate (6.6%) was reported in Somali Region, while the highest rate (83.8%) was reported in Dire Dawa. An increase was observed in five Regions (Tigray, Amhara, Oromia, Somali, and Gambella), while there was a decrease in the other six Regions. The performance was above the target in 3 regions (Tigray, Amhara and Dire Dawa), with the highest improvement being found in Tigray (+12.0%).

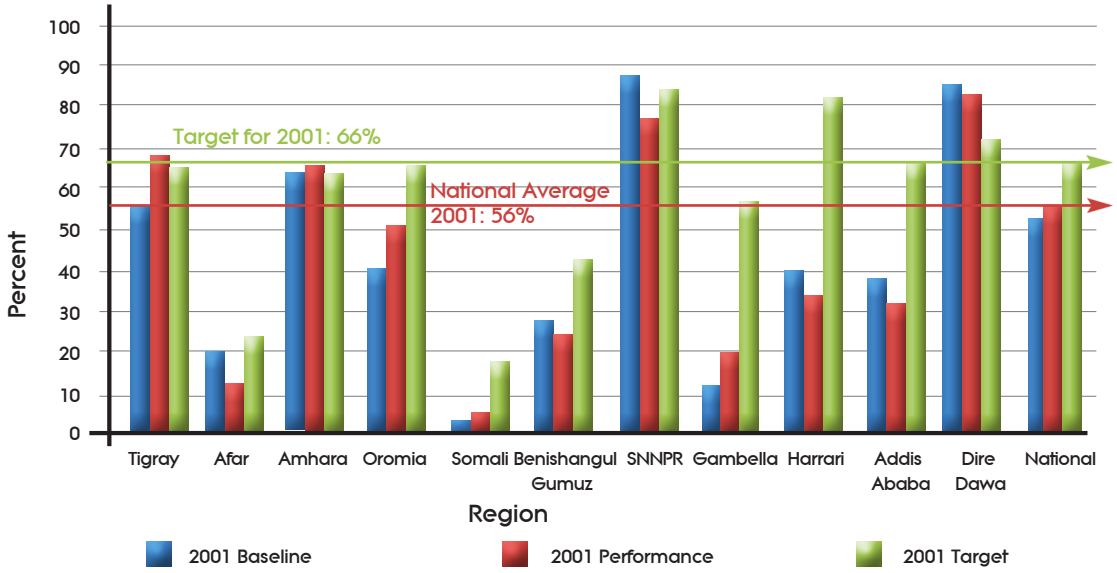

Figure 39: Comparison of Baseline, Performance and Target of Contraceptive Acceptance Rate by Region (EFY 2001)

X

CHILD HEALTH SERVICES




A substantial portion of all under-five deaths in Ethiopia is due to preventable diseases (pneumonia, diarrhea, malaria, measles, and HIV/AIDS) and malnutrition is the underlying cause of death in about 54% of the cases. MDG4 aims to reduce child mortality with a target of reducing under-five mortality rates by two thirds over the period 1990-2015. Improving child health is one of the priorities of HSDP III, which has set a target for the reduction of under-five mortality rate from 123 to 85 per 1000 live births and the infant mortality rate from 77 to 45 per 1000 live births. The progress made in Ethiopia in this regard is encouraging. This section of the report gives an overview on immunization and IMCI services.

10.1 Immunization

One of the indicators used to monitor progress towards the achievement of MDG4 is immunization coverage. 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 immunization coverage.

Table 17 shows 2001 baseline, performance and target for pentavalent 3 immunization coverage, measles immunization coverage and full immunization coverage as well as the overall HSDP III target set for EFY 2002. In EFY 2001 pentavalent immunization coverage was 81.6%, measles immunization coverage was 76.6%, while the percentage of fully immunized children was 65.5%. HSDP III target has been already achieved for measles immunization coverage and percentage of fully immunized children.

Table 17: Immunization coverage indicators (2001 Baseline, Performance and Target and HSDP Target for EFY 2002)

INDICATOR	EFY 2001 Baseline	EFY 2001 Performance	EFY 2001 Target	HSDP Target
Pentavalent 3 Vaccine Coverage	85.4%	81.6%	91.9%	85%
Measles Vaccine Coverage	75.9%	76.6%	86.4%	75%
Full Immunization Coverage	66.4%	65.5%	-	54%

Trend in Immunization Coverage

There were fluctuations in immunization coverage, with Pentavalent 3 vaccine coverage decreasing from 85.4% in EFY 2000 to 81.6% in EFY 2001, measles vaccine coverage slightly increasing from 75.9% to 76.6%, and full immunization coverage fluctuating around 66% (66.4% in EFY 2000 and 65.5% in EFY 2001) (Figure 40).

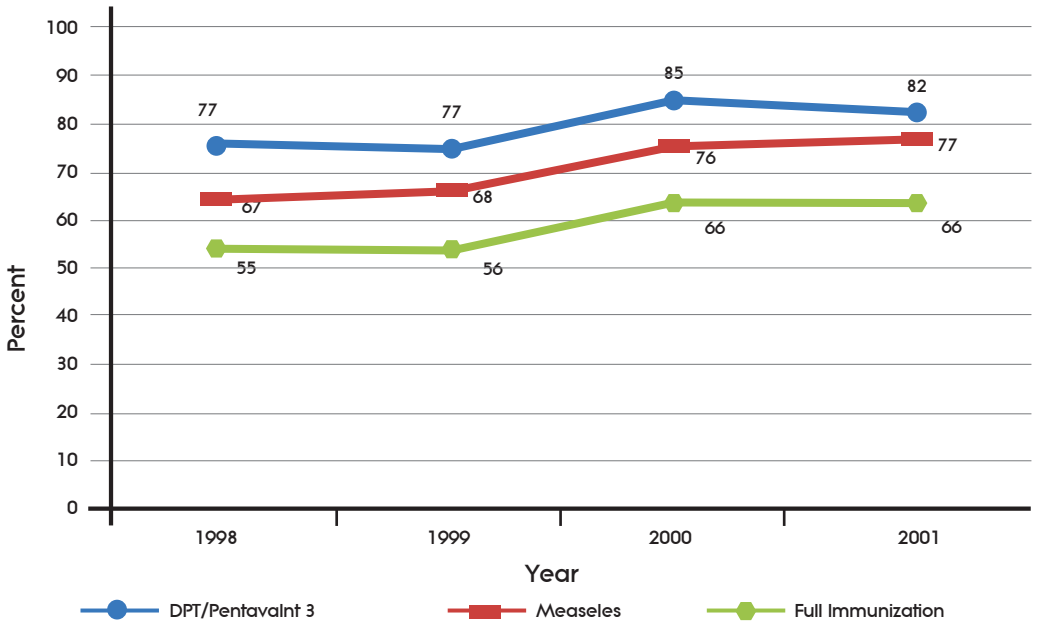

Figure 40:Trend in DPT/Pentavalent 3 Immunization Coverage, Measles Immunization Coverage and Percentage of Fully Immunized Children (EFY 1998-2001)

Regional Distribution of Pentavalent 3 Vaccine Coverage

Pentavalent 3 coverage was 81.6% at the national level in EFY 2001, short of the target (91.9%) set for the year and below the performance in EFY 2000 (85.4%). The highest coverage (91.0%) was found in Harari and SNNPR, with the lowest one being observed in Somali (37.6%) (Figure 41). An increase was observed in five Regions only (Somali, Benishangul-Gumuz, Gambella, Harari, and Addis Ababa), while a decrease was observed in the other six regions, therefore explaining the downward fluctuations found at the national level. Only Addis Ababa reached its Regional target.

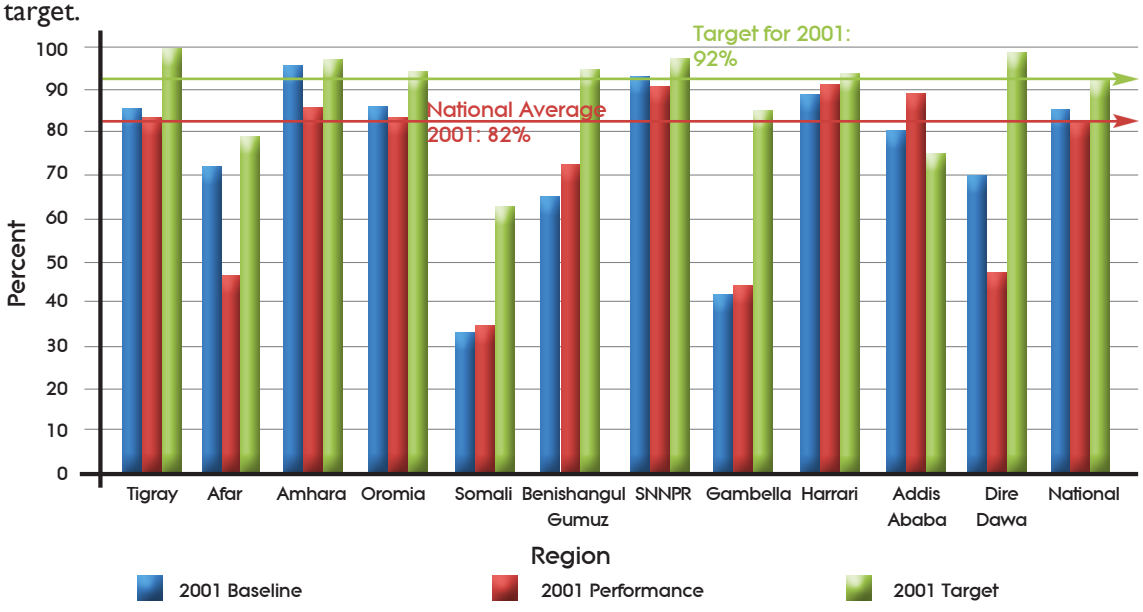

Figure 41: Comparison of Baseline, Performance and Target of Pentavalent 3 Immunization Coverage by Region (EFY 2001)

Regional Distribution of Measles Vaccine Coverage

Measles vaccine coverage was 76.6% at the national level in EFY 2001, short of the target (86.4%) set for the year, but above the performance in EFY 2000 (75.9%). SNNPR was the best performing Region (90.5%), followed by Addis Ababa (82.1%) and Tigray (80.9%). The lowest coverage (between 40% and 45%) was found in Dire Dawa, Afar, Gambella, and Somali Regions: 40.0%, 41.4%, 42.9% and 44.9%, respectively. An increase was observed in five Regions (Oromia, Somali, Benishangul-Gumuz, Gambella, and Addis Ababa), while a decrease was observed in six Regions (Tigray, Afar, Amhara, SNNPR, Harari, and Dire Dawa). Only Addis Ababa showed a performance above target (Figure 42).

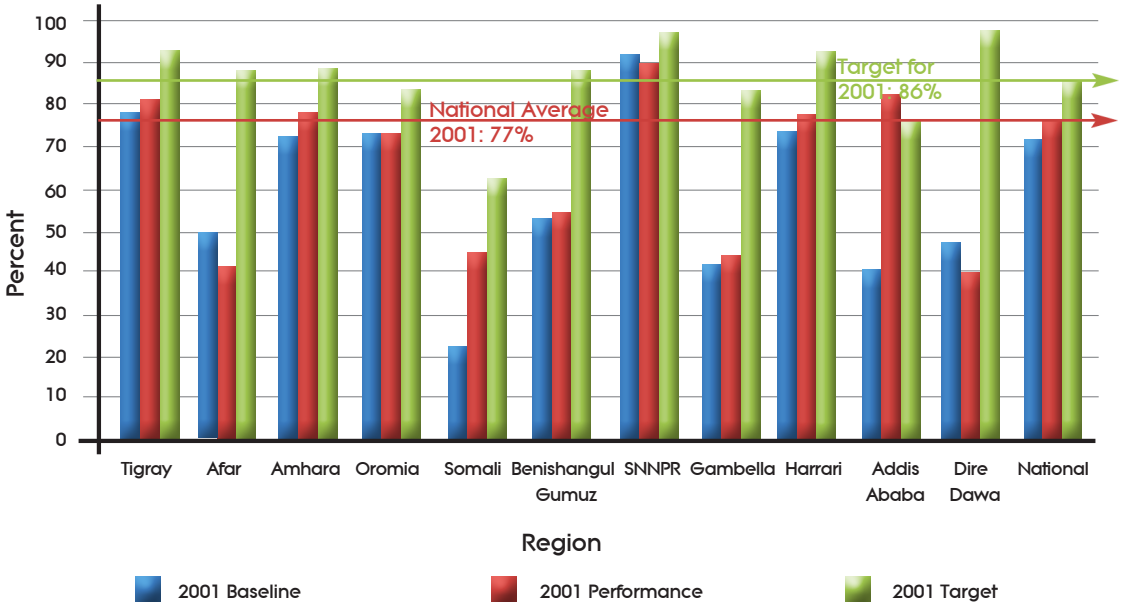

Figure 42: Comparison of Baseline, Performance and Target of Measles Immunization Coverage by Region (EFY 2001)

Happy family with a fully immunized child

10.2 The Integrated Management of Neonatal and Childhood Illnesses

The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) is a strategy adopted by Ethiopia to improve the quality of the management of childhood illnesses. It has three components: improving the skills of health workers, health systems and family and community practices. It links preventive and curative services. Programs such as immunization, nutrition, and control of malaria and other infectious diseases are implemented in an integrated manner. The main activities under IMNCI are prevention and control of ARI, diarrhea, malaria, malnutrition, measles and HIV/AIDS.

At the beginning of EFY 2001, the number of health centers providing IMNCI in the country was 548, with an addition of 382 new health centers in EFY 2001 there is now a cumulative total of 930 health centers providing IMNCI (Table 18). This increase was below the target set for EFY 2001 to cover 1,767 health centers. A total of 81 hospitals were also providing IMNCI services at the end of EFY 2001. Benishangul-Gumuz, Gambella, Harari, and Addis Ababa achieved the target set for EFY 2001. Among the larger Regions, it is only SNNPR that has almost achieved the target of the number of health centers providing IMNCI during EFY 2001, while Tigray, Amhara, and Oromia Regions have achieved around 50% of the planned target.

Most of the public hospitals in Oromia, Amhara, SNNPR and Tigray provided IMNCI while none of the hospitals in Addis Ababa provided the service. Two hospitals each in Afar, Benishangul-Gumuz, and Harari, four hospitals in Somali and one hospital each in Gambella and Dire Dawa rendered IMNCI services.

Table 18: Distribution of Health Facilities Providing IMNCI by Region (EFY 2001)

Region	Cumulative number of HCs providing IMNCI in EFY 2000	Cumulative number of HCs providing IMNCI in EFY 2001	Cumulative number of HCs providing IMNCI planned in EFY 2001	Hospitals that provide IMNCI in EFY 2001
Tigray	40	99	188	13
Afar	14	13	33	2
Amhara	125	225	565	17
Oromia	166	252	596	22
Somali	9	13	34	4
Benishangul-Gumuz	14	14	22	2
SNNPR	140	269	279	17
Gambella	3	8	6	1
Harari	2	4	4	2
Addis Ababa	29	26	24	0
Dire Dawa	6	7	16	1
TOTAL	**548**	**930**	**1,767**	**81**

To achieve this performance various types of training were given to different categories of health workers on IMNCI, IMNCI case management, facilitation skills, supervisory skill training and emergency triage assessment and treatment. Different types of educational materials (models, charts, booklets, registers, books) were also distributed to Regions.

Community IMNCI (C-IMNCI) interventions are well underway in 215 woredas in ten Regional States. Of these, 30 woredas initiated the program in EFY 2001. In order to expand C-IMNCI from 185 to 215 woredas in EFY 2001, training was given to trainers and volunteers in 45 Woredas and for 271 health workers, 338 HEWs and 4,355 health volunteers. Refresher trainings and review meetings as well as distribution of educational materials were undertaken in 83 C-IMNCI woredas for volunteer frontline workers. TOT has been given in 12 rounds for 300 health workers, 480 HEWs and 720 woreda and kebele leaders in 60 Woredas.

XI

UTILIZATION OF HEALTH SERVICES




UTILIZATION OF HEALTH SERVICES

As in previous years, the indicator presented to measure the utilization of health services is the OPD attendance per capita. It is the average number of outpatient visits (first and repeat) per person per year, reflecting the interaction between demand and supply of outpatient care.

Concerning the trend over time, there were fluctuations in OPD attendance per capita from 0.34 in EFY 1998 to 0.25 in EFY 2000 and 0.30 in EFY 2001, a level of performance which is about half of the target (0.66) set for the end of HSDP III.

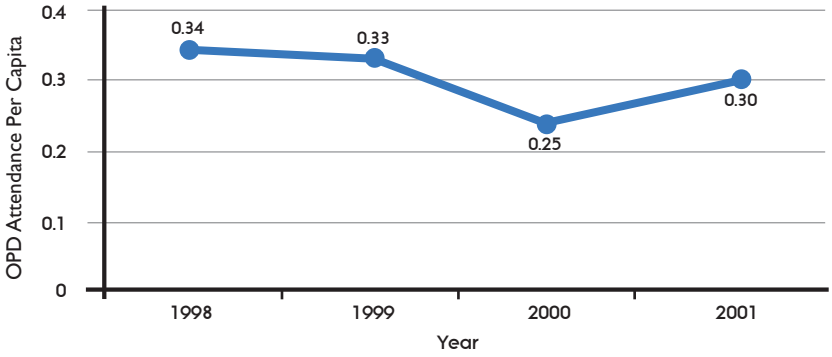

Figure 43:Trend in OPD Attendance Per Capita (EFY 1998-2001)

Wide variations were observed across regions in EFY 2001, ranging between 0.72 visit per capita in Tigray Region and 0.18 in Somali Region, with Addis Ababa (0.65), Benishangul-Gumuz (0.53), Amhara (0.37), Harari (0.36), and Dire Dawa (0.33) showing a performance above the national average. All regions showed an improvement in performance in EFY 2001 with respect to EFY 2000 (Figure 44). This may be due to increase in OPD service utilization or to improvement in reporting. Of note is also the fact that the use of outpatient services is inversely related to certain barriers that may be physical (distance), economic (cost to patient), cultural (health care seeking behavior) or technical (poor quality of care), and a better understanding of the patterns of service utilization is a priority for the health sector.

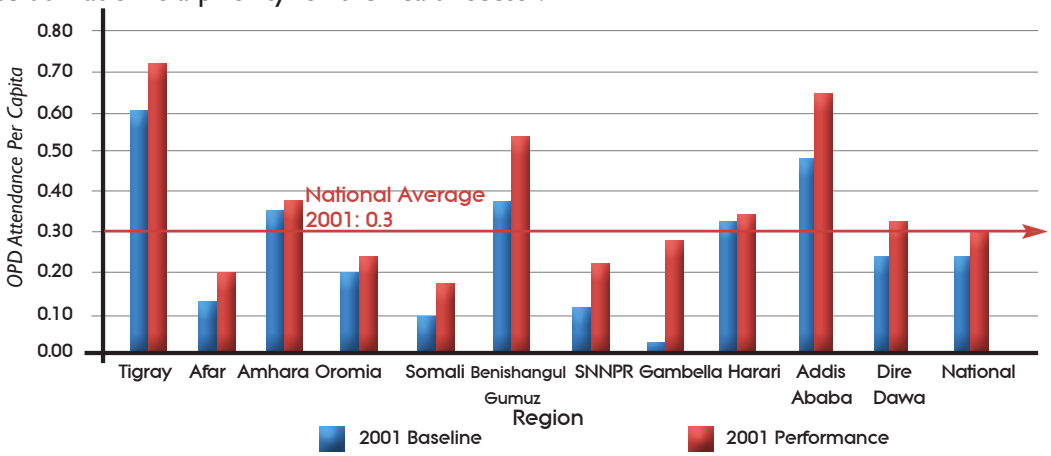

Figure 44: Comparison of Baseline and Performance of OPD Attendance per Capita by Region (EFY 2001)

The low OPD attendance calls for better and more efficient utilization of resources at health facility level. Hence, two interventions may be required for this. The first will be awareness creation among the general population to increase demand for modern health services, while the second will be making the health system more friendly, easily accessible and affordable.

XII

STRENGTHENING OPERATIONS RESEARCH AND RELATED ACTIVITIES




STRENGTHENING OPERATIONS RESEARCH AND RELATED ACTIVITIES

The main objective of operations research in the sector is to identify and study priority public health concerns aimed to generate evidence that would help decision-makers in their effort to improve quality of health care and develop realistic health sector policies, strategies and practices. In EFY 2001, operations research was conducted in the areas of nutrition, traditional medicine, maternal and child health, malaria, HIV/AIDS, and surveillance of major public health problems.

12.1 Nutrition

12.1.1 EOS Coverage Validation Survey:

The objective of this study is to validate EOS coverage. The survey which was started in EFY 2000 has been completed in EFY 2001. According to the findings, the coverage in most Woredas is above 80%, however, in some Woredas it is below 80%. The study also shows that the coverage of the Vitamin A supplementation and De-worming program has been successful.

12.1.2 National Nutrition Baseline Survey:

In order to conduct a baseline Nutrition Survey, questionnaire and methodology of the study have been finalized including preparatory arrangements necessary for conducting the survey such as pre-testing of the questionnaire, translation of the questionnaire into Amharic and preparation of manual for data collectors and supervisors.

12.1.3 Food Shelf Life:

For the study on determination of food shelf-life, data has been collected from 29 food processing factories.

12.2 Operations Research on HIV/AIDS, TB and Malaria

12.2.1 Research protocol has been prepared to undertake study on early warning indicators of drug resistance to HIV.

12.2.2 For the Threshold Survey to assess the drug resistance of HIV/AIDS nation-wide, study sites have been selected in seven regions. In Addis Ababa, six health centers have been found suitable for collection of blood samples.

12.2.3 Study on immune response towards different antigens of TB/HIV patients has been initiated. The study population has been selected, and 21 antigens have been tested on the blood samples taken from the study population. Follow-up for 6 and 18 months has been made on 50 and 52 study participants respectively.

12.2.4 Assessment study on the resistance to TB drugs was planned for implementation in EFY 2001. The study protocol has been presented to the research committee of EHNRI and has passed ethical review.

12.2.5 For the study on efficacy of anti-malarial drugs, ninety samples have been collected and data entry has been made.

12.2.6 The study on potency of four chemicals (Malation, DDT, Paramethrin and Deltametrin) on mosquitoes has been initiated; study sites have been selected, mosquitoes have been collected and their species identified. Data entry has been completed for data collected from Amhara, Tigray, Gambella, and Benishangul Gumuz Regions.

12.2.7 Study on the insecticidal property and utilization of insecticide treated nets has been started. 120 bed-nets were distributed in the selected study sites and data have been collected four times. Lack of adequate number of mosquitoes has constrained the study.

12.3 Surveillance Studies

12.3.1 Surveillance studies on Polio, Measles, Rubella and Influenza viruses have been made at national level through laboratory examinations on collected samples. Results have been reported to the FMOH and the WHO as appropriate.

12.3.2 A national level surveillance study on HIV, Syphilis, Hepatitis B, Hepatitis C and Herpes Simplex has been started. Methodology and questionnaires have been prepared in consultation with the CSA. The study protocol has been revised, and the study is expected to commence in EFY 2002.

12.4 Operations Research on Traditional Medicine and Drugs

12.4.1 Three herbs with proven efficacy in the treatment of malaria have been collected from different regions. Fractionated extract has been prepared, given daily to mice in varied doses, and follow-up made in food-intake, weight change, behavior, histopathological and hematological changes.

12.4.2 To study anti-helminthic traditional herbs, the selected herbs have been collected together with hookworm parasites from different regions. The study has been conducted by testing the potency of the herbal extracts on the hookworms.

12.4.3 Seven types of herbs that are used for treatment of skin diseases of animals were collected from different regions. Ticks and sheep kedes were also collected and the potency of the herbal medicine tried on these external parasites.

12.5 Study on Health Commodity Tracking

The study on health commodity tracking covers the bigger Regions and a representative sample of emerging Regions. The purpose of the study is to examine the whole pipeline of distribution up to the end user and assess the quality of data on inventory from bottom-up and top-down. The study focuses on the tracking and inventory system and how efficiently and effectively the commodities bought through the support of PBS II and GAVI-HSF reach the end user. Data collection is nearly completed and the first draft report will be ready soon.

XIII

PUBLIC BUDGET ALLOCATION AND EXPENDITURE




PUBLIC BUDGET ALLOCATION AND EXPENDITURE

One of the basic principles of the Health Care Financing Strategy of the Government of Ethiopia is to increase the proportion of budget from public funds to the health sector and to enhance its utilization. Since this is one of the critical inputs that affect the performance of the sector, review of the annual performance in EFY 2001 has to look into allocation and expenditure patterns of the health sector during the reporting year. Hence, the performance of the sector in relation to public budget allocation and expenditure is presented as follows.

13.1 Percentage Share of the Health Budget Allocation from Total Budget

As shown in Figure 45, percentage of total Regional block grant budget allocated to the health sector ranged from 2.7 % in Addis Ababa to 19.8% in SNNPR. The national average was 10.1%. A decrease in the share of the health budget is noted in Gambella, Harari, Dire Dawa and Addis Ababa. The percentage of the total budget allocated to the health sector has increased from 9.14% in EFY 2000 to 10.11 in EFY 2001. The allocation on health per capita is ETB 38.03[1] in EFY 2000. This figure was 28.5 Birr in EFY 2000.

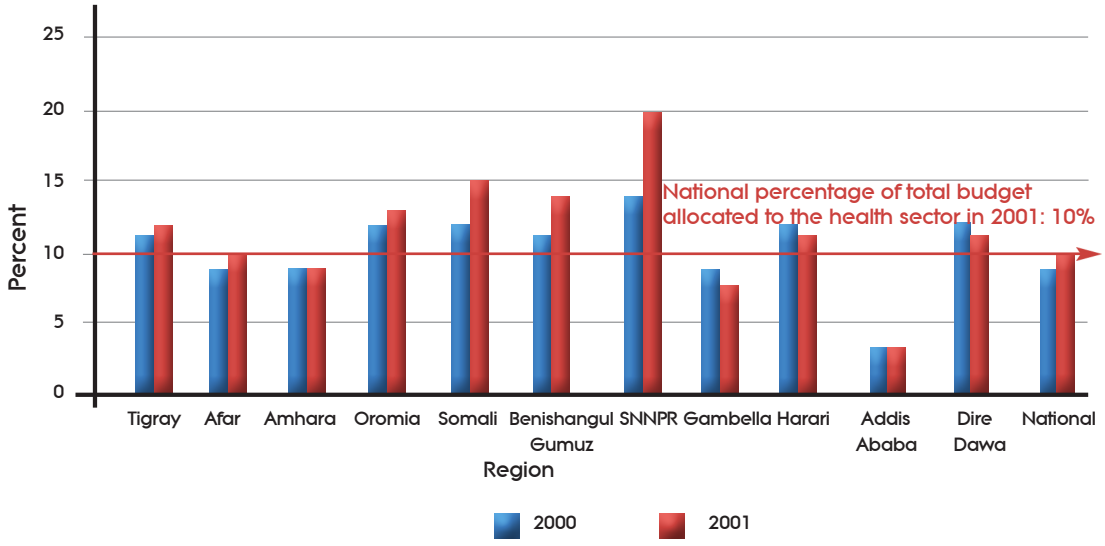

Figure 45: Distribution of the Percentage of Total Budget Allocated to the Health Sector by Region (EFY 2000 and 2001)

The total and per capita allocation of ETB 38.03 on health remains below the sector's need for delivery of accessible and quality health care services in the country. Getting timely financial data appears another constraint which shows the need to continue to advocate for better budget allocation to the health sector, strengthen implementation of the on-going HCF reform such as facility level revenue retention and use as well as facilitating the introduction of social and community based insurance.

[1] Source : MOFED report.

13.2 Per Capita Public Expenditure on Health

Per capita public expenditure on health indicates the level of resource availability for the health sector as well as the government's commitment for delivering quality health care of an acceptable standard.

As shown in the following Figure 46, there has been a general rise in the per capita public expenditure for health over the last four years. The Per capita public expenditure on health has grown from ETB 16.00 in EFY 1998 to ETB 26.60[2] in EFY 2001. An important caveat to keep in mind however is that the comparisons in the figure below do not include resources for the health sector from other sources such as out of pocket spending by individuals, expenditure from private for profit and private not for profit organizations (NGOs) and from multilateral and bilateral donors (those that are off-budget).

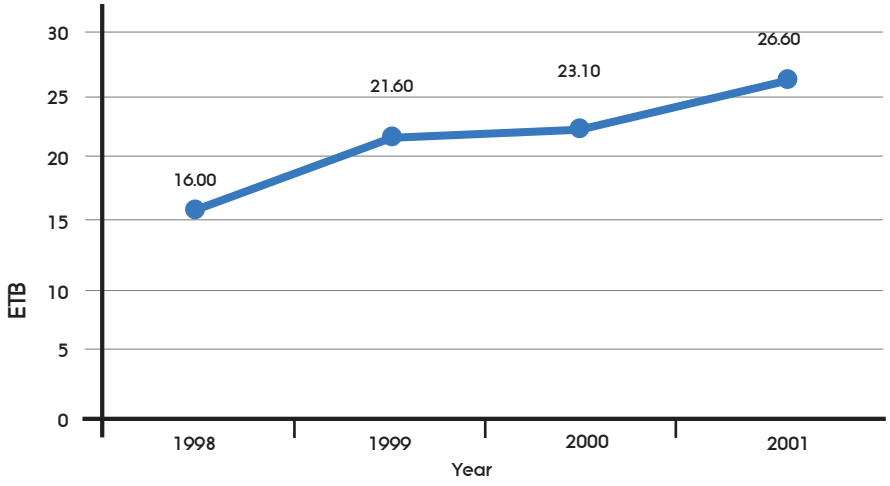

Figure 46: Trend of Per Capita Public Expenditure on Health ETB (in EFY1998-2001)

Figure 47 shows the level of per capita public expenditure of Regions in EFY 2001 and compares it with EFY 2000. Per capita public expenditure on health varied widely among the Regions from ETB 14.37 in Somali to ETB 81.37 in Harari. Somali (14.37), Oromia (15.73), Benishangul-Gumuz (17.10), Afar (20.99) and Gambella (21.23) had per capita public expenditure for health lower than the national average (26.60).

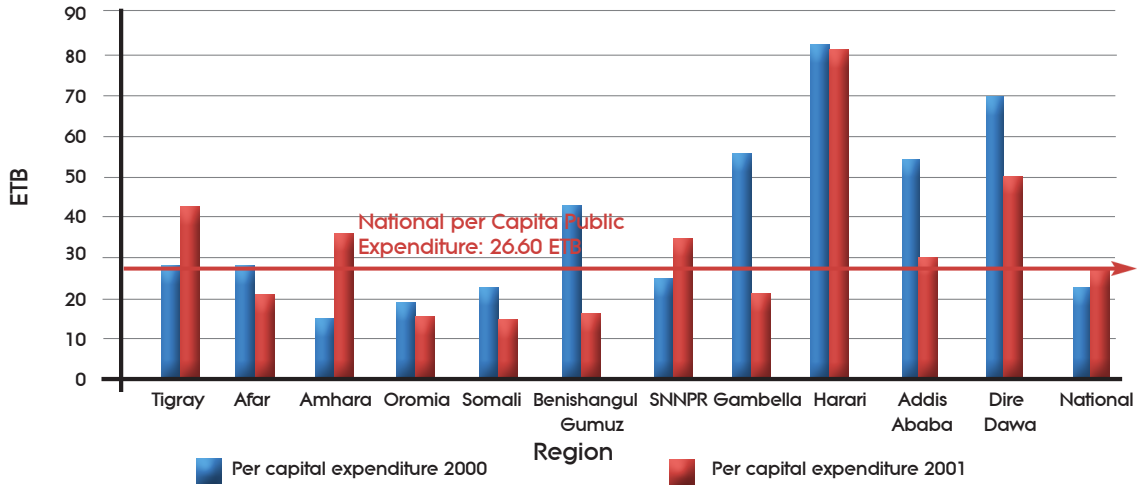

Figure 47: Comparison of Per Capita Expenditure on Health (ETB) in EFY 2000 and 2001

[2] Source : Woreda report of note is the fact that 119 Woredas (15% of the total) did not report the expenditure; therefore, there is under reporting on expenditure.

13.3 Comparison of Per Capita Public Allocation and Per Capita Public Expenditure on Health

Figure 48 compares per capita allocation with per capita expenditure on health by region. At the national level, the per capita allocation was ETB 38.03, about ETB 11 higher than the expenditure. Regions with higher allocations per capita had a slightly lower expenditure rate (Dire Dawa, Addis Ababa, and Benishangul Gumuz), while those with lower allocation show higher rates of budget utilization (Tigray, Amhara). This requires further inquiry of the reasoning behind.

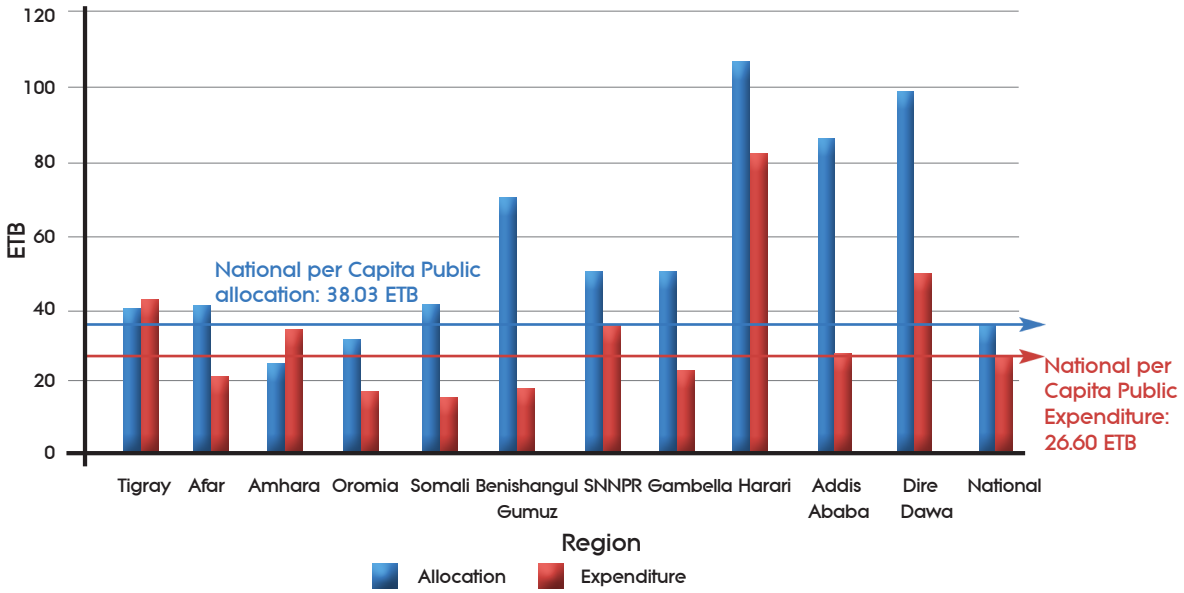

Figure 48: Comparison of Per Capita Public Allocation and Per Capita Public Expenditure on Health (ETB) EFY 2001

XIV

DEVELOPMENT PARTNERS' CONTRIBUTION TO THE HEALTH SECTOR




DEVELOPMENT PARTNERS' CONTRIBUTION TO THE HEALTH SECTOR

The following report reflects on Development Partners' (DP) contribution to the fourth year of HSDP III revealing DPs commitments and disbursement. The report also makes discussions and analysis with respect to the level of predictability of donors funds achieved so far as envisioned in the Code of Conduct and IHP+ Compact and tries to answer questions related to whether the actual external assistance to the sector is increasing as expected or not.

EFY 2001 registered remarkable progress in terms of putting the right frameworks and arrangements to implement alignment and harmonization agenda a step forward. Based on the HHM and the Code of Conduct developed and agreed earlier in the implementation of HSDP III, the IHP road map was finalized and a Compact was signed at the beginning of the fiscal year.

Table 19: Commitment and Disbursement of funds by Development Partners, EFY 2001

Source of fund	Commitment (USD)	Disbursement (USD)	Percentage of disbursement
MDG Performance Fund			
Spanish Cooperation	7,500,000.00	7,500,000.00	100
DFID	5,400,000.00	5,400,000.00	100
WHO	665,000.00	665,000.00	100
UNFPA[1]	1,000,000.00	0	-
UNICEF	-	-	-
Irish Aid	-	-	-
MoFED	-	-	-
Total MDG PF	**14,565,000.00**	**13,565,000.00**	**93.1**
GAVI			
HSS	8,025,398.00	8,025,398.00	100
ISS [2]	2,549,500.00	-	0
CSO	2,000,000.00	2,000,000.00	100
Total GAVI	**12,574,898.00**	**10,025,398.00**	**79.73**
Global Fund			
HIV/AIDS	162,200,000.00	105,000,000.00	64.7
Malaria	18,836,469.00	0	0
Tuberculosis	14,725,156.00	10,858,414.00	73.74
Total GF	**195,761,625.00**	**115,858,414.00**	**59.18**
Protection of Basic Services (Component II)			
IDA/World Bank[3]	-	-	-
CIDA	2,381,418.00	2,381,418.00	100
DFID	7,348,250.00	7,348,250.00	100
Netherlands	1,900,028.00	1,900,028.00	100
EC	52,437.25	52,437.25	100
Irish Aid	293,014.00	293,014.00	100
Total PBS	**11,794,581.25**	**11,794,581.25**	**100**

Source of fund	Commitment (USD)	Disbursement (USD)	Percentage of disbursement
Technical Assistance Health Pool Fund			
RNE/Netherlands	877,822.00	877822	100
Irish Aid	757,334.50	757,334.50	100
UNICEF	539,928.43	539,928.43	100
Austrian Development Co-operation	528,267.50	528267.5	100
DFID	298,210.50	298,210.50	100
Italian Cooperation	135,067.50	135,067.50	100
Total HPF	**3,136,630.43**	**3,136,630.43**	**100**
UN Agencies & Others			
UNICEF	11,771,819.88	11,908,455.00	101.2
WHO	2,514,500	2,171,255	86.3
UNFPA	1,880,282	1,212,077.00	64.5
USAID[4]	111,422,114.00	44,944,100.00	40.3
PEPFAR[5]	23,000,000.00	0	0
CDC[6]	11,311,805.00	2,620,000.00	23.2
Clinton foundation[7]	5,727,259	6,072,277	106
Italian Cooperation	4,081,163	4,081,163	100
JICA[8]	2,640,000.00	684,300.00	25.9
GLRA	1,461,573	1,325,031	90.7
Irish Aid[9]	900,000	0	0
Total	**176,710,515.88**	**75,018,658.00**	**42.5**
Grand Total	**414,723,816.56**	**229.579,247.18**	**55.4**

As depicted in the above table (Table 19), During EFY 2001 a total amount of 14.5 million USD was pledged to be put in to the MDG PPF by four (Spanish cooperation, DFID, and WHO, and Irish Aid) of the seven signatories of the JFA. From the total amount committed for the first year, 13 million USD has been disbursed timely by three of the signatories (Spanish cooperation, DFID, and WHO) while a total amount of 40 million USD is expected to be transferred from MoFED to MDG PPF's account soon. Of the remaining three DPs, UNFPA has made a late (100%) disbursement at the beginning of EFY 2002 while the rest, UNICEF and Irish Aid have not disbursed, nor have they confirmed their commitment for 2001.

It is worth noting that, of the DPs who signed the IHP compact; WHO, UNICEF, UNFPA, World Bank, Spanish Cooperation, DFID, and Irish Aid were finally willing to sign the Joint financial arrangement and agreed to put money in to the MDG PF. This calls for true behavioral change to practice harmonization and alignment by the rest of the DPs.

Nevertheless, The Pool has managed to collect 13 million USD at the beginning of the year securing only 13% of the initially pledged 100 million USD.

The GAVI Alliance channeled its support through three different umbrellas and made a total commitment of 12.7 million USD through the MDG Pool Fund. With 79% total disbursement out of the committed amount the smallest disbursement was under the umbrella of ISS. GAVI disbursed 100% for HSS and CSO programs on time whereas the ISS fund was disbursed only at the beginning of 2002 budget year.

The Global fund made a considerable portion of the total commitment to the sector for the fiscal year disbursing 59% of the total amount committed, where majority (73%) of Commitment for Tuberculosis and two third of HIV/AIDS' committed amount is disbursed. There was no disbursement made by the Global Fund for Malaria program during this fiscal year.

As shown in table below (figure 48) from the three pooled funding mechanisms; the Protection of Basic Services (PBS) which is a contribution from six DPs, (IDA/World Bank, CIDA, DFID, RNE/ Netherlands, EC and Irish Aid) disbursed 100% of the total committed amount for the budget year. World Bank has disbursed all the commitment for the three years (2006-2009) during the previous two years (EFY 1999 & 2000). EFY 2001 has been the last year for PBS I and the entire remaining amount from the three years commitment was disbursed.

Six Donors (RNE, Irish Aid, UNICEF, Austrian Development Cooperation, DFID and Italian Cooperation) contributing to the Technical Assistance Health Pool Fund managed by UNICEF have disbursed the entire committed amount and UNICEF is on preparation to sign an agreement (MoU) with contributors for the next Phase of the Fund.

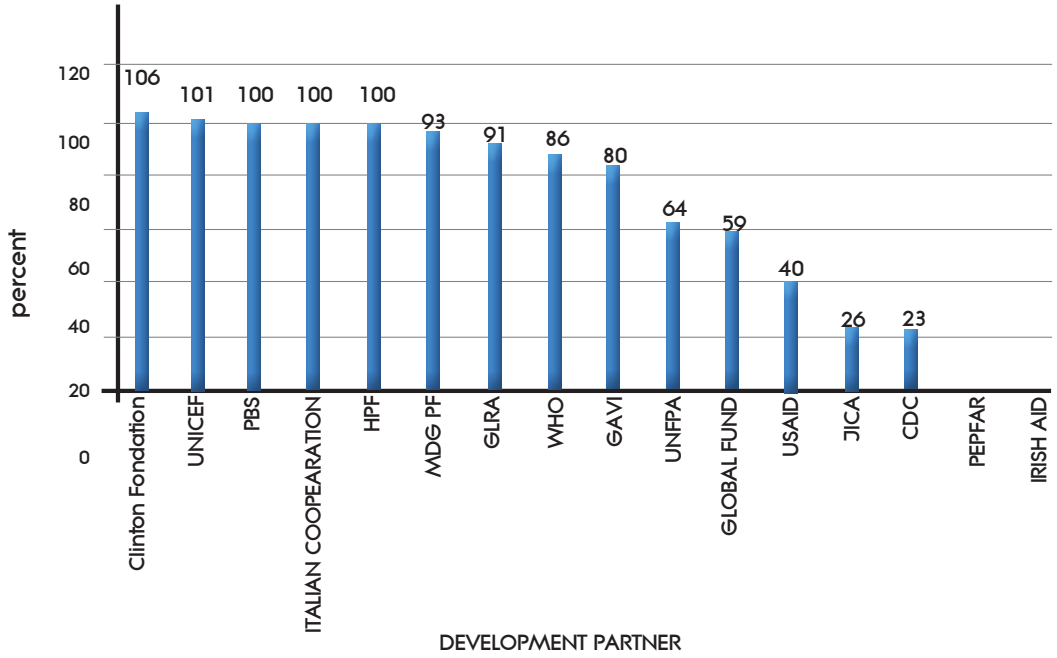

Figure 49: Percentge distribution of disbursement versus commitement by development partners (EFY 2001)

Individual DPs including UN agencies and Bilaterals through various programs have also contributed to the Health Sector during EFY 2001. The disbursement from UN Agencies made an average of 83 percent making 101%, 86%, and 64% respectively through the Biennium and the CIPAP. Disbursement by Individual DPs listed revealed uneven pattern ranging from 106% (Clinton Foundation) to zero disbursement (Irish Aid and PEPFAR). Italian cooperation to support HSDP has also managed to disburse 100%, while USAID and JICA failed to meet their commitment disbursing less than 50%.

It is worth noting that when we look at the absolute disbursement by DPs (Figure 50) during the fiscal year a significant portion came from the Global Fund to Fight TB, HIV/AIDS and Malaria constituting around 50% the total amount disbursed from DPs. Pooling arrangements through the PBS C-2, HPF-II, and MDG Performance Fund account to a proportion of 5%, 1% and 6% respectively. UN Agencies made a total of 7% contribution comprising of UNICEF, WHO, and UNFPA which contributed a proportion of 5%, 1%, and 1% respectively. In addition, Contribution from Italian cooperation, Clinton foundation, CDC, and GLRA makes a proportion of 2%, 3%, 1%, and 1% respectively. Regarding PEPFAR, only the commitment made for HC construction and renovation could be mentioned as information on the rest of the fund which is more than 300 million USD is not available.

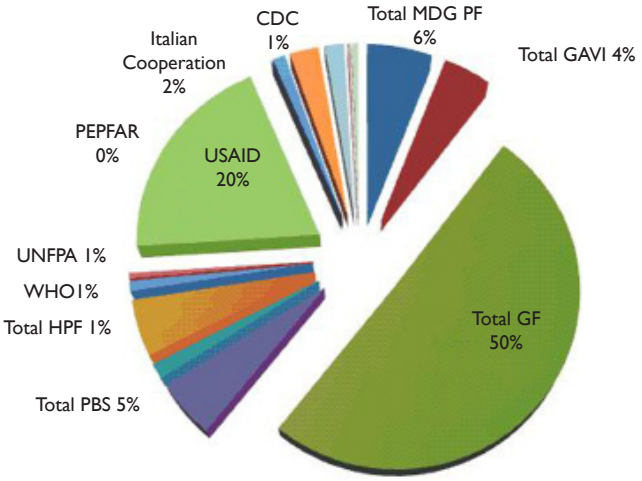

Figure 50: A Comparison of absolute Disbursement by proportion for EFY 2001

In 2001 EFY about a total of 414 million USD was committed by the above listed Development Partners, out of which only 55 % was disbursed. The over all fund disbursement rate has significantly lowered in 2001 as compared to the previous year. While total commitment for the sector has shown some degree of increment (from 406 to 414 million USD) compared to the last year, there is decline in the absolute total disbursed amount (from 331 to 229 million USD) and proportion of actual disbursement (82% to 55%). The total amount of aid disbursed and received during budget year 2001 has prominently lowered by 30% from EFY 2000's disbursement.

Some persisting challenges encountered include; inadequate cooperation by some DPs to provide reliable commitment and disbursement data when needed, inconsistencies of information obtained from various sources, and use of different calendar year by some DPs for fund disbursement. Much remains to be done in terms of abiding to the provisions of the IHP Compact and improves on the predictability of resources and additionally of funding to close the prevailing gap in financing the sector.

The utilization of the MDG Pool Fund should be encouraged further and attract many more donors to harmonize their support in 2002. The Government and DPs need to work together to make this system work as per the plan. DPs who didn't disburse significant amount of their commitments should review and tackle the problems in order to improve their contribution in 2002 EFY.

Implementation Status of MDG Pooled Fund:

As indicated on the JFA, The MDG Pooled fund is established to finance the gaps identified on the comprehensive plan. In accordance urgent gaps to be financed by the pooled fund were identified by FMOH and presented for approval to the JCCC. The specific activities were identified in line with the eligible expenditures stated on the JFA. The Activities and the status of implementation is elaborated in the next few paragraphs.

Procurement of important vaccines

Available stock of BCG, TT10 and OPV vaccines was far below the reorder point level which needed immediate intervention. Therefore FMOH proposed procurement of total quantity of 7.3million, 6.6million and 10million doses of BCG, TT10 and OPV vaccines respectively to be funded by MDG PF.

In addition AD and reconstituting syringes which will be used to provide the vaccines were also included in the approved plan. The total expenditure for the items is 3,317,271.10 USD. The preferred modality to import the vaccines is through air while the syringes are shipped.

Currently the syringes are partially delivered and the vaccines are expected to be fully delivered by mid October. The procurement process is smooth so far.

Printing of Family Folders to be used by Health Extension Workers

A family oriented health record system is to be in place by the year 2002. The Family folder will be used by Health Extension Workers to record and follow up the health status of each household. In order to make this happen, 15 million family folders has to be printed and distributed to each HP. FMOH secured 30 million birr out of the overall 95 million birr cost needed. The remaining gap of 65 million birr is covered by MDG PF.

Currently the bidding process to select a printing firm has started. However the process is a bit delayed due to procedural problems. A close follow up is in place by the policy and plan directorate of FMOH on the issue.

Procurement of Implanon®

Disease prevention and health Promotion General Directorate of the FMOH planned to provide 3 million implanon by EFY 2002. For the first quarter it is planned to procure a total quantity of 1 million implanon. Out of this, implanon costing 3.1million USD was proposed to be procured by MDG PF.

Currently the procurement process is started and being handled by UNFPA. The main challenge is that there is only single supplier internationally and there are competing orders that may delay the delivery. Negotiation has been made with the supplier to mitigate the expected delays. These negotiations appeared fruitful in terms of prioritizing deadlines.

Strengthening the communication between partners, FMOH and the supplier is recommended to effectively utilize the budget as per the intended time frame.

Fund Utilization

Regarding the fund utilization of MDG Pooled fund out of the total 13.5 million USD disbursed from Development Partners 3.3million USD (24%) is fully utilized while for USD 9.6 million (71%) the bidding process has started. The rest 663 thousand (5%) is not yet utilized. The following table will demonstrate the status of utilization.

Table 20: Summary of status of implementation of MDG PF funded activities

Eligible Expenditures on the JFA	Specific Activities	Approved Amount (USD)	Status of Utilization	Challenges Encountered	Way Forward
Procurement of Public Health Commodities	Procurement of vaccines	3,317,271.00	Syringes are under delivery Vaccines are expected to be delivered by mid October	No challenges reported	Continuous follow up
Maternal and Child Health	Procurement of Implanon®	3,100,000.00	Procurement Process Activated	No challenges reported	Continuous follow up
Health System Strengthening	Printing of Family Folders	6,500,000.00	The bidding processes started	Delay because of procedural issues	Strict and continuous follow-up on the bid process

XV

STRENGTHENING MONITORING & EVALUATION AND COORDINATION




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Monitoring and Evaluation has been an important area to undertake by the FMOH, Regions, Zones and Woredas in EFY 2001. Accordingly, the following activities were undertaken during the year.

The status of implementation of EFY 2001 has been monitored by FMOH and Regions. At the FMOH level, the monitoring of EFY 2001 plan implementation has been vigorously undertaken through the Joint Steering Committee (JSC) of the FMOH and the RHBs. This has been done as in the past year every two months.

RHBs have also been serious in undertaking monitoring the implementation of EFY 2001 plan and in the expansion and delivery of essential health services by the different levels of health facilities to improve the health status of the population in their respective Regions and to achieve the health MDGs.

Monthly meetings have been conducted at FMOH level to follow the implementation of departmental planned activities prepared on the basis of the guideline issued in EFY 2001. Departments reported physical and financial status reports, problems, constraints and bottlenecks encountered during the implementation of their planned national and departmental activities.

Work visits have been undertaken by the Federal and Regional level Management Committees and departmental teams as in the previous years to the monitor field activities especially related with epidemics prevention and control and other health related emergency outbreaks.

Supervisory visits have been undertaken in Regions to monitor the work of HEWs and model families and to motivate and inspire them for quality and expanded services. As in the past, strengths and weaknesses at the different level of the health system and particularly at the Kebele level have been discussed and measures have been taken to overcome the problems.

Similar field visits have been also undertaken by FMOH and RHB in pastoral and semi pastoral regions and areas to provide special support services related to the implementation of HEP in the concerned regions.

The Joint Coordination Committee (JCC) which comprises of the FMOH and development partners has met on a weekly basis and continued to play a decisive role in addressing coordination, harmonization, financing and monitoring issues at FMOH and Regional levels. The Joint Review Mission (JRM) has also vigorously addressed plan implementation issues at its regular meetings and at field visits.

FMOH- RHBs Joint Mid-Year Performance Review carried out to assess the progress of planned activities, indicative Federal and Regional targets for year 2002 Woreda-based plan and regional ARM have been conducted in the respective regions. The HSDP Annual Review Meeting (ARM) has been conducted in Mekelle in the presence of partners and stakeholders representing Federal, Regional, Woreda and community level institutions and organizations; including HEWs. The proceedings of the Meeting has been finalized and distributed.

In addition to this, a mid-year monitoring meeting has been undertaken with all Regions in

Adama. HSDP implementation and BPR process reports have been presented and discussed in the meeting. A plan has been set to undertake a festival in Adama town in EFY 2002 on best practices in the implementation of HSDP to acknowledge the results of Regions with best performances.

With regard to the submission of reports, six-monthly and annual reports have been submitted to the Prime Minister's Office (PMO), nine months report to Ministry of Women's Affairs and an annual PASDEP report to MOFED.

According to JRM Report, preparatory activities like training of master mentors, printing of the necessary tools and forms have been undertaken to rollout to all Federal and Regional hospitals. At regional level, training was also given to all health center and hospital staff to initiate the new HMIS facilities.

XVI
CONCLUSION




CONCLUSION

This report has presented the planned activities, major achievements, and challenges in relation to the progress in implementation of HSDP III in EFY 2001.

In the reporting year, remarkable achievements were made in the health sector. The major achievements include the finalization and implementation of the eight BPR Core Processes and five support processes and the preparation of a sector-wide Woreda-based core plan for EFY 2002. Encouraging achievements have also been observed in other areas of health system development and capacity building.

The general goals of HSDP III are to reduce child mortality, to improve maternal health; and to combat HIV/AIDS, malaria, TB and other diseases. Significant progress has been made towards the achievement of these goals, but there are also formidable challenges that affect performance. An increase in maternal health services coverage was observed in the EFY 2001. It is estimated that 24.9% of the total deliveries are currently attended by a skilled health professional in Ethiopia, and the clean and safe delivery service coverage is 10.8%. Despite the progress observed in EFY 2001, the performance is still below the target.

One of the indicators used to monitor progress towards the achievement of MDG4 is immunization coverage. In EFY 2001 Pentavalent immunization coverage was 81.6%, measles immunization coverage was 76.6%, while the percentage of fully immunized children was 65.5%. HSDP III target has been achieved already for measles immunization coverage and percentage of fully immunized children.

A cumulative number of 31,831 HEWs were trained and deployed up to end of EFY 2001, which is above the target of 30,786 (103%) set for the year. Another new development in EFY 2001, is the completion of preparatory activities and commencement of implementation of the urban HEP in seven Regions.

Encouraging results were achieved also in HIV/AIDS control in Ethiopia, with combination of stable HIV prevalence, sustained prevention efforts and increased ART coverage, making it possible to achieve MDG6. However, as in previous years, the performance in the provision of PMTCT services in EFY 2001 has shown very slow progress and the coverage has been extremely low.

A three-pronged approach has been implemented for malaria prevention and control, consisting of early diagnosis and effective treatment, selective vector control and epidemic prevention and control. In particular, Artemisinin Combination Therapy (ACT) has been used as first line treatment for falciparum malaria, complemented with the distribution of a cumulative total 22.2 million ITNs to provide each household in malarious areas with two ITNs. The main strategy to strengthen malaria prevention and control is the use of HEP, with encouraging early results. The Malaria Indicator Survey conducted in December 2007 and published in 2008, showed a steep rise in ITN coverage and use in the previous two years, in particular: in malarious areas, 66% of households were protected by at least one ITN; and that ITN use by children under five years and pregnant women increased to nearly 42% and to over 60%, respectively, in those households that own at least one net.

TB control is still far from reaching international standards for MDG achievement. TB case detection rate is still largely below the international target, while treatment success rate is almost reaching it. Despite the fact that community-based Directly Observed Treatment (DOT) is among the most cost-effective interventions in the health sector, TB detection rate in Ethiopia is still inadequate to meet the target for TB control.

EFY 2001 is the fourth year of HSDP III. All of the strategic issues included in the HSDP-III have been addressed through the Civil Service Reform Program and the BPR. These change processes need time to mature.

In addition, there are serious challenges to implementation such as: improving the low RDF capital on the part of PFSA; delay in procurement, repacking, and distribution of medical equipment to health posts and health centers; poor integration of PMTCT with ANC services; low percentage of deliveries attended by skilled health personnel; limited number of skilled and motivated human resources; slow transfer of funds to the MDG pooled fund account by some development partners and inability at regional level to fully utilize the budget and to submit financial reports on time.

In order to address these challenges, way forward has been indicated in this performance report. Some of the major measures recommended for implementation in EFY 2002 include the following:

- Focus should be increasingly on cost-effective interventions aimed at reducing maternal mortality; in particular access and utilization of Basic Emergency Obstetric Care (BEOC) and Comprehensive Emergency Obstetric Care (CEOC).
- To improve the performance in TB prevention and control, it is necessary to scale-up the community-based Directly Observed Treatment-Short course (DOTS) program, strengthen the capacity at grassroots levels, and improve the reporting system. Concerning the low rate of case detection, future strategy should consider consultation with Regions on how to strengthen the human resources and structure at regional level, increase the use of HEWs in case detection work and apply various educational means to raise the awareness of the community.
- To address challenges faced in the provision of PMTCT: it is necessary to strengthen involvement of the leadership at all levels and enhance the integrated multi-sectoral response at all levels; provide capacity building support to sector offices so that they are able to strengthen their HIV/AIDS mainstreaming efforts; and enhance the integration of counseling, testing and PMTCT in antenatal clinics as per the new BPR to increase the uptake of the service.
- The provisions of the IHP Compact have to be adhered to and the prevailing gap in financing the sector has to be addressed.
- Further strengthening of health systems is required to achieve the MDGs.
- Scaling up of HMIS and enabling it to support planning, M&E and the decision-making process should continue without fail.

In conclusion, it is hoped that ARM 2009 will look into this report very closely and come up with additional relevant recommendations and courses of action that will help to consolidate gains made so far, improve on weaknesses and accelerate implementation to achieve HSDP-III targets.