

**Federal Ministry of Health**

**Health Sector Strategic Plan**

**(HSDP-III)**

**2005/6-2009/10**

**Planning and Programming Department, 2005**

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## ACRONYMS

ADLI	Agricultural Development-Led Industrialization
AIDS	Acquired Immunodeficiency Syndrome
ALERT	All-African Leprosy Research and Training Center
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARM	Annual Review Meeting
ART	Anti Retroviral Therapy
ARV	Anti-retroviral
BCG	Bacillus Caulmette Guerin
BEOC	Basic and Emergency Obstetric Care
BOF	Bureau of Finance
BOFED	Bureau of Finance and Economic Development
CB	Capacity Building
CBOs	Community-based Organizations
CBRH	Community-based Reproductive Health
CDTI	Community based Distribution and Treatment with Ivermectin
CHAs	Community Health Agents
CHWs	Community Health Workers
CJSC	Central Joint Steering Committee
CMH	Commission on Macroeconomics and Health
CR	Consolidated Report
CRDA	Christian Relief and Development Association
CSA	Central Statistical Authority
CSR	Country Status Report on Health & Poverty
CSRP	Civil Service Reform Program
CSW	Civil Service Workers
DACA	Drug Administration and Control Authority
DAG	Development Assistance Group
D&C	Dilation and Curettage
DOTS	Directly Observed Treatment Short Course
DPPC	Disaster Prevention and Preparedness Commission
DPT	Diphtheria, Pertussis and Tetanus Vaccine
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic and Health Survey 2000
EHNRI	Ethiopian Health and Nutrition Research Institute
ENA	Essential Nutrition Actions
EFY	Ethiopian Fiscal Year
EHD	Environmental Health Department
EHSP	Essential Health Service Package
EHW	Environmental Health Worker
EOC	Emergency Obstetric Care
EPHA	Ethiopian Public Health Association
EPI	Expanded Program of Immunization
ESHE	Essential Services for Health in Ethiopia
EU	European Union
FBOs	Faith Based Organizations
FGOE	Federal Government of Ethiopia
FLHW	Front Line Health Worker
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FOAG	Federal Office of the Auditor General

FP	Family Planning
FY	Financial or Fiscal Year
GAVI	Global Alliance for Vaccines and Immunization
GC	Gregorian Calendar
GDP	Gross Domestic Product
GFATM	Global Fund Against AIDS, Tuberculosis and Malaria
GHP	Good Hygienic Practices
GMP	Good Manufacturing Practices
GNP	Gross National Product
GOE	Government of Ethiopia
HAART	Highly Active Anti Retroviral Treatment
HAPCO	HIV/AIDS Prevention and Control Office
HACCP	Hazard Analysis and Critical Control Points
HAP	Harmonization Action Plan
HCF	Health Care Financing
HCFS	Health Care Financing Strategy
HCU <sub>s</sub>	Health Care Units
HDI	Human Development Index
HEA	Health Extension Agent
HEC	Health Education Center
HEP	Health Extension Package
HESP	Health Extension Service Package
HEW	Health Extension Workers
HF	Health Facility
HIPC	Highly Indebted Poor Countries
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPN	Health, Population and Nutrition
HP <sub>s</sub>	Health Posts
HRD	Human Resource Development
HSD&QC	Health Service Delivery and Quality of Care
HSDP	Health Sector Development Programme
HSEP	Health Service Extension Programme
ICB	International Competitive Bidding
IDA	International Development Association (World Bank)
IEC/BCC	Information, Education and Communication/Behavioral Change Communication
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
ITN	Insecticide Treated Nets
JCCC	Joint Core Coordinating Committee
JCM	Joint Consultative Meeting (FMOH and HPN group)
JHPT <sub>s</sub>	Junior Health Professional Trainings
JICA	Japan International Cooperation Agency
JRM	Joint Review Mission
JSI	John Snow Incorporated
KAP	Knowledge, Attitude and Practice
KMC	Kangaroo Mother Care
LTTA	Long Term Technical Assistance
M&E	Monitoring and Evaluation
MAPPP	Medical Association of Physicians in Private Practice
MOCB	Ministry of Capacity Building

MDGs	Millennium Development Goals
MDT	Multi-Drug Therapy
MEDAC	Ministry of Economic Development and Cooperation
MEFF	Macro-Economic Fiscal Framework
MHSP	Essential Health Services Package
MMR	Maternal Mortality Rate
MOCB	Ministry of Capacity Building
MOF	Ministry of Finance
MOFED	Ministry of Finance and Economic Development
MPS	Making Pregnancy Safer
MTR	Mid Term Review
NAC	National Advisory Committee
NCB	National Competitive Bidding
NDL	National Drug List
NGOs	Non Governmental Organizations
NHA	National Health Accounts
NIDS	National Immunization Days
NNT	Neonatal Tetanus
NORAD	Norwegian Agency for International Development
OPV	Oral Polio Vaccine
OR	Operational Research
ORT	Oral Re-hydration Therapy
PAP	Programme Action Plan
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PASS	Pharmaceutical Administration and Supply Service
PEP	Public Expenditure Programme
PER	Public Expenditure Review
PHARMID	Pharmaceuticals and Medical Supplies Import and Distribution
PHCU	Primary Health Care Unit
PIM	Programme Implementation Manual
PLWHA	People Living with HIV/AIDS
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PMTCT	Prevention of Mother to Child Transmission
PPD	Planning and Programming Department
PPPH	Public-Private Partnership for Health
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
RED	Reaching Every District
RH	Reproductive Health
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
RTCs	Regional Training Centers
SAFE	Surgery, Antibiotic, Face washing and Environmental Improvement
SDPRP	Sustainable Development and Poverty Reduction Program
SNNPR	Southern Nations Nationalities and Peoples Region
SPM	Strategic Planning & Management
SPs	Special Pharmacies
STIs	Sexually Transmitted Infections
SSA	Sub Saharan Africa
TB	Tuberculosis
TBAAs	Traditional Birth Attendants
TGE	Transitional Government of Ethiopia



TLCP	Tuberculosis and Leprosy Control Programme
TOR	Terms of Reference
TOTs	Training of Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZHD	Zonal Health Department

## **Preamble**

Ethiopia has been implementing Health Sector Development Programme (HSDP) since 1997/8 (1990 EFY). The first phase of HSDP was completed in 2002 (1994 EFY) and the second phase will be completed in June 2005 (1997 EFY). This necessitated the development of the third phase of HSDP, which covers a period of five year i.e. July 2005 to June 2010.

Therefore, the Federal Ministry of Health (FMOH) established a National Planning Team (NPT), which is a multidisciplinary team of experts drawn from the different departments of FMOH in November 2005. The team was chaired by the Planning and Programming Department. The team modified the TOR already developed for the preparation of HSDP-III. This TOR was subsequently approved by the Management Committee of FMOH.

The methodologies applied during the development of HSDP-III are:

- consultation of the existing Regional Health Bureaus (RHBs) and FMOH SPMs;
- development of the document in Strategic Planning Management (SPM) format;
- alignment of HSDSP with the Millennium Development Goals (MDGs), Health Service Extension Programme (HSEP), Accelerated Expansion of Primary Health Care Services, Child Survival Strategy, the Health Human Resource Development Plan and other relevant policy documents;
- consultation of existing health sector and health sector related documents such as HSDP II, ARM proceedings, JRM reports, Country Status Report on Poverty and Health, Health and Health Related Indicators etc;
- consultation of different experts in FMOH in specific areas.

The Zero Draft of HSDSP was distributed to the Management Committee of FMOH and feedback was obtained on 2<sup>nd</sup> February 2005. The document was amended based on the comment and distributed to the RHBs, the JCCC and the HPN Donor Group for their review and comment. Subsequently, first round consultation meetings were conducted between 23<sup>rd</sup> and 31<sup>st</sup> of March 2005 with the RHBs (three days), JCCC (half day) and HPN Donor Group (half day) at FMOH.

The feedbacks obtained from these three stakeholders were carefully recorded and used to amend the document. In the mean time, the costing of HSDP-III was done by two technical experts from the World Bank and ESHE Project and included in the document. Subsequently, second round consultation was conducted with all stakeholders and the comments were incorporated to give the document the current shape.

## **EXECUTIVE SUMMARY**

### **Introduction**

Ethiopia has been implementing Health Sector Development Programme (HSDP) since 1997/8 (1990 EFY). This is the third phase of HSDP. It is developed in a Strategic Planning Management (SPM) approach through extensive consultation with the Regional and Federal stakeholders as well as HSDP Partners.

With an area of 1.1 million sq. k.m. and an estimated total population of 72.5 million in 2004, Ethiopia is the second most populous country in Sub-Saharan Africa. A very large proportion of the population (85%) lives in the rural areas. The country experiences a heavy burden of disease mainly attributed to communicable infectious diseases and nutritional deficiencies. Though potential health service coverage has reached 64% in 2004, utilization rate still remains low at 0.36 outpatient visits per capita. Shortage and high turnover of health human resource, and inadequacy of essential drugs and supplies have contributed to one of the highest maternal and child mortality rates.

### **Overview of Achievements of HSDP-I & II**

There has been encouraging improvements in the coverage and utilization of the health service over the periods of implementation of HSDP-I and II. For example, the number of Health Centers has increased from 243 in 1996 to 412 in 2001 (70 % increase at the end of HSDP-I) and subsequently to 600 in 2004. The number of Health Posts increased from 76 in 1996/97 to 1,193 in 2001 and subsequently to 4,211 in 2004. Moreover, the number of Hospitals has increased from 87 in 1996 to 110 in 2001 and then to 131 in 2004.

In terms of human resource development, the number of graduating health workers and their availability has improved over time, the most remarkable improvement being in Health Officers and Nurses. For instance, the total number of health workers has increased from 16,782 to 37,233 during the period of HSDP-I. This figure further increased to 45,860 by the year 2004 (a year before completion of HSDP-II). Moreover,

around 2,800 Health Extension Workers (HEWs) were trained and deployed and 7,138 were admitted for training in 2004/5.

During HSDP-I and II, contraceptive coverage improved from 4.0% to 25%; antenatal service from 5% to 42%; and postnatal service from 3.5% to 13.6%. Infectious and Communicable Disease prevention and control such as HIV/AIDS, malaria and tuberculosis are also showing encouraging signs of improvement.

### **Programme Description of HSDP-III**

HSDP-III is meant to serve as a comprehensive national plan and as a guiding framework for further Regional and Woreda detailed planning and implementation of the Health Sector development activities for the coming five years. Development of HSDP-III in SPM format has allowed a closer scrutiny of the strengths, weaknesses, opportunities and threats in the sector and using the analysis has helped to set coherent and relevant goals and objectives for the coming five years. The major goals of HSDP-III are improving maternal health, reducing child mortality and combating HIV/AIDS, malaria, TB and other diseases with the ultimate aim of improving the health status of the Ethiopian peoples and achieving the Millennium Development Goals (MDGs).

#### **The major objectives of HSDP-III are:**

1. to cover all rural Kebeles with Health Service Extension Programme (HSEP) to achieve universal primary health care coverage by year 2008;
2. to reduce maternal mortality ratio from 871 to 600 per 100,000 live births;
3. to reduce under five mortality rate from 123 to 85 per 1000 live births and infant (under one) mortality rate from 77 to 45 per 1000 live births;
4. to reduce total fertility rate from 5.4% to 4%;
5. to reduce the adult incidence of HIV from 0.68 to 0.65 and maintain the prevalence of HIV at 3.5;
6. to reduce morbidity attributed to malaria from 22% to 10%;
7. to reduce case fatality rate of malaria in age groups 5 years and above from 4.5% to 2% and case fatality rate in under-5 children from 5% to 2%; and
8. to reduce mortality attributed to tuberculosis from 7% to 4% of all treated cases.

## **The National and Global Policy Environment**

HSDP-III has been formulated within the following National Policy context and has tried as much as possible to harmonize the relevant goals, objectives and targets set.

- The National Health Policy;
- The Sustainable Development and Poverty Reduction Programme;
- Health Service Extension Programme;
- Accelerated Expansion of Primary Health Care Coverage;
- The Health Care Financing Strategy;
- The National Strategy for Child Survival;
- Policy and Strategy for Prevention and Control of HIV/AIDS;
- The National Health Communication Strategy;
- Health Human Resource Development Plan;
- The National Drug Policy;
- The National Population Policy;
- The National Policy on Women;
- Policy and Strategy on Democracy, Good Governance and Decentralization;
- The Capacity Building Strategy and Programme;
- The Rural Development Policy and Strategy.

More over, Ethiopia is not alien to Global Policies and Initiatives and works within their perspectives so as to contribute and benefit from them maximally. Some of these initiatives are the Global Fund to Fight HIV/AIDS (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Alliance for Vaccine Initiatives (GAVI), the Rollback Malaria Initiative (RBM), etc. Achievement of the Health Millennium Development Goals (MDGs) is, of course, one of the top Global Policies that has important bearing on the formulation and implementation of HSDP-III.

## ***Components and Targets of HSDP-III***

HSDP has been divided into seven components in order to facilitate the planning and budgeting process. These are:

- 1. Health Service Delivery and Quality of Care:** - This subcomponent focuses on strengthening the preventive, curative and promotive aspects of health care mainly through the implementation of HSEP. Maternal and child health services, HIV/AIDS, Malaria, Tuberculosis and personal and environmental hygiene will also be given due attention.

Accordingly, DPT3 coverage is expected to increase from 70% to 80%, contraceptive prevalence from 25% to 60% and the proportion of deliveries attended by skilled health workers from 9% to 32% during the programme period. In addition by the end of the programme period, VCT services will be provided in 100% of Hospitals & Health Centers and PMTCT service at 100% of the Hospitals and 70% of the Health Centers. It is also planned to increase the number of People Living with HIV/AIDS (PLWHA) on Antiretroviral Therapy (ART) from 13,000 to 263,000; the proportion of households utilizing 2 bed nets from 2% to 100%; and tuberculosis treatment success rate for smear positives from 76% to 85%.

- 2. Health Facility Construction, Expansion, Equipping and Access:** - The component aims at increasing access and improving the quality of health services through the rehabilitation of existing health facilities and construction of new ones and provision of the necessary inputs such as medical equipment and furniture.

Thus, the potential health services coverage will be increased from 72% to 100 % during the programme period through construction of new health facilities and upgrading of the existing ones. 80% of the health facilities will also be equipped and furnished as per the standard; and 30% of the Health Centers will be upgraded to enable them to provide Emergency Obstetric Care Service.

- 3. Human Resource Development:** - The HRD component aims at training and deploying of relevant and qualified health workers of different categories for the whole sector and improving the management of human resource within the public sector in order to enhance the efficiency of the health workers, retaining them within the sector and maintain a high level of professional ethics.

Hence, all health facilities will be staffed according to their respective standards and Regional Health Bureaux (RHBs) and District Health Offices (DHO) as per the demand of the organizational structure. Through these intervention, the ratio of HEWs to population is expected to reach 1:2,500; and the ratio of midwives to women of reproductive age group will increase from 1:13,388 to 1:6,759. Health Human Resource Development Strategy will be developed and implemented in order to address both the production and retention of staff in the sector.

- 4. Pharmaceutical Service:** A well functioning pharmaceutical service is the corner stone for any worthwhile health service. Thus, this intervention aims at ensuring regular and adequate supply of effective, safe and affordable essential drugs, medical supplies and equipment in the public and the private sector and ensuring their rational use.

A comprehensive Logistic Master Plan will be developed and implemented during HSDP-III. The plan is to increase availability of essential drugs from 75% to 100% in all public health facilities; to scale up the supply of imported and locally produced drugs; increase safety, efficacy and quality investigation from the present 40% to 100%; and to reduce the overall drug wastage from 8% to 1%.

- 5. Information, Education and Communication:-** This component aims at improving the Knowledge, Attitude and Practice (KAP) on personal and environmental hygiene and common illnesses and their causes; and promotion of political and community support for preventive and promotive health services through educating and influencing planners, policy makers, managers, women groups and potential end users .

Hence, the main targets are provision of appropriate health communication materials to 100% of the HEWs and equipping 100% of the Kebeles implementing HSEP with portable IEC equipment; increasing the KAP of the population on HIV/AIDS, Malaria and TB by 50% of its 2005 status; and to increase adolescent awareness and knowledge on HIV/AIDS and Sexually Transmitted Infections from 77% and 30% to 95% and 80%, respectively

**6. Health Management Information System and Monitoring and**

**Evaluation:-** The HMIS and M&E component aims at informed policy formulation, planning, programme implementation, monitoring and evaluation and at improving the knowledge and skills of health managers in these areas. It also aims at enhancing community involvement in the management of health facilities and public health interventions. The objectives of this component, is thus to implement the Civil Service Reform Programme in the health sector to ensure efficient, effective, transparent, accountable and ethical service delivery at all levels of the health system; to develop and implement a comprehensive and standardized national HMIS and M&E System so as to ensure evidence based planning and management of health services; and to harmonize the donor-government efforts in planning, reporting, monitoring and evaluation.

**7. Health Care Financing:-** The health care financing component aims at mobilizing increased resources to the health sector; promoting the efficient allocation of resources and developing a sustainable health care financing system. The targets set under this component are increasing overall health expenditure per capita from 5.6 USD to 9.6 USD; doubling the share of health as a proportion of total Government budget; and expanding the Hospital based of Special Pharmacies from 82% to 100% and that of Health Centers from 58% to 100%. In addition social health insurance will be designed and implemented for employees in the formal sector and community health insurance will be designed and pilot tested.



## **Strategies of HSDP-III**

In order to achieve the aforementioned goals and objectives, HSDP-III has adopted the following strategies:-

- Vigorous implementation of the Health Service Extension Program for the effective prevention and control of communicable disease and promotion of healthful living;
- Improving the quality of health care through provision of adequate resources, implementation of a two way referral system, enhancing the capacity of HEWs for the detection, referral and follow-up of patients, and strengthen secondary and tertiary hospitals, and referral laboratories;
- Improving the number, skills, distribution and management of health workers; ensuring the planned training of health managers in adequate number and appropriate knowledge and skills;
- Mobilize adequate financial resources, ensure efficient utilization, and strengthen sustainable financing mechanisms for the health sector;
- Improving the health information system and the capacity for effective monitoring and evaluation;
- Improving the logistic management system.
- *Ensure full community participation in the planning, implementation, monitoring and evaluation of health care;*
- Promoting intersect oral collaboration, harmonization and alignment, and coordinate the activities of the public sector, private sector, international organizations and NGOs in health interventions.

### ***1.1 Cost and Financing of HSDP-III***

HSDP-III is fully costed using the Marginal Budgeting for Bottleneck (MBB) tool. MBB is an analytical costing and budgeting tool that determines the additional cost of vital interventions and aims at helping policy makers to plan and manage health programs better. The focus of MBB on marginal cost and impact of mortality reduction makes it a particularly helpful tool to estimate the extra efforts and resources needed to reach the MDGs.

To conduct the MBB analysis, the following steps were followed:

- defining the key high impact health interventions to be integrated into existing and planned service delivery arrangements in Ethiopia;
- identifying bottlenecks hampering the implementation of these service delivery strategies;

- setting health coverage targets; and
- estimating the impact and cost of various health service delivery options.

Accordingly, the costing of HSDP-III is done in three different scenarios with the following services and cost implications:-

- Scenario One takes into account the full implementation of the HSEP through training of HEWs, construction of Health Posts and provision of the necessary drugs and supplies. It also considers enhancement of access to the Health Centers (80% access) and enabling some of them to provide Emergency Obstetric Care services. The incremental cost of this scenario would be an average of Birr 47.4 per capita per year, representing an increase of 89% of the total expenditures and almost doubling public expenditures. This scenario requires a total allocation of around Birr 19.3 Billion over five years.
- Scenario Two considers the full implementation of the Accelerated Expansion of Primary Health Care in addition to the implementation of HSEP. It also allows 53% PMTCT and 55% ART coverages. Significant increase of access to Health Centers (94% access) as well as construction of new Hospitals and renovation of the existing ones would be undertaken. The incremental cost of this scenario would be Birr 68.7 per capita per year. This scenario requires a total allocation of around Birr 27.7 Billion over five years.
- Scenario Three assumes the MDGs Needs Assessment that considers no financial constraints. It sets high level coverage targets for all interventions e.g. 64% coverage for PMTCT and 80% coverage for ART. A major construction, expansion and renovation of Hospitals is also planned under this scenario. The incremental cost of this scenario would be an average of Birr 93.8 per capita per year, and more than 200% increase in public health expenditure. This scenario requires a total allocation of around Birr 37.5 Billion over five years

In terms of the achievement of MDGs, Scenario One is considered to be a modest and pragmatic option based on the available resource, implementation capacity and the country's macro-economic framework. The scenario ensures the full achievement of MDG-4 (reducing child mortality by two third) and MDG-6 (halt and begin to reverse the spread of HIV/AIDS, the incidence of malaria and other major diseases). It will also ensure the reduction in the Maternal Mortality Ratio by 36% and possibly help to achieve about 70% of the overall goals. On the other hand, resource in line with the other scenarios will need to be in place if we were to achieve fully the Health MDGs by year 2015.

## **Programme Implementation Arrangements of HSDP-III**

The programme implementation arrangement of HSDP-III will be similar to that of HSDP-II as summarized below.

- Expanding and strengthening the scope of governance of HSDP at District level.
- Strengthening collaboration among the FMOH, RHBs and DHO.
- Widening the role of community and NGOs in planning, implementation and governance of health care delivery activities, particularly at District level.
- Strengthening Government, Donor, NGOs and Private sector collaboration.
- Harmonizing the planning, implementation, monitoring and evaluation system among the different stakeholders.
- Enhancing the effectiveness and linkage of implementation, monitoring and evaluation of HSDP at all levels of the health system.

Seventeen key indicators have been selected to monitor the progress of HSDP-III at national level. These indicators are in line with the PASDEP objectives and targets of the MDGs.

# 1. Country Profile

## 1.2 Introduction

This chapter gives an overview of the profile of Ethiopia in terms of geography and climate; population; education; administrative structure; socio-economic environment, health status and health system organization.

## 1.3 Geography and Climate

Ethiopia, located in the North Eastern part of Africa, also known as the Horn of Africa, lies between 3 and 15 degrees north latitude and 33 and 48 degrees east longitude. With a total area of around 1.1 million square kilometers, it borders with five countries - Eritrea in the north, Djibouti in the east, Sudan in the west, Kenya in the south and Somalia in the southwest. The size of the country and its location has accorded it with diverse topography, geographic and climatic zones and resources.

Its topographic features range from peaks as high as 4,550m above sea level at Ras Dashen to 110m below sea level in the Afar Depression<sup>1</sup> with most of the country, covering 40% of the land area, categorized as highland and lying above 1,500 meters above sea level. The Great East African Rift Valley divides the highland into two- the western and northern highlands and the southeastern.

There are three broad ecological zones that follow the above topography. The “Kolla” or hot lowlands are found below approximately 1,000 meters, the “Weyna Dega” between 1000-1500 meters, and “Dega” or cool temperate highlands between 1500 and 3000 meters above sea level. Mean annual temperatures range from 10-16<sup>0</sup>c in the “Dega”, 16-29<sup>0</sup>c in the “Weyna Dega” and 23-33<sup>0</sup>c in the “Kolla”. In general, the highlands receive more rain than the lowlands with annual rainfalls of 500mm to over 2000mm for the former and 300mm to 700mm in the latter. In addition, irregularity of rainfall is a characteristic of climates in Ethiopia and the country is prone to recurrent droughts and famines.

## 1.4 Population

Ethiopia’s population has been growing rapidly in recent years. It has been growing at a rate of 2.7% p.a. since 2000, which means increment by 2 million persons annually. With a total Population of 73 million in 2005<sup>2</sup>, it has become the second most populous country in Africa, following Nigeria, which has a population of 140 million. At an annual growth rate of 2.7%, the population is also expected to reach 82.1 Million by the year 2009<sup>3</sup>. Nearly half of the population (49.7%) is female. The average household size is 4.8<sup>4</sup>. 85% of the total population lives in rural areas, making Ethiopia one of the least urbanized countries in the world. As in many other developing countries the rate of growth of the urban population (4.1%) is higher than that of the total population (2.7%). Rapid population growth exacerbates critical gaps in basic health services especially when growth of the economy is low or per capita incomes are in decline.

The average population density is 57 per square km<sup>5</sup>, with great variation among regions. Higher densities are found in the highland areas, mostly above the 1,500m contour line. About 23.2% of the population is concentrated on 9% of the land area putting pressure on cultivable land and contributing to environmental degradation. On the other hand, roughly 50 percent of the land area represents sparsely populated areas with nomadic or semi-nomadic pastoral people living in arid plains or in a semi-desert environment. The settlement pattern of the population and its density greatly affect the provision of health care including the accessibility and utilization of existing health care facilities.

The structure of the population of Ethiopia shows the dominance of the young as is typical of many developing countries. About 43.5% of the population comprises those under the age of 15 years; 51.9% between the ages of 15 and 59 years and only 4.6 % aged 60 years and above. A large proportion of women (24%) are in the reproductive age (15-49 years). The main characteristic of the Ethiopian population is therefore its youthfulness, with children (0-14 years) and youth (15-24 years) together accounting for almost 64 percent of the total.

Total fertility rate for the country is high with 5.9 children per woman during the years 1995 to 2000<sup>6</sup>. The level of fertility is significantly lower in urban (TFR of 3.3) compared to rural (TFR of 6.4) areas of the country. Fertility is highest in the Oromia Region (6.4 births per woman) and lowest in Addis Ababa (1.9 births per woman).

The overall dependency ratio for the country is estimated as 85.9 dependents per 100 people in the working age group 15-64. The impact of HIV/AIDS has also been exacerbating the dependency ratio by depleting the productive group of the population.

## ***1.5 Education***

The general level of education has marked influence on the spread of diseases, the acceptability of health practices and utilization of modern health services. However, the literacy status of the population is low. The total adult literacy rate is 38% (50% for males and 26.6% for females). The gross enrollment ratio in primary schools at national level is 74.2% (67.6% for girls).<sup>7</sup> Although more than triple from the 20% enrollment level of 1994, it is still much lower than the Sub Saharan Africa (SSA) average of 86%<sup>8</sup>. This makes the population more at risk of preventable diseases including HIV/AIDS.

## ***1.6 Administrative structure***

The new Ethiopian constitution, introduced in 1994 created a federal government structure. The federal structure is composed of nine Regional States: Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Southern Nations Nationalities and Peoples Region (SNNPR), Gambella and Harrari and two city Administrations (Addis Ababa and Dire Dawa).

The National Regional States and City Administrations are further divided into 611 woredas. Woreda is the basic decentralized administrative unit and has an administrative council composed of elected members. The 611 woredas are further divided into roughly 15,000 Kebeles organized under peasant associations in rural areas (10,000 Kebeles) and urban dwellers associations (5,000 Kebeles) in towns.

The Federal state has a bicameral parliament: the House of Peoples' Representatives, whose members are elected from the regions, zones, *woredas* and *kebeles*; and the House of Federation, whose members are designated from their respective regions.

The highest governing body of the national regional states is the Regional Council with elected members and headed by a president nominated by the party that holds the majority seats. The president is assisted by heads of various regional bureaus. Each region has its own parliament and is responsible for legislative and administrative functions except for foreign affairs and defense.

With the devolution of power to regional governments, public service delivery, including health care, has to a large extent fallen under the jurisdiction of the regions. The approach has been to promote decentralization and meaningful participation of the population in local development activities. For administration of public health care, there is a Regional Health Bureau (RHB) at the Regional level. Due to the Government's commitment to further decentralize decision-making power, *woredas* are currently the basic units of planning and political administration.

### **1.7 The socio-economic environment**

Ethiopia is one of the least developed countries in the world with an estimated *per capita* income of US\$100 or US\$720 in purchasing power parity terms in 2002.<sup>9</sup> Poverty is pervasive with 47% of the population estimated to live below the poverty line. The UNDP's Human Development Index (HDI) for 2004 ranks Ethiopia 170 out of 177 countries and is estimated at 0.309<sup>1</sup>. When adjusted for gender differences, the HDI in Ethiopia drops slightly to 0.297 reflecting some gender inequality.

The Government has been implementing a comprehensive economic reform program over the past decade. This had an important bearing on developments in the health sector. Prior to 1991, economic policy was characterized by extensive Government controls, macro-economic imbalances and restriction on private sector initiative all of which resulted in low economic activity and persistent declines in economic growth. With a change of government in May 1991, new economic measures were put in place to operationalize a free market economy and redirect Government interventions to social and infrastructure development. In particular, health and education service delivery and investment in roads and water resources development were given prominence<sup>2</sup>.

The reform program has resulted in remarkable economic performance. Macro economic stability was attained and persistent declines in GDP reversed. In fact real GDP grew by an

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<sup>1</sup> The HDI measures, within one composite index, achievements (or lack thereof) in human development. It is calculated out of 1 and includes life expectancy at birth, adult literacy and school enrollment rates and adjusted per capita income in terms of purchasing power parity. To the extent that it is less than 1, the HDI reflects the shortfall in human development confirming that poverty is extensive.

<sup>2</sup> Starting with the Transitional Period Economic Policy successive Recovery and Structural Adjustment Programs, underpinned by a series of Policy Framework Papers (PFPs) agreed with the World Bank and the International Monetary Fund (IMF), were put in place to stabilize and liberalize the economy and promote private sector participation.

average of 5.8% p.a. in the period covering 1992/93- 2001/02. Seen against a population growth rate of 2.7% p.a. over the same period, this is a significant achievement. Year to year changes were however affected by external factors including the conflict with Eritrea and drought. Between 1998 and 2000 GDP growth was slowed by the conflict with Eritrea and in 2003 there was a sharp decline to a negative rate because of drought. There was a strong rebound since then with a real GDP growth rate of 11.6% in 2003/04<sup>10</sup>. The economy recovered from the exceptionally poor performances of the previous two years due to good performance in agriculture.

The policy environment created by the economic reform and macro economic stability and growth helped to address poverty in a comprehensive way through the adoption of the Sustainable Development and Poverty Reduction Program (SDPRP), which is now instrumental in prioritizing poverty related health program targets. The Government is also committed to meeting targets set by global initiatives notably, the Millennium Development Goals (MDG) and the recommendations of the WHO Commission on Macroeconomics and Health (CMH) aimed at strengthening the link between improved health and economic development.

A marked feature of the reform is the strong commitment to shift the composition of government expenditures in favor of social and economic infrastructure. Accordingly, allocations to the health sector rose from around 3% to 6% from 1991 to 1997. During the first phase of the HSDP, the share of the health sector out of total Government budget allocations was maintained at around 5-6% despite the expansion in defense expenditures due to the war with Eritrea<sup>11</sup>. Public expenditure on health as a percentage of GDP is 1.9%, with total health spending estimated at 5.6% of GDP<sup>12</sup>. Recent increased government spending on health has been complemented by fiscal decentralization and broad reforms in the administration and management of public finance.

Although spending on health both public and private has been increasing from US\$ 4 to US\$ 5.60 per capita, this is very low level compared to levels in SSA Countries i.e. Kenya (US\$31), Uganda (US\$18) and Tanzania (US \$ 8)<sup>13</sup>. Meeting the targets set by the CMH and for meeting the MDGs (about US\$34 per capita) call for substantial increases of the present levels of spending on health.

## **1.8 Health status**

Ethiopia has poor health status relative to other low-income countries, even within SSA (see Table 1-1). This is largely attributed to preventable infectious ailments and nutritional deficiencies. Infectious and communicable diseases account for about 60-80 % of the health problems in the country. The Health and Health Related Indicator of MOH indicates that malaria, helminthiasis and respiratory tract infections are the major causes of outpatient visits at the health institutions.

Widespread poverty along with general low income levels of the population, low education levels (especially among women), inadequate access to clean water and sanitation facilities and poor access to health services have contributed to the high burden of ill-health in the country.

**Table 1-1 Comparison of Ethiopian Demographic data with that of the World and Sub-Saharan African Countries in year 2005**

	Population Mid-2003 (Millions)	Births Per 1,000 Pop.	Deaths per 1000 Pop.	Rate of Natural Increase (%)	Infant Mortality Rate	Total Fertility Rate	Percent of Population of Age		Life Expectancy at Birth (Years)		
							<15	65+	Total	Male	Female
World	6,477	21	9	1.2	54	2.7	29	7	67	65	69
Ethiopia	73	39.9	12.6	2.7	77	5.9	44	3	48	47	49
Sub Saharan Africa	752	41	17	2.4	94	5.6	44	3	48	47	49

Average life expectancy at birth is also relatively low at 48 (47 for males and 49 for females)<sup>14</sup> and is further expected to decline to 49.4 years if present HIV infection rates continue<sup>15</sup>.

This situation is further aggravated by the high population growth. Young people constitute one third of the total population in Ethiopia. This implies a profound reproductive health needs. The major reproductive health problems faced by the young population in the country are gender inequality, early marriage, female genital cutting, unwanted pregnancy, closely spaced pregnancy, unsafe abortion, and Sexually Transmitted Infections (STIs) including HIV/AIDS<sup>16</sup>.

Poor nutritional status, infections and a high fertility rate, together with low levels of access to reproductive health and emergency obstetric services, contribute to one of the highest maternal mortality ratio in the world, which is 871/100,000 live births<sup>17</sup>.

Nutritional disorders rank among the top problems affecting the population in general and children and mothers in particular. Ethiopian Welfare Monitoring Survey, 2004 found that:

- 46.9% of children under the age of five years were stunted;
- 8.3% were wasted;
- 36.1% were underweight;

Infant and under five mortality are 97/1000 and 140/1000 respectively as per EDHS, 2000. Malaria remains as the major causes of morbidity as well as mortality in the country. A study conducted in year 2001 indicated that only 31% of cases of fever seen in health facilities were properly managed; only 7 % of children with malaria received early diagnosis and treatment and the case fatality rate was 5.2%<sup>18</sup>.

The HIV epidemic has taken off rapid over the last two decades and the prevalence is estimated at 4.4% of the adult population in 2003. It is also estimated that 1.5 million people are living with HIV/AIDS and this is a staggering number to cope with for a resource poor country. Although there is an encouraging result in the rate of progression of the epidemic in the last few years, the rate is not slow enough to be complacent. Given the size of the population and the magnitude of damage already inflicted, it will take a number of years to see a noticeable decline in the socio-economic impact of the disease. Likewise, despite the advances in management of the epidemic and the increasing resource availability, the condition faced is still far from the ideal, one which is unlikely to give respite in the near future.



Worldwide, non-communicable diseases account for some 60% of mortality and 47% morbidity<sup>19</sup>. Changing nutritional intake is causing an increase in the incidence of diabetes and hypertension. Increasing urbanization contributes to an increase in morbidity and mortality from traffic accidents. It is estimated that by year 2020 over 70% of the global burden of diseases will be caused by non-communicable diseases. In Ethiopia, although a national data is no available, some small-scale studies show that chronic and non-communicable diseases are emerging as public health problems. For instance, study in Butajira area, Central Ethiopia showed that 24% of the DALYs is attributed to non-communicable disease<sup>20</sup>.

Another small-scale study in Jimma indicated a prevalence rate of 7.3% for cardio-vascular diseases, hypertension, asthma, epilepsy cancer and diabetes mellitus<sup>21</sup>. Regarding mental health, studies have indicated that the prevalence of mental health problems range from 3.5% to 17% in Ethiopia with prevalence being higher among women<sup>22</sup>. Drinking of alcohol, use of stimulant “Chat” and different internal strife aggravates these problems<sup>23</sup>. In terms of DALYS, mental health problems accounted for 11% of the total loss<sup>24</sup>. Ethiopia is also known to have one of the highest road traffic accident in the world. In one study, it was reported that the road traffic injury and fatality rates were 946 and 59.5 per 10,000 registered vehicles, respectively<sup>25</sup>.

## **1.9 Health System Organization**

The Government of Ethiopia is committed to democracy and empowerment of the people. Decentralization has been used as an important instrument for the full realization of the rights and powers of the diversified population. The health policy has also emanated from commitment to democracy and gives strong emphasis to the fulfillment of the needs of the less privileged rural population.

Arguably, the most significant policy influencing HSDP design and implementation is the policy on decentralization. This is well articulated within the constitution and in a number of major and supplementary proclamations, and provides the administrative context in which health sector activities take place.

Important steps have been taken in the decentralization of the health care system. Decision-making processes in the development and implementation of the health system are shared between the Federal Ministry of Health (FMOH), the Regional Health Bureaus (RHBs) and the Woreda Health Offices. As a result of recent policy measures taken by the Government, the FMOH and the RHBs are made to function more on policy matters and technical support, while the woreda health offices have been made to play the pivotal roles of managing and coordinating the operation of the primary health care services at the woreda levels.

A Primary Health Care Service should include preventive, promotive and basic curative services. In order to realize this, HSDP I introduced a four-tier system for health service delivery, characterized by a primary health care unit (PHCU), comprising one health center and five satellite health posts, and then the district hospital, zonal hospital and specialized hospital. A PHC-unit has been planned to serve 25,000 people, while a district and a zonal hospital are each expected to serve 250,000 and 1,000,000 people respectively. The Health Sector has recently introduced an innovative health service delivery system through the implementation of the Health Service Extension Programme (HSEP). Accelerated Expansion of Primary Health

Services strategy has also been endorsed as part of facilitating the implementation of the HSEP. Furthermore, there will be a restructuring of the health service delivery system in terms of the role of the health facilities and professional mix of the staff during the implementation of HSDP-III as indicated under the Policy Framework section of this document.

Table 1:2 shows the number of health facilities and health facility to population ratio per region in 2004/05 (EFY 1997). These figures include government institutions, non-governmental organizations (NGOs) and the private sector, and the population figure is based on the CSA projections. However, it is important to note that the distribution of both the public and private health facilities is skewed towards the urban areas. The growing size and scope of the private health sector, both for profit and not-for-profit, offers an opportunity to enhance the health service coverage. An increasing number of indigenous and international NGOs are currently involved in various aspects of service delivery, and there are currently an estimated 1,578 private clinics and 19 private and 20 NGO owned hospitals in the country. In addition, there are 276 pharmacies, 381 drug shops and 1,787 rural drug vendors in the country. Responsibility for logistical support is shared between FMOH and the RHB. Health Management Information System (HMIS) has been established for routine reporting of activities and health service utilization, and structures are in place for periodic monitoring and evaluation of the health system as a whole.

**Table 1-2 Regional Distributions of Health Facilities and their ratio to Population, 2004/05**

Region	Population (P)	Hospital (H)	H/P	Health Center (HC)	HC/P	Health Post (HP)	HP/P	Private Clinic (PC)	PC/P
Tigray	4,223,014	15	281,534	48	87,979	211	20,014	31	136226
Afar	1,358,718	2	679,359	9	150,969	59	23,029	3	452906
Amhara	18,626,047	18	1,034,780	126	147,826	1421	13,108	304	61270
Oromia	25,817,132	30	860,571	185	139,552	912	28,308	672	38418
Somali	4,218,297	6	703,050	16	263,644	121	34,862	2	2109149
Ben.-Gumz	609,509	2	304,755	11	55,410	65	9,377	19	32079
SNNPR	14,489,705	17	852,336	161	89,998	1316	11,010	116	124911
Gambella	240,394	1	240,394	8	30,049	22	10,927	7	34342
Hareri	189,550	5	37,910	2	94,775	7	27,079	21	9026
Addis Ababa	2,887,615	32	90,238	29	99,573	43	67,154	382	7559
Dire Dawa	383,529	3	127,843	5	76,706	34	11,280	21	18263
National	73,043,510	131	557,584	600	121,739	4,211	17,346	1,578	46289

Source: FMOH (2004/05) Health and Health-Related Indicators

## 1.10 Health Care Coverage and Utilization

The overall potential health service coverage in EFY 1997 is estimated at 72%<sup>3</sup>. However, this varies substantially among the regions depending on their topographic and demographic characteristics. Geographical distance from a health facility and socio economic factors are the major obstacle for the bulk of the Ethiopian population. However, the trend over time shows that there is a steady increase both in coverage and utilization. The potential health service coverage has increased from 45% to 57% and then 72% during 1997, 2002 and 2005 respectively. The percapita health service utilization that was 27% until 2000 has increased to 30% in 2004 (see table 1-3).

**Table 1-3 Estimated Health Service Coverage and Utilization by Region, 2004/05**

Region	Population	Potential service coverage (%)	Outpatient visits per capita <sup>26</sup>
Tigray	4,223,014	96.5	0.8
Afar	1,358,718	71.4	-
Amhara	18,626,047	57.2	0.4
Oromia	25,817,132	67.2	0.2
Somali	4,218,297	41.6	0.1
B/Gum	609,509	190.3	0.5
SNNPR	14,489,705	90.9	0.2
Gambella	240,394	185	0.5
Harari	189,550	145.1	0.7
Addis Ababa	2,887,615	77.6	0.5
Dire Dawa	383,529	93.2	0.4
National	73,043,510	72.1	0.3

Coverage in terms of health workers remains poor. The existing number of health workers and health worker to population ratio for 2004/5 (EFY 1997) is shown in Table 1-4 below.

<sup>3</sup> Potential Health Service Coverage is calculated by multiplying the total number of PHC facilities i.e HC, HS and HP by the respective standard number of population to be served i.e 25,000 for HC, 10,000 for HS and 5000 for HP, and dividing the sum of these numbers by the total population.

**Table 1-4 Health Workers /Population Ratio, 2004/05**

Region	Population	Physician*		Nurse		Environmental Health Worker		Health Extension worker	
		No.	Ratio	No.	Ratio	No.	Ratio	No.	Ratio
Tigray	4,223,014	77	54,844	1,414	2,987	100	42,230	400	10,558
Afar	1,358,718	17	79,925	230	5,907	15	90,581	0	0
Amhara	18,626,047	131	142,184	2,004	9,294	332	56,103	718	25,942
Oromia	25,817,132	186	138,802	3,389	7,618	383	67,408	740	34,888
Somali	4,218,297	55	76,696	385	10,957	23	183,404	0	0
Benishangul	609,509	14	43,536	277	2,200	18	33,862	30	20,317
SNNPR	14,489,705	106	136,695	2,336	6,203	258	56,162	750	19,320
Gambella**	240,394	6	40,066	248	969	11	21,854	0	0
Hareri	189,550	41	4,623	214	886	11	17,232	49	3,868
Addis Ababa	2,887,615	167	17,291	610	4,734	4	721,904	0	0
Dire Dawa	383,529	30	12,784	190	2,019	15	25,569	50	7671
Central		247		713		11			
NGO		578		912		19			
OGA		354		5,403		105			
Private		444		484		7			
National	73,043,510	2453	29,777	18,809	3,883	1,312	55,673	2737	26,687
WHO Standard		1:10,000		1:5,000					

As shown in the table, the physician to population ratio is much lower than the WHO minimum standard of one physician for 10,000 people. However, it is important to note that the figure is mainly based on health workers in the public sector due to lack of complete report from the private sector while substantial number of physicians working in the private sector are also providing service to the public. Besides, health assistants are known to work at all levels of the health system and their duties are more or less similar to that of the nurses. Despite the noticeable improvement in distribution of human resources as a result of actions taken in the last decade, there is still some concentration of health workers in regional capitals and places perceived to offer better facilities than others.

### 1.11 Health Care Financing

Health services in Ethiopia are financed by four main sources. These are government (both federal and regional); bilateral and multilateral donors (both grants and loans); non-governmental organizations; and private contributions.

The National Health Accounts exercise for financial year 2000/01 revealed that the major contribution is that of households' contribution (36%), government (33%), and bilateral and multilateral donors (16%)<sup>27</sup>.

## **2. Overview of the Implementation of Health Sector Development Program-I and II**

The following topics highlight the plans, achievements and challenges encountered during the implementation of HSDP-I and II and the way forward in relation to key programmatic areas.

### **2.1. Health Service Delivery and Quality of Care**

There are five subcomponents under this component. These are the Health Service Extension Programme (HSEP), Prevention and Control of Communicable Diseases, Family Health Services, Hygiene and Environmental Health Service and Medical Services.

#### **2.1.1. The Health Service Extension Programme (HSEP)**

HSEP is a new initiative included in HSDP-II. It is an innovative community based health care delivery system aimed at creating healthy environment as well as healthful living. The main objective of HSEP is to improve access and equity to preventive essential health interventions provided at kebele and household levels with focus on sustained preventive health actions and increased health awareness. It also serves as effective mechanism for shifting health care resources from being dominantly urban to the rural areas where the majority of the country's population resides. Therefore HSEP could be considered as the most important institutional framework for achieving the MDGs.

With regard to HSEP, 16 different packages have been rigorously produced. They have been made available in Amharic and English, printed and distributed to 24 technical and vocational training institutions, RHBs and the concerned bodies in the regional states. National student selection criteria and entry requirements are adopted in all regions and the working relationship between the FLHWs and HEWs is clarified. Regional implementation guidelines have also been developed and reporting formats have been adapted to regional realities. TOT was provided to 199 health workers and they subsequently trained 2,757 female HEWs.

Pilot implementation was launched in 5 regions in 2002/03 and encouraging results were seen in terms of community's acceptance and demand for services provided through HSEP. Improvements were seen in construction and utilization of latrines, utilization rate of contraceptives and vaccination services in areas where the programme has been implemented so far. Furthermore, the HSEP has been modified to suit to the life style of the pastoralist population. In 2004/05, the total number of institutions selected and made available for training of HEWs has increased to 24 (from 14 in 2003/04). In the same year, the total number of students admitted for training is 7,138.

It is important to monitor the programme closely in order to identify areas of challenge that should be tackled and key lessons that would contribute to improved outcome. Institutional arrangements for management of HSEP at all levels, putting regular supervision in place, monitoring the quality of training and soliciting cooperation of other social sectors are areas that need attention. Moreover, with the increased service demand that will be created through the

presence of two HEWs in each kebele, the need to ensure the sustained availability of infrastructure, vaccines and contraceptives becomes paramount. There is also a need to implement the same sort of HSEP in the urban areas; and in schools through collaboration with the concerned bodies at different levels.

### 2.1.2. Family Health Service

With respect to maternal and child health services, the targets set during HSDP-I were to increase contraceptive prevalence rate from 9.8% to 15-20%; DPT3 coverage from 59.3 to 70-80%, and reduce population growth rate from 2.9% to 2.5-2.7%. The achievements at the end of HSDP-I with respect to these targets showed that contraceptive prevalence rate (CPR) increased to 17.2%, DPT3 coverage dropped to 51.5% and population growth rate as per the DHS 2000 was 2.7%. Although targets were not set for antenatal service (ANC) and postnatal service coverage at the beginning of HSDP-I, the progress with regard to these indicators showed that ANC coverage increased from 5% to 34% and postnatal service coverage increased from 3.5% to 7%.

And during HSDP-II, the targets set were to increase the DPT3 coverage from 51.5% -70%; achieve polio elimination and certification by 2003; increase TT2 for pregnant women from 27% to 70% and for non-pregnant women from 14.8% to 32%; expand IMCI implementation to 80% of the health facilities; increase CPR from 18.7% to 24%, ANC coverage from 30% to 45% and proportion of deliveries assisted by trained health workers from 10% to 25%.

The achievement by year 2004/5 indicated that CPR increased to 25.2%, ANC coverage increased to 41.5%; proportion of deliveries assisted by trained health workers declined to 12.4%; and postnatal care attendance increased to 13.6% (from 3.5% in 1989). With regard to child health, DPT3 coverage has reached 70% and proportion of fully immunized children has reached 44.4%<sup>28</sup>. Ethiopia has also been polio free for close to four years and AFP surveillance has achieved certification level standard except for the recently reported case of polio due to cross border infiltration of cases. Table 2-1 gives a summary of the targets and achievement during HSDP-I and II.

**Table 2-1-Summary of Targets and Achievements during HSDP-I and II in Maternal and Child Health Services**

Indicator	HSDP-I			HSDP-II	
	Baseline	Target	Achievement	Target	Achievement
DPT3	59.3	70-80%,	51.5	70	70.1
CPR	9.8%	15-20%	18.7	24%,	25.2
ANC	5%	-	30	45	41.5
Ass delivery	3.5%	-	7%	25	12.4
TT2 for pregnant	-	-	27	70%	43.3
TT2 for non-pregnant	-	-	14.8	32	25.8
Post natal care coverage	3.5	-	6.8	20	13.6

In order to achieve these targets, perinatal and newborn health were identified as priority area in the Health Policy. Regarding maternal and adolescent health services, priority was given to the provision of Safe Motherhood services to cater for normal pregnancies, deliveries and referral centers for high-risk pregnancies; post abortion care; addressing the sexual and reproductive needs of adolescents; encouraging paternal involvement and discouraging harmful traditional practices; appropriate nutrition education to mothers and children and provision of family planning services.

A number of operational researches have been conducted. The areas of the studies include contraceptive and logistic system, contraceptive training needs, Norplant implementation and community-based distribution, among others. A procedure manual for contraceptive logistic was also developed to implement an effective logistic system; trainings were provided to regional RH managers on contraceptive technologies and MPH courses and short courses to health workers were sponsored by UNFPA.

A National Reproductive Health Taskforce with technical working group for Making Pregnancy Safer (MPS), family planning, nutrition, STIs/HIV, logistics and adolescent RH have been formed to assist the programme with resource mobilization, monitoring and development of appropriate policies and guidelines. An advocacy material that shows the maternal and newborn mortalities in Ethiopia and their impact in terms of economic loss and loss of lives was also developed using the REDUCE module.

Making Pregnancy Safer was launched in 2001 and implemented in four regions on pilot basis. Health workers were also trained on basic emergency maternal and newborn lifesaving obstetric services, EOC, cesarean section and anesthesia. 10 hospitals and over 40 HCs were equipped with basic essential equipment and supplies, and vehicles were procured and distributed to enhance programme implementation and the referral system. The review of the programme conducted in year 2003 revealed improvement in the quality of service and handling of obstetric emergencies that stimulated the rapid scaling up of the programme coverage.

With regard to child health, IMCI was adopted nationally in 1997 as a major strategy to reduce childhood mortality and morbidity and promote childhood development. It has three components i.e. improving: the skills of health workers, health systems, family and community practices. It links preventive and curative services and programmes such as immunization, nutrition, malaria and infectious diseases are implemented in an integrated manner. The main activities under IMCI are prevention and control of ARI, diarrhea, malaria, malnutrition, measles and HIV/AIDS.

Since 2001, IMCI has been in its expansion phase, hence, 36% of health facilities are implementing IMCI and 4,303 health workers were trained (43% of the targeted 10,108). The district coverage is also about 23% (131 of the targeted 580 districts). Pre-service IMCI training is being provided to health workers of different categories in 65% of government health professional training institutions. Community IMCI activities are initiated in 9 regions while interventions are well underway in the two pilot regions (Amhara and Tigray). C-IMCI baseline surveys and needs assessment have been conducted. Moreover, essential materials for implementation of C-IMCI i.e. National Implementation Guideline and Communication Strategy, the 20 Key Family Practices for Ethiopia, training manual and Key Messages for Community

Resource Persons have been prepared and applied. The National Child Survival Strategy document, which addresses the major causes of child morbidity and mortality, was finalized and endorsed in 2004.

Furthermore, Interagency Coordination Committee (ICC) has been established and meets regularly to address issues on improving routine EPI, supplementary immunization activities and disease surveillance. This committee also plays a key role in resource mobilization for EPI. Supplemental immunization of polio, measles and neonatal tetanus was introduced in order to reach the remote areas of the country, strengthen the routine immunization activity and eradicate/eliminate the 3 vaccine preventable diseases. Several sessions of training were given to midlevel managers and cold chain technicians using Midlevel Managers and Immunization in Practice Modules. The programme has also replaced the reusable syringe by AD syringe and all injection vaccines were given using the disposable syringes and safety boxes. Since the introduction of the Reaching Every District (RED) strategy, most woredas have been developing micro-plans.

Major constraints encountered during the implementation of MCH programmes were: understaffing and high turnover of both technical and managerial staff at all levels, inadequate follow-up and supportive supervision, shortage of transportation, lack of motivation of service providers, and poorly functioning of outreach sites and weak referral system. There are also high vaccine wastage rates, critical shortage of basic equipment for the management of emergency obstetrics at facility level and short supply of contraceptives and vaccines. Regarding EPI, there is a high vaccine wastage rate (65% for BCG, 30% for measles, 20% for DPT, 15% for OPV and 10% for TT). This is mainly attributed to poor planning of static and outreach sessions, lack of awareness of the community, poor management of the cold chain system and the currently applied One Vial One Child Policy<sup>29</sup>. One of the threats to EPI is the adjournment of GAVI's support for injection materials (2002-2004) necessitating the financing of these commodities from the Government Budget and other HSDP partners.

The following are the future directions towards the improvement of MCH service.

- Operationalize the harmonization of maternal and child health programs with the Health Extension Programme.
- Accelerate capacity building at the Regional and District level for planning, training, follow up and support supervision.
- Building the capacity of training institutions to scale-up IMCI pre-service training through training of instructors and provision of financial and material support.
- Involve NGOs and the private sector to scale up maternal and child health interventions.
- Strengthen the collaboration and integration among relevant programs like RBM, EPI, Nutrition, MPS, IMCI and HIV/AIDS etc., to avoid duplication of efforts and maximize the impact.
- Optimally utilize the opportunity of the child survival initiative to scale up maternal and child health interventions.
- Introduce new vaccines against Hepatitis B and Haemophilus Influenzae.



### **2.1.3. Prevention and Control of Diseases**

The progress in prevention and control of HIV/AIDS, malaria, tuberculosis, leprosy blindness and onchocerciasis are given priority and described below.

#### **HIV/AIDS Prevention and Control Programme**

It is now more than two decades since the HIV/AIDS epidemic started in Ethiopia. HIV/AIDS was recognized as top priority from the very inception of HSDP. The plan was to prepare National HIV/AIDS Policy supporting disease prevention and case management (including home-base care), strengthen IEC/BCC, mobilization of resources and coordinating multisectoral effort to ensure proper containment of the spread of the disease and reduce its adverse socio-economic consequences.

As part of attaining these objectives, the Government issued a policy on HIV/AIDS in 1998, and a National AIDS Council, National AIDS Secretariat, and other relevant bodies have since been established and made functional. A five-year strategic plan that covers the period 2000-2004 for both central and regional levels was prepared and implemented.

The priority intervention areas in the country in relation to HIV/AIDS to date were IEC/BCC, condom promotion and distribution, voluntary counseling and testing (VCT), management of sexually transmitted infections (STIs), blood safety, infection prevention/universal precaution, prevention of mother to child transmission of HIV (PMTCT), management of opportunistic infections, care and support to the infected and affected, legislation and human rights and surveillance and research.

In order to facilitate the implementation of these interventions, a number of guidelines, manuals and other relevant documents have been prepared on counseling, case management, home-based care and other areas. The Policy on Supply and Use of Anti Retroviral Drugs has been implemented within the framework of the existing HIV/AIDS Prevention and Control Policy and Strategy. In addition, intensive and continuous advocacy has been conducted leading to the involvement of more and more NGOs, UN and Bilateral Organizations, CBOs and the community at large in the prevention and control of HIV/AIDS. A document on Social Mobilization on HIV/AIDS; and a Five Year Multisectoral Strategic Plan on HIV/AIDS have also been developed and endorsed in 2005. The strategic plan is geared towards enhancing and strengthening the ongoing multisectoral prevention and control activities. Six strategic issues have been identified in the strategic plan after a thorough analysis of limitations, gaps and achievements of the prevention and control efforts thus far. These are capacity building; community mobilization and involvement; integration with health programmes; leadership and mainstreaming; coordination and networking; and targeted response.

A lot of IEC activities have been undertaken in order to bring about the desired behavioral changes by raising the level of awareness of the population in general and the youth in particular. These activities have addressed the HIV-Epidemic supported by various partners (NGOs, Civil Society etc). A number of laboratories capable of conducting tests for HIV/AIDS have also been established throughout the country and a research institute that conducts basic and applied research on the trend of spread as well as biological properties of HIV/AIDS has been

established and is to provide essential supportive services. A system that enables the supply of laboratory reagents and HIV/AIDS test kits has been created, and a lot of work is being done by government institutions and private organizations in the supply and distribution of these supplies.

WHO has set a target of providing ART to 3 million PLWHA by 2005. Accordingly, FMOH and the Drug Administration and Control Authority have finalized the Guideline on Anti Retroviral Treatment (ART) and around 13,000 People Living with HIV/AIDS (PLWHA) are currently on ART as part of efforts made to achieve this target. Substantial amount of fund has also been secured from GFATM. Training of health workers in testing, counseling and treatment with ART is in progress. For instance, a performance level ranging from 106% to 226% of the planned target was attained in relation to training on HIV/AIDS issues in year 2003/4, which is a 30% increase compared to the previous year<sup>30</sup>. Furthermore, PMTCT guideline has been prepared and subsequently, the service is being provided at 49 health institutions in 2004 in different parts of the country in collaboration with UN, Bilateral and local NGOs. Substantial improvement has also been made in the distribution of condoms and voluntary and premarital HIV-testing by different social groups. For instance, 66 million condoms were distributed in 2004, which is a 12-fold increase compared to the previous year<sup>31</sup>.

Challenges in the implementation of the programme are weak coordination and communication at all levels, inadequate implementation of blood safety procedures, scarcity and insufficient implementation of guidelines related to HIV/AIDS, shortage of supplies required to provide care and support, and weak human resource base. It is also important to note that given the size of the population, and the magnitude of damage already inflicted, the socio-economic impact of the disease will remain with us for many years to come.

Therefore, the future endeavor will be to effectively implement the Multisectoral SPM by strengthening the Health Sector capacity, enhancing fund absorption capacity; empowering the community and building its intervention capacity; and designating and implementation of effective IEC/BCC.

### **Malaria and Other Vector-born Diseases Prevention and Control**

Malaria is one of the country's foremost health problems ranking top in the list of communicable diseases. Three quarters of the landmass of the country is malarious and around two-thirds of the population is at risk of infection. Considerable attention has been given to malaria from the very inception of HSDP in order to reduce the overall burden of the disease.

The previous vertical approach to malaria prevention and control system was abolished and the service is integrated into the basic health service delivery system in order to ensure sustainability and effective prevention and control of malaria in general and epidemics in particular. National Strategic Plan for Control of Malaria in Ethiopia is developed based on the framework of the WHO Global Roll Back Malaria (RBM) Strategy. This plan aims to reduce the burden of malaria by 25% by year 2005 and achieve the Abuja RBM target of 50% reduction by year 2010. The utilization of ITN is to be enhanced to 60% by the end of 2007. Early diagnosis and prompt treatment, spraying of houses with insecticides, distribution of ITNs and promotion of community participation in the prevention and control of malaria have been priority interventions so far.

Various malaria related guidelines, documents and training materials have been produced and applied: the National Guideline on diagnosis and treatment of malaria, Strategic Guideline on How to Scale-up ITNs Coverage and Malaria Epidemic Monitoring Guideline could be mentioned among others. Several studies especially on the efficacy of various anti-malarial drugs have also been conducted. These include studies on: malaria in pregnancy; retrospective analysis of malaria data; malaria drug resistance; and a baseline study for RBM. Based on the findings of the study, alternative drugs have been used for malaria control and treatment purpose. For instance, Artemesinine combination therapy (ACTs) has been included as treatment tool to fight drug-resistant falciparum malaria and Rapid Diagnostic Test (RDTs) is being practiced in areas of limited laboratory diagnostic capacity. Trainings have also been provided to health workers and FLHWs. Moreover, encouraging results were seen in the early diagnosis and treatment and implementation of the strategy of immediate recognition of epidemic situations through weekly monitoring of the disease.

With regard to mobilization of resources for malaria, multilateral and bilateral donors have been organized and established the Malaria Control Support Team (MCST). This team helped a lot in identifying and filling the gap in malaria prevention and control programme. Significant achievement has also been made in soliciting funds from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) during the implementation period of HSDP-II. Furthermore, costing of the full set of interventions required to achieve the MDGs with respect to reversing the course of malaria in Ethiopia has been completed.

However, shortage and high turnover of personnel, inadequate community participation and slow pace of utilization of the fund allocated from GFATM have been found to be challenging. The process of international procurements and the recruitment of consultants are also facing a number of problems and taking a long time. The other challenges in malaria prevention and control include:

- anomalous climatic change creating epidemic conditions;
- the increase in water development schemes ;
- increasing population movements;
- the emergence and spread of resistance (insecticide, drug etc);
- unaffordable and shortage of the new ACT constraining access to prompt and effective treatment at home;
- inadequate supply of long lasting ITNs;
- lack of accurate and timely information.

Concerning Onchocerciasis control programme, the plan was to expand the programme to all the highly affected districts by 2005 and eliminate the disease by 2020. The evaluation of the past performance indicated that the programme has successfully been expanded to all the affected districts. The challenges encountered are high turn over of project coordinators at different levels, complex reporting procedure and slow resource absorption capacity. The future direction is to address these challenges and sustaining the programme through enhanced integration with the basic health services and enhancing community involvement in the control of the disease.

## **TB and Leprosy Control Programme (TLCP)**

The general objective of the TLCP is to reduce the incidence and prevalence of TB and Leprosy as well as the occurrence of disability and psychological suffering related to both diseases and the mortality resulting from TB to such an extent that both diseases are no longer public health problems. The general objective has been specified for the various TLCP activities as follows:

**Case detection:** to diagnose TB and Leprosy patients at an early stage of the disease to the extent that the case detection rate of new smear positive pulmonary TB patients is at least 70% of the estimated incidence and the proportion of disability grade II among new leprosy patients is less than 10%.

**Treatment:** to achieve and maintain success rate of at least 85% of newly detected smear positive pulmonary TB patients (PTB+) and extra pulmonary TB patients treated with DOTS. For Leprosy, treatment should achieve a treatment completion rate of at least 85% and prevention of Leprosy related disability during chemotherapy should be below 3%.

As part of achieving these objectives, a five-year strategic plan has been developed with details of budget and sources of funding. This plan has also been made to fit into the MDGs. Furthermore, substantial amount of financial supports secured from GFATM, GLRA, WHO, USAID are also great achievements that will help to supplement the scarce resources allocated from the Government.

DOTS/MDT is expanded to all regions. For instance, 86% of woredas in the country and 50% of the government health facilities are implementing DOTS/MDT (32% in 2000). The treatment success rate, which is the main indicator of programme effectiveness, has reached 76%. The treatment defaulter rate has also decreased from 10% in 1998/99 to 7% in 2000/01 and then to 5% in 2003/04 for patients on short-term chemotherapy. Additionally, encouraging results were seen in the areas of integration of DOTS/MDT into the routine health service delivery. Standardized national treatment manual and basic microscopy services are also put in place.

Challenges with regard to implementation of TLCP are shortage and high turnover of staff; inadequacy of on-the-job training and supervision; inadequate involvement of communities in the implementation of DOTS; and poor communication between the public and private TB care providers. All these led to substandard quality of service. It is important to note that an effective programme is expected to achieve a treatment success rate of 85%, except in areas that are highly affected by HIV/AIDS. As Ethiopia is one of the countries that are seriously affected by HIV epidemic where more than 10% of HIV positive TB patients are dying of opportunistic infections before completing their treatment, the possibility of attaining 85% cure rate appears to be a serious challenge.

In order to alleviate these problems, there is a need to strengthen the programme implementation capacity at all levels of the health system including capacity for the efficient use of financial resources. There should be proper planning for staff allocation and regular training. Involvement of the Health Posts in TLCP implementation and improvement of community mobilization with the implementation of the HSEP is expected to enhance the effectiveness TLCP.

## **Blindness Prevention and Control Programme**

Blindness is one of the major health problems of the country. Cataract, trachoma, glaucoma and childhood blindness are the major causes of blindness in Ethiopia. Trachoma and cataract alone constitute more than 70% of the total blindness in the country. The main causes of childhood blindness appear to be corneal scarring or phthisis bulbi, which is related to measles, vitamin-A deficiency, acute infections and trauma. More than 80% of all blindness in Ethiopia is avoidable (i.e. preventable or curable).

The major targets were to develop a national strategic plan, perform about 36,000 cataract surgeries, and assist in developing an administrative directive for corneal transplantation, and to conduct survey on prevalence of blindness. After the result of the survey, it was planned to decrease the prevalence of blindness from 1.5% to 0.7%.

Accordingly, the major areas of achievement are the launching of the Global Initiative VISION 2020; establishment of National and Regional Committees for the Prevention of Blindness; development of national Five-Year Strategic VISION 2020 Plans on Eye Care; and development and Standardization of cataract surgeons' training curriculum. Additionally, an Administrative Directive was developed to establish an Eye Bank of Global standard and a National Eye Bank was established.

Moreover, the number of ophthalmologists increased from 63 to 76 and the number of primary eye care units increased from 46 to 54; and that of secondary eye care units increased from 18 to 23 in the country. The number of cataract surgeries also increased from around 20,000 per year in 2002 to 25,000 per year in 2004. The Number of lid-surgeries for trachomatous-trichiasis increased from around 15,000 in 2002 to 35,000 per year in 2004. The achievement of the target set for prevalence of blindness has not been verified since evaluation survey is not yet conducted.

Major challenges encountered during implementation of the programme are:

- lack of up-to-date national survey data on blindness and low vision
- shortage of human resources and infrastructure for eye care
- shortage of medical and surgical supplies for eye care
- inadequate budget for eye care
- poor program coordination, especially at regional and woreda level

The future direction will be to increase the number of cataract surgeries, expand the number of woredas implementing comprehensive SAFE strategy and developing and implementing a national five year strategic plan in order to achieve the goals of Vision 2020.

## **Integrated Disease Surveillance (IDS)**

HSDP-II planned establishing and strengthening integrated disease surveillance in health facilities and at the community level. In order to realize this, Ministry of Health endorsed the Integrated Disease Surveillance (IDS) strategy, adopted by the WHO Regional Committee for Africa in 1998. Subsequently, IDS Strategy was applied nationwide by following the WHO's recommended implementation steps. The country has successfully completed sensitization and

systematic assessment of national surveillance and epidemic preparedness and response systems in 1999. The findings of the assessment were used in the preparation of IDSR strategic plan covering 2000-2004 that served as the basis for the annual IDSR work plan.

The other important accomplishments were establishment of IDSR structure at all levels, development of IDSR technical guideline and training modules, successful implementation of TOT and subsequent training of around 1350 health workers from all woredas and major health facilities. A multi disciplinary IDSR taskforce was established in FMOH to advise FMOH on the implementation of IDSR and quarterly feedback bulletin has also been regularly published on IDSR. Among the major achievements so far is the improvement of timeliness of surveillance data reporting from 72% to 85% in 2004.

Challenges with regard to IDRS include:

- weak communication means hampering timely transmission of surveillance data;
- poor analysis of data and utilization at the site of collection;
- inadequate supervision;
- and high turnover of staff.

The future direction, therefore, would be strengthening the capacity for effective data generation, analysis, utilization for action, and reporting at all levels of the health system. Health extension workers will also be made to be involved actively in case detection, notification of outbreaks and community mobilization. Furthermore, attempts will be made to enhance the active involvement of health professional training institutions in integrating the concept of IDSR in the teaching process.

#### **2.1.4. Medical Services**

The plan under this component was to improve the quality of health service and utilization by the population through reorganizing the health service delivery system into four-tier system; to implement decentralized management to ensure full community participation; to develop and implement essential health service package and referral system; and to develop health facility standards and staff and equip the health facilities accordingly.

Inline with this, there has been significant transformation of the old six-tier health delivery system into the new four-tier system spearheaded by the establishment of PHCUs. A complete set of national standards for health posts, health centers and district hospitals have been prepared, endorsed, published and distributed to regions<sup>32</sup>. These standards contain specifications for the building design, lists of equipment and furniture, the scope of service, detailed information on the cadres of staff required, and drug lists for each level. Essential health service package document has been finalized and referral system guideline has been drafted.

The CSRP, which is being introduced into all public health institutions, is also showing improvements in the quality of health care. For instance, introduction of the CSRP and implementation of the Business Process Reengineering in St. Paul Specialized Hospital, Adam Hospital and Assella Hospital has shown improvements in terms of reducing the waiting time; and friendly environment.

Furthermore, health service utilization rate has increased from 0.25 in 1996/97 to 0.27 in 2000/01 and subsequently to 0.36 in EFY 2003/04. Opportunities and options for curative services including inpatient care have also improved with the increasing number of private clinics and hospitals especially in urban areas.

The challenges with regard to medical service are delayed development of the essential package of services and referral system guidelines; delayed revision of coverage calculation system; shortage of diagnosis and treatment protocols; poor drug management system; and poor human resource management and unsatisfactory professional ethics. Therefore, the future planning should properly address these areas in order to improve the quality of care and ensure adequate utilization of the health service by the public.

#### **2.1.5. Hygiene and Environmental Health**

The objective of this subcomponent is to increase the coverage of hygiene and environmental health services to the population. One of the targets was increasing access to toilet facilities from 10 % to 17%, for which the achievement was 29 % in 2003/04. Access to safe water has also improved from 23.1% in 1997/98 to 35.9% in 2003/04; while access to sanitation increased from 12.5% to 29%<sup>33</sup>.

To mention some of the implemented activities, Public Health Proclamation was issued in 2000 and Public Health Regulation has been prepared and submitted for endorsement. 47 technical guidelines, leaflets, and posters and related teaching aids on various issues of hygiene and environmental health were also produced and distributed to health facilities. Based on the Public Health Proclamation, regions have endorsed Environmental Health Regulation. Moreover, National Sanitation Strategy that supports the implementation of MDGs is prepared in collaboration with the World Bank. Water Quality monitoring by the public sector has reached 44 %. In collaboration with EHNRI, MoWR, Regional Water and Health Bureaus, WHO and UNICEF, Rapid National Water Quality Assessment is underway.

Since sanitation has a lion share in HSEP, seven packages have been produced and distributed to the regions. In addition, the same packages that suit to the context of the pastoralists have been prepared. To support food-processing plants to produce safe food and be competitive in local and international market, ten food-processing plants from dairy, meat, fruit and vegetable, flour and edible oil have been selected and started implementing HACCP with support from UNIDO. Public Health Microbiology of EHNRI has been equipped at a cost of Birr 1.2 million. Controls and inspection of imported food has shown 24 % increment in 2003/04 as compared to the 2002/03.

Provision of water and sanitation services to Health facilities i.e. 80 health centers and 20 health stations was targeted through the support of WHO. The achievement was provision of the said services to 17 health centers and 15 health stations only. Two additional International Vaccination Centers have also been opened at St. Paul and St. Peter TB. Specialized Hospital. As a result, the number of outgoing international passengers who received yellow fever and meningitis vaccination has increased from 45,977 and 34,852 in 2000/01 to 80,154 and 71,594 in 2003/04, respectively. Quarantine posts have also generated about Birr 3.4 million from the services rendered.

In spite of the abovementioned achievements, there has been low performance in the inspection of solid waste disposal (76%) and control of water sources quality (44%) in 2003/04. One of the lessons learned in the area of hygiene and environmental health services is that full commitment of all stakeholders in general and top management of RHBs in particular could result in significant achievement in short period of time. The 75 % achievement in latrine coverage of SNNPR in a year time through mobilization of communities and administrative staff's at all regional levels could be cited as best example.

Following are major challenges encountered during the implementation of the program.

- The service has not reached the majority of rural population and in some regions it is limited to urban areas focusing only on inspection of catering establishments.
- Data on sanitation coverage are scanty and varied
- Contribution of environmental health services in prevention and control of major diseases such as malaria, TB and diarrheal diseases in children is not realized and remained un-integrated into these programs.
- Hygiene education and promotional works lack systematic approaches.
- There is low level of leadership and attention for environmental health services from regional health bureaus to Woreda Health Offices. Except for salary, there is no earmarked budget for environmental health in several regions and virtually non-existence at health facility level. Environmental Health is abolished from the organizational structure in one region and downgraded in others.
- There is lack of carrier structure for sanitarians resulting in poor commitment to their job. In some regions, sanitarians are denied post basic trainings.
- Due to poor coordination system, the activities of NGO and others working in water and sanitation areas have been fragmented and difficult to monitor.

To overcome the above major challenges and constraints, there should be a radical change in the overall management of the hygiene and environmental health services, which includes the following measures-

- Intensive mobilization of communities and advocacy work in order to give due attention to the hygiene and environmental health services.
- The scope of the service has to be well understood by RHBs, Zonal and Woreda Health officials.
- The service has to be supported with budget, and donor groups involved in the health sector have to provide technical as well as financial support.
- The adopted staffing norm, which recommends “at least one sanitarian to one health centre”, has to be revisited.
- There should be a system that could capture the activities of NGO's and others involved in sanitation and hygiene promotion in order to enable effective coordination.

## 2.2. Health Facilities Construction and Rehabilitation

The objective of this component is to increase access to, and to improve the quality of, health services through the rehabilitation of existing health facilities and construction of new ones. The target during HSDP-I was to increase health service coverage from 40 to 50-55% and to further



increase to 65% from 52% during HSDP-II. It was also planned to equip and furnish PHCUs according to the standard.

In order to meet these targets, the number of government health centers has increased from 243 in 1996/97 to 412 in 2001/02 (70 % increase at the end of HSDP-I) and subsequently to 600 in 2004/05. The number of HPs increased from 76 in 1996/97 to 1,193 in 2001/02 and subsequently to 4,211 in 2004/05. Moreover, the number of hospitals has increased from 87 in 1996/97 to 110 in 2000/01 and then to 131 in 2004/05.

Furthermore, considerable rehabilitation of health facilities, and buildings and furnishing of support facilities has been undertaken. The overall picture is of an encouraging trend towards improved infrastructure at the lower levels of the health system, which strengthens access to more peripheral areas and the first level referral echelon. Consequently, the potential health service coverage has increased from 45% in 1996/97 to 72.1% by 2004/05.

In order to expand and achieve universal health coverage by the end of year 2008 and improve the delivery of primary health care service to the most neglected rural population, the Accelerated Expansion of Primary Health Service Coverage Strategy has been prepared and launched.

However, the development of a maintenance program needs to be addressed with some urgency, as do concerns with quality of construction. With further decentralization of responsibilities to woreda level, issues of limited engineering and supervisory capacity are likely to be further exacerbated. The need to strengthen “almost all” district hospitals, for example through the strengthening of laboratory services, and ensuring functioning x-ray and blood bank facilities, should not be overlooked.

Implementation capacity has been a significant constraint in undertaking civil works. Externally financed construction projects have been delayed due to non-compliance to agreed procedures. Furthermore, there is no standard way of budgeting for preventive maintenance leading to low budget allocation for this purpose.

### 2.3. Human Resource Development (HRD)

The major objective of the human resource development component of HSDP is to train and supply relevant and qualified health workers of different categories governed by professional ethics. The specific objectives are to i) supply skilled manpower in adequate number to new health facilities ii) improve the capacity of the existing health manpower working at various levels iii) initiate and strengthen continuing education and in-service training iv) review and improve the curricula of some categories of health workers and v) rationalize the categories of personnel.

It was envisaged that the practical training of different categories of health workers would take place in different levels of health institutions (the health centers, district hospitals, zonal hospitals and specialized hospitals). The training of support staff such as administrators, accountants, general technical staff, social workers etc. was expected to take place within the regular teaching institutions and recruitment, as required, to be performed following the civil

service regulations. It was also planned to provide on the job and targeted short-term training to orient the staff to specific health care service requirements.

In order to meet these objectives, the training capacity was increased and strengthened. For instance, two already existing MOE institutions with health worker training programmes (Alemaya and Dilla) started operating diploma and degree level training programmes in 1990 EFY. New training programmes and schools under RHBs were started in Arbaminch, Gambella, Jijiga, Borena and Benishangul Gumuz; a number of training institutions were expanded and rehabilitated; training materials were provided to training institutions; teachers were provided with pedagogic training; and several training curricula were revised.

Health Human Resource Development Plan was developed with projection of the required human resource by category and strategies of improving the quality of training and human resource management. The number of graduating health human resource and availability of all categories of health professionals has also improved over time, the most remarkable improvement being in health officers and nurses (see table 2.2 and 2.3). Moreover, the achievement in the training of primary health care workers was 133% and overall, the number of health workers of all categories trained in 2003/04 was 2,876, which shows an increase by nearly 64 % as compared to the 2002/03 (1,758).

Table 2-2 The increase in the production of selected categories of Health Human Resource in Ethiopia, during HSDP I and II as compared to the 1989 E.C.

Human resources category	Average No of yearly graduates			Difference at 1997 as compared to 1989
	Before HSDP 1989 & before <sup>34</sup>	HSDP I Average (1990-94) <sup>35,36</sup>	HSDP II Average (1995-97) <sup>37*</sup>	
All physicians	244	205	387	59% increase
Specialist physicians	68	63	127	87% increase
General practitioners	176	142	260	48% increase
Public health officers	46	137	251	45% increase
Nurses (except midwives)	683	667	2601	81% increase
Midwives (Senior)	90	50	75	17% decrease
Pharmacists	32	34	59	81% increase
Laboratory techn.	190	214	382	101% increase

The major challenges in relation to human resource in the sector are poor deployment and retention of all health professionals; poor human resource management; challenges in areas of training of midwives; poor quality of training due to frequent changes in the modality of training; lack of national exam to assess the trainees; shortage of budget, staff and training materials for RTCs; and irregularities of continuing educations and on the job training.

Table 2-3- The total number of available human resources for health and availability during the HSDP I and II as compared to 1989 E.C.

Human resources category	Availability to population					
	Before HSDP 1989		End HSDP I 1994		HSDP II	
	Total No	Ratio to population	Total No	Ratio to population	Total No	Ratio to population
All physicians	1,483	1: 38,619	1,888	1:35,603	2,453	1:29,777
Specialist	314	1:182,396	652	1:103,098	1,067	1:68,457
General practitioners	1,169	1: 48,992	1,236	1: 54,385	1,386	1:52,701
Public health officers	30	1: 1,909,085	484	1:138,884	776	1:94,128
Nurses Bsc, & Diploma (except midwives)	3,864	1:14,822	11,976	1:5,613	17,300	1: 4,222
Midwives (Senior)	250	1:229,090	862	1:77,981	1,509	1: 48,405
Pharmacists	156	1:367,131	118	1:569,661	191	1:382,427
Pharmacy Tech.	317	1:180,671	793	1: 84,767	1,428	1: 51,151
Environmental HW	657	1: 87,173	971	1: 69,228	1,312	1: 55,673
Laboratory technicians & technologists	621	1:92,226	1,695	1:39,657	2,837	1: 25,747

Inadequacy of guidelines for partnership between the public and private sector has also resulted in lack of a clear implementation framework in the area of training accreditation, licensing and re-establishing the system of national certifying examination for quality control and certification purpose. The other area that needs to be addressed as a matter of urgency is development of a clear guideline on deployment and transfers of health professionals at national and inter-regional levels in order to avoid the subsequent illicit behavior impacting staff morale (see sections 3.10.1 and 3.11 for the future directions).

#### **2.4. Pharmaceutical Services**

The objective of the pharmaceutical services component is to ensure a regular and adequate supply of effective, safe and affordable essential drugs, medical supplies and equipment in the public and the private sector and ensuring their rational use.

The Drug Administration and Control Authority (DACA) and Pharmaceutical Administration and Supply Services (PASS) of the Federal Ministry of Health are the two responsible bodies in the pharmaceutical sector. DACA is responsible for the overall policy implementation and administration of the sector while PASS is responsible for the procurement and supply of medical equipments and drugs to health institutions.

DACA has included the total revision of National Drug Policy (NDP) and the subsequent development of the master plan in its SPM 1996-98. The 1987 National Essential Drug List has been revised and is ready for printing. In addition, two studies entitled “Assessment of the Pharmaceutical Sector in Ethiopia (FDRE/WHO, 2003)” and the “Drug Supply and Use in Ethiopia (HCF Secretariat, 2002)” have been published. One of the most important recommendations of these studies is institutional strengthening including the availability of qualified pharmacists.

The local production of pharmaceuticals and medical supplies has increased consistently. By the end of 2003, three of the 13 pharmaceutical manufacturers have received DACA’s licenses for export. The number of importers has also increased from 49 in 2001/02 to 70 in 2003/04. Except for the drug shops that show increment from 250 to 381, the number of pharmacies has decreased from 304 to 276 and rural drug vendors from 1950 to 1787 for the period 2000-2004 (1992-97EFY)<sup>38</sup>. Drug formulary and standard treatment for different levels of health facilities have also been developed. In general, the availability of drugs in the health facilities has improved.

To build the capacity of Drug and Quality Laboratory, new equipment, including a complete condom testing equipment has been installed at a cost of Birr 3.5 million through EMSAP. Guidelines have been developed and distributed on drug and pesticide registration, adverse drug reaction reporting, drug advertising and promoting, imports and wholesalers working methods, and standard for intravenous fluid production in hospitals. Inspection guideline has also been distributed to all regions where the regional pharmacists were given delegated responsibilities for inspection and licensing. In year 2003/04 (1996EFY), achievements made in inspection of health care units and drug outlets; and in-service training on drug management were 65% and 76% of the planned targets respectively. Studies have also been conducted on adverse drug reaction monitoring and drug information.

With regard to pharmaceutical human resource, the number of diploma schools for druggists and pharmacy technicians has increased resulting in increasing number of these groups of personnel in the public sector. A school of pharmacy was also opened in Jimma University in 1994 EFY, and the same year the School of Pharmacy in AAU started two postgraduate courses. Recently, the private teaching institutions have started training in pharmaceutical areas. Several trainings have also been conducted on different topics and the produced guidelines. Moreover, a drug information bulletin is being published regularly.

The national availability of essential key drugs, based on a survey result published in 2003, was 75%, 85% and 95% for public health facilities, regional drug stores, and private retail drug outlets, respectively<sup>39</sup>. These figures were lower than the 100% target set in HSDP-I. However, the general availability of drugs has improved significantly during the period of HSDP-II. On the other hand, the general average for presence of expired drugs by year 2003 was 8%, 2% and 3% in health facilities, regional drug stores and private retail drug outlets, respectively. Although the results are not alarming, the significant variation among facilities and regions identified in the study calls for precaution and further investigation. Though drug formulary, standard treatment

guidelines for different levels of health facilities and other relevant documents have been developed at the national level, they are often not available in health facilities.

One of the challenges encountered in the field is the high attrition rate of pharmaceutical personnel to the private sector. For instance, the number of pharmacists in the public sector decreased steadily during the period of HSDP-I. Contrary to the pharmacists, the number of pharmacy technicians working in the public sector has increased steadily.

The other challenging areas are the weakness in the drug management, monitoring and evaluation system; weakness in the implementation of proclamation and some elements of NDP; low budget allocation to drugs; lack of proper stock management at health facilities as revealed by lack of stock control tools; lack of linkage between the drug registration process with inspection of manufacturing sites abroad; inadequate in-service training of health workers and shortage of stores.

Therefore, the future direction should be strengthening the overall drug management system, and improving the implementation of policy/proclamations in order to achieve the objectives set under the pharmaceutical component. The need for revision of some aspects of the National Drug Policy (NDP) is indicated by DACA and needs attention in the next steps. Attention will also be given to strengthening the medical equipment maintenance system.

### ***2.5. Information, Education and Communication (IEC)***

The objective of the IEC component was to support the development and implementation of a national IEC plan and strategy whose goals include:

- Improve health KAP about personal and environmental hygiene and common illnesses and their causes; and
- Promote political and community support for preventive and promotive health services through educating and influencing planners, policy makers, managers, women groups and potential collaborators

The activities planned were development of strategic framework and implementation guidelines, skills training for central and regional IEC coordinators, utilization of different communication channels for health information dissemination, conducting KAP and other community based studies to support IEC interventions and provision of technical support and the required inputs to the regions.

With regard to this component, implementation guidelines on promotional materials design, development and production as well as modern and traditional media use were produced and distributed. RH/IEC curriculum was developed; and training of health communicators at baccalaureate level has been started at Jimma University. A number of trainings and workshops were conducted on the abovementioned guidelines. Several sessions of IEC/ BCC messages have been broadcasted using mass media and a number of IEC materials were produced and distributed. Moreover, a National Health Communication Strategy has recently been finalized and ready for popularization, adaptation and implementation.

One of the major constraints to the implementation IEC/BCC is the delay in developing behavioral change communication strategies for national and regional levels, focusing on youth (HIV/AIDS, RH in general, personal hygiene), married couples (family planning, safe

motherhood, nutrition) and health workers (interpersonal communication and counseling)<sup>40</sup>. There is also inadequate technical capacity of staff at all levels of the health system; inadequate budgetary allocation for IEC; poor coordination of the many players both within the government and NGOs on IEC and inadequate quality monitoring system for IEC. In general, there is inadequate capacity and ineffective system for planning, implementing, monitoring and evaluation of IEC/BCC activities at all levels of the health system leading to ineffectiveness of IEC/BCC efforts to serve as vehicles through which behavioral change can be effected. Therefore, the future direction should be putting in place a system that can effectively address these areas (see 3.10.3 and 3.11).

## **2.6. Health Management and Management Information System**

### **2.6.1. Health Management**

The major objective of this subcomponent is to improve knowledge and skills in the areas of policy formulation, planning and budgeting, financial management, programme implementation and M&E for staff of FMOH, regions and woredas and enhance community involvement in the management of health facilities and community based health interventions. The objectives set during HSDP-II were implementation of the CSRP; appointment of health managers with appropriate skills; establishment of management boards, health councils etc at all levels; and revision of Programme Implementation Manual (PIM).

The achievement so far indicates that the implementation of the civil service reform is underway at all levels of the health system. Due attention has also been given to the staffing of woreda health offices for the effective implementation of decentralized health system. Encouraging results were achieved with regard to staffing of woreda health offices as per the standard; though the achievement is far from the desired. Hospital management boards have also been established in federal and some regional hospitals as part of hospital reform activities. Yet, the revision of PIM has not yet been realized.

Moreover, Management Committees at RHBs and at ZHD meet every 15 days, although in some regions weekly meetings are held to discuss on the follow-up of regular activities. Planning is increasingly being undertaken in bottom-up fashion, particularly as many regions have established woreda health offices (with varying coverage). Several regions carry out planned supervisory visits, and have developed supervision manuals that are available to health management staff at the zonal, woreda and facility levels. Most regions have undertaken activities to build capacity in management, particularly among administrative staff.

The recent drive to develop SPM created substantial momentum within FMOH and RHBs. The bottom-up approach within FMOH sparked a lot of commitment and positive energy. In most regions, trainings have been given on SPM, CSRP and SDPRP at various levels. The Majority of RHBs and FMOH have developed SPMs. It has also been found out that most of the SPMs are inline with the HSDP components. One of the components of human resource management is the result oriented performance evaluation system (ROPES) that has been initiated in some regions and linked to the SPM.

However, capacity for effective health management at all levels of the Ethiopian health system remains low, largely due to the overall shortages in human resources, and is exacerbated by high

turnover of staff in key management positions. Activities related to management capacity strengthening are also felt to have suffered disproportionately from general budget cuts. In addition, the frequency and quality of management meetings varies around the country, with implications for the quality of management at lower levels of the system. Although many health facilities have functioning management committees, participation is largely of health staff rather than community representatives as was envisaged under HSDP.

### **2.6.2. Health Management Information System (HMIS)**

The objectives HMIS is to review and strengthen the existing HMIS at federal, regional, woreda, health facility and community levels to produce timely information for planning management and efficient decision-making.

Targets set during HSDP-II were:

- Establish/ strengthen HMIS at all levels of health service delivery system
- Establish HMIS units at all levels (FMOH, RHB, woreda health offices and HF levels), and
- Establish/strengthen the database at FMOH, RHBs, woreda and health facilities.

With regard to this subcomponent, the FMOH has revised and reduced the number of reporting formats from 25 to 12 and efforts are also being made to establish networking between FOMH and RHBs. A national HMIS advisory committee (NAC) has been established with representation from different stakeholders<sup>41</sup>. NAC is established with a view to facilitating the development of a national policy and strategy on HMIS and M&E. TOR and plan of action for NAC and for integrated HMIS, M&E and ICT application in one package has also been completed. TOR has also been produced to hire a consulting firm that will accomplish specific activities that will help to establish a uniform HMIS. Furthermore, FMOH and some regions are publishing the annual Health and Health related Indicators.

Some Regional Health Bureaus have gone a step further in improving HMIS/M&E to serve as exemplary models. For instance, in Tigray, focal persons for HMIS have been assigned at regional, woreda and health facility levels. Networking through email has been implemented in 30 Woredas of this region. SNNPR RHB has also adopted a generic reporting system, produced guideline, trained staff at all levels and instituted a computerized data system. Most of the regions have adopted reporting systems on major health indicators and health sector activities based on formats developed jointly by the FMOH and the regions.

Challenges faced in relation to HMIS are lack of coordinated effort and leadership, lack of strategy and policy, shortage of skilled human resource and lack of guideline. The timeliness and completeness of HMIS reporting remains poor, and such delays contribute to the failure (at all levels) to use data as the basis for informed decision-making in planning and management. In addition, parallel reporting mechanisms persist with programmatic and donor-supported initiatives resulting in multiple reporting formats and an increased administrative workload (see section 3.11 for future direction).

### **2.7. Monitoring and Evaluation (M&E)**

The major objective of the M&E component is to strengthen the M&E system at federal and regional levels and establish a system in all woredas. The specific objectives were to:-

- Develop/strengthen a M&E system that functions at regional and woreda levels,
- Standardize M&E guidelines, harmonize supervision guidelines for RHBs and woreda health offices
- Regularly monitor progress and achievements of HSDP components as a whole and improvements in service delivery, quality of care and financial performance
- Evaluate the impact, effectiveness and cost-effectiveness of HSDP II components.

Accordingly, various monitoring and reporting mechanisms were instituted as part of HSDP, notably a) the establishment of joint steering committees, at both central and regional level, to oversee implementation, and b) regular reporting by regions and FMOH departments, as an input to two Consolidated Reports (for the previous financial year and the first six months of the current financial year). These are presented for comment at the Annual Review Meeting (ARM), which serves as a forum for sharing experience between regions, discussion of HSDP progress, and of other issues raised by stakeholders.

However, joint steering committees are not established at woreda level and the RJSC are not fully functional. The linkage between the CJSC and RJSC is also weak. The general level of timeliness and completeness of routine reporting, both by regions and relevant FMOH departments, has also been low. The ARM of HSDP is seen as one of the major fora for monitoring and evaluation of HSDP progress, yet follow-up of the findings and recommendations emanating from the meetings is inadequate.

Furthermore, the need for joint government and donor agreement on a limited set of key indicators for monitoring sector performance remains to be addressed. Regardless of whether actual financial support is pooled, the move towards a sector-wide approach in health requires that procedures for planning and monitoring of sectoral performances be increasingly harmonized, not least to reduce the administrative burden on the implementing levels.

Operational research (OR), as a critical part of M&E, does not appear to be undertaken in a coordinated manner, and suffers from limited fund allocation (with the possible exception of the Health Care Financing component).

## ***2.8. Health Care Financing***

The objectives of the Health Care Financing component are to mobilize increased resources to the health sector, promote efficient allocation of resources and develop a sustainable health care financing system. Increased resources imply local retention of revenue, cost -sharing: reduced resource leakage from high waiver, expand special pharmacies, user- fees revision and risk-sharing.

In order to materialize the objectives of HCF, background studies have been conducted; complimentary reforms have been closely monitored; and reform implementation strategy/action plan has been designed with sequencing of interventions. A study on National Health Accounts (NHA) was also conducted using the 1995/96 EFY data. Local training in health care financing and management, outsourcing, and hospital management efficiency were done. HCF strategy orientation workshops were conducted in all regions and over 1,100 people were sensitized.



The FMOH initiative to open 150 special pharmacies has been achieved. They were established in all regions and essential drugs and other medical supplies worth of 5.5 million Birr were distributed from the Federal Ministry of Health to the facilities in the regions. The establishment of private practitioners/providers association that has been facilitated by Ministry of Health is an encouraging move towards the involvement of the private sector in the realization of the Health Care Financing Strategy.

Furthermore, the preparation of a draft Health Service Delivery, Administration and Management Proclamation and five regulations (fee waiver and exemption, hospital management board, out-sourcing of non-clinical services, fee retention at facility level and establishing private wings in government hospitals) have been completed. The Proclamation and the regulations will soon be presented to Parliament for endorsement. The Health Bureau of Addis Ababa has translated most of the reforms into action, following the endorsement of the proclamation and the regulations by the regional council. Addis Ababa and SNNPR have shown an encouraging result in terms of implementing a reform on the user fee and retention of revenue generated at the health facilities respectively. Preparations are also underway to revise the existing exemption and waiver system.

To further accelerate the implementation of HCF Strategy, the following must be addressed:

- approval and endorsement of the draft proclamation and the five regulations at national level.
- intensive sensitization and awareness creation on the regulations and the HCF reform.
- capacity building in planning, budgeting, financial management, contract management in line with the Civil Service Reform Program.
- continued advocacy work on community health insurance and prepayment schemes. Together with assessing its feasibility and identifying potential community groups for introducing the scheme.

## **2.9. Crosscutting Issues**

### **2.9.1. Gender**

Gender is one of the crosscutting issues considered in HSDP-II. The targets set during HSDP-II were:-

- To create functional women's affairs departments or units at the different structure of the health service
- To increase the level of awareness of health workers and support staff on the National Policy on Women and all related aspects of gender issues;
- Increase the utilization of health services by women.

If we look at the status of these targets, the establishment of functional women's affairs units is not satisfactory. However, a number of sensitization and trainings sessions have been conducted in different parts of the country on gender issues. Regarding the utilization of health services by women, though the overall health service utilization rate has increased, it is difficult to show the status of utilization by women due to lack of gender disaggregated data.

However, is important to indicate some of the efforts made and achievements with regard to gender. Gender Mainstreaming Guideline has been produced and familiarized. The Women's

Affairs Department of FMOH has also conducted a study entitled Impact of Poverty on Women, which has closely scrutinized issues related to poor access to health services by women. One of the achievements that is worth mentioning is the decision to recruit all HEWs from women. This is expected to have a significant impact on empowerment of women as well as the effectiveness of HSEP programme.

The major weaknesses with regard to gender are poor follow-up of implementation of the guideline and the recommendation of the study, inadequate technical support to the regions due to shortage of staff at FMOH level, poor institutionalization of gender at regions and lack of gender disaggregated data that hindered proper planning and implementation of gender related activities.

### **2.9.2. Pastoralist Health Service**

Pastoralists constitute about 10% of the Ethiopian people. However, there is no appropriate health service delivery package to address their needs. Therefore, the objectives set in HSDP-II were:-

- to establish an appropriate health service delivery for the pastoralist population
- to increase coverage and utilization of health services in pastoralist population.

As part of developing appropriate health service delivery for the pastoralist population, the HSEP has been modified to suit to the context of the pastoralists. Government has also given due attention to improvement of the living conditions of pastoralists, which mainly reside in the Newly Emerging Regions. The Ministry of Federal Affairs has handled the issue of providing a multisectoral support to this group of people. A board composed of members recruited from six ministries was established under this Ministry and, subsequently, a technical committee has been set to gather momentum and coordinate multisectoral efforts geared towards provision of integrated support to the Newly Emerging Regions.

Some initiatives are underway to join intersectoral effort to promote development. For instance, the design of Pastoral Development plans in Afar & Gambella and the establishment of Pastoralist Development Commission in Oromiya could be mentioned. A concept paper, "Health Service Delivery to Pastoralists", has also been developed by FMOH. The 16 national packages have been tailored to pastoralists needs and will be translated into local languages before application.

### **2.9.3. Nutrition**

Better nutrition is key to economic growth and socio-economic development by increasing labor productivity as well as through its effect on the cognitive achievements and abilities of children. Heavy workloads and poor diet combined with frequent pregnancies also have an adverse impact on the women's nutritional status. Low birth weight is also a key factor in both under five and infant mortalities. Access to adequate health care is vital to ensure that the households will be

productive enough to secure sufficient food and thereby adequate nutritional status of all its members.

Although making adequate nutrition available to the population is the role of the Agricultural and Rural Development Sector, the Health Sector has to enhance good nutritional practice through health education and treatment of severely malnourished children. The Health Sector might also prevent nutritional health problems through provision of micronutrients to the vulnerable group of the population (mothers and children). With regard to nutrition, the Ministry of Health has developed a guideline for what Essential Nutrition Actions (ENA) should be taken that impact on nutrition. The ENA targets infant and young children under the age of 2 years, as well as women of reproductive age as main beneficiaries. The ENA, which can use the health services as their entry points, include promotion of optimal breast feeding as well as complementary feeding at six months, nutritional care of sick children during and after illness; improving women's nutrition, controlling anemia, Vit-A and iodine deficiencies. National Strategy on Infant and Young Child Feeding, Micronutrient Deficiency Control, and Management of Severe Malnutrition guidelines have been prepared and distributed for utilization.

UNICEF donated salt iodizing machines have been distributed to Ethiopian Salt Producer's Association and the follow-up for universal salt iodization is in progress. The enhanced Outreach Strategy for Nutrition, which is believed to be essential bridge for the HSEP has been launched in 325 drought affected woredas. This strategy incorporates Vit-A supplementation and nutritional screening for therapeutic feeding of the severely malnourished children as its key components.

The inadequate and erratic rain pattern predisposes the country to recurrent episodes of drought and malnutrition. With regard to this, the leadership of the federal and regional governments was good in regions where there are well-established procedures for management of crises. However, the experience in some parts of the country have revealed weak operational and management capacities of the local governments. The emergency response at the FMOH level focused on the following areas of intervention:

- conducting active surveillance;
- measles vaccinations and vitamin- A distribution campaigns;
- capacity building for health workers in case management for severely mal nourished children and management of childhood diseases;
- procurement and distribution of emergency health kits;
- establishment of temporary treatment centers for severely malnourished children and;
- strengthening referral systems.

Furthermore, special assistance was provided to regions with weak capacity. Federal DPPC and MOH deployed five mobile teams to Afar region to help the region respond to the drought, to coordinate activities and to report to the federal level on new developments.

The following are areas of challenge that need to be addressed with regard to nutrition.

- Lack of a clear ownership with regards to nutrition
- The Emergency Health Response Taskforce at FMOH level suffers from high turnover of chairpersons, minutes of meeting were not often recorded, there were no follow-ups on

previous decisions and the attendance in general was quiet low. The condition was the same in the regions.

- Shortage and irregular supply of Vit-A

## 2.10. Financial Resource allocation and Utilization

HSDP-I anticipated funding of up to 5 billion Birr over five years from budgetary (treasury funds, grants and loans) and cost recovery. It was also envisaged in PAP that increased funding to the sector would be realized through mobilizing additional resources; and a better execution was to be achieved, planning and resource management capacity was improved and external funding agencies joined under a sectoral development programme.

However, the financing of HSDP-I was below the expected level in the initial plan. Utilization rates according to officially reported expenditures also ranged from 50% to 80% of the budget over the HSDP-I period<sup>42</sup>. Nine out of the eleven regions had a budget execution rate ranging from 30% in Somali to 92% in Addis and Amhara for the year 2001/02. Almost all regions spent a larger share of their recurrent budget compared with their capital budgets while the Federal Ministry of Health spent a significantly larger share of its capital budget. User fee did not contribute to the funding of HSDP-I with the exception of SNNPR hospitals that were able to retain 50% of their revenues in the later years of HSDP-I.

The total budget required for the implementation of HSDP-II was 6.8 billion Birr. A closer observation of the two phases of HSDP shows a progressively increasing trend of budget allocation and resource mobilization in HSDP-II. For instance, Government budget allocation for year 2002/03 (EFY 1995) was 1.5 Billion Birr and percapita allocation was Birr 22.25<sup>43</sup>. This is an increase by 46% and 42%, respectively as compared to the figures for year 2001/02 (EFY 1994) (1.05 Billion and 15.7 Birr respectively). The budget utilization rate, both for recurrent and capital, has also shown an encouraging improvement over the two years of implementation of HSDP-II (see Table 2-4).

**Table 2-4 Capital and Recurrent Health Budget Utilization Rate for the year 2002/03 to 2004/04 by Region**

Region	2002/03		2003/04		2004/05	
	Recurrent	Capital	*Recurrent	Capital	*Recurrent	Capital
Tigray	99	25	95	28	87	19
Afar	21	42	221	26	83	80
Amhara	51	2	79	29	95	49

Oromia	26	26	56	16	78	25
Somali	113	24	87	24	86	152
Ben-Gum	80	30	96	22	100	60
SNNPR	37	19	82	13	126	3
Gambella	79	45	123	29	79	46.2
Hareri	83	38	97	40	103	66
Addis Ababa	136	3	88	53	105	3
Dire Dawa	89	27	82	35	96	119
Federal MOH	93	702	**84	805	87	87
National	52	58	82	73	89	52

*\*From treasury source*

*\*\*From treasury, assistance and external loan sources*

Implementation of the expansion of the Special Pharmacies (SP) has also been successful during HSDP-II. SPs have an increased role in improving drug availability by filling the shortage of the recurrent drug budget in health facilities when drug support phases out. Resource mobilization from grant has also been remarkable, especially from the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis. Although it is difficult to speculate the overall financial utilization rate of the programme since HSDP-II is not yet fully evaluated, the two ARMs of HSDP have raised concerns over the low speed in utilizing this fund and inadequacy of budget at the operational level.

The main challenges with regard to mobilization and efficient uses of financial resources are:

- lack of a common implementation procedures among the Donors and the Government (one plan-one budget-one report)
- under reporting of financial utilization
- greater spending of health budget on tertiary curative services than preventive primary services

### **3. Health Sector Development Programme-III**

#### **3.1. The Policy Framework**

##### **3.1.1. Introduction**

Health care is one of the crucial components of basic social services that has a direct linkage to the growth and development of a country as well as to the welfare of a society. Effective planning and implementation of health services requires mobilization of the collective efforts of the relevant national and international organizations. One of the mechanisms to ensure this collaboration is harmonization of health policies, strategies and implementation modalities with national and global perspectives to create synergy and to enhance the efficiency and effectiveness of health service delivery. As has clearly been articulated in the various health sector documents, both HSDP-I and HSDP-II were sector-wide approaches implemented within the context of these national and international policy environments. This section, therefore, deals with the national and global policy contexts that are taken into account during the formulation of HSDP-III.

The formulation of HSDP-III will be a five-year programme intended to be implemented from 2005/06 to 2009/10 (July 1997 EFY to June 2002 EFY). The main policy contexts that are considered during the design and implementation of HSDP-III are a commitment towards the achievement of MDGs by aligning HSDP-III with the PASDEP; institutionalization of community health services through the implementation of HSEP (rural, urban, pastoralist and school); the conjoint Accelerated Expansion of PHC Services; implementation of Health Human Resource Development Plan, the Health Care Financing Strategy, Essential Health Service Package, Child Survival Strategy, the National Reproductive Health Strategy, and the National Health Communication Strategy.

Other policies that have important bearing on the Health Sector Development are the National Drug Policy, National HIV/AIDS Policy, National Women's Policy and National Population Policy. Moreover, the ongoing political and administrative reforms and strategies such as Agricultural Development Led Industrialization (ADLI), Rural Development Policy and Strategy, Policy on Decentralization, and Capacity Building Programme are very important policy initiatives.

##### **3.1.2. National Policy Context**

The following are the National Policy contexts that will be taken into account during the planning and implementation of HSDP-III.

##### **The National Health Policy**

The Government of Ethiopia formulated the National Health Policy in 1993. The policy emanated from commitment to democracy and gives strong emphasis to the fulfillment of the needs of the less privileged rural population that constitutes about 85% of the total population in Ethiopia. The Health Policy mainly focuses on:

- Democratization and decentralization of the health system;
- Development of the preventive and promotive components of the health service;
- Ensuring accessibility of health care to all population;

- Promoting inter-sectoral collaboration, involvement of the NGOs and the private sector; and
- Promoting and enhancing national self-reliance in health development by mobilizing and efficiently utilizing internal and external resources.

The health policy has also identified the priority intervention areas and strategies to be employed to achieve the health policy issues.

### **The Plan for Accelerated and Sustained Development to end Poverty**

Over the last decade, the Government has recognized the intimate relationship and greater linkage between health improvements and economic development and, as a result, it has given the health sector development utmost priority. The policy environment created by economic reform and macro economic stability in Ethiopia has also helped in addressing poverty in a comprehensive way through the adoption of SDPRP and subsequently PASDEP. PASDEP is a national development programme as well as the main poverty reduction strategy document. It is also an evidence of the Government's commitment to the MDGs. PASDEP is inclusive of all the MDG relevant sectors (Health, Education, Road and Water, etc) and most of the targets for the sector programs are inline with MDGs.

HSDP is the main medium of translating the health component of the PASDEP with minimum targets more or less similar with the MDGs. As described above, three of the 8 MDGs are directly related with the Health Sector i.e. reduction of under-5mortality rate by two-third and maternal mortality ratio by three-fourth as well as halting and reversing the spread of HIV/AIDS by 2015. Inline with this, MMR, U5MR and HIV/AIDS, malaria and other diseases of public health importance are among the major issues for which objectives, strategies have been set with detailed indication of key activities in HSDP-III.

The formulation of HSDP-III needs to focus on the prevention and control of poverty related diseases through the adoption of innovative and practical strategies to enhance the achievement of the MDGs. The analysis of the current health situation in Ethiopia clearly shows that reaching the MDGs implies not only a dramatic scaling up of key services, but also implementation of mechanisms to ensure adequate and efficient utilization of the services by the whole community, particularly by the rural populations, the poor women and children. In order to materialize this, high impact and community based health interventions like the Health Service Extension Programme (HSEP), Accelerated Expansion of Primary Health Care Facilities and Essential Health Service Packages become important.

### **Health Service Extension Programme**

As clearly stipulated in HSDP-II, HSEP is introduced in recognition of failure of essential services to reach the people at the grassroots level. As such, it constitutes all the key activities necessary for rapid development, particularly primary health care. The pilot phase was completed and nationwide implementation has recently commenced.

HSEP includes 16 packages in four main areas:

#### **1. Hygiene and environmental sanitation**

This area shares seven of the sixteen packages. These are:

- proper and safe excreta disposal system;
- proper and safe solid and liquid waste management;

- water supply safety measures;
- food hygiene and safety measures;
- healthy home environment;
- arthropods and rodent control; and
- personal hygiene.

## 2. Disease prevention and control

This area shares four of the sixteen packages. These are:

- HIV/AIDS prevention and control;
- TB prevention and control;
- Malaria prevention and control; and
- first aid

## 3. Family health services

This area shares five of the sixteen packages. These are:

- maternal and child health;
- family planning;
- immunization;
- adolescent reproductive health; and
- nutrition.

## 4. Health Education and Communication

HSEP is implemented in the following modalities:

- 1) an outreach programme centered around rapid vocational training of health extension workers, two per kebele, and construction and equipping of health posts (a health post per kebeles) through Accelerated Expansion of PHC Facilities, which is described below. These health extension workers are civil servants and will offer key technical services such as immunization and family planning, to each kebele (5000 inhabitants).
- 2) a community promotion programme centered around volunteer/private sector community promoters/TBAs, working under the supervision/guidance of the health extension worker and providing support to households for behavioral change (e.g. breast feeding, complementary feeding, immunization, use of bed nets, clean delivery etc). The previous Frontline Health Workers (CHAs, TBAs etc) will be incorporated into the system by serving as volunteers that work under the supervision of the Health Extension Workers.
- 3) a programme strengthening the quality of and demand for clinical care particularly treatment of diarrhea, malaria in children, assisted delivery, early referral for mothers and children with danger signs, HIV testing and counseling as well as prevention of mother to child transmission in existing health stations and health centers.

In order to facilitate these interventions:

- it is planned to train 30,000 HEWs;
- it will be necessary to rationalize the number and professional mix of staff at HCs commensurate with their new role;
- the existing Health Stations (HS) will be progressively upgraded to HCs or downgraded to HPs as appropriate;
- Woreda Health Offices are expected to be staffed with the required management and supervisory professional staff; and
- availability of drugs and medical supplies will be ensured.



The following modifications will also be made to facilitate the implementation of HSEP in pastoralist areas:

- implementation of outreach health service since it is cheaper and more appropriate to the life style of the pastoralists than the mobile style;
- training of 6th graders as HEWs for 6 months;
- recruitment and training of CHAs and TBAs among literate, traditional healers or religious leaders; and
- establishment of a modified PHCU.

### **Accelerated Expansion of Primary Health Care Coverage**

There is a very high unmet health care need in rural Ethiopia that needs to be addressed through rapid expansion of PHC services. Expansion in terms of improving physical availability of essential health services will reduce distance between facilities and users. Although the construction of additional facilities and rehabilitation is a major component of HSDP II, recent reviews of the implementation of HSDP II raised concerns over the speed of the expansion. The report clearly emphasized that despite major efforts in this regard, majority of the population still remains uncovered by PHC services and the trend will continue if the present pace of implementation is maintained. Moreover, achievement of the targets set by the PASDEP, MDGs and the recommendations of WHO's Commission on Macroeconomics and Health (CMH) aimed at improved health and economic development will be difficult. For instance recent studies clearly indicate that:

- reduction of poverty and achievement of the development goals of the country requires a much faster implementation and scaling up of development of the health sector;
- meeting the MDGs would be impossible unless implementations are accelerated and interventions are scaled up.

Cognizant of these facts, the Accelerated Expansion of PHC Coverage Strategy has already been developed and endorsed by the government with a view to achieving universal coverage of primary health care to the rural population by 2008. It proposes a faster rate of establishment of primary health care facilities as an essential institutional framework to scale up PHC and for the successful implementation of HSEP. Therefore, new health posts will be constructed and equipped in order to support the provision of preventive and promotive health service to rural populations through the HSEP. Besides, construction and equipping of new health centers and upgrading of health stations to health centers will be undertaken. Maintenance of health facilities and medical equipment will also be implemented in a planned and systematic way by the responsible institutions in the health sector.

The facility expansion calls for significant additions of health professionals and supervisory staff. Based on the current standard staffing pattern, 10 health professionals and 12 administrative and supportive staff are needed for a health center and 2 health extension workers will be posted per a health post. In view of the huge resource outlay in terms of facilities, human resource and finance, that will be required, the Accelerated Expansion of PHC services has proposed realistic strategies.

## **The Health Care Financing Strategy**

The Health Care Financing Strategy of Ethiopia that was developed and implemented since 1998 has the aim of increasing resource flow to the Health Sector; improving efficiency of resource utilization; and ensuring sustainability of the financing system in order to improve the coverage and quality of health service.

The strategy was developed based on the realization of the low Government spending on health, low percapita health expenditure in the country, and the highly skewed health resource allocation in favor of the urban centers. In order to alleviate these problems, it proposes alternative financing methods, mechanisms of resource mobilization, efficient utilization, and ensuring sustainability.

The Health Care Financing Strategy and the subsidiary guidelines that were produced to realize the execution of the strategy will be vigorously implemented in the period of HSDP-III. Furthermore, the Government is committed to introducing an appropriate health insurance system both for the formal and informal sector employees.

## **The National Strategy for Child Survival**

The National Child Survival Strategy that has already been finalized has the overall objective of reducing under-five mortality to 67/1000 population by 2015 to achieve the MDGs. The strategy addresses the major causes of child mortality that account for 90% of under five deaths i.e. pneumonia, neonatal conditions, malaria, diarrhea, measles, malnutrition and HIV/AIDS as underlying condition. It aims to reduce neonatal, child and under-five mortality rates proportionally. The full implementation of the Child Survival Interventions will enable a reduction in Under-five mortality by 48% by 2009 and by 61% by 2015, which is greater than the MDGs target of reduction of Under-five by 52%. The objectives, strategies and key activities of the strategy have been fully articulated into the various components of HSDP-III in order to avoid repetitions.

High impact and cost-effective child survival interventions will be implemented at high coverage levels by focusing on children of the poorest and most marginalized sections of the population. These interventions will be delivered through the provision of services at:

- family and community level
- population oriented/outreach
- and clinical/health facility basis.

The strategy also contributes to the reduction of maternal mortality (by 36%) through ensuring the availability of good quality essential health care for women at the health facilities as well as in the community through integration with the HSEP.

## **The National Reproductive Health Strategy**

The Ministry of Health is in the process of finalizing the National Reproductive Health Strategy in order to guide the Reproductive Health interventions and reach the MDGs. The strategy will provide a framework for:

- addressing the reproductive rights and needs of men, women, youth and adolescents;
- creating a conducive environment to reproductive health and sexual behaviors;
- ensuring safe pregnancy outcomes and increased access to and utilization of family planning; and
- addressing emerging reproductive health related morbidity and mortality such as reproductive organ cancers;

The strategy will also consider the interrelations between socio-cultural determinants such as gender discrimination and harmful traditional practices and their negative impact on reproductive health. Expected outcomes include reduction in maternal mortality ratio by three-fourths and reduction in total fertility rate to 4.

### **Develop and implement Health Human Resource Development Strategy:**

Health Sector is one of the labor-intensive sectors that heavily rely on the availability of adequate and skilled human resource. The Ministry of Health has recently finalized the Health Sector Human Resource Development Plan. The Plan served to forecast the human resource requirement for HSDP-III. However, there is a need to develop a long-term Human Resource Development Strategy through an in-depth analysis of the health human resource situation in the country. The strategy will come up with different options for the production and retention of human resource for the sector

### **The National Drug Policy**

Taking into account the importance of regulation on drug manufacturing, import, distribution, and utilization as well as the high level of expenditure devoted to drugs from the limited health budget, the Government of Ethiopia has formulated and implemented the National Drug Policy from the start. This Policy is part and parcel of the Health Policy and aims to meet the country's demand for essential drugs; improve drug supply and distribution; ensure safety, efficacy, quality and affordability of drugs; build domestic manufacturing capacity; and support drug research and development. Hence, the policy will constitute to have a role in the achievement of the objectives of HSDP-III.

### **Policy and Strategy for Prevention and Control of HIV/AIDS**

HIV/AIDS is a growing threat on efforts made for economic growth and poverty reduction. Although the disease causes wide-ranging social, economical, political and individual crises, the main brunt of its effect lies on the Health Sector. Cognizant of this reality, the Government issued the National HIV/AIDS Policy in 1998 and Policy on Use and Supply of Anti-Retroviral Drugs in 2002. Subsequently, a revamped 5 year Multisectoral Strategic Plan on HIV/AIDS was developed in 2005 with a view to guiding the multi-sectoral interventions. Moreover, other documents, including the document on social mobilization on HIV/AIDS in 2005, have also been developed and applied.

Substantial amount of fund has been secured from the GFATM to finance the prevention and control of HIV/AIDS recently. It has also been realized that with the increased funding, the capacity of the health care system has to be strengthened and some provision was made from the fund for this purpose. In fact, GFATM in the 5<sup>th</sup> round of applications has included the area of

“Health System Strengthening” in addition to the three traditional areas and Ethiopia has applied for it. It is hoped that this funding will address a critical but neglected area in the fight against the HIV/AIDS pandemic.

HIV/AIDS is primarily a public health problem and a chronic infectious disease with its important implications for the health sector mainly in terms of care and support and recently in terms of demand for the HAART. Therefore, prevention and control of HIV/AIDS has fully been integrated in to the HSEP. This would be expected to raise the awareness of the population and bring about positive behavioral change; avoid stigma and discrimination; and enhance care and support provided by the community. A package of services that would be delivered with regard to HIV/AIDS will be implemented at different levels of the health system as per the Essential Health Service Package. HIV/AIDS will also be integrated into all health projects and programmes delivered by all actors in the health sector. Furthermore, public private partnership will be strengthened.

Moreover, it is very important to devise a mechanism to support sustainable financing to care and support PLWHA. For instance, the FMOH has recently initiated to kick start a regular monthly contribution of money by its staff towards an HIV/AIDS fund. Similar initiatives will also be encouraged and expanded at different levels of the health sector as well as other sectors.

The Ministry of Health will spearhead the leadership in the national response to HIV/AIDS. Federal and Regional HAPCO will be directly accountable to the Federal Ministry of Health and the Regional Health Bureaus, respectively. The zonal and woreda health offices and the health extension at the Kebele level will directly coordinate and implement the multisectoral HIV/AIDS response at their respective levels.

### **The National Health Communication Strategy**

Ministry of Health has recently finalized the Health Communication Strategy document. The strategy was developed after a thorough analysis of the prevailing problems regarding the delivery of IEC/BCC activities in the sector. It defines the goal of health communication as informing and providing basic health and health related knowledge and skills that could persuade and enable people develop positive attitude and values, useful to adopt health promoting behavior and maintain it.

The document describes different strategies for the delivery of IEC/BCC; indicates the institutional arrangement for the implementation of the strategy; and mechanisms of monitoring and evaluating the IEC/BCC activities.

HSDP-III will give due emphasis to the adaptation and implementation of the strategy by the different stakeholders in the Health Sector.

### **Health Service Delivery Strategy**

In order to achieve the goals and objectives set in HSDP-III, it is mandatory to define what services are delivered at what level of the health services. This issue has been elaborated in the Essential Health Service Package that has recently been finalized. The objectives of Essential Health Service Package are:

- ***to enhance the effectiveness of the health sector program:*** the development of an EHSP will help improve effectiveness of the health sector program and its management by increasing attention towards health service output.
- ***to promote standardization of essential services:*** the EHSP enhances availability and delivery of equitable services for each district by defining the minimum standard for each level of care. The access to this package by pastoralists and scattered communities will also be specifically handled. These help ensure equitable access to essential health services.
- ***to serve as a management tool:*** the EHSP will serve as basis for management of health services, to guide resources allocation by the districts as well as for monitoring and evaluation of the performance of the health facilities.

The major components of the EHSP for Ethiopia are classified building on HSEP. The HSEP is taken as an essential package at the community level. A category containing basic curative care and treatment of mental and major chronic conditions is introduced starting from the HC level. Thus, the EHSP is organized into the following five components:

- 1 Family Health Services;
- 2 Communicable Disease Prevention and Control Services;
- 3 Hygiene and Environmental Health Services;
- 4 Health Education and Communication Services; and
- 5 Basic Curative Care and Management of Major Chronic Conditions

In order to facilitate the proper implementation of the EHSP, there will be some changes in the role of the health institutions, the type and professional mix of staff in the health care institutions and the role of woreda health office, zonal health departments/ regional health bureaus as follows:

1. Health Posts (HPs) will focus mainly on preventive and promotive aspects of health care i.e. promotion of healthful living and healthy environment; prevention of major infectious diseases and epidemics; mobilizing and empowering the community in health matters.
2. Health Centers (HCs) will focus on the provision of first line curative health care and technically support the HPs in their catchments area selected HCS will also provide emergency surgery service.
3. The hospitals will serve as the secondary and tertiary referral care centers to provide a wide range of services including surgery (district), specialist services (zonal hospitals) and sub specialist services (specialized hospitals); they will also serve as higher training institutions for different categories of health workers.

Woreda health offices will monitor the HPs, health stations and health centers. The Regional Health Bureaus/Zonal Health Departments will monitor the District and Zonal hospitals. The Federal Ministry of Health will monitor the Specialized Hospitals.

## **The National Population Policy**

High fertility is a major contributor to poverty. It is also obvious that unregulated fertility is associated with high maternal, neonatal and child mortality due to teenage pregnancy, short birth interval, underweight babies etc. High prevalence of infectious diseases and nutritional deficiencies further complicate these conditions. In order to regulate the adverse effects of high population growth, the Government of Ethiopia formulated, some ten years ago, a National Population Policy and has been rigorously implementing it.

### **The Non-communicable Diseases and Traditional Medicine Strategy**

Although the major disease burden in Ethiopia is related to infectious communicable diseases and nutritional deficiencies, the non-communicable diseases are also emerging as public health problems. Even though, the list of non-communicable disease is long, more attention will be given to injuries and violence, mental and neurological disorders, cardio-vascular diseases, diabetes mellitus, chronic obstructive pulmonary disease, and cancers.

Traditional medicine is practiced widely in Ethiopia. Therefore, HSDP-III will give focus to collection and preservation of traditional medicine and establishment of regulatory framework. In the long-term, due attention will be given to the safety, efficacy and sound use of traditional medicine. This will be effected through generation of clinical based data, formulation and use for treating priority diseases. A model training manual will also be developed and used to train traditional medical practitioners.

### **The National Policy on Women**

Ethiopian women constitute the larger proportion of the population and are participating in various economic sectors making a major contribution to the welfare of the society. Hence, economic development is impractical without ensuring women's right to fully participate in the planning, implementation, monitoring and evaluation of development activities. Moreover, as child bearers, women have direct contact, and hence can shape behavior of the young generation, which becomes the backbone of the country's economy. This entails that empowerment of women is a crucial issue in order to improve the health of mothers, children, households and the society in general.

Therefore, the Government had formulated and implemented the National Women's Policy since 1994. Furthermore, strategies of HSDP fully address this concern by giving priority to maternal health services through adopting strategies that are accepted to have a greater impact on women's well-being such as, the Making Pregnancy Safe and the Safe Motherhood Initiative.

### **Democracy, Good Governance and Decentralization**

Decentralization is one of the most significant policies of the Government influencing the design and implementation of HSDP. Deepening democracy and good governance; and ensuring ownership and meaningful participation of the community in local decision-making process are inline with the principles of primary health care. Moreover, decentralization of activities is also encouraged in the Federal Ministries, Regional Bureaus and Woreda Councils to share functions and responsibilities and make implementations efficient and effective. With this in mind, the health system has been decentralized initially to the Regional Health Bureaus and subsequently to Woreda Health Offices to bring decision-making power closer to the community.



## **The Capacity Building Strategy and Programme**

The Government's Capacity Building Strategy aims at strengthening overall capacity of the Government at all levels as well as in nongovernmental institutions for effective implementation of development activities. It is a comprehensive approach in that it tries to address the institutional, systems and human resource aspects of institutions. Through this Strategy a Civil Service Reform Programme with result oriented performance system is being introduced into the public sectors including the Health Sector. The initial input to the Health Sector has been rewarding and encouraging thereby supplementing the efforts being made to make the health service delivery effective and efficient.

The Civil Service Reform Program (CSRP) is introduced in February 2002 as part of capacity building programme, in order to create a civil service which is both efficient and competent to achieve the economic, social and political missions of the Government, and to promote a culture of administration which reflects direct participation by the people's representatives. The CSRP has five sub-programs: i) Expenditure Management and Control; ii) Human Resources Management; iii) Service Delivery; iv) Top Management Systems; and V) Ethics Reforms. These are all relevant to the health sector since they address some of the challenges and issues in HSDP.

Strategic Planning and Management (SPM) is also one of the initiatives being introduced into the public services at all levels under the leadership of the Ministry of Capacity Building. This is a participatory and bottom up approach to planning based on assessment of local situation and identification of strategic issues that need to be addressed to facilitate the achievement of development goals and objectives. Therefore, the HSDP-III document is different from the previous versions in that it is developed in SPMs approach.

Information and Communication Technology (ICT) Policy is a policy issued under the Capacity Building Strategy that considers the convergence of computing, telecommunication, broadcasting technologies and the need for systemization of access and preservation of information. It is designed with the aim of using ICT for enhancing the efficiency, effectiveness and transparency in the civil and public services; and maximizing connectivity to the global information infrastructure among others. In the Health Sector, it aims the application of ICT to:

- modernize health service administration;
- set up and expand telemedicine;
- improve the access of health professionals and the public to up-to-date health information; and

The implementation of the health component of this policy will be given considerable attention in HSDP-III.

## **Rural Development Policy and Strategy**

The importance of particular policies and strategies to support the rural population, and the agricultural sector, cannot be underestimated in a country where 85% of the population lives in rural areas and 51% of GNP is derived from the agricultural sector. In this respect, both the

Rural Development Policies and Strategies (RDPS) issued in 2001, and the Agricultural Development-Led Industrialization (ADLI) policy developed in 1994, are of strategic importance for the Health Sector Development. RDPS outlines various policy directions related to health, emphasizing health both as a human right, and as playing a key role in building the capacity of the population to contribute to overall development, stressing primary health care and participation, and the need to ensure services for the pastoralist population. ADLI also emphasizes primary health care and environmental health, the need for intersectoral collaboration and decentralized management as strategies contributing to increased agricultural production.

### **3.1.3. The Global Health Policy Context**

Ethiopia is not an exception to the influences of Global Policies initiated by organizations such as the World Bank, WHO, UNICEF, UNAIDS and the World Trade Organization. Such Global Initiatives are also associated with some form of financing the interventions that would significantly augment the resource of the Government. It is also important to realize that new initiatives such as the HSEP and Accelerated Expansion of PHC Services that are believed to be effective mechanisms for achieving the targets set in the PASDEP and MDGs would require the acceptance and support from partners at national, regional and global levels.

Achievement of MDGs is one of the top Global Policies that is influencing the national development policies and strategies. MDGs emerged from the “Millennium Declaration” adopted by the United Nations General Assembly in September 2000. The declaration shows a global consensus on poverty reduction and enhancing human well-being. The eight MDGs that are to be reached by 2015 are described below. Those goals that are relevant and directly linked to the health sector (goals 4,5 and 6) are described with their specific targets.

Goal-1-Eradicating extreme poverty and hunger

Goal-2: Achieving universal primary education

Goal-3: Promoting gender equality and empowering women

Goal-4: Reducing child mortality

Target 4a: Reduce infant and under five mortality rates by two third, between 1990 and 2015.

Goal-5-Improving maternal health

Target 5a reduce maternal mortality ratios by three-quarters, between 1990 and 2015.

Goal-6-Combat HIV/AIDS, malaria and other diseases

Target 6a halt by 2015 and begin to reverse the spread of HIV/AIDS.

Target 6b Halt by 2015 and begin to reverse the incidence of malaria and other major diseases

Goal-7: Ensuring environmental sustainability

Goal-8-Developing a global partnership for development

The partnership between the government and donors has been improving over the past years. In the Health Sector in particular, the consultation forums have been strengthened and the frequency of dialogue with the donors has been improving overtime. This has improved the benefit that the country has been getting from the various Global Initiatives.



It is to be recalled that Ethiopia has secured commitments from the Global Fund to Fight HIV/AIDS (GFATM) and is also one of the countries chosen to benefit from the President's Emergency Plan for AIDS Relief (PEPFAR). The Global Alliance for Vaccine Initiatives (GAVI), the Rollback Malaria Initiative, and the World Bank Multisectoral Loan for HIV/AIDS, EMSAP are also supporting Ethiopia's endeavors in the health field and thereby the rapid poverty reduction strategy. Therefore, the Health Sector needs to take these situations into account when trying to position itself for implementation of targeted interventions.

### **3.2. Vision of HSDP**

To see Healthy, productive and prosperous Ethiopians.

### **3.3. Mission of HSDP**

To reduce morbidity, mortality and disability, and improve the health status of the Ethiopian people through providing a comprehensive package of preventive, promotive, rehabilitative and basic curative health services via a decentralized and democratized health system in collaboration with all stakeholders.

### **3.4. Values of HSDP**

The following are selected as values and philosophies of the sector after a deeper analysis of the internal and external contexts and mandates of the sector. They are believed to provide commitment and momentum to the efforts made to effectively discharge the responsibilities of the sector and meet the expectations of the public.

1. Focus on promotive, preventive and basic curative aspects of health care
2. Deliver integrated, efficient, quality, equitable and pro-poor health service
3. Efficient use of resources and application of appropriate technology
4. Involve the community on health care decision-making process
5. Promote transparent, result oriented and democratic working culture
6. Abide by professional ethics
7. Sense of urgency for the national development
8. Enhance teamwork, partnership and multisectoral approach
9. Be gender sensitive
10. Be ready for continuous change

### **3.5. Mandate Analysis**

The mandate of an organization is usually codified in laws, regulations, decrees, or characters. There might also be informal mandates that an organization must fulfill in the form of expectations of high-level authorities and other stakeholders. The mandate of an organization can be influenced by socioeconomic and political moves in a country. Therefore, it should be revised and updated to fit into the prevailing conditions. SPM process forces civil service institutions to drop mandates that no longer apply in achieving the set objectives, and adds new mandates that need to be in place.

Mandates are formally defined in Ethiopian laws and regulations for organizations like FMOH and RHB. As the health sector is a collection of organizations, mandates are rather defined for specific organizations than for the whole sector. Therefore, the following topics describe the formal mandates of these organizations. Besides, additionally recommended mandates are retrieved from the Federal and Regional SPMs and briefly pointed out.

### **3.5.1. Mandates of the Federal Ministry of Health**

Proclamation No. 471/1995 of the Federal Democratic Republic Of Ethiopia provides definition of Powers and Duties of the Executive Organs. This proclamation, in part 3 No. 10 states the common Powers and Duties as follows:

1. in its field of activity;
  - a. initiate policies and laws, prepare plans and budgets, and upon approval implement same;
  - b. ensure the enforcement of federal laws;
  - c. undertake study and research; collect, compile and disseminate information;
  - d. provide assistance and advice to Regional States, as necessary;
  - e. enter into contracts and international agreements in accordance with the law;
2. direct and coordinate the performances of the executive organs made accountable to it under the laws establishing them or under Article 33 of this proclamation; review the organizational structures as well as the work programs and budgets of the executive organs and approve their submission to the appropriate government organs;
3. supervise the public enterprises, made accountable to it, in accordance with the Public Enterprises Proclamation No. 25/1992, and ensure that they operate as development catalysts;
4. exercise the powers and duties given to it under this proclamation and other laws;
5. submit periodic performance reports to the Prime Minister and the Council of Ministers.

The Ministry of health shall have the powers and duties to:

1. coordinate and direct the country's health sector development program;
2. devise and follow up the implementation of strategies for preventing and eradicating communicable and non-communicable diseases;
3. devise and follow up the implementation of strategies for preventing malnutrition and food contamination; certify and supervise the safety of food stuffs;
4. undertake the necessary quarantine at the main entry and exit points of the country to safeguard public health;
5. undertake appropriate measures in the events of disasters and other situations that threaten public health, and coordinate measures to be taken by other bodies;
6. ensure the availability and proper utilization of essential drugs and medical equipment in the country;
7. create conducive conditions for research, registration and utilization of traditional medicines; and give the necessary support to practitioners to register and practice their profession;
8. establish and administer health research centers;
9. set and supervise the enforcement of health service standards;
10. determine the qualification requirement of professionals desiring to engage in public health service at various levels, and issue certificates of competence to them;
11. ensure the carrying out of drug administration and control activities;
12. delegate part of its powers to regional health bureaus and other government organs as deemed necessary.

Moreover, key institutions such as Drug Administration and control Authority, the Health Education Centre and the Ethiopian Health and Nutrition Research Institute have specific mandate. These mandates that are related to ensuring safety, efficacy, quality and proper use of drugs; improving the knowledge, attitude, behaviour and practice of the population on prevention and control of disease and healthy life style; conducting researches and studies that will contribute to the improvement of the health of the population are not described in detail in this document since these specific mandates could be described in the SPM Plans of the respective institutions.

### **3.5.2. Mandates of the Regional Health Bureaus**

The Health Bureau shall have the powers and duties to:

1. Prepare, on the basis of the health policy of the country, the health care plan and program for the people of the region, and to implement same when approved;
2. Ensure the observance in the region of laws, regulations and directives issued pertaining to public health;
3. Organize and administer hospitals, health centers, clinics, and research and training institutions to be established by the regional self-government;
4. Issue license to health centers, clinics, laboratories and pharmacies to be established by domestic organizations and investors; supervise to ensure that they maintain standard fixed at the national level;
5. Ensure that professionals engaged in public health services in the region satisfy the prescribed standards; and supervise same;
6. Ensure adequate and regular supply of effective, safe and affordable essential drugs, medical supplies and equipment in the region;
7. Cause the application, together with modern medicine, traditional medicines and treatment methods whose efficiency is ascertained;
8. Cause the provision of vaccinations, and take other measures, to prevent and eradicate communicable diseases;
9. Participate in quarantine control undertaken for the protection of public health;
10. Ascertain the nutritional value of foods.

### **3.5.3. Mandates that need to be verified and supported by Proclamation**

FMOH is involved in the overall coordination of the implementation, monitoring and evaluation of HSDP and has been acting as the Secretariat of HSDP. It also chairs the Central Joint Steering Committee and the Joint FMOH and HPN Donor Consultative Meeting. These mandates need to be supported by a proclamation.

RHBs have expressed the need to have a legally supported mandates over the following areas:

- regulation, monitoring and providing technical support to private health training institutions in the regions;
- assessing the health impact and appropriateness of civil constructions before constructions are permitted by the concerned bodies;

- checking safety and quality of water sources constructed by bureau of water and others;
- conduct studies on the regional public health problems and implement the results; and
- adapt and implement health education strategy that focuses on the regional public health problems;

An area that needs further study and clarification is the clear description of the mandates of the FMOH and RHBs over the licensing, and deployment of different level of health professionals.

### **3.6. Analysis of Stakeholders**

Stakeholders are individuals, organizations or agencies that could influence or be influenced positively or negatively during implementation of HSDP. Analysis of a stakeholder and a collaborator is a process of scrutinizing the essence, interests, behaviors, and the nature and level of impact brought about by these stakeholders. The degree of influence from stakeholders varies depending on:

- their span of control over the generation and allocation of resources;
- level of political power;
- scope of participation in the sector; and
- range of use of services provided by the sector.

The attainment of missions and objectives of HSDP is largely dependant on the collective efforts and roles played by the different stakeholders. Therefore, stakeholder analysis in HSDP is a critical issue that helps to define the boundaries of all actors in the health system; clarify contributions expected from each actor; and describe areas of possible collaboration to create synergy to achieve the goals and objectives set in HSDP.

Stakeholders of HSDP can be categorized into two groups i.e. internal and external. Internal stakeholders are those groups that hold the primary responsibility of planning, implementation, monitoring and evaluation of HSDP. These include top management and civil servants of the FMOH, RHBs, ZHDs, Woreda Health Offices, and government health institutions, DACA, Health Education Center, HAPCO, Ethiopian Health and Nutrition Research Institute.

The vision and missions set by HSDP cannot be achieved by the sole effort of the internal stakeholders. External stakeholders have also a major role to play. External stakeholders of HSDP include the community at large, the Prime Minister's Office, Council of Ministers', the House of People's Representatives and their respective representations at all levels, the HPN Donor Group, Ministry of Education, Ministry of Finance and Economic Development, Ministry of Water Resources, Ministry of Capacity Building, Federal Civil Service Commission and its respective representations at all levels, Environmental Protection Authority, Civil Society Organizations, and other government agencies like the Ethiopian Red Cross Society, the private for profit sector and health professionals' associations.

**Table 3-1 Analysis of Internal Stakeholders**

Stakeholders	Expectations	Likely Reaction and Impact if Expectations are not met	Degree of Importance	Appropriate Institutional Response
Civil Servants of the Health Sector at all levels	Conducive working environment Democratic and participatory leadership Responsive organizational structure, transparent and clear division of labor Adequate pay and career development	Attrition Demotivation and poor performance Poor service quality and client dissatisfaction	1	Incentive packages Conducive working environment Trainings and career structure Participatory planning, implementing, monitoring and evaluation of sectoral activities Dynamic and responsive organizational structure
Top management at all levels of the Health Sector	Adequate and quality service Achievement of the mission Proper budget use Timely report Observance of government rules and regulations Good reputation	Corrective measures Failure to achieve the sectoral mission Poor reputation Grievance of stakeholders and collaborators leading to poor working relationship	1	Building implementation capacities at all levels Participatory and realistic planning Conducive working environment

**Table 3-2 Analysis of External Stakeholders**

Stakeholder <sup>4</sup>	Expectation	Likely reaction and impact if expectation is not met	Degree of importance	Appropriate institutional response
Community	Access to quality health service Adequate information Involvement in the planning, implementation, monitoring and evaluation of health care in their areas	Dissatisfaction Loss of confidence Opting for alternatives Low level of health awareness Deterioration of the health status of the population	1	Relevant policies and strategies Provide equitable, accessible and acceptable quality health service Appropriate IEC/BCC using appropriate media Evidence based health care Prompt response to client complaints Ensure community participation
The Prime Minister's Office, the Council of Ministers', the House of People's Representatives	Implementation of national policies, proclamations, regulations and guidelines	Corrective measures on the assignment of top government officials Organizational restructuring	1	Put in place strong monitoring and evaluation system and comprehensive capacity building mechanisms
HPN Donor Group	Recognition Implementation of	Devise exit strategy out of supporting the	1	Transparent procedures Efficient resource utilization

<sup>4</sup> The sector ministries include their respective representations at regional and woreda levels

Stakeholder <sup>4</sup>	Expectation	Likely reaction and impact if expectation is not met	Degree of importance	Appropriate institutional response
	projects/programmes as per the agreement Consultation and participation in the development of policies and strategies of the health sector	Health Sector Withholding of support and endorsement of new policy initiatives Discourage new partners from joining the sector		system Build fund absorption capacity Strengthening joint consultative fora
Ministry of Education	Existence of Health Human Resource Development Plan Standard curricula Availability of health education and services to the students	Mismatch between the demand of the health sector and supply of human resource Poor health awareness and status of students	2	Strengthening intersectoral collaboration
Ministry of Finance and Economic Development	Realistic planning Efficient & effective utilization of funds Abiding to the government financial rules & regulations & donor specific agreements	Reduction in budget allocation Poor implementation of plans	1	Building capacity for realistic planning and efficient and effective utilization of resources Strengthening intersectoral collaboration
Ministry of Water Resources	Joint venture on water and sanitation areas	Scarcity of water sources	2	Strengthening intersectoral collaboration
Ministry of Labor and Social Affairs	Clear rules and guidelines in relation to the working conditions of employees Collaboration in issues related to the vulnerable and disadvantaged groups	Scarcity of water sources and poor hygiene	3	Strengthening intersectoral collaboration
Ministry of Capacity Building and its functional institutions at all levels	Alignment of HSDP with the national capacity building strategy Implementation of CSR in the sector	Lack of support from MOCB Dissociation of HSDP from the national development strategy Negative implication on the achievement of sectoral goals and objectives	3	Alignment of HSDP with the national capacity building strategy Strengthening mutual consultations with MOCB Implementation of CSR in the sector
Federal Civil Service Commission	Abide by the rules, regulations and procedures in relation to human resource management and administration Adequate information exchange	Failure to respond to the sectoral request for support in relation to human resource management and administration Denying the sectoral delegations in issues related to employment Absence of incentives	3	Applying civil service rules, regulations and procedures Strengthening information exchange
Environmental	Harmonization of HSDP-III	Un-harmonized	3	Harmonization of HSDP and

Stakeholder <sup>4</sup>	Expectation	Likely reaction and impact if expectation is not met	Degree of importance	Appropriate institutional response
Protection Authority (EPA)	and EPA's policies and implementation procedures	policies, laws and regulations Duplication of efforts and wastage of resources		EPA's policies, laws and regulations and adequate information exchange
NGOs and other Government Agencies like Ethiopian Red Cross Society	Recognition and involvement in the sectoral activities Transparent partnership strategies	Dissatisfaction and reduction/termination of their contribution to the Health Sector Uncoordinated effort	2	Formulation and implementation of clear policies Strengthening mutual consultations and thrust
The private for profit sector	Clear working guidelines Technical support Prompt response to needs Technical support	Pool out from the sector Low health service delivery due to decline in investment ventures	2	Formulate clear and transparent working guidelines Technical support and follow-up
Health Professionals' associations	Participation in the formulation of health related policies and strategies Ensuring adequate incentive mechanisms and support to the health workers	Pressure on the Government Reduction of support to implementation of sectoral policies	3	Establish participatory approach and provide technical assistance Ensure implementation of the rights and benefits of health workers

### 3.7. Analysis of Collaborators

Collaborators are organizations that can provide support to the achievement of the objectives of the Health Sector. A list of collaborating organization, the area of collaboration and the relative advantages of the collaboration are presented in the table below.

**Table 3-3 Analyses of Collaborators**

S.N.	Collaborator	Area of Collaboration	Relative Advantage
1	Ministry of Information	Dissemination of policies guidelines and other health information to the public through mass media.	The public receives health information easily and improvement in health awareness of the society at lesser cost and shorter time.
2	Ministry of Foreign Affairs	Provide information to the rest of the world to attract investment in the health sector.	Reach the international community easily through the diplomatic mission.
3	Ministry of Infrastructure and respective Regional Bureaus	Approval of the design of health facilities.	Assures establishment of standardized health facilities in the country. Assures construction expenditures are inline with government financial regulation
4	Ethiopian Science & Technology Commission	Define and approves standards of medical equipments, health researches, etc.	Assures standardized medical equipment.
5	Population Office	Mobilize fund, and exchange of information related to reproductive health and population issues.	Expand & strengthen the reproductive health service.
6	Central Statistics Office	Collection analysis and utilization of data for planning and decision making .	Obtain health related data at low or no cost.
7	DPPC	Evaluate and approve health projects	Reach the affected people/group quickly



S.N.	Collaborator	Area of Collaboration	Relative Advantage
		initiated by NGO's.;Jointly Co-ordinate efforts to tackle health problems arising from natural and man made calamities.	Obtain early warning information; Functional Coordination of NGOs in health services
8	PHARMID and its branch offices	Process custom clearance, and distribute drugs medical equipment and supplies to region upon delegation.	Facilitate the availability of drugs and medical supplies on time.
9	Quality and Standard Authority of Ethiopia and branch offices	Sets standards that have public health importance.	Protect consumers and the public at large from consumption of substandard goods and services.
10	Ministry of Agriculture and Rural Development	Exchange information on agro-chemicals and zoonotic diseases	Timely intervention of health problems associated with agro-chemical and zoonotics.
11	Ministry of Youth, Culture and Sports	Adolescent reproductive health.	Reach the young generation easily
12	Judicial bodies and Anti-corruption Commission	Prevention of corruption and illegal practices	Easy prevention of corruption and measures against malpractices
13	Investment Commission	Licensing of newly established industrial and health related projects.	Protect public from environmental hazards and ensure health service standards.
14	Ministry of Federal Affair	Joint planning and implementation for the provision health services to pastoralists.	Creates conducive working environment to reach pastoralists.
15	Custom Authority and its branches		Timely and safe receipt of imported goods Protect the public from smuggled and unfit foods and beverage

### 3.8.SWOT Analysis

The analysis of strengths, weaknesses, opportunities and threats is part and parcel of the SPM process. Prior identification of the strengths, weaknesses, opportunities and threats helps to build on the strengths, to improve the weakness, to use the opportunities and put in place some mechanisms for minimizing the impact of the threats in order to achieve the goals and objectives set in HSDP-III. The following topics give summary of the strengths, weaknesses, opportunities and threats (see Annex-1 for the details).

#### Strengths

- Development and implementation of several relevant policies, strategies, guidelines, proclamations, treatment protocols a regular framework of planning cycle
- Alignment of HSDP targets with the PASDEP and MDGs
- Democratization and decentralization of the health system and existence of formal organizational structure that addresses key health interventions at all levels
- Commencement of HSEP and development of essential health service package
- Existence of a separate institution to regulate and also a department to administer and procure drugs and medical supplies at FMOH
- Availability of standard for the different levels of health facilities.
- Adoption of strategies like Roll Back Malaria, MPS, IMCI, DOTS etc that are universally thought to be cost-effective

- Strong effort and success in mobilizing external resources and technical assistance
- Increasing capacity of health professionals training institution through the Capacity Building Programme and development of Health Human Resource Development Plan
- Availability & well functioning cascade of governance of HSDP (CJSC, RJSC, regular ARM, HPN Donor Group meeting etc)
- Commencement of implementation of the CSRP in the Health Sector in order to improve the quality of health service.
- Presence of local initiatives in the areas of HMIS/M&E that can serve as exemplary models
- Encouraging pace of expansion of special pharmacies

#### **Weaknesses**

- Poor follow-up of implementation of policies, guidelines, standards and protocols; and delayed revision of PIM.
- Shortage, high turnover and poor management of human resource impeding the efforts made towards the achievement of national PASDEP targets and MDGs
- Poor quality of training, ineffective deployment and inequitable distribution of human resources among regions
- Inappropriate management and utilization of resources i.e., human, financial and logistic (drugs, medical equipment and supplies)
- Delays in formalizing the agreement with some partners & slow absorption of approved funds such as GFATM.
- Inadequate health service coverage and utilization
- Weak implementation of the referral system
- Delayed implementation of health service delivery system that is suitable for the pastoralist population.
- Unsatisfactory coordination of activities between the RHBs and FMOH
- Ineffective management and coordination of public-private activities in the health sector.
- Inadequate construction implementation capacity leading to slow rehabilitation and maintenance of facilities.
- Imbalance between new constructions, staffing, equipping, furnishing and recurrent budget allocation.
- Some health facilities lack water supply, electricity & other utilities.
- Inappropriate and low quality of IEC/BCC services.
- Lack of adequate capacity to implement decentralized health system at woreda level.
- Lack of focus, clear vision and direction regarding the role and implementation of HMIS and inadequate use information for decision making.
- Inadequate institutionalization of HCF at all levels of the public health sector.

#### **Opportunities**

- Government's commitment to improve the health service delivery and quality of care by giving priority to the HSDP and focusing on poverty related diseases.
- Financial and technical support from Global Initiatives and HSDP Partners to support the Government's effort to achieve the MDGs.
- Initiation of the process of harmonization between the Government and Donors' procedures.

- Increasing participation of the private sector in the health service delivery and human resource development.
- Expansion of the private construction sector.
- Increasing domestic manufacturing capacity of drugs.
- Increasing human resource output via the Capacity Building Programme.

### **Threats**

- Exacerbation of socio-economic problems due to climatic anomalies and man-made disasters
- Illiteracy, poverty and high level of population growth.
- Fast spread of diseases like HIV/AIDS, TB etc which are influenced by factors beyond the formal domain of the Health Sector.
- Lack of capacity to implement the decentralized health system.
- Rising cost of medical equipment, drugs, supplies and construction materials.
- Irrational drug use and emergence of drug resistance.
- Increasing donor dependency.
- Quality of training may be compromised for quantity.
- Migration of experienced professionals from the public sector.
- Limited capacity of the existing means of communication to reach all segments of the population impacting on IEC/BCC activities.
- Diversity of culture and language of the people demanding diverse means of communication which can have a huge resource implication.
- Establishment of new posts for HMIS at woreda and health facility levels may take time due to resistance from civil service authorities.
- Resistance from some HSDP partners to adhere to the agreed requirements and harmonization of budget cycle, fund disbursement and reporting.
- Approval of the draft proclamation and regulation of HCF by the Council of Ministers and the House of People's Representatives might take time.
- Inadequate resource mobilization within and outside the country to meet the amount needed for financing the MDGs requirements.

### **3.9. Goals, Objectives, Strategies and Key Activities of HSDP-III**

The following sections describe the goals, major objectives, and specific objectives of the HSDP components and key activities.

#### **3.9.1. Goals of HSDP**

**The ultimate goal** of HSDP-III is to **improve the health status** of the Ethiopian peoples through provision of adequate and optimum quality of promotive, preventive, basic curative and rehabilitative health services to all segments of the population.

The following are the general goals of HSDP-III that contribute to the achievement of the ultimate goal:

1. to reduce child mortality;
2. to improve maternal health;
3. to combat HIV/AIDS, malaria, TB and other diseases.

#### **3.9.2. Major Objectives of HSDP**

The major objectives of HSDP-III are:

1. cover all rural kebeles with HSEP to achieve universal primary health care coverage by year 2008;
2. to reduce U5 mortality rate from 123 to 85 per 1000 population and infant mortality rate from 77 to 45 per 1000 population;
3. to reduce maternal mortality ratio to 600 per 100,000 live births from 871;
4. to reduce total fertility rate from 5.9 to 4;
5. to reduce the adult incidence of HIV from 0.68 to 0.65 and maintain the prevalence of HIV at 3.5;
6. to reduce morbidity attributed to malaria from 22% to 10%;
7. to reduce case fatality rate of malaria in age groups 5 years and above from 4.5% to 2% and case fatality rate in under-5 children from 5% to 2%; and
8. to reduce mortality attributed to TB from 7% to 4% of all treated cases.

#### **10.1.1. Objectives, Strategies and Key Activities of HSDP-III**

HSDP has been divided into components in order to facilitate the planning and budgeting process. HSDP-III will thus cover:

1. Health Service Delivery and Quality of Care.
2. Access to Services: Health Facility Construction, Expansion and Transport.
3. Human Resource Development.
4. Pharmaceutical Service.
5. Information Education and Communication.

6. Health Management Information system and Monitoring and Evaluation; and
7. Health Care Financing.

The following topics address selected objectives that address both the indicators that will be used to monitor HSDP-III at national level and key programmatic areas in the sector. The detailed targets for comprehensive monitoring of different programmes at different levels can be referred to in Annex-3.

The objectives HSDP-III have been divided into three levels based on their cost implication, which is done in three scenarios. The objectives that are set below are in line with the **Scenario One** of the costing exercise. The detailed objectives/targets for the three scenarios could be referred to in the fourth chapter of this document.

While the objectives and the strategies are set for each subcomponent, the key activities are described separately for the different levels of health service delivery. These are:

- HSEP (HP) level;
- the Health Center level;
- Hospital level; and
- Support activities that are crucial for the effective implementation of the service delivery and provided mainly by the FMOH, RHBs and woreda health offices.

The key activities related to Health Facility Construction, Expansion and Transport; Health Management, Management Information System, Monitoring and Evaluation and Health Care Financing are also cascaded as per the roles and responsibilities of the Woreda Health Offices, RHBs and FMOH.

### **10.1.2. Health Service Delivery and Quality of Care**

#### **Family Health Services**

##### **Objectives**

- To increase family planning service coverage from 25% to 60%.
- To increase deliveries attended by skilled attendants from 12% to 32%.
- To provide CEOC in 87% of the hospitals and 20% off health centers.
- To provide BEOC in 100% of the health centers.
- To reduce the prevalence of teenage pregnancy and unsafe abortion from 20% and 50% to 5% and 10% respectively.
- To increase DPT3 coverage from 70% to 80% and increase the proportion of fully immunized children from 45 to 80%.
- To increase the proportion of neonates with access to proper neonatal resuscitation and Ampicilne/Gentamycine for neonatal sepsis from 6% to 32%.
- To expand IMCI implementation from 36% to 90% of health facilities; C-IMCI implementation from 12% to 80% of the districts; and the pre-service IMCI training from 65% to 95% of health professionals teaching institutions.

## **Strategies**

- Promotion of preventive and promotive health services through the Health Service Extension Programme.
- Adapt and implement the pastoralist, urban and school HSEP; and mainstream HSEP into the existing structure.
- Facilitation of the proper implementation of the National Reproductive Health and the National Strategy for Child Survival.
- Promotion of the implementation of the Essential Health Service Package and the Referral System.
- Facilitation of the proper implementation of the MPS (through development of national strategy, implementation plan and GL), IMCI programmes and micro planning using the Reach Every District (RED).
- Introduce new vaccines against Hepatitis B and Haemophilus Influenzae.
- Building the capacity for effective programme implementation, monitoring and evaluation.
- Enhance partnership with NGOs/CBOs/Private sectors and international organizations to scale up interventions.
- Support efforts towards empowerment of women and promote maternal mental health.

## **Key Activities at the Health Service Extension Programme (HP) level**

- Implement the Family Health component of the Essential Health Service Packages for this level including maternal mental health that encompass:
  - Basic ANC, including treatment of anaemia, malaria, and hook worm in pregnancy
  - Immunization of mothers and children,
  - Clean & Safe home and institutional delivery.
  - PNC with counseling on ENA, FP and treatment of anaemia.
  - Promotion of ENA, growth monitoring, Vit-A and Iron complementation, demonstration.
  - Treatment of childhood illnesses using IMCI algorithm & Promotion of community IMCI.
  - FP information and services (condom, oral and injectable contraceptives).
  - ARH services (counseling on sexuality, HIV/AIDS and HTP, Provision of condom.
  - Mobilizing the people for all types of health actions in collaboration with the kebele health committees.
  - Improve vaccine management at HP and outreach sites.
  - Conduct monitoring and evaluation of community resource persons by HEWs.

## **Key Activities at Health Centers**

- ANC to normal & referred high risk mothers, including PMTCT services.
- Treatment of complications in pregnancy (pre/eclampsia, abortion, & malaria).
- BEOC and management of complications (PPH, local infection and neonatal sepsis).
- Diagnosis, referral & transportation of emergencies like APH, complicated labour.
- CEOC in one upgraded HC where there is no DH in the district.
- PNC including treatment of breast abscess and puerperal sepsis.
- Management of common childhood illnesses using IMCI algorithm.
- FP services including long-term contraceptives & Post abortion care including MVA.

- Treatment of moderate and severe malnutrition (supplementary & therapeutic feeding)
- Immunization services at HC and outreach.
- Provide adolescent friendly health services for the prevention of unwanted pregnancy, STIs and HIV/AIDS.

### **Key Activities at Hospital Level**

- Skilled intervention of high risk mothers including in-patient and at maternity waiting area.
- Provide Comprehensive Emergency Obstetric Care and perform destructive delivery.
- Treatment of premature births& those with birth injury; management of neonatal hypothermia& all forms of neonatal infections.
- Management of all forms of retained placenta including hysterectomy.
- Treatment of all forms of puerperal problems including infections, psychosis & fistula.
- Provision of all forms of FP including permanent methods.
- Treatment of abnormal menstruation including D&C.
- Out patient and inpatient treatment of all infections supported by laboratory and X-ray diagnosis.
- In patient treatment of all forms of malnutrition.
- Initial immunization at birth & follow up doses to those coming for other services and from catchment area.

### **Support Activities**

- Mobilize financial resource; procure and distribute vaccines, cold chain equipment and injection materials.
- Ensure that health facilities are staffed as per the standard and organize in-service trainings on IMCI, BEOC, EPI and other MCH issues for health professionals.
- Expand and upgrade some health centers to provide CEOC.
- Make available RH supplies and establish effective logistic management system.
- Implement the Cold Chain Maintenance Plan; Revise the outreach sites based on eligible population and terrain; implement Micro Planning using the RED approach and conduct regular integrated supervision; and monthly updating of immunization monitoring charts.
- Ensure mainstreaming of ARH and Child Survival strategies in planning at all levels.
- Provide technical assistance as required (e.g. conducting operational researches, regional planning...).
- Liaison with the private sector to enhance service delivery and promote social marketing of relevant commodities (condoms, contraceptives, ORS.).
- Organize in-service training of HEWs on MCH issues including harmful traditional practices.
- Accelerate the necessary training (initial and refresher) of community resource persons.

### **Communicable Disease Prevention and Control**

#### **Objectives:**

- To achieve provision of VCT services in 100% of hospitals & health centers and PMTCT service at 100% of the hospitals and 70% of the health centers, respectively.
- To increase the number of PLWHA on ART from 13,000 to 263,000.

- To increase the proportion of households with 2 bed nets, properly utilized from 2% to 100% (through procurement and distribution of 20, million bed nets to 10,000 households).
- To increase tuberculosis treatment success rate for smear positives cases from 76% to 85%.
- Reduce the prevalence of leprosy grade-II disability from 12% to less than 10%.
- To reduce active trachoma in targeted 80 Woredas by 80% and increase the current Cataract Surgical Rate (CSR) from 350 to 600 per million population per year.
- To ensure the therapeutic coverage of Onchocerciasis control above 65% in all CDTI areas and ensure its sustainability.
- To interrupt indigenous transmission of Dracunculosis in endemic areas of Ethiopia.
- Achieve and maintain timeliness and completeness of the IDS reports of 80%.
- To establish permanent health emergency management team in the FMOH and ad hoc teams in 100% of RHBs and 80% of woreda health offices.

### **Strategies**

- Promotion of preventive and promotive health services through the Health Service Extension Programme and implement Essential Health Care Package.
- Adapt and implement the pastoralist, urban and school HSEP; and mainstream HSEP into the existing structure.
- Enhance Behavioral Change Communication; comprehensive management of STIs, and universal precaution; promote condom utilization, VCT, PMTCT, HAART, blood safety and epidemiological surveillance system for the effective prevention and control of HIV/AIDS.
- Facilitation of the proper implementation of the Multisectoral HIV/AIDS Strategic Plan.
- Enhance capacity for providing ITN, environmental management, early detection and control of epidemics, and early diagnosis and prompt treatment of cases for the effective prevention and control of malaria.
- Enhance political commitment; detection of smear positive cases using microscopy; stick to the standard treatment course; regular supply of drugs and supplies; and strengthen the recording and reporting system for the effective prevention and control of tuberculosis.
- Introduce selective vector control strategy and early diagnosis and treatment of leishmaniasis.
- Work with traditional healers in order to reduce harmful traditional practices.
- Strengthen integrated disease surveillance both at health facility and community levels including the epidemiological surveillance system on HIV infection and AIDS case reporting.
- Build capacity for effective implementation, coordination, monitoring and evaluation of disease prevention and control programmes at different levels of the health system and introduce innovative ideas through operational research.
- Empowerment of the community on the CDTI activities and ensure intersectoral collaboration and adequate and timely supply of Ivermectine through timely request and effective distribution.
- Enhance case search and containment activities of Dracunculosis.
- Adapt the different disease prevention and control guidelines, manuals and protocols to the different regional contexts.
- Strengthen the collaboration between the various disease prevention and control programmes.



- Institutionalize health emergency management at all levels of the health system (*see Annex-7 for the details*).

### **Key Activities at the Health Service Extension Programme (HP) level**

- Malaria prevention and control (drainage of breeding sites, indoor residual spraying, case detection using Rapid Diagnostic Test and provision of treatment to all uncomplicated cases ITN distribution and promotion of their use).
- TB & leprosy continuation treatment, defaulter tracing, follow up for reactions & complications.
- HIV/AIDS and STI related support and guidance on home based care, information and encouragement on VCT, promote male's participation in PMTCT programs, promotion of ABC, and distribute condoms.
- Prevention and control of rabies in collaboration with agriculture sector.
- Control of Onchocerciasis through community mobilization and provision of Ivermectine.
- Conduct sustained follow-up and notification of epidemic prone diseases and AFP and be involved in epidemic control activities.

### **Key Activities at Health Centers**

- VCT services, on STI/HIV/AIDS, treatment of STI and opportunistic infections.
- Diagnosis and treatment of TB and leprosy, training, & advice of leprosy patients
- ART of diagnosed AIDS patients.
- Epidemic control with free treatment of cases immunization and chemoprophylaxis.
- Provision of full course of anti rabies Vaccination.
- Provide effective treatment of uncomplicated malaria with microscopy diagnostic services.

### **Key Activities at Hospitals**

- Diagnosis and treatment of TB and leprosy at OPD and inpatient.
- Diagnosis and treatment of STI, AIDS (with ARV, treatment of all opportunistic infections), VCT, and PMTCT.
- Confirmatory investigations on epidemics and treatment of cases.
- Inpatient isolated care to clinical rabies cases, and provision of anti-rabies vaccine.

### **Support Activities**

- Mobilization of financial resource.
- Continuous supply of test kits & reagents, and opportunistic infections treatment and prevention drugs, diagnostic equipments, infection prevention and protective materials to all health facilities including ITNs to the community.
- Organize training of counselors, health service providers, program managers and sentinel site staff on prevention and control of selected diseases, IDSR and monitoring and evaluation of health programmes.
- Revise the different disease prevention and control guidelines, manuals and protocols; adapt them to the different regional contexts and make them available at the health facilities.
- Prepare a comprehensive and simple guideline and training manual for community surveillance of selected communicable diseases and train HEWs on the utilization of the guideline and the manual.

- Revise IMCI treatment algorithm in light of the new malaria treatment guidelines and incorporate it in the IMCI training module.
- Strengthen malaria epidemic prevention and control through development of malaria epidemic preparedness plans in epidemic prone districts; provision of Weekly Epidemic Monitoring Chart to all health facilities; and implementing malaria epidemic early warning systems in selected sentinel districts.
- Strengthen research and information system:
  - train staff and equip the integrated disease surveillance units;
  - revise the recording & reporting formats;
  - expand routine sentinel HIV/AIDS surveillance sites with increased rural representation;
  - coordinate and supervise national behavioral surveillance survey;
  - publish “ AIDS in Ethiopia” biannually;
  - conduct tests to demonstrate effectiveness on non-DDT alternatives;
  - make available current National Data on Eye Care by conducting a National Survey on Blindness, Low Vision Survey, and prevalence of active trachoma in children aged 1-9 years.
- Encourage private investors, development organizations, etc to manage the diagnosis and treatment of HIV/AIDS, malaria, and TB; and on local production of ITNs.
- Expansion of DOTS and providing all the necessary inputs and infrastructure to all health facilities.
- Incorporate the programmatic aspect of Tuberculosis and Leprosy prevention and control and IDSR in the pre-service curricula of all health training institutions.
- Expand the number of woredas covered with comprehensive SAFE strategy (Surgery, Antibiotic, Face washing and Environmental Improvement) to 80 woredas in the country.
- Timely request and effective distribution of Ivermectin.
- Establish health emergency response team in FMOH, RHBs and woreda health offices.

## Hygiene and Environmental Health

### Objectives: -

- Increase latrine coverage from 20% to 80 % and ensure 100 % of the facilities are properly handled, sustained and utilized.
- Promote communal solid waste disposal sites in 100% of villages and ensure 100 % utilization rate.
- Improve medical and other waste management system in 100 % of public and private health institutions.
- Increase drinking water quality monitoring from 44 % to 90 %.
- To achieve 100% monitoring of food safety in food processing industries.

### Strategies: -

- Popularize the sanitation MDG Needs Assessment, The Sanitation Strategy and the Public Health Regulation and advocate for its implementation at all levels.
- Harmonize the sanitation services with HSEP, mobilize communities and empower women.

- Work closely with schools parent-teacher-student committee members, officials of higher learning institutions and kebeles.
- Expand the WASH movement to all regions.
- Create a system for "Sanitation Performance Award" to individuals, communities, organizations etc. Initiate inter and intra regional experience sharing programs.
- Encourage the involvement of the private sector in sanitation improvement, programmes and ensure services provided by them meets Public Health requirements.
- Implement medical injection safety strategy.
- Strengthen the capacity of Public Health Chemistry Laboratory of EHNRI and all Regional Public Health laboratories.

#### **Key Activities at the Health Service Extension Programme (HP) Level**

- Promote personal and environmental hygiene and provide support to the community on the preparation and utilization of solid and liquid waste disposal facilities.
- Increase the community's awareness and involvement on safe water supply and prevention of water contamination.
- Promote behavioral change to improve food hygiene and safety.
- Promote and bring behavioral change on the control of vector born diseases; rodent control and healthful housing.
- Build a "Healthy House Model " for demonstration in 50 % of villages.
- Work with the relevant institutions in order to ensure irrigation development projects and water conservation schemes don't pose health hazard to the public.

#### **Key Activities at Health Centers**

- Provide school & prison health service, delousing, and control of rodents and insects.
- Conduct quality control of water supply, and promotion hygiene and environmental sanitation.
- Undertake testing (at public health lab) of food samples during related outbreaks & remedial actions.
- Conduct regular medical and laboratory examination, & check up of food handlers and routine inspection of manufacturing plants.
- Inspect, screen and treat students for contagious eye and skin diseases.

#### **Key Activities at Hospitals**

- Provide feedback to HC and HP based on disease surveillance.
- Vaccinate yellow fever and meningitis vaccination to out going international passengers in selected federal hospitals.

#### **Support Activities**

- Solicit fund for crucial environmental health programs and construction of quarantine posts.
- Procure water testing kits to be distributed at all woredas
- Prepare and disseminate appropriate hygiene, sanitation and occupational safety educational materials; guideline on Sanitation Performance Award; directories of all industries, catering establishments, and institutions.

- Establish HACCP teams and provide technical support to selected food processing plants in the implementation of GMP, GHP and HACCP.
- Strengthen research and information system:
  - Conduct feasibility studies in environmental health services.
  - Conduct need assessment of the Regional Public Health Laboratories.
  - Conduct field assessment to validate the presence / absence of yellow fever in the country.
- Develop guideline for the involvement of the private sector and NGOs in sanitation activities and monitor their services.
- Conduct regular meetings as appropriate to evaluate performances in environmental health activities.
- Organize refresher courses to Environmental Health workers.
- Organize training for health workers on medical injection safety.
- Fully equip and staff the existing Regional Public Health Laboratories and establish one laboratory for the eastern regions.
- Conduct baseline survey on sanitation and KAP of each community.
- Improve medical and other waste management system in public and private health institutions.
- Restructure the administrative set up of quarantine posts and international vaccination centers; and open 2 new posts.

## Curative Services

### Objectives

- Proportion of people seeking care in case of illness or injury from 41% to 55%.
- Increase the ratio of emergency surgery service to population to 1/100,000.
- Increase the percapita health service utilization rate from 0.30 to 0.66.
- Achieve 80% mainstreaming of detection and management of mental health problems in the health system.

### Strategies

- Implementing a two way referral system.
- Enhance the capacity of HEWs for the detection, referral and follow-up of patients.
- Strengthen secondary and tertiary hospitals, and referral laboratories.
- Enhance partnership with the private sector and promote social marketing of relevant commodities.
- Build capacity of health institutions for prevention and control of chronic and non-communicable diseases.
- Integrate mental health services with the existing health service delivery system.
- Improve the quality and management of clinical services through the introduction of the CSRP

### Key Activities at the Health Service Extension Programme (HP) Level

- Treatment of diarrhoea, malaria, intestinal parasites and (pneumonia in children).
- Treatment of eye and skin infections with ointments.
- Treatment of emergency conditions (diarrhoea with ORS, fractures with splint, & anti pain).

- School health service (education, screening for major chronic diseases and ailments).

### **Key Activities at Health Centers**

- Treatment of all forms of infections, intestinal helminths, anaemia, and measles complications.
- Diagnosis & medical treatment of trachoma, other eye infections, & allergic conjunctivitis.
- Tooth extraction and antibiotic treatment to acute gingival and periodontal infections.
- Resuscitation referral and transportation of medical and surgical emergencies.
- Removal of foreign body in the eye, nose & ear.
- Treatment and follow up of mental health problems, epilepsy, DM, uncomplicated hypertension, & asthma.
- Screening and management of school children for major chronic problems and disabilities.

### **Key Activities at Hospitals**

- OPD and inpatient treatment of all forms of infections.
- Treatment of complicated eye infections including surgical intervention.
- Dental extraction & management of all forms of dental and periodontal infections.
- Management of fractures (immobilization/POP).
- Surgical treatment of acute abdomen and injury & blood transfusion services
- Remove all foreign body in the eye, ear and nose.
- Treatment of complicated cases of Bronchial asthma with oxygen support.
- Management of all forms of respiratory infections at OPD and in patient.
- Diagnosis, initiation of treatment & follow up of Diabetes Mellitus.
- OPD and in-patient management of hypertension including complicated ones.
- Managing of multi drug resistant TB in the zonal hospitals.
- Provide specialist and sub-specialist services at the zonal and specialized hospitals, respectively.

### **Support Activities**

- Train trainers of HEWs on the four components of HSEP; chronic and non-communicable diseases including mental health in order to enable them educate the community; identify and refer; and make follow-up of patients.
- Organize regular refresher training for health workers to improve the quality of health care including use of diagnosis and treatment algorithms; national drug lists and treatment guidelines.
- Ensure the availability of adequate number of human resource, medical equipment, drugs, supplies and other supportive inputs.
- Finalize, adapt and implement the referral system guideline in order to establish a functional referral linkage between the different levels of health service delivery.
- Develop, adapt and implement guidelines on management of disease of public health importance.
- Provide training to hospital and health center staff on CSRPs.
- Develop, adapt and implement mental health policy.

- Train and assign psychiatric nurse, psychiatrists; provide basic training to general practitioners and health officers; and developing research and subspecialty center in mental health.
- Establish hospital boards to improve the management and quality of health services.
- Conduct regular evaluations of health service quality through facility surveys and conduct operational researches.
- Conduct monthly supervision of health centers by Woreda health office and bi-annual supervision by Regional Health Bureau.

### **10.1.3. Access to Services: Health Facility Construction, Expansion and Transport**

#### **Objectives:**

- Increase the potential HP coverage from 20% to 100%.
- Increase the potential HC coverage from 18% to 100%.
- Increase the general potential health services coverage from 72% to 100 %.
- Equip and furnish 80% of the health facilities as per the standard.
- To upgrade 30% of the health centers to enable them provide EOC services.
- To establish at least one functional medical equipment workshop in each region.

#### **Strategies**

- Implement the Accelerated Expansion of PHC Service (construction of new HPs, HCs and upgrading of HS to HCs).
- Build the capacity for construction and renovation of health facilities.
- Provide transportation facilities and provide maintenance service to strengthen referral and outreach activities.
- Apply the standards of health facility design.
- Enhancing the capacity of district health offices in the expansion of PHC facilities and services.
- Mobilize resources for the construction and renovation of health facilities.
- Strengthen the national medical supplies and equipments supply and maintenance system.

#### **Key Activities at Woreda Health Office Level**

- Implement the health service standards.
- Supervise the construction, and equipping and furnishing of 10,736 health posts; 253 new health centers; upgrading of 1,457 health stations into health centers; construction of 5 new district hospitals and renovation of 37.
- Ensure proper allocation (one car/ambulance per health center), maintenance and functioning of vehicles for health activities in the woreda.
- Ensure proper maintenance of buildings.

#### **Key Activities at RHB Level**

- Adapt and implement the standard design for zonal hospitals and the other standards
- Deploy professional engineers/ architects.

- Provide technical support to Woreda Health Offices in bidding and subcontracting of health facilities and familiarize relevant personnel on the standards of construction and supervision.
- Construct 2 new zonal hospitals.
- Adapt and implement the health service standards.
- Undertake health facility mapping.
- Establish, equip and strengthen medical equipments maintenance workshops at regional level.
- Revise the existing facilities against availability, infrastructure and access constraints.

#### **Key Activities at FMOH Level**

- Develop and implement a standard design for zonal and specialized hospitals and revise the existing standards as required.
- Deploy professional engineers and architects.
- Provide technical support to RHBs on bidding of construction, specification and procurement of medical equipment and vehicles.
- Familiarize relevant regional personnel on the standards of construction; bidding of constructions, equipping and furnishing; and supervision.
- Design appropriate health service including health service relevant to the pastoralist population.
- Conduct post occupancy evaluation of health facilities in collaboration with the RHBs.

### **10.1.4. Human Resource Development**

#### **Objectives:**

- Increase HEWs to population ratio to 1:2,500.
- To increase the ratio of midwives to women of reproductive age group from 1:13,388 to 1:6,759.
- To staff all health facilities according to the standard and RHBs and Woreda Health Offices as per their respective organizational structure.
- Establish implementation of transparent and accountable human resource management at all levels.

#### **Strategies**

- Increase the number and build the capacity of training institutions.
- Use the existing health institutions to train the health workers.
- Implement the Health Human Resource Development Plan.
- To improve the quality of training through provision of adequate number of skilled trainers, regular on-the-job training and fulfilling the necessary facilities for all training institutions.
- Establish a platform for the effective implementation of the CSRP and introduce incentive packages.
- To improve the quality and management of clinical services.
- Consider gender equality on human resource development and management.

### **Key Activities at the HSEP (HP) Level**

- Train about 7500 health extension workers per year in 2006, 2007 and 2008, and then to compensate attritions based on regional assessments.
- Deploy a total of (existing plus new): 30,000 HEWs with reasonable number of community promoters/volunteers.
- Annual two weeks refresher training of all HEWs on relevant health programs.
- In service training of all woredas' health office managers for supervision of Health Extension workers.

### **Key Activities at HC and Hospitals Level**

- Assign at least 2 diploma level nurse midwives who are able to do BEOC and one health officer with EOC training and practical exposure in each health center.
- Make available (existing plus new): -
  - General Practitioner 2,200
  - 1,050 specialists
  - 5,000 Health Officers
  - 8,300 clinical nurses
  - 3,570 midwives
  - 8,100 assistant nurses
  - 470 nurses anesthetists
  - 1,440 public health nurses
  - 6,600 Pharmacy professionals (Pharmacists & Pharmacy Technicians)
  - 1,650 Environmental Health Workers and sanitarians
  - 4,200 Medical Laboratory Staffs
  - 620 Radiographers
- Upgrade 6,480 health workers.
- Provide on-the-job skill upgrading trainings to 33,357 health workers and administrative staff.

### **Support Activities**

- Organize on-the-job skill upgrading trainings to health workers and administrative staff.
- Conduct regular sensitization of health workers and managerial staff on the CSRP.
- Establish a full HR database at federal, regional and Woreda levels.
- Develop, adapt and implement health professional licensing, deployment, transfer and release guideline.
- Conduct study on health labor market to assess necessary nature and levels of incentives for health workers to exert in rural areas.
- Make available the relevant CSRP guidelines and manuals at all levels of the health system and monitor their implementation.



### **10.1.5. Pharmaceutical Service**

#### **Objectives**

- To increase availability of essential drugs from 75% to 100% in each public health facilities.
- To ensure 80% availability of standard medical supplies and equipment in all public health facilities.
- To scale up the percentage of imported and locally produced drugs with safety, efficacy and quality investigated from 40 to 100 %.
- To reduce percentage of expired drugs from 8% to 1% in public healthy facilities.
- To increase the proportion of health institutions that practice rational use of drugs from 25% to 100%.
- To increase the inspection coverage of drug trading facilities from 20% to 100%.

#### **Strategies:**

- Build the capacity of PASS, DACA and pharmacy units at different levels of the health system to effectively and efficiently implement the National Drug Policy and Drug Administration and control Proclamation.
- To put in place efficient and effective drug and medical equipment management system at all levels of the health system.
- Systematize, modernize and expand drug information, collection, verification dissemination and use and strengthen operational research related to drug supply and use.
- Setup responsible bodies for providing technical support for adequate supply, and rational use of drugs; and enforcement of regulations promulgated to control the pharmaceutical sector.
- Provide necessary instruments and tools to ensure proper management and use of drugs at health facilities.
- Strengthen the national drug quality laboratory and quality assurance procedures.
- Coordinate and strengthen the existing multi-sectoral approach for controlling illegal trades.
- Promote proper registration and conservation of traditional medicine.

#### **Key Activities at the HSEP (HP) Level**

- Provide the necessary drugs, supplies and commodities necessary for the implementation of HSEP (vaccines, drugs, contraceptives, ORT, bed-nets, IEC materials...).

#### **Key Activities at HC and Hospitals Level**

- Establish and Strengthen Drug and Therapeutics Committee in health centers, hospitals, ZHDs, Woreda Health Offices and RHBs.
- Carryout trainings on drug supply management for special pharmacies, rational drug use, adverse drug reactions monitoring, management of drug information centers and maintenance of medical equipments.
- Conduct regular supervision on dug supply management and design methods to improve the system.
- Train health professionals on proper use of newly introduced drugs, medical supplies and equipments; national drug list and treatment guidelines.
- Equip hospitals with drug information materials and other facilities.

- Initiate new Special Pharmacies in all public health centers and hospitals.
- Make available the National Standard Treatment Guidelines, the National Formularies and the Drug List at health facilities.

### **Support Activities**

- Revise, familiarize and disseminate the National drug Policy, the National List of Drugs, Essential Drug List and update the relevant implementation guidelines and documents.
- Develop National Pharmaceutical Plan of Action; guideline for good prescribing and dispensing practice and national medical supplies and equipments list and ensure their application through training, adequate dissemination and supervision.
- Organize Regional Drug Administration and Control Authorities in three different parts of the country.
- Construct standardized national and regional medical warehouses.
- Develop regulations for the implementation of the drug administration and control.
- Develop a national guideline on traditional medicine.
- Establish and equip new mini laboratories in branch offices of DACA and ensure standard operating procedures.
- Conduct national medical equipments inventory; and quality control on imported drugs, supplies and equipment.
- Design and implement a functional pharmaceutical logistic system and logistic information management system.
- Establish drug information resource centers at national levels and six regions and conduct periodic monitoring and evaluation of the sector through computerization of drug data management system.
- Facilitate the procurement of drugs and medical supplies for the health institutions.

### **10.1.6. Information, Education and Communication (IEC)**

#### **Objectives**

- To develop and implement IEC/BCC that ensures effective social mobilization to tackle diseases of public health importance through promotion of personal and environmental hygiene and healthful living.
- To ensure 100% popularization, adaptation and implementation of the National IEC/BCC Strategy at all levels of the health system.
- To provide appropriate health communication materials to 100% the HEWs and to equip 100% of kebeles implementing HSEP with portable IEC equipment.
- To increase the KAP of the population on HIV/AIDS, Malaria and TB by 50% of its 2005 status (2005 status to be retrieved from the upcoming DHS).
- To increase adolescent awareness and knowledge on HIV/AIDS and STDs from 77% and 30% to 95% and 80%.
- To increase adolescent awareness and knowledge on contraception from 80% to 95%.

## **Strategies**

- Strengthen the community based IEC/BCC through the HSEP.
- Creation and strengthening IEC/BCC planning and implementation capacity at all levels and integrate development and dissemination of IEC/BCC with the different health programmes.
- Public advocacy & education on prevention and control of communicable diseases.
- Making optimal use of modern mass media and traditional channels of communication based IEC initiative.
- To put in place a system that ensures the quality of IEC/BCC disseminated by all stakeholders (public,, private, NGOs..) is up to the standard.
- Enhancing the involvement of NGOs, the private for profit sector, professional associations and religious organization in the dissemination of IEC/BCC and coordination of their activities.
- Provide technical support from HEC to RHBs, Woreda Health Offices and other sectors involved in IEC/BCC.

## **Key Activities at the HSEP (HP) Level**

- Provide appropriate health learning materials to the HEWs for effective social mobilization on prevention and control of communicable diseases, family health services, hygiene/environmental health; gender based violence and harmful traditional practices.
- Training of the HEW and community promoters in key health messages and dissemination of the IEC material (leaflet, booklets, etc).
- Community meetings and home visits by HEW and community promoters to conduct health promotion at household.

## **Key Activities at HC and Hospitals Level**

- Provide in-service professional training for health educators in order to enable them provide appropriate BCCC.
- Provide appropriate health learning materials to facilitate IEC/BCC at health facilities.

## **Support Activities:**

- Adapt the National Health Communication Strategy to the context of different regions and subsequently develop/update, familiarize and implement IEC/BCC implementation guidelines.
- Design and implement IEC/BCC materials and guidelines for the HEWs, health centers, hospitals and other workplaces.
- Production of TV/radio spots, purchasing of air time.
- Assign and train IEC coordinators in each RHB and woreda health offices.
- Initiate the development of career structure for health education/promotion specialists.
- Undertake baseline KAP surveys on diseases of public health importance.
- Undertake regular monitoring and evaluation of IEC interventions at all levels.
- To advocate for the allotment of separate smoking areas in public and work places.

## **10.1.7. Health Management, Management Information Systems and Monitoring and Evaluation**

### **Health Management**

#### **Objectives**

- To implement the five Civil Service Reform Programmes in the health sector to ensure efficient, effective, transparent, accountable and ethical civil service at all levels of the health system.
- To staff 100% of WHOs and RHBs by health managers with appropriate professional knowledge and skills that are governed by professional ethics and discipline at all levels of the health service structure.
- Establish health management boards/ committees/ and health councils at all levels of the health system.

#### **Strategies**

- Popularize the CSRP and putting in place the necessary organizational and other inputs to facilitate its implementation.
- Ensuring the planned training of health managers in adequate number and appropriate knowledge and skill within the frame work of the National Capacity Building Programme.
- Ensuring community participation in the planning, implementation, monitoring and evaluation of local health services.
- Ensuring political and administrative support for the fulfillment of the goals and objectives of the health sector.

#### **Key Activities at the Woreda Health Offices Level**

- Conduct regular community mobilization and sensitization in order to ensure genuine community participation and develop democratic decision making process.
- Establish health management boards, councils and committees at woreda health offices, health institutions and the community level in collaboration with the relevant institutions.
- Conduct regular revision of the newly introduced management system and take corrective measures.
- Employ health managers and fill the vacant posts in the woreda health office.

#### **Key Activities at the Regional Health Bureaus Level**

- Conduct regular sensitization and refresher trainings to health managers and health workers on programme management and CSRP.
- Allocate posts, budget and proper incentive package for the assignment of skilled health mangers.
- Adapt and implement the guidelines and establish health management committee, hospital boards and orient them on the CSRP.
- Conduct regular revision of the newly introduced management system and take corrective measures.
- Employ health managers and fill the vacant posts in the regional health bureau.

### **Key Activities at the Federal Ministry of Health Level**

- Conduct regular advocacy works and popularization of the goals and objectives of the health sector to top level managers to ensure political support.
- Develop appropriate guidelines and facilitate the establishment of health management boards, councils and committees at all levels of the health system.
- Introduce innovative working methods into the existing management system at all levels by conducting regular revision of service standards, developing and implementing personnel performance appraisal system etc inline with the CSRP.
- Conduct regular revision of the newly introduced management system and take corrective measures.
- Employ health managers and fill the vacant posts in the Federal Ministry of Health.

### **Health Management Information Systems**

#### **Objectives**

- Develop and implement a comprehensive and standardized national HMIS and ensure the use of information for evidence based planning and management of health services.
- To review and strengthen the existing HMIS and at federal, regional, woreda, health facility and community levels and ensure use of health information for decision-making at all levels.
- To achieve 80% completeness and timely submission of routine health and administrative reports.
- Achieve 75 % of evidence based planning.

#### **Strategies**

- Institutionalize HMIS at all levels.
- Build capacity of health workers to analyze, interpret and use health information for making decisions.
- Introduce appropriate HMIS technology at all levels of the health system in collaboration with the concerned bodies such as the National ICT Authority.
- Define the minimum standard of inputs required for HMIS at different levels of the health system.
- Initiate and sustain regular programme review and feedback system.

### **Key Activities at the Woreda Health Offices Level**

- Establish HMIS posts and assign appropriate personnel in the organizational structure of woreda health office and health institutions as per the national standard.
- Implement the qualification requirements, job descriptions, career path and incentive packages standards of personnel working on HMIS.
- Ensure the proper reporting and feed back for the health extension workers and HMIS personnel in the health institutions.
- Provide the necessary health and administrative reports to the RHBs as per the guideline.
- allocate funds for HMIS and provide the necessary facilities for the HMIS units/personnel and the health extension workers.
- Implement and monitor the pilot HMIS in collaboration with the RHBs.
- Collaborate on the expansion of the geographic information system and woreda connectivity.

### **Key Activities at the Regional Health Bureaus Level**

- Adapt and implement qualification requirements, job descriptions, career path and incentive packages for personnel working on HMIS at different levels of the health system.
- Adapt and implement National HMIS Strategy, manuals and standards developed at national level.
- Conduct regular on the job training to HMIS focal personnel, programme managers and health workers.
- Equip HMIS units at all levels.
- Implement HMIS on pilot basis in collaboration with the FMOH.
- Collaborate on the establishment of electronic network from federal to woreda level as part of implementation of HMIS.
- Initiate and sustain the development of Health and Health Related Indicators in the regions.
- Advocate the allocation of adequate funds for implementation of National HMIS in woredal.

### **Key Activities at the Federal Ministry of Health Level**

- Assign a multidisciplinary team at PPD/MOH and provide the necessary facility so that it will be able to spearhead the development and implementation of HMIS at national level.
- Develop and popularize the National HMIS Strategy and user-friendly manuals.
- Develop and popularize qualification requirements, job descriptions, career path and incentive packages for personnel working on HMIS at different levels of the health system.
- Standardize HMIS indicators, harmonize the reporting system and collect gender disaggregated data.
- Develop, adapt and implement HMIS user-friendly guidelines and revise ICD coding system.
- Initiate pre-service training on HMIS in health professional training institutions.
- Implement HMIS on pilot basis before nationwide replication.
- Conduct system analysis for the application of ICT to HMIS, pre test and implement the application and expand geographic information system.
- Mobilize funds for implementation of National HMIS.
- Monitor the implementation of programme review and research recommendations through HMIS.
- Publish Health and Health Related Indictors bulletin annually.

### **Monitoring and Evaluation**

#### **Objectives:**

- To develop and implement comprehensive and integrated Monitoring and Evaluation guideline at all levels of the health system.
- Establish WJSC and form linkages between woreda-regional and central joint steering committees.
- Conduct regular supervision and review meetings at woreda health office level.
- To conduct JRM, ARM, final evaluation of HSDPII and regular FMOH Donor consultative meetings.
- To harmonize the donor-government reporting cycles and monitoring and evaluation system.

## **Strategies**

- Strengthening the monitoring and evaluation capacity at all levels.
- Initiate consultation among different programme implementers in order to harmonize and establish an integrated Monitoring and Evaluation system.
- Implement an up-to-date financial management system at all levels of the health system.
- Initiate negotiation and consultation with HSDP partners.
- Expand the HSDP Governance by establishing WJSC at woreda level.

## **Key Activities at the Woreda Health Offices Level**

- Allocate adequate financial resource, human resource, and facilities for monitoring and evaluation.
- Participate on the JRMs, ARMs; a midterm, an annual review and final evaluation of HSDP.
- Woreda Joint Steering Committee and enhance their linkage with the Regional ones.
- Conduct regular review meetings of health programmes through the involvement of the community and ensure the proper implementation of the recommendations.
- Conduct regular follow up of the performance of the health extension workers and take corrective measures.
- Carry out regular internal audits at woreda health office and health facilities to ensure proper expenditure of health sector resources.

## **Key Activities at the Regional Health Bureaus Level**

- Adapt and implement the national monitoring and evaluation guideline and instruments.
- Establishing M&E units in the RHBs, provide human resource, facilities, and finance.
- Provide training to programme coordinators at regional and woreda health office level.
- Strengthen the Regional Joint Steering Committee and enhance their linkage with the Woreda and Central Joint Steering Committees.
- Organize regional review meetings of health programmes and ensure the proper implementation of the recommendations.
- Establishment of operational research units in the RHBs and conduct operational research as per the national standard.
- Collaborate on the JRMs, ARMs; a midterm, an annual review and final evaluation of HSDP.
- Carry out regular internal audits to ensure proper expenditure of health sector resources
- Facilitate the monitoring and evaluation of national health programmes.

## **Key Activities at the Federal Ministry of Health Level**

- Develop and popularize standardized monitoring and evaluation guideline and instruments
- Strengthen monitoring and evaluation unit in the PPD/MOH and provide the necessary facilities, training and finance.
- Establish a systematic and coordinated monitoring of national programmes in the departments of the FMOH.
- Establish Health Economics and Policy Unit in the Planning and Programming Department of FMOH.
- develop standard protocol and priority areas for operational research.

- Organize and conduct JRMs, ARMs; a midterm, an annual review and final evaluation meeting of HSDP.
- Conduct the regular meetings with the JCCC and HPN Donors Working Group.
- Conduct regular internal audits in the FMOH and assist external audits of donor supported programmes.
- coordinate the implementation of the Harmonization Plan.

### **10.1.8. Health Care Financing**

#### **Objectives:**

- To increase over all health expenditures per capita from 5.6 USD to 9.6 USD.
- To double the share of health as a proportion of total Government budget (domestic spending and Direct Budget Support).
- To ensure retention and utilization of 100% of revenue generated at hospitals and health centers.
- To expand special pharmacies to cover 100% of hospitals from the current level of 82% and 100% of health centers from the current level of 58%.
- To design and implement social health insurance for employees in the formal sectors and pilot test community health insurance.
- To setup HIV/AIDS fund at all levels of the health sector and advocate its establishment in the other sectors.

#### **Strategies:**

- Institutionalize and build the capacity for the implementation of health care financing at all levels of the health system.
- Strengthening the planning, budgeting and financial management capacity at Woreda level in order to increase efficiency in the use of available resources.
- Promote equitable health resource allocation for the vulnerable and high need group.
- Strengthen the system of public private partnership in the health sector and strengthen social initiatives towards sustainable financing of care and support for PLWHA.
- Put in place the legal framework of HCF and introduce a system of effective hospital governance, waiver and exemption, facility revenue retention, introducing private wing in public hospitals, outsourcing non-clinical (ancillary) services.
- Promote increased resource allocation to the health sector at all levels through sensitization of managers and decision-makers.
- Strengthening the existing linkages with MOFED and BOFED in order to facilitate the effective introduction of HCF reforms.

#### **Key Activities at the Woreda Health Offices Level**

- Monitoring and coordination of health care financing system by the woreda health offices.
- Establish management boards at the health facilities and the community level to oversee the proper implementation of the health care financing scheme as per the guideline.
- Encourage the establishment of community health care insurance schemes in the woredas.
- Allocate additional resources for the expansion of special pharmacies in health facilities under the woreda health office.



- Implement the revenue retention at health facilities and exemption policy in collaboration with the relevant sectors at woreda level.
- Establish HIV/AIDS fund at health institutions in the woreda and advocate for its establishment in the other sectors.
- Work in collaboration with the NGOs and the private sector as per the guideline.

#### **Key Activities at the Regional Health Bureaus Level**

- Adapt and implement one proclamation and five regulations on health care financing at regional and woreda level in collaboration with the relevant sectors.
- Adapt and familiarize implementation guideline and management modalities for fee revenue retention and utilization at facility level.
- Provide training to the health care financing personnel at woreda health office and health facilities and relevant sectors on health care financing including special pharmacies operation and management
- Advocate for allocation of resources for the expansion of special pharmacies
- Establish HIV/AIDS fund at regional health institutions and advocate for its establishment in the other sectors
- Carryout regular donor- mapping at regional level
- Adapt the directive for NGO's and the private sector operating in the health sector.

#### **Key Activities at the Federal Ministry of Health Level**

- Endorse, popularize and implement one proclamation and five regulations on health care financing.
- Develop and familiarize implementation guideline and management modalities for fee revenue retention and utilization at facility level.
- Mobilize additional resources for the expansion of special pharmacies and conduct trainings on Special Pharmacies operation and management.
- Strengthen the HIV/AIDS fund at FMOH and regional and advocate its establishment in the federal hospitals and other sectors.
- Carryout regular donor- mapping at national level.
- Develop a directive for NGO's and the private sector operating in the health sector.
- Conducting National Health Accounts Study.

#### **10.1.9. Crosscutting Issues**

Gender, nutrition and pastoralist health service are issues that cut across different sectors as well as the components of HSDP. While gender and nutrition are treated under this topic, pastoralist health service is treated under “strategic Issues” of this document since it is identified as a strategic issue i.e. an issue that could become a bottleneck in the course of achieving the desired objectives and targets, therefore, needs more emphasis.

## Gender

### Objectives

- Mainstream gender at all levels of the health system.

### Strategies

- Improve the institutionalization of gender in the sector.
- Promote the implementation of Gender Mainstreaming Guideline (GMSG) in the sector.
- Build the capacity of gender units and focal points in the Health Sector.
- Promote gender desegregation of health data.

### Key Activities

- Assess the status of implementation of GMSG and develop intervention plan based on the findings of the study.
- Develop user-friendly manuals to facilitate the implementation of GMSG
- Establish posts for gender focal persons, train the assigned personnel and provide them with the necessary facilities.
- Conduct sustained advocacy and orientation for women employees in order to enhance their capacity to play a meaningful role in the organizational activities as well as to ensure the observance their rights.
- Enhance collaboration of other actors (NGOs, private etc) in the promotion and implementation of gender issues.
- Monitoring the proper and equitable implementation of employment, transfer, trainings etc of women in the health sector.

## Nutrition

### Objectives:

- To reduce stunting, wasting, and low-birth-weight of children by 50% of its current status (*to be retrieved from DHS 2005*).
- To create access for 90% of children 6-59 months for nutritional screening.
- To increase the proportion of infants 0-5months exclusively breast fed from 38% to 63%
- To increase the proportion of infants 6-11months breast fed from 75% to 80%
- To increase the proportion of children aged 6-59 months getting vitamin-A prophylaxis from 30% to 54%
- To reduce iodine deficiency disorders by achieving 100% access to iodized salt
- To reduce maternal anemia by 50% of its current status

### Strategies:

- Integration of Essential Nutrition Action (ENA) into the existing maternal and child health services
- Strengthen the capability of the Health Extension Workers (HEW) with appropriate nutrition knowledge
- revitalize the baby friendly hospital initiatives

- Strengthen the implementation of the Enhanced Outreach Strategy (EOS) by the HEW
- Promote universal salt iodization
- Enforce the legislation for iodization of salt
- Contribute towards the establishment of ownership and well coordination of general nutrition action

**Key Activities:**

- Endeavor for the adoption of the National Nutrition Policy
- Train instructors of HEW on community ENA
- Prepare community ENA reference to HEW
- Conduct nutritional assessment and nutritional surveillance and dissemination of nutrition information through available media of communication
- Expansion of vitamin-A supplementation to ensure 90% coverage
- Conduct quality inspection on commercially available table salt
- Nutrition program monitoring and evaluation through supportive supervision and review meetings.
- Provide support to the establishment of therapeutic feeding centers and treatment of severely malnourished children
- Organize and participate in the discussion fora with stake involved in nutrition activities

**10.2. Strategic Issues of HSDP-III**

Strategic issues are areas that need due attention in order to achieve the goals and objectives set in a programme. Following are strategic issues that are considered to be bottlenecks and hence need to be addressed for the smooth implementation of HSDP-III. The criteria used to identify them as strategic issues are:

- the importance of an issue in improving the implementation of sectoral programme
- the impact of an issue in creating obstacles to the implementations of the sectoral programme if left unaddressed
- the importance of an issue in creating opportunities or threats
- availability of different options to address the issue

**10.2.1. Shortage, High Turnover and Mismanagement of Human Resource**

Health sector is one of the sectors that heavily rely on the availability of adequate and skilled human resource. The National Health Policy has also pointed out that “*development of human resource with emphasis on expansion of frontline and midlevel health professionals with community base, task oriented training shall be undertaken<sup>44</sup>*”. One of the issues that characterize human resource in the health sector is the multiplicity of disciplines making it difficult to substitute one professional for another field. This entails availability of the optimum number and professional mix of human resource for the effective coverage and quality of the intended services.

A series of HSDP reviews have underlined that shortage and inequitable distribution of professionals in the health sector has seriously affected the implementation of key health programmes. For instance, it is indicated that Ethiopia has one of the lowest ratio of doctors to population ratio in the world. The expanding population size and increasing migration of health professionals to the private and NGO sectors as well as outside migration have made the problem chronic. There is poor deployment and most of these limited number of staff operate in urban areas. As a result the rural areas have faced a continuous shortage of human resources. For instance, midwifery skills are particularly lacking with larger regions having less than one midwife per 100,000 people.

Additionally, the shortage and high turnover of engineering staff as coupled with down sizing of engineering units in RHBs has hampered the capacity to implement and supervise construction activities at RHB & WHO levels. This could adversely affect the implementation of the Accelerated Expansion of Primary Health Care Services, whereby significant number of health facilities will be constructed at a national scale in short period of time.

Motivation to work efficiently and effectively appears to be inadequate due to narrow opportunities for training (upgrading, in-service and continuing); and lack of clear, transparent and flexible transfer and release rules and regulations particularly in remote areas. Salaries for health workers are very low in absolute terms and in comparison to the international market, even though they are high relatively to the GDP. This makes migration very attractive for highly qualified health professionals. Furthermore, non-conducive working environment, shortage of staff housing and transport facilities for highly qualified personnel to stay in remote areas. Fear of contracting HIV/AIDS due to shortage of supplies for universal precaution are other reasons for demotivation of staff to stay in the public sector. The other major concern in the area of human resource is sub-optimal professional skills due to poor quality of training. This has originated from poor pedagogic skills of tutors, insufficient training curricula and shortage of the necessary teaching aids.

The government's comprehensive capacity building programme has enhanced the intake and output of health professionals through scaling up of infrastructure, human resource and logistics for training institutions. Considerable measures have also been taken in the area of human resource management, with the aim of motivating and standardizing job position and title through development of salary scales and career structure for all formally trained health workers ranging from junior health workers to consultant health specialists.

While all these initiatives are commendable steps, the working environment and remuneration in the public sector still leaves a lot to be desired. Moreover, the existing poor quality of training coupled with the planned high output of health professionals both from the government and the private sector, will have a negative effect on the public health services unless due attention is given to it. In summary, problem related to human resource in the Health Sector are:

- Presence of several vacant posts at different levels of the health system.
- Migration of skilled and experienced staff from the public sector.
- Increasing burden of work on the existing small number of staff.
- Presence of administrative problems that hinder recruitment of skilled and well experienced staff.

- Poor quality of pre-service training and fragmented and uncoordinated in-service training.
- Lack of attention to study and solve the causes of migration of staff from the public sector.
- Dependence on consultants and technical assistances leading to inadequate sustainability of key health programmes.

### **10.2.2. Inefficient Civil Service System**

Effective implementation of policies, rules and regulations issued by the Government highly depends on the efficiency of the civil service system. Although the Ethiopian civil service system has a long history of implementing policies and programmes, it was not designed to effectively satisfy the public interest. Its orientation, attitude, ethical behavior and work practice were generally weak and was unable to modernize itself for the efficient and effective government functions. Government directives and regulations governing the management and control of public funds were cumbersome. Personnel management practices and remuneration systems were out of date and the mechanisms of enforcing ethical codes were too weak or ineffective.

Responding to this situation, an in-depth evaluation of the entire civil service was undertaken and the findings indicated that the system at all levels doesn't keep pace with the political environment and was not geared towards achieving national development goals and objectives<sup>45</sup>. The major problems identified were:-

- lack of customer focused civil service;
- lack of transparency and accountability;
- irrelevant focus on controlling and evaluation of staff rather than focusing on result oriented performance evaluation;
- inadequate safeguard system for public properties and lack of commitment to fight corruption.

These problems cut across all the sectors and hence the Health Sector is not an exception. Based on these findings, a comprehensive approach for improving the civil service system has been initiated in five programmatic areas, namely:

- Expenditure Management and Control.
- Human Resource Management.
- Service Delivery.
- Top Management.
- Ethics.

Although there are commendable improvements through the implementation of these programmes so far, the achievements are far from the desired. Therefore, the implementation of the CSRP should be one of the top in the list of priorities during the implementation of HSDP-III.

### **10.2.3. Weak Procurement and Management of Drugs, Medical Equipment and Supplies**

Providing basic curative and rehabilitative services are the major principles in implementation of HSDP in addition to preventive and promotive health interventions. Early diagnosis and treatment of public health problems like malaria and tuberculosis is also considered to be part of the preventive interventions. This could be achieved through provision of adequate inputs for this services i.e. medical equipment, drugs and supplies among others. Furthermore, availability of these inputs in adequate quantity and quality is a critical component of improving the quality of health service, which in turn enhances the health service utilization by the community.

The health sector suffers from complex and lengthy procurement procedures resulting in shortage and irregularity of the necessary drugs, supplies and equipment at the health facilities. The inefficiency of the procurement system has also resulted in the poor absorption capacity of funds allocated from HSDP partners. This has the overall effect of poor quality of service at the grass roots level.

The other major challenges are poor quality control system; substandard storage facilities; inefficient distribution; inadequate transportation; and poor inventory system. Weakness in inspection system and poor collaboration with law enforcement bodies has led to wide use of smuggled, counterfeiting and expired drugs which can have a negative impact on the health of the population.

Health facilities also suffer from deficient, outdated, poorly maintained medical equipment that hampers both the preventive (e.g. cold chain, insecticides, spray pumps...) and curative interventions (e.g. medical equipment for Emergency Obstetric Care services, X-ray machines, microscopes.). Therefore, the issue of management and supply of drugs, medical equipment and supplies is among the strategic issues of HSDP-III.

### **10.2.4. Lack of Emphasis to Preventive and Promotive Health Interventions**

It has long been recognized that focusing on preventive health interventions is cost-effective to bring about improvement in health status of the population than the curative ones. This principle was also well articulated in the principles of the Primary Health Care approach, which is pursued by HSDP. Moreover, it has been indicated that, *HSDP will develop a health care delivery system which provides a comprehensive and integrated primary health care service focusing on preventive and promotive aspects*<sup>46</sup>.

However, the major disease burden of the country is still attributed to preventable communicable diseases like malaria, HIV/AIDS, tuberculosis and perinatal and maternal conditions. These health problems are also known to have strong linkage to poverty. This implies that our endeavor to improve the socio-economic status of the community and our commitment to the achievement of the MDGs will be questionable if these diseases persist to prevail at the current level.

The health policy and the strategies adopted have emphasized the preventive and promotive aspect of health care. Reorganization of health service delivery system with the commencement of HSDP-I also aimed at effectively addressing the health problems by strengthening PHCU and

providing preventive, promotive, basic curative and rehabilitative health care service close to the population. HSDP-II has also shown stronger commitment on reducing poverty by refocusing on the preventable poverty related disease through developing HSEP, Child Survival strategy, etc.

However, the achievement so far is far from the desired, indicating that the emphasis given to preventive and promotive approach at the implementation level is not yet adequate and effective. Therefore, there is a need to refocus, show more commitment and gather a stronger momentum for the effective implementation of preventive and promotive health services.

#### **10.2.5. Inappropriate and Low Quality of IEC/BCC Services**

The major public health problems of the country are communicable diseases like diarrheal diseases, malaria, tuberculosis, HIV/AIDS and maternal and neonatal conditions. Improving the health KAP through basic hygiene and sanitation education and behavioral change communication is a cost-effective method of preventing these health problems. Moreover, strategic health communication is an integral part of quality health services, and an important means of creating demand for use of services and motivating positive attitude and practices to ensure health-promoting behavior.

Cognizant of this fact, IEC/BCC has been articulated into HSDP. However, while the role and importance of IEC/BCC has been recognized, its translation into a vehicle through which behavioral change could be effected has not been fully realized. It was indicated that no comprehensive communication intervention has been undertaken in the regions mainly due to lack of proper direction, leadership and technical know-how. IEC/BCC activities that have been implemented so far have not focused on social mobilization for effective awareness raising and ultimately positive behavioral change to tackle the preventable health problems prevailing in the country. The major reasons for this are lack of national health communication strategy, shortage of health education and communication specialists, high turnover of the few who have some knowledge and skills and inadequate institutionalization of IEC/BCC in the health system structures. There is also inadequate budgetary allocation to IEC/BCC activities at Regional and lower levels. Lack of coordination of the many players, within the Government, NGOs and the private sector, has resulted in duplication and unfocused efforts. The produced IEC messages are also of poor quality that could not adequately respond to the national disease burden.

The recent achievement in initiating training of health education and communication specialists at Jimma University is a significant step towards alleviating the human resource constraint in the area of IEC/BCC. However, a lot remains to be done to realize the contribution of IEC/BCC to effective social mobilization and improvement of the health status of the population.

#### **10.2.6. Ineffectiveness of HMIS in supporting planning, M&E and the decision-making process**

Delivering health care services to the population is a complex endeavor that is highly dependent on information for proper planning, implementation, monitoring and evaluation. Therefore, it

needs a functional HMIS. A good health management highly relies on accurate and relevant information to make health services responsive to the demands of the population.

In Ethiopia, it has long been recognized that health information is rarely used for management decision-making. Too much data is collected from the health facilities and reported in multiple formats to the FMOH. This data is of poor quality, incomplete and untimely. It is not analyzed at the site of collection. The root problems are lack of attention to HMIS, poor institutionalization, shortage of resource and lack of strategic direction. Parallel reporting mechanisms introduced by the vertical projects and different donors have also resulted in administrative burden on personnel working at the grassroots level. For instance, 150 health information-reporting formats were identified in one of the regional states. These altogether have hampered proper supervision, monitoring, and evaluation of the health programmes. Absence of a feedback system has also resulted in poor incentive to improve quality of data and reports by personnel working closer to the site of data collection. Since the country is implementing a sector wide approach where a functional HMIS is crucial, weakness of HMIS undermines accountability of the government to donors

HMIS and M&E have been top in the agenda of the sector from the very inception of HSDP. Hence, Strengthening of Health Sector Management and Management Information System and Monitoring and Evaluation have been articulated into HSDP. Nevertheless, the achievements so far are not satisfactory. There are domestic intra sectoral and multi-sectoral initiatives that are supportive to improvement of HMIS and thereby M&E. Besides, there are ample international initiatives to draw lessons from, in the course of strengthening HMIS/M&E in Ethiopia. Therefore, since functional HMIS and M&E are the backbone of effective health care delivery HSDP-III will consider them as strategic issues to achieve the set goal and objectives.

### **10.2.7. Harmonization and Alignment**

Harmonization refers to the synchronization of operational policies, procedures and practices with the aim of reducing transaction costs and strengthening the national systems, while alignment refers to the process which aims at increasing coherence, synergy and complementarities of external assistance with country owned strategies<sup>47</sup>.

The issue of harmonization and alignment has been an important agenda of the Ethiopian Government since the introduction of sector-wide development approaches in the health ,education, water and road sectors in 1996 and 1997.The introduction of the Ethiopian Sustainable Development and Poverty Reduction Programme (SDPRP) in 2002 has created a broader framework for harmonization and alignment by highlighting the great potential of a mechanism to better coordinate and align donor policies ,increasing Government ownership and promoting effectiveness and efficiency of external assistance. At the global level, the issue of harmonization has gained similar significance following the 2002 UN Monetary Conference on Financing and Development which called on donors to intensify their efforts to harmonize their procedures of disbursement and delivery taking into account the development needs and ownership of recipient countries. The harmonization agenda has been further pursued in the



International High Level Fora held in Rome in 2003, in Marrakech in 2004 and in Paris in 2005.

Parallel with the development of the SDPRP, the Government and donors have been engaged in the development of a comprehensive Harmonization Framework which culminated in the creation of the Joint GOE-DAG Taskforce on Harmonization in November 2002. In line with the recommendations of the Rome Declaration, this Taskforce has developed a Harmonization Action Plan (HAP) for Ethiopia, with the objective of enhancing aid effectiveness through harmonization and coordination to promote poverty reduction and the achievement of the Millennium Development Goals. The underlying principles of HAP are focused on:

- Delivery of development assistance in accordance with Ethiopia's needs and priorities as outlined in the PASDEP.
- Promotion of coordination and harmonization at all levels.
- working towards delegated cooperation among donors at the country level.
- improvement of information sharing and understanding of commonalities in policies, procedures and practices.
- Review of the multiplicity of donor missions ,reviews, conditionalities and documentation with the aim of reducing transaction costs for the GOE.
- Alignment with the GOE systems such as national budget cycles, financial systems , PASDEP /MDGs monitoring processes.

At the level of the health sector too, some progress have been made in terms of Government/Donors partnership and cooperation through the launching and implementation process of the Health Sector Development Programme(HSDP).The consultation procedures followed during the preparation of successive phases of the sector plan, the formation of a Central Joint Steering Committee(CJSC),a high level policy dialogue forum made up of Government, donors and NGOs representatives , the creation of the Federal MOH and HPN Donors Joint-Consultative Forum which has been meeting every two months since 2001 ,and its technical working group called the Joint Core Coordinating Committee(JCCC), the tradition of conducting joint monitoring, reviews and evaluations of the HSDP through annual Joint Review Missions(JRMs)and Annual Review Meetings(ARMs) can be cited as examples.

In spite such progresses and the overall commitment of the donors to the sector programme, the process of alignment and harmonization at the operational level, particularly in terms of integrated planning, financing, disbursement cycle, procurement, monitoring, evaluation and reporting systems has made very little or no progress .In terms disbursement, with the exception of a few donors that have recently opted for budget support, the majority continue to use different disbursement channels with various approval, replenishment and reporting procedures and conditionalities. Almost all donors have progress report requirements with different formats and delivery time schedules. Many donors continue to conduct their own reviews and to field supervision missions. All these unharmonized procedures do not only have the obvious disadvantage of increasing transaction costs, but are aggravating the administrative burden on Government implementing bodies at all levels, which are working with already stretched and inadequate capacity. The net result of this situation is reduction of implementation speed, efficiency as well as low disbursement/utilization rate of funds.

In summary, the Government believes that harmonized procedures should be the norm. Working within the Government system would substantially improve the effectiveness of resource utilization rather than establishing parallel systems. The onus, therefore, should be on donors to explain why they cannot accept harmonized financing, timing of disbursement, reporting and planning procedures. The challenge of accelerated poverty reduction and achieving the MDGs, particularly in the current situation of growing international initiatives and partnership as well as increased resource inflows, the question of aid effectiveness through increased harmonization is a critical issue that HSDP-III has to appropriately address within the framework of the HAP.

#### **10.2.8. Inadequate Health Service Delivery to Pastoralists Population**

Pastoralists constitute about 10% of the total population of Ethiopia. Even though they are among the most economically important groups in the country; they have a relatively poor socio economic condition. The conventional health service delivery system in the country also doesn't seem to take into account their particular requirements.

They are naturally mobile looking for water and grazing fields for their cattle with changing seasons. Low level of education, strong cultural influences, shortage of infrastructure and hard climatic conditions make it difficult to provide basic health service through the conventional health service delivery, which is static. This led to poor access and utilization of health services by this group of people.

Taking this into account, the Government has given due attention to improvement of the living conditions of pastoralists and has developed a programme for the accelerated development in the pastoralist areas. The Ministry of Federal Affairs has handled the issue of providing a multisectoral support to this group of people. A board composed of members recruited from six ministries was established under this Ministry and, subsequently, a technical committee has been set to gather momentum and coordinate multisectoral efforts geared towards provision of integrated support to the Newly Emerging Regions. The Ministry of Health is a key member of this board.

As part of developing appropriate health service delivery for the pastoralist population, the HSEP has been modified to suit to the context of the pastoralists. The package has to be finalized and implemented. Otherwise, poor health service coverage in the pastoralist areas will be a bottleneck to the achievement of universal primary health service coverage by 2008.

#### **10.2.9. Poor Coordination of Activities and Management of NGOs and the Private for Profit Sector**

The basis on which sector wide approaches are built is the principle of strong government ownership, political commitment and major responsibility to coordinate actors within (public, private, NGOs) and outside the sector. This is especially crucial in the health sector, as the objectives and targets of the health sector cannot be met by the sole effort of the government.

As the Global Initiatives expand to tackle TB, Malaria and HIV/AIDS, it is crucial to collaborate proactively with NGOs and the private sector in order to achieve the set goals and objectives.

This is mainly due to the limited capacity of the health personnel particularly in terms of presence in remote areas and existence of health and health related issues that lie outside the formal domain of the health sector. Therefore, capitalizing on the experience and preparedness of the other stakeholders (mainly NGOs and the private sector) to become involved in these important initiatives will significantly complement the public sector's capacity in tackling public health problems. Furthermore, development of a coordinated approach is much more likely to reap good results than maintenance of parallel systems.

In HSDP context, the private and NGOs sectors have been involved over a long period of time in health promotion and service delivery. Promotion of the participation of the private sector and NGOs in health care is also well pointed out in the National Health Policy. There is an encouraging development of collaboration of the public, private and NGOs sectors in HSDP. Inclusion of the NGOs in the CJSC, support provided from the health sector to establish the Medical Association of Physicians in Private Practice (MAPPP) and initiation of involvement of the private sector in the planning process by some RHBs could be cited as examples. Moreover, there is an increasing trend in the involvement of the private sector in the training of health professionals.

Although these are laudable initiatives by the Health Sector, the process of creating a firm framework of working together and effective integration, monitoring and evaluation of the activities of these stakeholders is still in its infantile stage. This is manifested by difficulty to quantify the contribution of the private sector and NGOs due to lack of a clear information exchange system; inadequate involvement of the Health Sector in the licensing and controlling the quality of teaching in the private training institutions; and lack of an effective monitoring system to ensure the application of the conventional rules, regulations and guidelines of the health sectors.

### **10.3. Strategic Action Plan**

The main objective of analyzing the strengths, weaknesses, opportunities and threats is to identify strategic issues that will become obstacles to the achievement of the missions and objectives. Strategic issues, therefore, need to be addressed properly. Part of this is developing a strategic action plan as follows.

**Table 3-4 Strategic Action Plan**

Strategic Issues	Proposed Measures	Output Indicators	Responsible Body
<p><i>Shortage, high turnover and mismanagement of human resource</i></p>	<p>⇒ Building the capacity of health training institutions under the health sector in order to increase their health professional output and improve the quality of training</p> <ul style="list-style-type: none"> <li>• Expansion of the exiting training institutions and construction of new ones.</li> <li>• Provide adequate and quality teaching aids</li> <li>• Assign additional teachers</li> <li>• Provide pedagogic skills training to teachers</li> <li>• Create a forum of dialogue with Ministry of Education and agree on how FMOH can actively be involved in strengthening the capacity of training institutions</li> <li>• Adapt and implement the Health Human Resource Development Plan</li> </ul> <p>⇒ Developing and implementing feasible incentive packages within the framework of the Civil Service Programmed</p> <ul style="list-style-type: none"> <li>• Conduct a study on possible causes of staff demotivation and attrition and propose measures</li> <li>• Develop a proposed incentive package and get approval from the appropriate body</li> <li>• Adapt and implement the package</li> </ul> <p>⇒ Develop Human Resource Development Strategy and working closely with MOE in order to mach the output of higher health professional training institutions with needs of the needs of the health sector</p> <ul style="list-style-type: none"> <li>• Work closely with HSDP Partners to study and develop HRD strategy for health</li> <li>• Popularize and implement the HRD Strategy</li> </ul> <p>⇒ Create a mechanism whereby the FMOH and RHBs can actively be involved in strengthening the capacity private</p>	<ul style="list-style-type: none"> <li>• No of health training institutions: newly constructed and expanded to accommodate the desired no. of trainees</li> <li>• No of health training institutions provided with adequate teaching aids and staffed according to the standard</li> </ul> <ul style="list-style-type: none"> <li>• Completion of study, development of incentive package and submission to the appropriate bodies for approval</li> <li>• Implementation of the package as per the regional contexts</li> </ul> <ul style="list-style-type: none"> <li>• No of health professional training institutions training health workers as per the number and categories indicated in the Health HRD Strategy</li> </ul>	<p>FMOH, RHBs, Woreda Health Offices</p>

Strategic Issues	Proposed Measures	Output Indicators	Responsible Body
	<p>teaching institutions in order to improve the quality and output of health professionals</p> <ul style="list-style-type: none"> <li>• Allowing trainees of the private training institutions to practice in the government health institutions</li> <li>• Prepare and implement guidelines and training quality monitoring checklists</li> <li>• Reinstitution the national board examination as a quality controlling mechanism</li> </ul>	<ul style="list-style-type: none"> <li>• No of RHBs implementing training quality monitoring as per the guideline</li> <li>• Institutionalization and full functioning of national board examination</li> </ul>	
<i>Weak and Inefficient Civil Service System</i>	<ul style="list-style-type: none"> <li>➤ Conduct a study on specific characteristics of civil service in the health sector</li> <li>➤ Design civil service reforms needed in the health sector within the framework of the general Civil Service Reform Programme and in collaboration with MoCB</li> <li>➤ Reform the organizational structures at different levels of the health system to suit to the implementation of an efficient civil service programme</li> <li>➤ Sensitize management and civil servants at different levels of the health system</li> <li>➤ Put in place a monitoring and evaluation system to ensure proper functioning of the civil service</li> </ul>	<ul style="list-style-type: none"> <li>• Scope of reformation of the organizational structure of organizations at different levels of the health system</li> <li>• Proportion of managers and civil servants sensitized on the CSRP</li> <li>• Presence of a functional civil service monitoring and evaluation system.</li> </ul>	FMOH, RHB, Woreda Health Offices, MOCB
<i>Weak Procurement and Management of Drugs, Medical Equipment and Supplies</i>	<ul style="list-style-type: none"> <li>⇒ Develop and implement the Logistic Master Plan</li> <li>• Study the existing situation</li> <li>• Propose different options</li> <li>• Select and implement appropriate logistic management system</li> <li>⇒ Build capacity for effective and efficient drug procurement, distribution and quality control at all levels of the health system</li> <li>• Assign personnel at PASS/FMOH, RHB and WHO levels</li> <li>• Train them on drug procurement, distribution and quality control at all levels of the health system</li> <li>• Provide them with the necessary facilities and</li> </ul>	<ul style="list-style-type: none"> <li>• Study report and options document</li> <li>• Adapted and implemented smooth procurement, storage and distribution system</li> <li>• Proportion of complete and timely reports; scope of implementation of supervisions and review meetings as per the plan</li> </ul>	<ul style="list-style-type: none"> <li>• FMOH, RHBs, Woreda HOs, HSDP Partners</li> <li>• FMOH, RHBs, Woreda Health Offices</li> </ul>

Strategic Issues	Proposed Measures	Output Indicators	Responsible Body
	<p>technologies</p> <ul style="list-style-type: none"> <li>• Develop national pharmaceutical management strategic action plan</li> <li>• Establish effective information and M&amp;E system</li> <li>• Conduct regular supervisions and review meetings</li> <li>• Construct and renovate stores</li> <li>• Procure vehicles and allocate operational costs</li> <li>• Train health workers on rational drug use and prescription</li> </ul> <p>⇒ Securing adequate financial resources and strengthen and expand special pharmacy and drug supply outlets through Revolving Drug Fund Schemes in order to alleviate the shortage of drugs.</p> <ul style="list-style-type: none"> <li>• Select health facilities and agree with the local management on the scheme</li> <li>• Train personnel on the implementation modalities and management of the schemes</li> <li>• Allocate seed money and start implementation of special pharmacy projects</li> </ul> <p>⇒ Build domestic capacity for maintenance of medical equipment through collaboration with the concerned government agencies, the private sector and NGOs</p> <ul style="list-style-type: none"> <li>• Conduct consensus building workshop with the concerned bodies (like the science and technology commission)</li> <li>• Develop medical equipment maintenance plan of action/proposal and solicit funding</li> <li>• Strengthen the existing medical equipment maintenance workshops and establish new ones <ul style="list-style-type: none"> <li>○ Assign personnel and provide training</li> <li>○ Construct/renovate facilities</li> <li>○ Procurement of tools</li> <li>○ Procurement of spare parts</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of health facilities with stock outs of essential drugs</li> <li>• No of newly constructed and renovated stores</li> </ul> <ul style="list-style-type: none"> <li>• No of newly established and well functioning special pharmacies</li> </ul> <ul style="list-style-type: none"> <li>• Development of medical equipment maintenance POA through a participatory approach</li> <li>• No of medical equipment workshops that operate in the appropriate facilities; that are staffed with skilled personnel and properly equipped</li> </ul>	

Strategic Issues	Proposed Measures	Output Indicators	Responsible Body
<p><i>Lack of Emphasis to Preventive and Promotive Health Interventions</i></p>	<ul style="list-style-type: none"> <li>➤ Implement HEP at larger scale               <ul style="list-style-type: none"> <li>• Train and deploy HEWs and community promoters</li> <li>• Provide the necessary drugs, supplies and commodities necessary for the implementation of HSEP</li> <li>• Strengthen Woreda Health Offices to monitor and supervise the implementation of HSEP</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• number of HEWs trained &amp; deployed</li> <li>• Availability of drugs &amp; supplies</li> <li>• Number of supervisions conducted</li> </ul>	<p>FMOH, RHBs and Woreda Health Offices</p>
	<ul style="list-style-type: none"> <li>➤ implement accelerated expansion of primary health care coverage               <ul style="list-style-type: none"> <li>• Construct &amp; make operational the already identified PHCUs</li> <li>• Train and deploy relevant health professionals</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• number of PHCUs constructed &amp; made operational</li> <li>• number of mid level and lower level health professionals trained and deployed</li> </ul>	
	<ul style="list-style-type: none"> <li>➤ Create awareness and build the capacity of lower level management the relevance of preventive and promotive health services</li> </ul>	<ul style="list-style-type: none"> <li>• Number of trainings &amp; sensitizations conducted</li> </ul>	
<p><i>Inappropriate and low quality of IEC/BCC services</i></p>	<ul style="list-style-type: none"> <li>⇒ Institutionalize IEC/BCC at all levels of the health system and deploy skilled IEC professionals</li> <li>⇒ Speedup the popularization, adaptation and implementation of the health communication IEC strategy</li> </ul>	<ul style="list-style-type: none"> <li>• No of regions that allocated posts for IEC/BCC and assigned appropriate personnel</li> <li>• No of regions that adapted and implemented the IEC/BCC Strategy and guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• FMOH, RHBs, Woreda Health Offices</li> </ul>
<p><i>Ineffectiveness of HMIS in supporting planning, M&amp;E and decision making in health</i></p>	<ul style="list-style-type: none"> <li>⇒ Institutionalize HMIS at all levels of the health system               <ul style="list-style-type: none"> <li>○ Set posts in the organizational structures of the health system</li> <li>○ Set qualification requirements and career path</li> <li>○ Assign skilled personnel</li> </ul> </li> <li>⇒ Develop and implement HMIS/M&amp;E strategy               <ul style="list-style-type: none"> <li>○ Activate the National HMIS advisory Committee</li> <li>○ Draft the strategy by the FMOH</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• No of regions that established posts and assigned personnel for HMIS at all levels</li> <li>• Development and implementation of qualification requirements and career path for HMSI personnel</li> <li>• No of regions that implemented the national HMIS strategy</li> </ul>	<ul style="list-style-type: none"> <li>• FMOH, RHBs, Woreda Health Offices</li> </ul>

Strategic Issues	Proposed Measures	Output Indicators	Responsible Body
	<ul style="list-style-type: none"> <li>○ Enrich the document through the participation of all stakeholders</li> <li>○ Endorse the document</li> <li>○ Follow the implementation</li> </ul> <p>⇒ Introduce appropriate technology and tools for HMIS and M&amp;E</p> <ul style="list-style-type: none"> <li>○ Study and set the appropriate type of technology and facilities required at different levels of the health system to implement HMIS/M&amp;E</li> <li>○ Solicit the necessary fund and provide the facility as per the standard</li> <li>○ Train personnel and provide technical assistance to ensure proper utilization</li> <li>○ Follow-up the implementation</li> </ul>	<ul style="list-style-type: none"> <li>● Scope of completion of the study</li> <li>● Proportion of RHBs, Woreda Health Offices and HFs that are equipped with the necessary HMIS/M&amp;E technology</li> <li>● No. of persons trained</li> </ul>	
<i>Harmonization</i>	<p>Harmonize donors planning, monitoring, disbursement and accounting procedures with that of the Government in order to avoid reinforcement of any vertical tendencies:</p> <ul style="list-style-type: none"> <li>● Develop and sign a code of conduct with partners</li> <li>● Revise Programme Implementation Manual of HSDP</li> <li>● Conduct resource mapping for HSDP-III and update it regularly</li> <li>● Conduct a study to see how the health sector fares in the woreda block grant</li> <li>● Establish pooled funding for the implementation of HSDP-III</li> <li>● Harmonize procedures, reporting and M&amp;E</li> </ul>	<ul style="list-style-type: none"> <li>● Code of conduct developed and implemented</li> <li>● PIM revised and implemented</li> <li>● Resource mapping conducted and regularly updated</li> <li>● Study conducted and finalized</li> <li>● Fund pooled for implementation of HSDP-III</li> <li>● Reporting formats and cycles, procedures and M&amp;E of sectoral programmes harmonized</li> </ul>	<ul style="list-style-type: none"> <li>● FMOH, RHBs, Woreda Health Offices, HSDP Partners</li> </ul>
<i>Inadequate health service delivery to pastoralists</i>	<p>⇒ Develop and implement appropriate health service system</p> <ul style="list-style-type: none"> <li>○ Finalize the modified HSEP for the</li> </ul>	<ul style="list-style-type: none"> <li>● No of regions that adapt and implement the modified HEP in</li> </ul>	<ul style="list-style-type: none"> <li>● FMOH, RHBs, Woreda Health Offices, other sectors,</li> </ul>



Strategic Issues	Proposed Measures	Output Indicators	Responsible Body
<i>population</i>	<p style="padding-left: 40px;">pastoralist population</p> <ul style="list-style-type: none"> <li>○ Test, adapt and implement the HSEP</li> </ul> <p>⇒ Solicit a multisectoral effort and strengthen the involvement of HSPD partners and NGOs</p> <ul style="list-style-type: none"> <li>○ Develop plan of action in consultation and collaboration with the relevant sectors in the regions</li> <li>○ Provide technical and financial assistance to ensure effective health service delivery</li> <li>○ Build capacity of local health training institutions in pastoralist areas</li> </ul>	<p style="padding-left: 40px;">pastoralist areas</p> <ul style="list-style-type: none"> <li>● Amount of funds solicited and used for the implementation of HSEP in pastoralist areas</li> <li>● Scope of provision of TA to the regions for the implementation of HSEP</li> </ul>	<p style="text-align: center;">HSDP partners</p>
<i>Poor Coordination of Activities and Management of the NGOs and the Private for Profit Sector</i>	<p>⇒ Putting in place institutional framework and implementation guidelines at all levels of the health system that can enhance public private and NGOs partnership</p> <ul style="list-style-type: none"> <li>○ Produce the necessary guidelines in a participatory approach</li> <li>○ Institutionalize and build the capacity of the public sector for the coordination of the NGOs and the private for profit sectors</li> <li>○ Enhance the consultation fora</li> </ul>	<ul style="list-style-type: none"> <li>● No of guidelines developed in a participatory manner to facilitate the public and private partnership</li> <li>● No of consultation meetings conducted with the NGOs and the private sector involved in health and health related activities</li> </ul>	<ul style="list-style-type: none"> <li>● FMOH, RHBs, Woreda Health Offices</li> </ul>

## **10.4. Programme Implementation Arrangements**

### **10.4.1. Governance**

The governance of HSDP III will be elaborated in the revised Programme Implementation Manual of HSDP.

### **10.4.2. Decentralization and community participation**

As per the principle operating within the regular structures of Government, and inline with the federal administrative structure, and the national commitment to democracy and decentralization, the implementing agencies of HSDP-III are FMOH at the Federal level, the Health Bureaus at the Regional level and the Health Offices at the woreda level. Financial matters remain the responsibility of the Federal Ministry of Finance and Economic Development (MOFED), regional Bureaus of Finance and Economic Development (BOFED), and the Woreda Finance and Economic Development Office at the *woreda* level.

Community participation is one of the fundamental principles on which the HSDP is based, yet progress with this aspect has been limited during the previous phases. Strategies to improve the involvement of community members in the planning, management, and monitoring of health sector activities will be undertaken at all levels.

### **10.4.3. Financial management**

The term financial management refers to the various procedures and processes governing the flow of funds, through the stages of authorization, disbursement, payments, reporting, accounting and auditing. In general, financial management of the HSDP-III will be inline with existing government procedures. However, in accordance with the desire to move increasingly towards pooled funding and budgetary support by donors, harmonized procedures will be put in place in order to satisfy the accounting and reporting requirements of the various bilateral donors; and to minimize additional transaction costs for Government. The various channels of funding including pooled funding mechanisms will be further elaborated in the Programme Implementation Manual, which is to be revised to reflect new developments.

The FGOE has set itself uncompromising standards of financial management, with various studies confirming that the basic systems are already in place to ensure adequate control of public funds. In Ethiopia, unlike many other countries in the region, the accounting system is sufficiently developed to track different sources of funding to final uses<sup>48</sup>. The challenge remains to routinely monitor and report on funding by HSDP component, and it is envisaged that this will be facilitated through the harmonization of budget coding outlined in the Financing Plan.

The Ethiopian budget system separates recurrent from capital expenditure, the underlying principle being to distinguish the continuing running costs of government services from the discrete investment expenditures that add to government assets. This distinction is however blurred due to tradition relating to the inclusion of external support within the budget<sup>5</sup>. At present the capital budget is composed of two different components: i) FGOE capital resources from domestic revenues; and ii) loans and grants coming from external partners. Traditionally, all external funding is thus recorded within the Capital budget, regardless of the actual nature of expenditure supported with such funds. Again, in theory the FGOE accounting system enables collation of financial data in sufficient detail to be able to at least report this on an *ex post* basis, and continued work will be undertaken to enhance financial management reporting.

All aid agreements continue to be negotiated at the federal level. However, historically, different donors have followed different disbursement procedures and mechanisms for aid management. It remains the government desire that disbursement is done through finance bodies in order to avoid fragmentation of financial management, ensure that MOFED has a complete picture, and to avoid wastage and unnecessary duplication of effort.

Although regional states have a substantial degree of autonomy, the Federal Government takes the lead in setting financial management standards. The regions are also required to report their expenditure in the formats and at the times specified by MOFED. MOFED has overall responsibility for the management of public funds, including federal subsidies to the regional states. The Federal Office of the Auditor General (FOAG) is the supreme audit institution of Ethiopia, with responsibility for auditing all federal funds, including subventions to the regional states. It is directly accountable to the Council of Peoples Representatives.

In practice, all federal and regional offices are required to submit monthly reports on expenditure, and these serve as conditions for further disbursement. Quarterly and annual financial reports are also collated by different bodies as part of a progress report in the implementation of projects. To the maximum extent possible, these regular financial reports are used as the basis for financial monitoring of the HSDP. However, it is agreed that the standard systems may be supplemented, if necessary, with special reporting arrangements to ensure adequate monitoring.

Auditing of Regional expenditure is constitutionally the responsibility of regional auditors-general. However, regions may delegate responsibilities to the federal government. The federal government has also the right to instigate audits of all federally-derived funds, which include all external aids and loans. Since HSDP had been prepared as an integral program covering all regions and the center, it has been agreed that an overall annual audit will be undertaken, to cover all elements of the program, i.e. central and regional, recurrent and capital, donor and locally funded. Internal audit mechanisms continuously monitor financial management and proper adherence to financial and procedural regulations. The FOAG remains the independent auditor for the program.

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<sup>5</sup> This problem is not unique to Ethiopia but is the case in many countries within the region.

#### **10.4.4. Procurement and Logistics Management**

The aim of a procurement procedure is to acquire goods and services in the most economic, efficient and transparent manner possible. Procurement planning is also very important for the timely implementation of programs and activities. Procurement can be undertaken individually or as a package. The advantage of packing, specially in the case of an integrated program, is the minimization of cost both in unit price and processing time. However, delay in implementation can happen and is important issue in the choice of a procurement arrangement.

The starting point in any procurement is the preparation of a bid document. The content, arrangements and volume may vary according to the size and type (equipment, civil works, consultancy, ICB NCB, etc) of procurement to be done, but it should be clear and comprehensive and ensure that the goods/services are described with sufficient details to form the basis for competitive bidding. In the standard situation after the bidding documents have been prepared, notices will be given in the appropriate media with sufficient instructions, and documents should be ready for sale from the dates the notices are printed or announced in the media.

Bid opening and evaluation procedures should and will comply with internationally accepted standards. The major elements in the bidding process are the formation of a tender committee, opening of bids in the presence of bidders, staged and detailed evaluation of bids, determination of the three successful winners of the bid and notification of the top winner.

Once the evaluation process is complete and the winners are identified, the successful bidder is promptly notified in writing, and is requested to sign a contract while the unsuccessful bidders shall be notified of the same.

During the implementation of Phase I and II HSDP the task of procurement management was shared between FMOH and RHBs. Major international procurement of goods and services were handled by the FMOH. While goods like medical equipment, vehicles and motors cycles etc are cleared and distributed to the RHBs by the respective suppliers under the supervision of FMOH and RHBs.

A reform process is underway to build the capacity of PASS in handling the procurement process. A logistic system study will also be conducted to look into the weakness and strength of the existing system and come up with an improved system at all levels of the health system.

The RHBs are responsible for the distribution of these goods to the Woreda Health Offices or health facilities, while installation and commissioning of major equipment like x-rays and generators, boilers etc at the site is undertaken by the suppliers.

Vaccines are supplied by UNICEF and also procured by the FMOH and vaccine management is undertaken by PASS and the Family Health Department of FMOH. Vaccines are cleared from the ports and transported to central stores and cold chains in two days.

At the center, there are dry and cold stores. The cold stores are well-equipped repair workshop, and standby power generator, and stock management is computerized. In order to avoid fragmentation of procurement management activities at the FMOH level, and to put in place an integrated and efficient procurement system, the Ministry has brought together all procurement activities under PASS. This service is entrusted with the responsibility of undertaking all procurement for FMOH and on behalf of the RHBs when delegated.

#### ***10.4.5. Monitoring and Evaluation (M&E)***

Monitoring and evaluation (M&E) is an action-oriented and preplanned management tool that operates on adequate, relevant, reliable and timely collected, compiled and analyzed information on programme/project objectives, targets and activities. The objectives of M&E are to improve the management and optimum use of resources of programme and to make timely decisions to resolve constraints and/or problems of implementation.

The key elements for a successful programme management and implementation are the designing of a programme built on a hierarchy of objectives, targets, activities and measurable indicators, The agreed indicators are the most important management tools for monitoring, review and evaluation purposes. Indicators are always directly linked to the objective setting of a programme..

HSDP will be monitored and evaluated on the basis of the detailed arrangements outlined in the revised PIM.

## **4. HSDP-III Costing, Financing and Performance Purchasing Strategies**

### ***4.1. Cost of programs and service delivery strategies***

This section examines the cost of implementing HSDP-III between 2005/06 and 2009/10. The costing exercise builds on the exercise conducted for the MDGs Needs Assessments that is briefly summarized in section 4.1.2. The MDGs Needs Assessment hypotheses have then been refined to include the specifics of the implementation strategies of HSDP-III, particularly regarding health service delivery activities. The perspectives for public funding are then examined using various hypotheses of economic growth and allocations to the health sector. Finally this section proposes various mechanisms to facilitate the absorption of funding of health services and increase the efficiency of public spending

#### ***4.1.1. Methodology***

The overall costing was conducted using the Marginal Budgeting for Bottlenecks (MBB) tool, a tool developed by the World Bank, UNICEF, USAID and WHO and further refined by the Millennium Project. The MBB tool is an analytical costing and budgeting tool that aims at helping policy makers to plan and manage health programs. The MBB focus on marginal cost and impact in mortality reduction makes it a particularly helpful tool to estimate the extra efforts and resources needed to reach the MDGs. The tool helped to set objectives on the basis of identified current bottlenecks in health service delivery in Ethiopia; calculate the cost of achieving health intervention targets; and estimate the impact of the health interventions on health outcomes, such as child and maternal mortality.

To conduct the MBB analysis, the following steps were followed:

- a. Defining the key high impact health interventions to be integrated into existing and planned services delivery arrangements in Ethiopia. The key interventions under each HSDP component and service delivery level are presented.
- b. Identifying bottlenecks hampering the implementation of these service delivery strategies. The principle of the tool is that by identifying the bottlenecks to implementation and expansion the planner can gain insight into their effect on the impact of interventions and can assess the cost and effectiveness implications of eliminating them. The tool systematically analyses the bottlenecks taking the five determinants: availability, accessibility, initial utilization, continuity, and quality of services. The results of an examination of the bottlenecks to the key interventions are summarized in the table below:

**Table 4-1 Key interventions and identified bottlenecks**

<b>Key Interventions</b>	<b>Main bottlenecks identified</b>
<b>Maternal and neonatal care</b> Focused antenatal care Clean and safe delivery Neonatal care Newborn temperature management PMTCT Family planning	Access to health facilities Shortage of skilled human resources at all levels, including community Lack of essential equipment and supplies Inadequate motivation of personnel Inadequate supervision
<b>Nutrition</b> Optimum breast feeding Complementary feeding Vitamin A supplementation	Inadequate access to basic information Shortage of skilled human resources Inadequate motivation of personnel Low utilization of services
<b>Disease control</b> Vaccination against measles and HiB Long Lasting Treated Net Safe water, sanitation and hygiene	Shortage of skilled human resources Inadequate supervision Inadequate motivation of personnel Logistical problems Lack of essential equipment and supplies Insufficient funding Poor management Lack of supplies Insufficient access
<b>Clinical care</b> Diarrhoea Malaria Pneumonia Neonatal Sepsis	Limited access to health facilities Lack of skilled human resources Poor staff motivation Barriers to referral Shortage of essential drugs

- c. Setting health coverage targets or “frontiers”. In doing the costing exercise three Scenarios have been considered. Section 4.1.3 and Table 4.2 provide details of the assumptions and access and coverage targets under each of the three Scenarios.
- d. Estimating the impact and cost of various health service delivery options. The impact in terms of child and maternal mortality reduction as well as halting and reversing the prevalence of HIV/AIDS, Malaria and TB for each Scenario is estimated along with the respective costs.

#### **4.1.2. Reaching the Health MDGs in Ethiopia**

This section summarizes the results of the health MDGs Needs Assessment exercise and attempts to estimate how much extra money would be needed to increase the health coverage from the current level to the 2015 MDG horizon (should funding not be a constraint), yet taking into account the specific geographic, human and institutional context of Ethiopia.

Reaching the health MDGs implies not only a dramatic expansion of the production of key high impact health services, but also the implementation of mechanisms to ensure adequate demand for and use of those services. On the basis of the HSDP-II plan and other GOE policy documents, five steps for further service expansion have been considered. These steps are described in Box 4-1. Each step allows for a progressive upgrade of services, strengthening both supply and demand for high impact services.

**Box 4.1 : Five Steps of Health Services Expansion in Ethiopia**

1. The first step, Information and Social Mobilization for behavior change, includes all activities related to general health information through the media (TV and radios), social marketing strategies and other social mobilization events. It includes activities outside health services at the workplace, in schools as well as in youth clubs. This step supports activities that trigger awareness of critical health issues as well as behavior change. The expansion of those services supports prevention of HIV as well as prevention of other communicable and non-communicable diseases by promoting behavior change, such as increasing hand-washing, use of condoms or bed nets, or utilization of safe water systems.

2. The second step is implementation of the Health Services Extension Program (HSEP), which entails all the key activities of the flagship health program developed by the Government over the last few years. This health services development program includes three major components: a) An outreach program centered by the Health Extension Workers (HEWs), 2 per kebele, and construction and equipment of HPs per kebele. These HEWs are, 10 graders trained in vocational school for one year, civil servants and will offer key technical services, such as immunization and family planning, b) A community promotion program centered around volunteer/private sector community promoters/ traditional birth attendants (TBAs) (1 for every 50 households or 250 inhabitants) working under the supervision/guidance of the HEWs and providing support to households for behavior change (i.e. breastfeeding, supplementary feeding, use of bed nets, clean delivery etc.), c) A program strengthening the quality of and demand for clinical care [particularly treatment of ARI and malaria in children, assisted delivery, HIV testing and counseling as well as prevention of mother to child transmission (PMTCT)] in existing health stations and HCs.

3. The third step is a Clinical First Level Services Upgrade, which includes the expansion of HCs throughout the country as well as the upgrading of Health Stations to offer basic clinical care. This step would lead to an increase in the access to clinical care at less than a one hour walk from the household (from 31 percent to 80 percent) and increased access to first level clinical care for adults (including TB DOTS treatment, malaria treatment with ACT, treatment of sexually transmitted infections (STIs) and opportunistic infections, expansion of HIV voluntary testing and counseling (VTC); and basic emergency obstetrical care including transport). HIV and malaria testing is made available through the use of rapid tests.

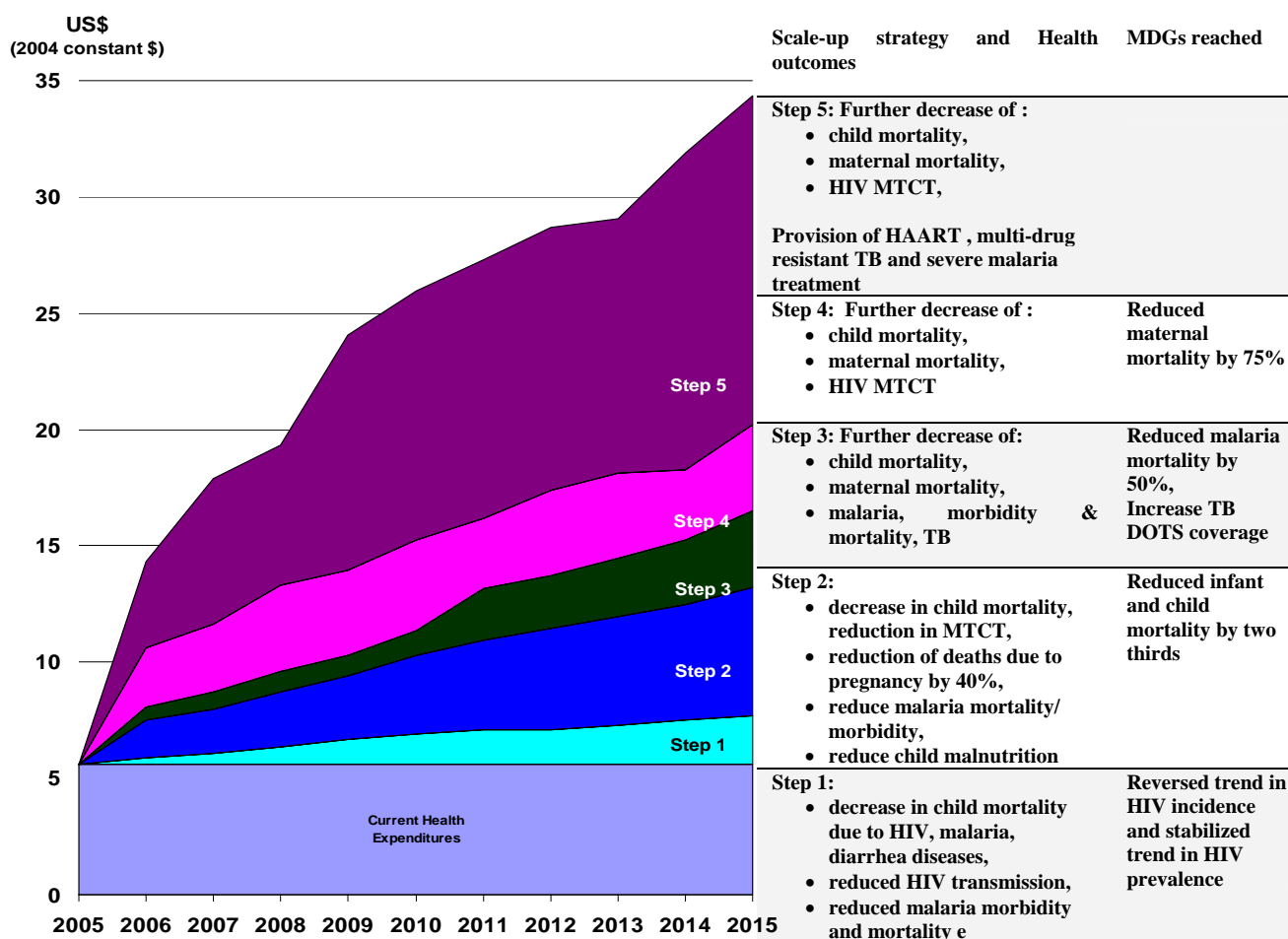
4. The fourth step, a Clinical Services Upgrade of Comprehensive Emergency Obstetric Care (CEOC), requires the operationalization of comprehensive emergency obstetrical care in all new and old HCs of the country. This implies equipping all HCs with an operation theater and staffing it with the appropriate number of nurse midwives and health officers with EOC and surgical skills. This step also entails establishing adequate means of transport, setting blood banks in all HCs and upgrading existing hospitals into full referral centers for emergency obstetrical care.

5. The fifth step is the Expansion and Upgrade of Referrals of Clinical Care, which entails the expansion and upgrading of referral services, including all woredas and zonal hospitals. This step would allow Ethiopian health services to upgrade their equipment and lab facilities to offer quality follow-up for HIV patients receiving HAART, and also expand referral services for neonatal care and complex emergency obstetrical care, thus contributing further to the reduction of under five and maternal mortality. This phase also includes the training of enough MDs and registered specialized nurses to adequately deliver, supervise and monitor the provision of quality referral clinical care.



The costing of the health services contributions to the MDGs has been conducted for each step of health services development using an incremental approach. Figure 4.1 below presents the cost estimates under each step. The costing has taken into account the common costs of removing the bottlenecks to implementation, as well as the costs for scaling-up the various service delivery arrangements. The cost for each step adds cumulatively upon the previous one. Each step corresponds to increasingly higher levels of coverage of health services and associated improvements in health outcomes.

**Figure 4.1 Costs of Scaling-up Health Services in Ethiopia to reach the Health MDGs**



In Figure 4.1 the base represent Ethiopia’s current total spending for health care. The Second National Health Accounts conducted in 2003 documented that Ethiopia spend a total of US\$ 5.6 per person per year. This amount represents spending from all sources: Government, external assistance, private and NGO sectors, and household out-of-pocket payments. The cost for each step is thus incremental to what Ethiopia is spending at the moment.

Step 1 “*Information and Social Mobilization for behavior change*”, would cost an average of US\$1.51 per capita over the 10 year. This information and behavior change approach would contribute to reversing the HIV incidence from 0.66 to 0.55 per 100,000 and maintaining the HIV prevalence at 4.4%. It would also contribute to increasing the level of information of mothers on child health practices and increase the coverage with key child survival interventions including use of ITNs, hand washing and water handling, breastfeeding and nutrition etc. The scaling up of this service delivery arrangement would likely buy a 5-10% decrease in U5M, mainly by affecting the level of information and use of key commodities of households through social marketing, information and targeted subsidies.<sup>6</sup> In terms of human resource development this step mainly involves the training of communication specialists as well as peer educators, mainly among the young and risk groups.

Step 2 “*Health Service Extension Program*”, would cost an additional US\$3.48 per capita per year on average over the period 2005-2015. This outreach and community oriented program would be the main vehicle for reducing infant and child mortality. With this investment Ethiopia will buy 59% reduction in U5M and 36% reduction in Maternal Mortality Ratio<sup>7</sup>. This step enables Ethiopia to reach the child mortality MDG by reducing U5M to 57/1000 live births in 2015 from the 2000 level of 140/1000. Other benefits of scaling up this program include an important contribution to the malaria MDG through the increased use of ITNs among children less than 5 and women, and increased treatment of malaria at community level. It also contributes to reaching the HIV MDG in introducing HIV testing and PMTCT in all existing health centers and health stations. Though the maternal health is not fully achieved at this step, through addressing the current unmet need for family planning the HSEP would also contribute to a reduction of 59% of the number of maternal deaths (Lifetime Risk of Dying)<sup>8</sup>. Human resource development for this step would involve increasing the number of community promoters/frontline workers trained in 2-4 weeks by 17 fold, and increasing the number of HEWs by a factor 8. This expansion is already planned and should not pose difficulties over a period of 10 years given the relatively low level of training required, and assuming resources would be available. The training and supervision of those low skilled workers as well as the strengthening of clinical referral to support this health service extension would on the other hand be more challenging. This would require an increase in the number of nurses midwives –12 graders trained in three years, BA level- by almost 6 fold by 2015. This would imply producing an additional 1,500 nurse midwives per year over a period of 6 years, at least doubling the current level production. This could largely happen through the increasing production of private schools of nursing.

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<sup>6</sup> By keeping the HIV epidemic controlled, this program affects child survival by mainly avoiding an increase in child mortality due to HIV, as has been observed in other countries of East Africa with much higher levels of HIV prevalence than Ethiopia (e.g Zambia, Kenya, Zimbabwe)

<sup>7</sup> The maternal mortality ratio is measured as the number of maternal deaths over the number of live births; as such it is sensitive to interventions occurring during pregnancy and labor.

<sup>8</sup> By reducing the number of pregnancies, family planning leads mechanically to less death of women linked to pregnancy and labor. But family planning does not affect the maternal mortality ratio which is the risk of mothers of dying once pregnant.

Step 3, “*Upgrade of first level clinical care*”, would cost an incremental average of US\$ 1.72 on top of the Health Services Extension Program. This step would strengthen the quality of and demand for first level clinical care at health post, clinic and health center level, leading to an increase in coverage with malaria treatment-including for adults- but also treatment of STI, and prevention<sup>9</sup> and treatment of opportunistic infections including TB DOTs. This program would lead to reaching the malaria MDG by reducing malaria specific mortality by about 50% and the TB MDG by ensuring appropriate treatment of all non resistant TB cases identified. This step would require the upgrading of health stations with an adequate number of clinical health workers, trained in one year (upgrading of health extension workers or existing junior/assistant nurses).

The full implementation of steps 1 to 3 will take the sector a long way in improving the health status of the population, and perhaps 70-80% towards the achievement of the MDGs.

Step 4, “*Expansion and upgrade of Comprehensive Emergency Obstetrical Care*” would cost an incremental US\$ 3.50 per capita over 2005-2015. This step would establish access to and support to demand for emergency obstetrical care in each health center as well as establishing assisted deliveries services at health post level. The reduction in maternal mortality ratio at this step is 54%. Combined with the family planning services contribution to reducing the risk of dying from pregnancy, Ethiopia is likely to achieve the maternal health MDG at this step. It would also buy additional benefits in terms of reduction of neonatal mortality; leading to 61% U5M reduction by 2015 (exceeds the MDG child mortality goal). The human resources implications of this step are important. The number of registered BA level nurses midwives would have to increase by more than 11 fold implying a tripling of the production over a period of 6 years. A major challenge would be also the production of health officers at master level, to conduct and oversee emergency obstetrical care at health center level. To sustain this step the number of health officers would have to increase by almost 6 fold. This would require quadrupling the production of health officers for a period of five to six years, a significant challenge. For both these categories, the costing takes into account a 35% hardship allowance for working in rural area.<sup>10</sup>

Step 5, “*Expansion and upgrade of referral care*” would cost an incremental US\$ 10.10 per capita over the period 2005-2015. This step would upgrade referral care in all woredas, so they would have a district hospital with referral diagnostic and monitoring capacity to provide support to the health centers. This service upgrade approach would buy additional gains in under five and maternal mortality, but also ensure quality provision of HAART to all those identified eligible. The mortality reduction at this step is estimated at 64% for the under five and 63% for the maternal mortality ratio. The human resources requirement for this step is particularly demanding with the increase in production of MDs by a five fold by 2015. Given that MD training takes 7 years, this would mean increasing the entry of students into medical schools in 2006 and 2007 by at

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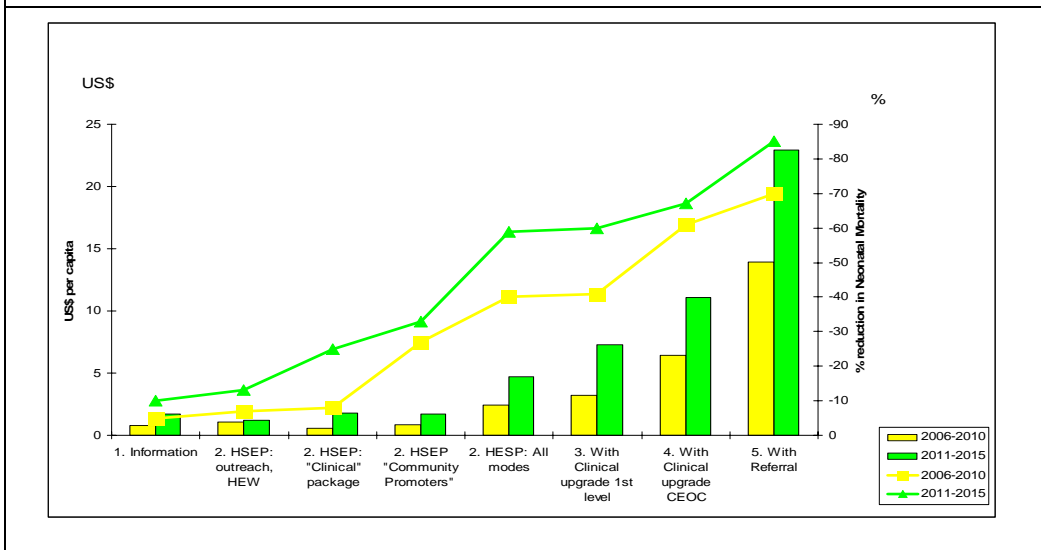
<sup>9</sup> Mainly PCP prophylaxis, for a cost of about US\$ 10 per patient per year

<sup>10</sup> This is based on initial data collected for a health worker study

least a 40 fold factor- this without accounting for the brain drain/migration factor.<sup>11</sup> This suggests that the only way for this step to develop will be to import MDs into Ethiopia. As Ethiopia is currently an exporter rather than an importer of MDs due to the high quality of its medical training, this would call for a major reshuffling of the current global health market.

To reach all of the health MDGs and expand HAART provision, all service scale-up steps must be implemented. To scale up and implement the five steps the financial resource requirement is an average of US\$ 20.31 per capita over the ten year period. However, as can be seen in Figure 4-1 above, some MDGs (such as reduction of child mortality or reversing HIV incidence and prevalence) can be achieved at a somewhat lower level of the supply curve than others (such as MMR and HAART provision. An example is provided below for child health Figure 4-2).

**Figure 4.2: Projected Cost and Associated Reduction in Child Mortality Linked to Implementation of Services Scale-up Strategies: Ethiopia 2005-2015**



#### 4.1.3. Three costing scenarios for HSDP-III

The costing framework shows the implementation cost of the HSDP-III and indicates resource needs and allocations across the seven different components for each year of the plan. Three scenarios are considered for this detailed costing exercise. For each scenario a separate set of health coverage targets are taken (Table 4.2). The assumptions implied in defining the scenarios are:

- a. **Scenario 1** takes full implementation of the *Health Service Extension Program* into account. It includes the establishment of the 13,635 health posts; the recurrent cost required to assign two HEWs per health post; the vaccines, cold chain, equipment, stock of drugs and supplies. This scenario also considers significant expansion at health center level including increasing access to health center to 80% with new HC construction of 253 and upgrading 1,457 health stations to HC.

<sup>11</sup> Available evidence suggests that Ethiopia trains 2 MDs for one to stay in Ethiopia and three for one in the public sector

- The scenario also consider all the human resource, equipment, drugs and supplies cost to enable HCs provide Basic Emergency Obstetric Care.
- b. **Scenario 2** is based on the full content of the *Accelerated Expansion of Primary Health Care*. This scenario takes the full HSEP and progressively increases access to health centers to 94% - adding to the base HCs of 600, new construction of 446 and up grading 2,107 health stations to reach a total of 3,153 HCs. All the human resource, equipment, stocks of drugs and supplies, operational costs are considered. Limited expansion is considered at the hospital level
- c. **Scenario 3** is based on the *MDGs Needs Assessment* that assumes no financial constraint. This scenario goes beyond the first two by setting high level of coverage targets for each intervention e.g. 80% coverage of ARV. A major expansion in hospitals is also considered.

**Table 4-2 Access and Coverage Targets for 3 Scenarios**

Delivery Modes	Key Interventions	Baseline 2004	Scenario 1	Scenario 2	Scenario 3
<b>1. HSEP/ Community Health Promotion</b>	Increase the proportion of population with access to HP	20%	100%	100%	100%
	Clean delivery	10%	50%	64%	64%
	Temperature management and KMC	31%	40%	60%	60%
	Use of condom	17%	49%	64%	64%
	ITN - pregnant women and infant	2%	49%	71%	80%
	Breastfeeding for children 0-5m	38%	63%	67%	67%
	Breastfeeding for children 6-11m	75%	80%	80%	80%
	Water/Sanitation/Hygiene	10%	67%	67%	67%
	ITN – under five children	1%	63%	71%	71%
	Complementary feeding	34%	63%	67%	67%
	Oral Rehydration Therapy	13%	65%	80%	80%
	Zinc for diarrhea management	0%	25%	50%	50%
	Anti-malaria dugs for children	17%	51%	75%	75%
	<b>2. HSEP/ Outreach</b>	Number of Health Post	4211	13,635	13,635
Family Planning		25%	45%	53%	63%
To increase ANC coverage		42%	80%	90%	90%
Tetanus toxoid for pregnant		43%	75%	90%	90%
Tetanus toxoid for non pregnant		26%	67%	90%	90%
Folate supplementation in pregnancy		6%	52%	52%	52%
DPT3 coverage		70%	80%	95%	95%
Fully immunized children		45%	54%	72%	72%
Vitamin A supplementation (12-23m)		30%	54%	72%	72%
Hib and Hepatitis vaccines		0%	54%	72%	72%
<b>3. Health Center</b>	Number of Health Center	600	2,229	3,153	3,153
	Proportion of population with access to HC	18%	80%	94%	94%
	Delivery by skilled attendant (at HF)	12%	32%	53%	64%
	PMTCT: Nevirapine and replacement feeding	1%	25%	53%	64%
	Antibiotics for PROM	3%	3%	53%	64%
	Antibiotics for pneumonia	20%	41%	72%	79%
	Antibiotics for dysentery & diarrhea	14%	27%	72%	79%
	% new born receiving adequate resuscitation	6%	30%	60%	82%
	Proportion of STI cases properly treated	20%	30%	60%	79%
	Treatment for Iron deficiency in pregnancy	5%	52%	75%	80%
	Anti-malarial combination treatment	0%	40%	72%	79%

Delivery Modes	Key Interventions	Baseline 2004	Scenario 1	Scenario 2	Scenario 3
	Ampiciline/Gentamycin for neonatal sepsis	6%	30%	60%	82%
	Antibiotics for opportunistic infections	20%	50%	72%	79%
	ARV combination treatment for AIDS	3%	39%	55%	79%
	Health facility coverage of DOTS/MDT	51%	72%	83%	87%
<b>4. District Hospital</b>	Number of District Hospital	40	42	56	86
	BEOC: % women referred for obstetric complications	1%	24%	43%	63%
	Management of complicated malaria	1%	24%	43%	63%
	Management of server prematurely/LBW	6%	25%	53%	71%
	Management of resistant AIDS	0%	24%	43%	63%
	Management of resistant TB	0%	24%	43%	63%
<b>5. Zonal Hospital</b>	Number of Zonal Hospital	39	41	49	61
	Comprehensive EOC	1%	27%	46%	63%
	Other emergency acute care	1%	27%	54%	63%
	Chronic care for TB and complicated AIDS	0%	27%	46%	63%
	Sterilization (FP)	6%	27%	53%	63%
<b>Note:</b> Baseline MOH 2004 health and health related indicator; Scenario 1 based on Step 1+2 of MDG Needs Assessment; Scenario 2 based on Step 1+2+3+4 of MDG NA; and Scenario 3 based on Step 1+2+3+4+ 5 of MDG NA					

The summary of the national total costs under the three scenarios and the breakdowns for the national base scenario are discussed below. Incremental cost estimates under the second and third scenarios are attached in Annex 4. Total cost distribution by region is presented in Annex 5.

#### **A. Summary of the Three Cost Scenarios**

As discussed earlier the costs derived from the costing and budgeting tool represent the extra amount of money, additional to current levels of expenditure, required to reach the national targets specified in the HSDP-III, i.e. the additional spending required on top of last years spending on health. The total cost estimate is thus calculated as the sum of the current level of public health spending and the additional cost estimate. According to the National Health Accounts 2003, and the 2004 health and health related indicator the base line public health spending is US\$ 2.77 per capita(i.e. government and external resources

The national total cost estimates for HSDP III implementation calculated as the sum of the baseline health spending and the incremental/additional cost estimate per scenario per year is presented in the Table 4.3 below. The total cost of HSDP III for scenario 1 would be an average of Birr 49.64 (US\$ 5.80) per capita per year, representing doubling public expenditures. The second scenario triples the present spending and the cost is estimated at Birr 70.94 (US\$ 8.29) per capita per year. The third scenario is estimated at Birr 96.06 (US\$ 11.22) per capita per year which is a quadruple present spending. In all three scenarios the capital cost is front loaded, i.e. most of the capital cost to be incurred in the initial years of HSDP III, so that over the five years the capital cost is sliding.

**Table 4-3 HSDP-III Total Cost Estimates Summary for the Three Scenarios****'in Million Birr**

Scenarios		2005/06	2006/07	2007/08	2008/09	2009/10	Total
Scenario 1	Per capita	38.6	43.1	49.1	55.4	62.0	49.64 (average)
		2,817.4	3,236.8	3,800.3	4,408.7	5,080.5	19,343.7
	Capital	2,226.1	2,019.4	1,871.1	1,722.8	1,516.2	9,355.7
	Recurrent	591.4	1,217.3	1,929.2	2,685.9	3,564.3	9,988.0
Scenario 2	Per capita	55.7	61.7	70.2	79.0	88.1	70.94 (average)
		4,071.1	4,638.6	5,433.1	6,290.7	7,217.6	27,651.1
	Capital	3,258.7	2,973.8	2,815.3	2,656.8	2,371.9	14,076.5
	Recurrent	812.4	1,664.8	2,617.8	3,633.9	4,845.6	13,574.6
Scenario 3	Per capita	69.5	81.2	95.5	109.8	124.3	96.06 (average)
		5,078.0	6,101.7	7,385.5	8,740.3	10,180.9	37,486.3
	Capital	3,821.4	3,540.9	3,405.4	3,269.8	2,989.3	17,026.8
	Recurrent	1,256.6	2,560.7	3,980.1	5,470.5	7,191.5	20,459.5

**B. Scenario 1**

The incremental/additional cost estimates under the 1<sup>st</sup> scenario are presented below (estimates of 2<sup>nd</sup> and 3<sup>rd</sup> scenarios are annexed in annex 4). These cost estimates are presented in three ways so as to facilitate the annual planning at different levels of the health system:

1. by HSDP components,
2. by service delivery levels, and
3. by major group of expenditure items.

Table 4.4 shows the cost estimates by HSDP components. The largest cost component (42.2% of the total cost) is for strengthening the pharmaceuticals component of HSDP i.e. for drugs and supplies (including ARV), vaccines and cold chain, and logistic system. The access component accounts for 25.9% of the total estimated cost: enhancing access through new construction, upgrading, rehabilitation, and equipping of health facilities as well as increasing transport facilities to improve the referral system. The service delivery and quality of care component takes 17.3% of the estimated cost.

**Table 4-4 HSDP-III Incremental Cost Estimate by Components**

**‘in million Birr**

Nature of Expenditure	Fiscal Year	HSDP Components							Grand Total
		Service Delivery and Quality of Care	Access to Services: New Construction, Expansion and Transport	Human Resource Development	Strengthening Pharmaceuticals	IEC	Management, HIS, M&E	Health Care Financing	
Capital	2005/06	279.3	1,139.5	4.3	425.2	77.9	0.1		1,926.2
	2006/07	270.6	978.0	8.5	425.2	64.9	0.2		1,747.4
	2007/08	293.5	830.9	17.1	425.2	51.9	0.5		1,619.1
	2008/09	316.4	683.9	25.6	425.2	38.9	0.7		1,490.8
	2009/10	307.7	522.4	29.9	425.2	26.0	0.8		1,312.0
Recurrent	2005/06	92.9	6.7	60.1	301.3	37.3	7.1	6.4	511.7
	2006/07	187.1	16.0	130.7	617.2	80.5	14.1	7.7	1,053.3
	2007/08	284.1	30.8	226.1	962.5	135.2	21.2	9.4	1,669.3
	2008/09	382.5	48.2	335.8	1,322.5	195.7	28.3	11.1	2,324.1
	2009/10	485.1	73.7	477.1	1,726.5	273.5	35.3	12.8	3,084.1
Total	2005/06	372.2	1,146.1	64.3	726.5	115.2	7.2	6.4	2,437.9
	2006/07	457.7	994.0	139.2	1,042.4	145.4	14.4	7.7	2,800.8
	2007/08	577.7	861.7	243.2	1,387.7	187.1	21.7	9.4	3,288.4
	2008/09	699.0	732.1	361.4	1,747.7	234.6	28.9	11.1	3,814.8
	2009/10	792.9	596.2	507.0	2,151.6	299.5	36.1	12.8	4,396.1
Grand Total		2,899.4	4,330.1	1,315.1	7,056.0	981.8	108.3	47.5	16,738.0
%		17.3	25.9	7.9	42.2	5.9	0.6	0.3	100.0

Analysis of the additional cost by service delivery levels reveals that a significant proportion of the resource is allocated to the primary health care levels. The projected allocation at the health center and health post levels account for 77.7% of the total cost. Hospitals will take 22.1% of the estimated cost of HSDP III (Table 4.5). These proportions of allocation by levels of service delivery are reflections of the government emphasis on the “Health Services Extension Program” and the “Accelerated Expansion of Primary Health Care”.



**Table 4-5 HSDP-III Incremental Cost Estimates by Service Delivery levels**

**‘in million Birr**

Nature of Expenditure	Fiscal Year	Service Delivery				Total
		Health Service Extension Program	Health Center	Hospitals	Administration	
Capital	2005/06	705.8	1,016.7	203.6	0.1	1,926.2
	2006/07	644.0	899.6	203.6	0.2	1,747.4
	2007/08	627.7	787.3	203.6	0.5	1,619.1
	2008/09	611.4	675.1	203.6	0.7	1,490.8
	2009/10	549.6	557.9	203.6	0.8	1,312.0
Recurrent	2005/06	146.1	211.6	150.6	3.4	511.7
	2006/07	306.0	427.7	315.5	4.1	1,053.3
	2007/08	497.3	654.6	512.3	5.2	1,669.3
	2008/09	706.1	886.8	725.0	6.2	2,324.1
	2009/10	956.4	1,135.1	985.5	7.2	3,084.1
Total	2005/06	851.9	1,228.3	354.3	3.5	2,437.9
	2006/07	950.0	1,327.3	519.1	4.4	2,800.8
	2007/08	1,125.0	1,441.9	715.9	5.6	3,288.4
	2008/09	1,317.5	1,561.9	928.6	6.8	3,814.8
	2009/10	1,506.0	1,693.1	1,189.1	8.0	4,396.1
<b>Grand Total</b>		<b>5,750.4</b>	<b>7,252.4</b>	<b>3,707.0</b>	<b>28.3</b>	<b>16,738.0</b>
<b>%</b>		<b>34.4</b>	<b>43.3</b>	<b>22.1</b>	<b>0.2</b>	<b>100.0</b>

To provide some insight into the expenditure breakdown Table 4.6 present the estimated cost by major expenditure items. These expenditure items as presented do not translate one-to-one into the chart of account. However, they could easily be grouped to fit the chart of account; this level of detail is more important to guide the annual budgeting and planning processes.

**Table 4-6: HSDP-III Incremental Cost Estimates by Expenditure Items**

‘in million Birr

Expenditure Item	2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total	
						Amount	%
Salaries and allowances	58.4	129.2	224.8	332.8	478.0	1,223.3	7.3
Office equipments & supplies (M&E, IEC)	13.2	39.7	92.5	158.6	264.2	568.1	3.4
Operational costs (electricity, water, telecommunication, maintenance, fuel)	33.8	39.8	51.9	66.6	88.8	280.9	1.7
New Construction	380.7	319.8	258.8	197.8	136.8	1,293.9	7.7
Upgrading and rehabilitation	478.0	398.4	318.9	239.4	159.8	1,594.6	9.5
Medical equipment (including delivery kits, scale)	250.2	275.4	314.4	353.5	378.6	1,572.2	9.4
Non-medical equipment (radio)	77.9	64.9	51.9	39.0	26.0	259.7	1.6
Vehicles (including motor bike and bicycle)	52.0	43.4	34.8	26.2	17.5	173.8	1.0
Essential Drugs	332.7	534.0	735.3	936.7	1,138.0	3,676.7	22.0
Medical supplies (e.g. ORS, Chlorine, Zinc, Vit A..)	6.7	8.5	10.3	12.1	13.8	51.4	0.3
Vaccines and cold chain	50.8	48.4	45.9	43.4	40.9	229.4	1.4
Contraceptives	35.4	36.5	40.5	45.8	55.2	213.4	1.3
Malaria drugs	41.7	56.8	72.7	88.9	106.2	366.3	2.2
ITNs	182.0	188.5	226.7	264.8	271.4	1,133.4	6.8
HAART	330.6	402.2	475.5	549.7	626.3	2,384.4	14.2
TB drugs	25.7	39.8	54.4	69.3	85.1	274.2	1.6
IEC	43.2	92.1	152.7	219.0	302.7	809.6	4.8
Training	44.7	83.3	126.4	171.5	206.7	632.6	3.8
<b>Grand Total</b>	<b>2,437.9</b>	<b>2,800.8</b>	<b>3,288.4</b>	<b>3,814.8</b>	<b>4,396.1</b>	<b>16,738.0</b>	<b>100.0</b>

## 4.2. Financing Plan

### 4.2.1. Evolution of public and private health spending over HSDP-II

Based on National Health Accounts data, both private and public spending have been on the increase between 1995/96 and 1999/2000. Expenditures on health have substantially increased between 1995 and 2000, from US\$ 4.09 to US\$ 5.60, and this increase occurred in both public and private spending. However, per capita health spending remains among the lowest in the world. The overall per capita health spending in Ethiopia is among the lowest in the world and is significantly lower than the SSA average of US\$ 12. The recent increase has only slightly narrowed the gap. This low level of spending mainly reflects a very low resource base or GDP. Ethiopia's total health spending as a percentage of GDP (4.1 percent) is comparable to the low-income countries' (LIC)

average. Ethiopia's private health spending share of GDP of 2.8 percent is on the high side when compared to the average SSA experience of 2.6 percent.

Funding of the health sector in Ethiopia is shared equally between the public and the private sectors. According to the most recent NHA data (second round), public spending in the health sector, both domestic and from external sources, represents the largest share of total spending (49 percent) and amounts to US\$ 2.77 per capita. Private consumption through out-of-pocket spending<sup>12</sup> also represents a large share of this spending (36 percent) or US\$ 1.96. NGOs contribute a much lower although not trivial amount, their contribution reaching nearly 10 percent of all health spending. However, the contribution of private enterprises accounts for only 5 percent of health spending (Table 4.7).

**Table 4-7 Ethiopia: National Health Accounts Data for 1999/2000**

Total expenditure on health	Millions Birr	Share of Total	Birr per person	US\$ per person (1999/00)
	2,931		46.1	5.6
General government expenditure on health	979	33%	15.4	1.87
Donors	471	16%	7.4	0.9
Private expenditure on health	1,480	50%	21.	2.6
Private enterprises	133	4.5%	2.06	0.25
NGO's and non-profit institutions (local and international)	290	9.8%	4.5	0.55
Net out-of-pocket spending on health	1,057	36%	16.6	2.02

Sources: Authors' estimates based on various sources including NHA 1999/2000, Min. of Health, Min. of Finance, IMF Statistics, PER 2003.

Donor funding has been flowing through extra-budgetary channels and is difficult to capture. From 1997-2001, the health sector received a yearly average of US\$ 57 million or 9.5 percent of the total aid available to all sectors. Loans are included in the budget and accounts, and most budgets support non-earmarked grants and some other grant funds. This is usually done on the basis of commitments presented by donors during budget preparation and are often not reflected in the government account. An unknown amount of donor funds are provided in kind such as medicines; these resources are usually not captured in the budget process. This affects the GOE's ability to accurately determine whether it is allocating an appropriate amount of its own budget for a specific item or budget category.

Cost-sharing represents a small share of expenditures in the public health system. It has been part of Ethiopia's health system since the early 1950s. When originally introduced, fees recovered a substantial portion of the total costs of providing the services. However, the level of fees remained unchanged for almost 50 years and today it has become almost symbolic. Moreover, close to 60 percent of users receive fee waiver. As a proportion of GOE health expenditures, fee remittances to the MOF have declined from 16 percent in 1986 to less than 6 percent in 1995/96.

<sup>12</sup> Out-of-pocket spending by individuals includes direct payments to private practitioners, traditional healers, private pharmacies, and government facilities in the form of user charges.

#### 4.2.2. Potential sources to finance cost of HSDP-III

As discussed earlier the cost of HSDP-III in the three scenarios present a progressively higher rise from the present spending pattern of the health sector. Within the current fiscal context, increasing resources for health in the order of the magnitude presented in the three scenarios will necessarily require substantially raising the share of public spending allocated to health services. Such an increase will be essential to enhance the contribution of health services to the health PASDEP objectives and MDGs.

A need based financing plan is presented in Table 4.8. Government budget is expected to finance 35.5% of the total estimated cost over the life of HSDP-III. A significant share of the cost (31.2%) is expected to be mobilized from global fund and GAVI. The contribution from other sector specific bilateral and UN agencies is estimated at 23.3%. Cost sharing by consumers is also expected to grow and cover 8.4% of the total HSDP III costs.

**Table 4-8 HSDP-III Projected Financing Plan**

Transfer Mode							'in Million Birr	
		2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total Amount	%
Government/Direct Budget Support	Per Capita	12.9	13.6	14.9	16.4	18.6	15.3	
		945.4	1,023.3	1,152.4	1,306.5	1,520.3	5,947.8	35.5
	Capital	776.5	665.3	558.5	451.7	340.5	2,792.5	46.9
	Recurrent	168.9	358.1	593.9	854.7	1,179.8	3,155.4	53.1
Global Funds GFAMT, GAVI	Per Capita	9.6	11.3	13.5	15.5	17.1	13.4	
		701.5	851.8	1,040.3	1,232.1	1,402.1	5,227.7	31.2
	Capital	553.9	553.3	584.3	615.3	614.7	2,921.6	55.9
	Recurrent	147.6	298.5	456.0	616.7	787.4	2,306.1	44.1
Sector Specific Funds: bilaterals, UN agencies	Per Capita	9.0	9.3	9.9	10.6	11.3	10.0	
		660.2	699.2	767.4	842.9	925.9	3,895.6	23.3
	Capital	560.4	496.4	446.7	397.0	333.0	2,233.5	57.3
	Recurrent	99.8	202.8	320.7	445.9	592.9	1,662.1	42.7
NGO/Private Sector	Per Capita	0.5	0.6	0.7	0.8	0.9	0.7	
		34.5	43.4	52.9	62.7	73.5	267.0	1.6
	Capital	23.0	20.1	17.2	14.3	11.4	86.1	32.2
	Recurrent	11.5	23.3	35.7	48.4	62.1	181.0	67.8
Out of Pocket Expenditure	Per Capita	1.3	2.4	3.6	4.7	5.8	3.6	
		96.3	183.0	275.4	370.7	474.4	1,399.8	8.4
	Capital	12.4	12.4	12.4	12.4	12.4	61.9	4.4
	Recurrent	83.9	170.7	263.1	358.3	462.0	1,338.0	95.6
Grand Total	Per Capita	33.4	37.3	42.5	47.9	53.7	43.0	
		2,437.9	2,800.8	3,288.4	3,814.8	4,396.1	16,738.0	100.0
	Capital	1,926.2	1,747.4	1,619.1	1,490.8	1,312.0	8,095.4	48.4
	Recurrent	511.7	1,053.3	1,669.3	2,324.1	3,084.1	8,642.6	51.6

The pace at which allocations on health can rise will depend on the rate of economic growth, the inflow of external resources for health, the potential for increasing and the priority given by local governments to health spending. Projections can be made assuming different scenarios of economic growth, pace of evolution in the share of public spending, as well as the resource commitment of HPN donors over the next five years.

### **4.3. MDG Performance Package Fund**

Even when budgets allocated to health increase, low budget execution often undermines service delivery. Spending rates are still low in all regions, justifying some reluctance of the Government to increase public funding for health. As presented in Section 2.10 of this document, almost all regions spent a larger share of their recurrent budgets compared with their capital budgets while the Federal MOH spent a significantly larger share of its capital budget. With the exception of Afar, all the other regions performed significantly better in spending their recurrent budgets compared to their capital budgets in 2002/03<sup>13</sup>.

This could mean that capital needs relative to implementation capacity in the regions tend to be overestimated, and/or there could be factors such as donor processes which impede faster execution of capital budgets at the regional level. Indeed the assistance to the Ethiopian health sector during HSDP-II has been particularly fragmented. The number of donors which provide extra-budgetary assistance has increased over time, in clear contradiction with recent international statements such as the Paris declaration during the recent High Level Forum.

The other possible causes of over-all under spending include inadequate capacity for program planning/budgeting and management at the regional, zonal, and Woreda levels. The problem of under-reporting could also be a contributing factor. The Public Expenditure Review (2003) mentions that donor inflows tend to be overestimated in the budget at the beginning of the year but actual expenditures are under-reported

In order to ensure that public funds are appropriately channeled towards priority areas for HSDP-III-particularly the implementation of HSEP-, public funds management and transfers –stemming from both domestic revenue and Direct Budget Support will need to be strengthened. First, the health budget allocation at the woreda level has to increase. This means progressively increasing resources to be channeled directly to the service delivery point. These resources should allow to finance key local recurrent costs associated with high performance of health services (eg: wages, incentives and bonuses, maintenance and functioning costs of buildings and vehicles, fuel for transport, community events etc) but also local investment costs (such as buildings construction and rehabilitation, investment in seed funds for special pharmacies/drug revolving funds, local training etc).

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<sup>13</sup> Source: MOFED cited in MOH/PPD Health and Health Related Indicators. 2002/03.

Secondly; the particular nature of health services- a large number of public good/high externality elements in service delivery and a high proportion of recurrent inputs bought internationally (medicines, commodities and equipment)- warrants the establishment of a strong Federal MOH Level MDGs Performance Package Fund to support the logistics of the implementation of HDSP-III. To this end MDGs Performance Package Fund could be created at Federal MOH. This fund could have three components (Annex-6):

- i. *Component #1 HSEP*: HSEP is the flagship program for the GOE to achieve the child health MDG and prevention of communicable diseases. It is fully integrated into HSDP III. Training of the health extension workers is progressing as planned and within the next two years all rural kebeles will have two female health extension workers. The government is committed to cover salaries and part of the health post construction costs. The effective implementation of HSEP, however, requires basic infrastructure (health post); equipment (cold chain, ORT kit, delivery kits..), essential health commodities (vaccines, contraceptives, ITNs), well trained HEWS and a well functioning system for logistics, supervision and reporting. The HSEP component of the MDG Performance Package Fund aims to provide these inputs to facilitate the implementation of the program.
- ii. *Component #2 Obstetric Care*: Considering the present level of the maternal mortality ratio and the coverage level of maternal health interventions, reaching the maternal MDG target represents an enormous challenge. It requires a concerted effort to enhance service delivery capacity at the health centre level. Access to health centre should increase as indicated in the ‘accelerated expansion of primary health services coverage in Ethiopia’ document. Health centres needs to be equipped with basic emergency obstetric care commodities. Human resources trained in Basic and Comprehensive Emergency Obstetrical Care need to be assigned at the health centre level. Also a well functioning referral system with the required transport is needed. Hence component two of the MDG Performance Package Fund should contribute to the resource requirements of quality obstetrical care.
- iii. *Component #3 Technical Assistance*: The technical assistance component aims to provide support in sectoral reviews, operational research, and other activities at FMOH level. This component is already established. Four donors have pooled over US\$ 650,000. The fund management is outsourced to UNICEF.

## Summary and Main Highlights of HSDP-III

The preparation of HSDP-III is meant to serve as a blue print and as a guiding framework for further Regional and Woreda detailed planning and implementation of the Health Sector activities for the coming five years. It has introduced substantial improvement in the planning process of the Health Sector as compared to HSDP-I and II mainly in the following perspectives.

***Linkage with the MDGs and the National Development Policies and Strategies:*** - the formulation of HSDP-III fully reflects the Government's renewed commitment to the achievement of the Health MDGs and is based on the various policies and strategies that were developed and endorsed to serve as the vehicles for the achievement of MDGs such as the HSEP, Accelerated Expansion of Primary Health Care Coverage, the Human Resource Development Plan etc. These have been fully articulated in the document. HSDP-III also constitutes the health chapter of the National Sustainable Development and Poverty Reduction Programme-II.

***Development of HSDP-III in SPM Approach:*** - the current drive to develop SPM in all sectors and at all levels is part of the "Top Management Sub Programme" of the CSRP. Development of HSDP-III in SPM format has allowed a closer scrutiny of the strengths, weaknesses, opportunities and threats in the sector and using the analysis has helped to set the goals and objectives for the coming five years. In addition to the formulation of the programme, HSDP-III has looked into the bottle necks (Strategic Issues) in the previous two phases of HSDP and treated them separately with special emphasis. The recommendations made during the series of evaluation of HSDP so far have been given special consideration in the formulation of the strategic issues of the Health Sector.

***Ownership and Participation:***-while the ownership of HSDP-III remains with the government at various levels, HSDP-III has fully embraced the active participation of all the major stakeholders during the development process. SPMs of the RHBs have been used as an input, the consultation process has been enhanced and the comments of the stakeholders have been incorporated in the document. Since the concerns of all the stakeholders has been addressed in HSDP-III, it will be expected to serve as the basic framework of planning, implementation, monitoring and evaluation of health activities at all levels of the health system.

***The Costing Exercise:***- for the first time, this HSDP-III is fully costed using the Marginal Budgeting for Bottleneck (MBB) approach. This approach has helped to define high impact interventions, identify the main bottle necks, set targets to be achieved and estimate the impact and cost of different health service delivery options. Accordingly, the costing of HSDP-III is developed using three different scenarios thus facilitating the decision-making process to consider the most suitable option based on the available resource, implementation capacity and the country's macroeconomic framework.

Furthermore, the formulation of HSDP-III is based on the sense of urgency that the pace of planning and implementation of health interventions is no longer *business as usual*. It

reflects the need for more commitment, stronger momentum, scaling up of interventions and faster implementation rates in order to bring about the desired improvement in the health status of the Ethiopian people towards achieving the MDGs in the year 2015.

This might have specific implications both for the Government and HSDP Partners. Doubling of the resources allocated for the Health Sector might be the minimum requirement for the effective implementation of HSDP-III. There is also a need to ensure full integration of HSDP-III in the planning and implementation process at all levels of the Health System with particular emphasis to the operational levels. Furthermore, the Government has to create conducive environment for the effective implementation of HSDP-III through accelerated and effective implementation of the ongoing Civil Service and Health Sector Reform Programmes.

HSDP Partners are also expected to enhance the collaboration efforts with the Government through increased resource mobilization; enhanced consultation processes; and harmonization of planning, implementation, monitoring and evaluation of health interventions in order to enhance the planned accelerated and effective delivery of the required health services to the population, reduction of poverty and achievement of the MDGs.



**Annex-1 SWOT Analysis of HSDP**

<b>Component</b>	<b>Strength</b>	<b>Weakness</b>	<b>Opportunity</b>	<b>Threat</b>
<b>Health Service Delivery and Quality of Care</b>	<p>Existence of formal organizational structure that addresses communicable diseases, family health services and hygiene and environmental health services at all levels</p> <p>Commencement of health extension package</p> <p>Development and implementation of several guidelines and treatment manuals</p> <p>Adoption of strategies like Roll Back Malaria, MPS, IMCI, DOTS etc that are universally found to be cost-effective</p> <p>Strong effort and success in mobilizing external resources</p> <p>Focus of HSDP on promotive, preventive essential curative and rehabilitative approaches</p> <p>Development of essential health service package</p> <p>Alignment of HSDP targets with the MDGs</p>	<p>Shortage of skilled human professionals and lack of staff retention mechanisms</p> <p>Lack of well established organizational structure for health extension package</p> <p>Shortage of drugs, equipment and supplies</p> <p>Low health service coverage and utilization</p> <p>Low level of resource utilization</p> <p>Expenditure of major proportion of the sectoral resource on curative health care</p> <p>No evaluation of the effectiveness of the 4 tier system so far</p>	<p>Government's commitment to improve the health service delivery and quality of care</p> <p>Generous financial support from Global Initiatives and HSDP Partners</p> <p>Increasing participation of the private sector in the health service delivery</p> <p>Decentralization of the health system to the woreda level</p> <p>Implementation of PASDEP which gives emphasis to the poverty related communicable diseases</p>	<p>Instabilities and exacerbation of socio economic problems due to recurrent war and drought</p> <p>Illiteracy, poverty and an unabated population growth</p> <p>Uncontrolled spread of diseases like HIV/AIDS, TB etc which are influenced by factors beyond the health sector</p> <p>Donor dependency</p> <p>Lack of capacity to implement the decentralized health system</p> <p>Weak intersectoral collaboration</p> <p>Weak community participation</p>
<b>Health Facility Construction, Expansion and Rehabilitation</b>	<p>Availability of standard design for the different levels.</p> <p>Relatively adequate budget is allocated from external sources for PHCU's.</p>	<p>Engineering capacity at RHB &amp; Woreda level is low or absent.</p> <p>Inappropriateness of the conventional 4tier system for the pastoralist population</p> <p>Imbalance between new constructions, staffing, equipping, furnishing and recurrent budget</p>	<p>Expansion of the private construction sector.</p> <p>Progressive improvement in construction technologies</p> <p>Community contribution and participation in the construction</p>	<p>Increasing cost of construction materials.</p> <p>Donor dependency</p> <p>High attrition rate of engineering staff at all levels.</p>

Component	Strength	Weakness	Opportunity	Threat
		<p>allocation. Some health facilities lack water supply, electricity &amp; other utilities Slow rehabilitation and maintenance programme. Standards are not fully enforced in certain regions. Disabled access is compromised in the technical standards of health facility construction</p>	<p>of HPs</p>	
<b>Human Resource Development</b>	<p>Increasing capacity of health professionals training institution through the Capacity Building Programme. Development of Health Human Resource Development pl Establishment of Ethiopian Health Professionals Council</p>	<p>Low health workers to population ratio Inequitable distribution of human resource among regions Delayed implementation of HRD strategy Weak public private sector partnership in health professional training. Poor quality of training particularly in the private sector Lack of health professionals ethical standards</p>	<p>Increasing participation of the private sector in the human resource development Technical assistance from HSDP partners to fill some gaps in the sector</p>	<p>Quality may be compromised for quantity. Exodus of human resources from the public sector Brain drain of experienced professionals</p>
<b>Pharmaceutical Services</b>	<p>Existence of organizational structure to control, administer and procure drugs and medical supplies at FMOH. Presence of National Drug Policy, Policy on Anti-Retroviral Drugs Supply and use Essential Drug list and related regulations. Increasing number and effectiveness of special pharmacy projects.</p>	<p>Very low level of funding compared with the minimum level recommended by WHO. Poorly organized logistic, storage and inventory system. Delays in formalizing the agreement with some partners &amp; slow implementation of approved funds like GFATM.</p>	<p>Increasing domestic manufacturing capacity of drugs The opening of the School of Pharmacy at Jimma University &amp; commencement of training of pharmacy technicians and druggists in the private health training institutions. Increased no. of local</p>	<p>The drug supply may be affected when the IDA credit moves from direct supply of drugs to general budget support. Critical shortage of trained pharmaceutical personnel in the public sector.</p>

Component	Strength	Weakness	Opportunity	Threat
	Availability of fund from government and external sources.		pharmaceutical establishments	
<b>IEC</b>	<p>Institutionalization of IEC (at least at FMOH and RHBs)</p> <p>Development of national IEC strategy</p> <p>Recognition of IEC as one of the major components of HSDP</p> <p>The focus of HSEP on health promotion at the household and community level will have a synergistic effect</p>	<p>Delayed development and adaptation of national IEC strategy</p> <p>Lack of baseline KAP data to set relevant and measurable objectives and targets for IEC/BCC</p> <p>Shortage of IEC focal persons at all levels of the health system (particularly at lower levels)</p> <p>Inadequate impact assessment of health education messages</p> <p>Poorly regulated broadcasted IEC messages</p>	<p>Institutionalization of ICT as an authority which can supplement IEC</p> <p>Commencement of training of IEC professionals at degree level</p>	<p>Inability of the existing means of communication to reach all segments of the population</p> <p>Diversity of culture and language of the people demanding diverse means of communication which can have a huge resource implication</p> <p>High prevalence of illiteracy</p>
<b>Health Management, Management Information System and Monitoring and Evaluation</b>	<p>Availability &amp; well functioning cascade of governance by sector HSDP (CJSC, RJSC, REGULAR ARM, HPN Donor Group)</p> <p>HMIS and M&amp;E are already included as key components in the HSDP</p> <p>Availability of health and health related policies, strategies, proclamations, regulations, guidelines, directives and standards</p> <p>Presence of a long-term strategy and a regular framework of planning cycle</p> <p>Existence of a rich experience in planning</p> <p>Commencement of implementation of the CSRP in the Health Sector</p> <p>Decentralized governance</p> <p>National level indicators are selected and harmonized with PASDEP</p>	<p>Lack of adequate capacity to implement decentralized health system at woreda level</p> <p>Poor follow-up of implementation of proclamations, guidelines, directives and standards</p> <p>The Health Policy has not been revised or evaluated so far</p> <p>Lack of focus, clear vision and direction regarding the role and implementation of HMIS</p> <p>Lack of HMIS &amp; M&amp;E policy, guideline and user-friendly manuals</p> <p>Fragmented regional initiatives on HMIS &amp; M&amp;E</p> <p>Poor institutionalization of HMIS at lower levels of the health system</p> <p>Incomplete, untimely and inaccuracy of reports</p> <p>Weak logistic and financial resources allocation for HMIS/M&amp;E</p>	<p>Donors are keen to provide financial and technical support to HMIS &amp; M&amp;E</p> <p>Pressure from national PASDEP monitoring unit to strengthen HMIS</p> <p>Presence of local initiatives in SNNPR and Tigray Regions to draw lessons from</p> <p>Lessons can be learnt from HMIS initiatives in developing countries like Ghana</p>	<p>Establishment of new posts at the peripheral levels may take time due to resistance from civil service authorities</p> <p>Collaboration between the MOH, MOE and RHBs to develop curriculum on HMIS and start training needs advocacy and takes time</p> <p>Resistance from HSDP partners to adhere to the agreed requirements and harmonization of budget cycle, fund disbursement and reporting</p> <p>Lack of woreda joint steering committee</p>

Component	Strength	Weakness	Opportunity	Threat
	Availability of a well established consultation fora with HPN Donor Group which has been enabling to secure significant amount resource for the Health Sector	Duplication and multiplicity of formats and incompatible vertical reporting systems resulting in poor quality of data Data not analyzed and not used for decision making Poor communication among departments collecting vertical reports at all levels		Inadequate focus on the rationalization of monitoring indicators
<b>Health Care Financing</b>	HCF Strategy is comprehensive and directional Revision and completion of regulations on waivers and exemptions, hospital board formation, outsourcing of some non-clinical services, revenue retention and preparation for introducing private wing in public owned hospitals Presence of adequate technical assistances Encouraging pace of expansion of special pharmacies	HCF is not institutionalized at all levels Slow decision-making process on implementation of HCF Strategy and the subsequent regulations Weak utilization of technical assistance from HSDP partners at FMOH	Increasing support from HSDP partners	Approval of the draft proclamation and regulation by the Council of Ministers and the House of People's Representatives might take time Inadequate resource availability towards financing MDG requirements
Emergency preparedness and Response	Wide network of health institutions, the initiation and implementation of IDSR.	Absence of a structure at FMOH and not strong EPT at all levels for emergency preparedness and response, lack of strategy for health emergency preparedness and response. Poor capacity on emergency preparedness and response.	Good commitment from NGOs and UN agencies to support emergency preparedness and response interventions. Presence of a mechanism to coordinate various actors working in emergency response, the decentralization and the Health extension program	Recurrent drought, severe environmental degradation compromising the coping capacity of vulnerable communities

**Annex 2- List of Indicators for Monitoring HSDP at National Level and their definitions**

<b>Serial No.</b>	<b>Category</b>	<b>Indicator</b>
1.	<b>Input</b>	Government budget allocation to the Health Sector
2.		Total percapita health expenditure
3.	<b>Process</b>	Essential drugs stock out rate
4.		HMIS completeness and timeliness reporting rate
5.		HSDP harmonization
6.		Ratio of budget allocation to utilization/expenditure
7.	<b>Output</b>	Primary health service coverage
8.		Health service utilization rate
9.		Contraceptive prevalence rate
10.		Proportion of deliveries attended by skilled health personnel
11.		DPT3 Coverage
12.		HIV Incidence
13.		ITNs coverage rate
14.		In patient case fatality rate
15.		TB case detection and treatment success rates
16.		Improved sanitation access rate
17.		Proportion of institutions staffed as per standards

**1. GOVERNMENT BUDGET ALLOCATION TO THE HEALTH SECTOR**

<b>Definition</b>	The absolute amount of government budget allocated to the health sector.
<b>Data Source(s)</b>	Administrative data
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	It measures commitment of the Government to the health sector

**2. TOTAL PERCAPITA HEALTH EXPENDITURE**

<b>Definition</b>	Health expenditure from all sources: Government, donors, NGO/private, and household out-of-pocket
<b>Data Source(s)</b>	National Health Account Survey
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	It measures how the health sector fares in relation to other priorities

### 3. ESSENTIAL DRUGS STOCK OUT RATE

<b>Definition</b>	Percentage of facilities (service delivery points, warehouses) that experienced a stockout of essential drugs expected to be provided or issued by that site at any time during a specified period.
<b>Data Source(s)</b>	Data are collected through the Routine Information System (RHIS). Data can be validated through structured supervision and health facility surveys.
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	This indicator measures essential drugs availability (or lack of) over a period of time, and serves as a proxy indicator of the ability of a program to meet clients' needs. Other related indicators (mean duration of stockouts) may help differentiate between products stocked out for a short period of time versus those stocked out for extended periods.

### 4. HMIS COMPLETENESS AND TIMELINESS REPORTING RATE

<b>Definition</b>	Proportion of health and administrative reports that are submitted according to schedule and containing all the required information.
<b>Data Source(s)</b>	Routine Health Information System
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	It gives an indication of the performance of the Routine Health Information System. It is also needed for analysing the morbidity and mortality data reported and perform the necessary adjustments.

### 5. HSDP HARMONIZATION

<b>Definition</b>	Proportion of HSDP partners that harmonized their planning and reporting formats; and procurement procedures with the government's ones.
<b>Data Source(s)</b>	Health Information System
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	It measures effectiveness and efficiency of partnership.

### 6. RATIO OF BUDGET ALLOCATION TO UTILIZATION/EXPENDITURE

<b>Definition</b>	Proportion of budget allocated to different levels of the health system that has been spent within the fiscal year.
<b>Data Source(s)</b>	Administrative reports
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	To measure the resource absorption capacity of the health sector. The indicators should be disaggregated by capital vs recurrent costs and government vs donors funds.

## 7. PRIMARY HEALTH SERVICE COVERAGE

<b>Definition</b>	Proportion of population living within walking distance (10 km) from a health facility (HC and HP).
<b>Data Source(s)</b>	The data are collected through the Routine Health Information System. Alternatively, community surveys can be conducted.
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	This indicator estimates the proportion of population with geographical access to health services. In terms of time needed to reach the health facility, 10 km can be equated to two hours of traveling time.

## 8. HEALTH SERVICE UTILIZATION RATE

<b>Definition</b>	Ratio of visits made to health facilities for curative services (new and repeated OPD consultancies) over total population.
<b>Data Source(s)</b>	Routine Health Information
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	It provides a summary indication of different determinants which affect the use of the health services (distance, economic access, quality of care, etc.). It can be used to compare the performance of different health facilities and of the same health facility over time, and to determine the work load and subsequent staff deployment.

## 9. CONTRACEPTIVE PREVALENCE RATE (CPR)

<b>Definition</b>	The percentage of women, aged 15–49 in marital or consensual unions, who are practicing, or whose sexual partners are practicing, any form of contraception.
<b>Data Source(s)</b>	Contraceptive prevalence data are obtained mainly from household surveys, notably the Demographic and Health Surveys, Multiple Indicator Cluster Surveys and contraceptive prevalence surveys.
<b>Periodicity</b>	Every five years
<b>Purpose and Issues</b>	<b>MDG indicator.</b> CPR is accepted as the "best" performance indicator for family planning programmes. Strictly speaking, the CPR can be derived only from survey data. In years where surveys are not conducted, CPR can be derived by the <b>couple-years of protection (CYP)</b> , based on service statistics.

## 10. PROPORTION OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL

<b>Definition</b>	The proportion of deliveries attended by skilled personnel is the percentage of deliveries attended by personnel trained to give the necessary care to women during pregnancy, labour and the post-partum period; to conduct deliveries; and to care for newborns. Skilled health personnel include only those who are properly trained and who have appropriate equipment and drugs (doctors, nurses or midwives). Traditional birth attendants, even if they have received a short training course, are not to be included.
<b>Data Source(s)</b>	Data are collected through the Routine Health Information System (RHIS). Data can be validated through household surveys, in particular Demographic and Health Surveys and Multiple Indicator Cluster Surveys every five years.
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	<b>MDG indicator.</b> The indicator is a measure of a health system's ability to provide adequate care for pregnant women. Due to the difficulty of measuring maternal mortality, a series of process indicators for evaluating the progress towards the reduction of maternal mortality by focusing on professional care during pregnancy and childbirth are used.

## 11. DPT3 COVERAGE

<b>Definition</b>	The proportion of children below 1 year of age receiving 3 doses of DPT according to national schedule.
<b>Data Source(s)</b>	Routine Health Information System. Data can be validated by community surveys (EPI 30 cluster surveys, Multiple Indicator Cluster Surveys and Demographic and Health Surveys).
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	The indicator provides a measure of the coverage and the quality of the child health care in the country. Lack of precise information on the size of the cohort of children less than one year of age can make immunization coverage difficult to estimate.

## 12. HIV INCIDENCE

<b>Definition</b>	Proportion of new HIV positive adults over total adult population. The incidence is estimated through the percentage of pregnant women ages 15–24 whose blood samples test positive for HIV.
<b>Data Source(s)</b>	Data on HIV in pregnant women come from tests on leftover blood samples taken for other reasons during pregnancy. These samples come from selected antenatal clinics during routine sentinel surveillance.
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	<b>MDG indicator.</b> In generalized epidemics, the infection rate for pregnant women is similar to the overall rate for the adult population. Therefore, the indicator gives a fairly good idea of relatively recent trends in HIV infection nationwide. The indicator should be reported as the median for the capital city, for other urban areas and for rural areas.



### 13. ITNs COVERAGE RATE

<b>Definition</b>	Proportion of households with two ITNs (LLN, treated within last 6 months)
<b>Data Source(s)</b>	The data can be collected by health services at community level. Data are validated through household surveys.
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	The indicator allows monitoring the use of insecticide-treated materials to limit human-mosquito contact. Different studies might provide non-comparable results. A standard protocol should be adopted. Surveys are undertaken only every few years. As the data on bednet use are new, no trend data are yet available.

### 14. INPATIENT CASE FATALITY RATES

<b>Definition</b>	Proportion of inpatients who died during admission (general and associated to specific diseases).
<b>Data Source(s)</b>	RHIS reports. Data can be validated through health facility surveys. Data on disease specific death rates at community level can be collected by community surveys (Multiple Indicator Cluster Surveys) every three to five years.
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	A general CFR among inpatients will give an indication on the quality of care provided. More specific information will be obtained by collecting CFRs for specific diseases of public health importance, namely: malaria, diarrhoea, pneumonia and obstetric complications. CFRs will be reported by age groups (under 5 years of age and 5 years and above). The CFRs in children under five years of age will provide a proxy indicator for assessing the quality of paediatric care (IMCI protocol).

### 15. TUBERCULOSIS CASE DETECTION AND TREATMENT SUCCESS RATES

<b>Definition</b>	The tuberculosis detection rate is the percentage of estimated new infectious tuberculosis cases detected under the directly observed treatment, short course (DOTS) case detection and treatment strategy. The treatment success rate is the percentage of new, registered smear-positive (infectious) cases that were cured or in which a full course of DOTS was completed.
<b>Data Source(s)</b>	Data are collected by the Routine Health Information System (RHIS).
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	<b>MDG indicator.</b> It monitors the performance of the control programme.

## 16. IMPROVED SANITATION ACCESS RATE

<b>Definition</b>	The percentage of the urban and rural population with access to facilities that hygienically separate human excreta from human, animal and insect contact.
<b>Data Source(s)</b>	Two data sources are common: administrative or infrastructure data that report on new and existing facilities, and data from household surveys.
<b>Periodicity</b>	Administrative data are available annually. Household surveys are generally conducted every three to five years.
<b>Purpose and Issues</b>	<b>MDG indicator.</b> When data are from administrative sources, they generally refer to existing sanitation facilities, whether used or not, while household survey data are based on actual use of facilities by the surveyed population. While access is the most reasonable indicator for sanitation facilities, it still involves severe methodological and practical problems.

## 17. PROPORTION OF INSTITUTIONS STAFFED AS PER STANDARDS

<b>Definition</b>	Proportion of institution (clinical and managerial) which positions are covered by relevant staff according to the standards.
<b>Data Source(s)</b>	Routine Health Information and Administrative Reports
<b>Periodicity</b>	Annually
<b>Purpose and Issues</b>	It gives an indication of manpower distribution and availability of human resources. Further data can be collected on the percentage and type of vacant positions.

### Annex-3, Detailed Programmatic Indicators and Targets of HSDP-III

Impact	Indicator	Baseline	Target
<b>Improve the health status of the population</b>	Reduce maternal mortality ratio	871 per 100,000 live births	600 per 100,000 live births
	Reduce under five mortality rate	123 per 1000 population	85 per 1000 population
	Infant mortality rate	77 per 1000 population	45% per 1000 population
	Reduce total fertility rate	5.4	4

Outcome	Indicator	Baseline	Target
<b>Reduce the major disease burden in the country</b>	Morbidity attributed to malaria	22%	10%
	Case fatality rate of malaria in under- 5 children	5.2%	2%
	Case fatality rate of malaria in age groups 5 years and above	4.5%	2%
	Mortality attributed to TB	7% of all treated cases	4% of all treated cases

Output	Indicator	Baseline	Target
<b>Improve the health service coverage</b>	Primary health care coverage	72%	100%
	Proportion of rural kebeles implementing HSEP		100% rural kebeles
	Scope of mainstreaming of HSEP in HSDP		Achieve
	Proportion of pastoralist population with access to HSEP	0%	100%
	Proportion of health centers upgraded and provide CEOC services	0	30%
	Proportion of hospitals and HCs providing PMTCT services	8.6% (49)	100% of hospitals and 70% HCs
	Proportion of hospitals and HCs providing VCT services	59.8%	100% Hospitals and HCs
	Number of HIV sentinel surveillance sites	66	120
	Health facility coverage of DOTS/MDT	53.6%	72%
	Proportion of health facilities implementing IMCI	36	90%
Proportion of districts implementing C-IMCI	12%	50%	

<b>Output</b>	<b>Indicator</b>	<b>Baseline</b>	<b>Target</b>
<b>Strengthen the prevention and control of communicable diseases</b>	Incidence of HIV	0.68%	0.66%
	Prevalence of HIV	3.5%	3.5
	Number of PLWHA receiving ART	13,000 (3%)	263,000
	Proportion of STI cases properly treated	20%	30%
	Proportion of people who used condom with non regular sex partner in the latest intercourse	17%	49%
	Proportion of patients receiving antibiotics for opportunistic infections	20%	50%
	Proportion of malaria epidemics detected and contained within 2 weeks of onset	55%	100%.
	Case detection rate of new smear positive pulmonary TB patients	34%	50%
	No. of TB patients notified and treated	118,000	178,000
	Treatment success rate of all types of TB cases	76% cured or completed treatment	85% cured or completed treatment
	To reduce the prevalence of leprosy		to less than 1/10,000
	Reduce the prevalence of leprosy grade-II disability	12%	< 10%
	Therapeutic coverage of Onchocerciasis control in all CDTI areas	65%	Above 65%
	Cataract Surgical Rate (CSR)	350 per million population per year	600 per million population per year
<b>Strengthen the maternal and child health services</b>	Contraceptive prevalence rate	25.2 %	45%
	ANC service coverage	42.1%	80%
	TT2 coverage for pregnant women	43.3%	75%
	TT2 coverage for non-pregnant women	25.8%	67%
	Proportion of deliveries attended by skilled attendant	12.4%	32%
	Proportion of clean deliveries	10%	50%
	Postnatal care service coverage	13.6%	31%
	Proportion of pregnant women getting folate supplementation	6%	52%
	Proportion of women referred for obstetric complications	1%	24%
	Proportion of pregnant women getting treatment for iron deficiency anemia	5%	36%
	DPT3 coverage	70.1%	80%
	Measles immunization coverage	61.3%	75 %
	Proportion of fully immunized children	44.5%	54%
	BCG = 65% Measles =30% DPT= 20%, TT 10% OPV =15%	To less than 20% for BCG and Measles To less than 10% for DPT,TT and OPV	Vaccine wastage rate

<b>Output</b>	<b>Indicator</b>	<b>Baseline</b>	<b>Target</b>
<b>Strengthen the maternal and child health services</b>	Proportion of pregnant women using ITNs	2%	49%
	Proportion of under five children utilizing ITNs	2%	63%
	Proportion of children from HIV +ve mothers getting PMTCT (nevirapin and replacement feeding or exclusive breast feeding)	0.1%	25%
	Proportion of children who got Hib and Hepatitis vaccines	0%	54%
	Proportion of children getting proper temperature management including KMC	10%	40%
	Proportion of children aged 6-9 months initiated on complementary foods on top of breast feeding	75	80
	Proportion of children aged 6-59 months getting vitamin-A prophylaxis	10%	54%
	Proportion of pregnant mothers getting treatment for Iron deficiency in pregnancy	5%	25%
	Proportion of children aged 0-5 months on exclusive breast feeding	34%	63%
	Proportion of children who got zinc for diarrhea management	0%	25%
	Proportion of children aged 6 months to 11 months on optimum breast feeding	75%	80%
	Proportion of infants with complementary feeding	34%	63%
<b>Strengthen the hygiene and environmental health services</b>	Latrine Coverage	29%	80 %
	Proportion of water sources checked for potability	35.9%	90 %
<b>Improve availability, safety and efficacy of essential drugs</b>	Proportion of public health facilities with essential drugs	80%	100%
	Percentage of expired drugs in public healthy facilities	8%	1%
<b>Improve the availability adequate human resource in the sector</b>	HEWs to population ratio	1:26687	1:2,500
	Doctors to population ratio	1:29777	1:14,662
	Proportion of health professionals teaching institutions providing pre-service IMCI	66%	95%
<b>IEC/BCC that ensures effective social mobilization to tackle diseases of public health importance designed and implemented</b>	Scope of adaptation and implementation of the National IEC/BCC Strategy at all levels of the health system	0	100%

<b>Output</b>	<b>Indicator</b>	<b>Baseline</b>	<b>Target</b>
<b>Health information used for making decision</b>	Scope of implementation of the five sub-programmes of CSP in the Health Sector		100%
	Scope of staffing of Woreda Health Offices and RHBs by skilled professionals as per the standard		100%
	Completeness and timely submission of routine health and administrative reports		80%
	Achieve 75 % of evidence based planning		75%
<b>Comprehensive and integrated Monitoring and Evaluation system designed and implemented</b>	Scope of development, adaptation and implementation integrated M&E GL and revision of PIM	0	100%
	Scope of harmonization of donor-government reporting cycles, accounting procedure and monitoring and evaluation system (one plan-one report)		75%
<b>Adequate resource mobilized, efficiently utilized and sustained for the Health Sector</b>	Scope of institutionalization of HCF	0	100%
	Scope of generation of resource for the sector through <ul style="list-style-type: none"> <li>▪ Increasing proportion of health facilities with SPs</li> <li>▪ Retention of revenues generated at health facilities</li> <li>▪ Implementation of appropriate HCF scheme at all districts</li> </ul>	<ul style="list-style-type: none"> <li>▪ 82% hospitals</li> <li>▪ 58% of health centers</li> </ul>	<ul style="list-style-type: none"> <li>▪ 100% of hospitals and health centers</li> <li>▪ Retention of revenues at 100% of health facilities</li> <li>▪ 50% of the districts</li> </ul>
<b>Health emergencies (epidemics, outbreaks etc) properly contained</b>	The proportion of woredas having emergency preparedness strategy document and guidelines	0	100%
	Proportion of woredas having and implementing emergency preparedness and response plan	10%	80%
	The No. of woredas with rapid response team	10%	80%
	Proportion of outbreaks/epidemics with laboratory investigation/result	50%	80%
	Proportion of woreda health offices submitting timely and complete surveillance reports	72%	80%
	Proportion of HEWs trained on IDSR	0%	100%
	Proportion of outbreaks of epidemic prone diseases notified to woreda within two days of surpassing the epidemic threshold	60%	100%

<b>Input</b>	<b>Indicator</b>	<b>Baseline</b>	<b>Target</b>
<b>Financial Input</b>	<b>Health expenditures per capita</b>	<b>5.6 USD</b>	<b>9.6 USD</b>
	Share of health as a proportion of total budget	Doubling of the current amount.	
<b>Human resource input</b>	Train and deploy health human resource as per the Health Human Resource Development Plan.		100% implementation of HRD Plan.
<b>Logistic Input</b>	Make available the required logistic input (drugs, supplies, medical equipment, vehicles etc)		

### Annex 4: Cost Estimates of Scenario 2 and Scenario 3

Annex 4a: Scenario 2 - HSDP-III Incremental Cost Estimates by Program Components

Nature of Expenditure	Fiscal Year	HSDP Components							Total
		Health Service Delivery and Quality of Care	Access to Services: New Construction, Expansion and Transport	Human Resource Development	Strengthening Pharmaceuticals	IEC	Management, HMIS, M&E	Health Care Financing	
Capital	2005/06	306.6	1,938.5	8.6	614.3	83.5	0.1		2,951.6
	2006/07	292.4	1,675.5	17.1	638.7	69.6	0.3		2,693.6
	2007/08	309.7	1,462.2	34.3	687.6	55.6	0.6		2,550.0
	2008/09	327.1	1,248.9	51.4	736.4	41.7	0.8		2,406.4
	2009/10	312.9	985.9	60.0	760.8	27.8	1.0		2,148.4
Recurrent	2005/06	140.6	12.7	93.2	412.7	60.5	9.7	6.4	735.9
	2006/07	281.3	31.6	203.0	844.0	121.0	19.4	7.7	1,507.9
	2007/08	421.9	62.7	346.9	1,319.6	181.5	29.1	9.4	2,371.1
	2008/09	562.5	100.0	509.4	1,827.6	242.0	38.8	11.1	3,291.5
	2009/10	703.2	155.7	719.5	2,446.7	302.5	48.5	12.8	4,389.0
Total	2005/06	447.2	1,951.2	101.8	1,026.9	144.0	9.8	6.4	3,687.4
	2006/07	573.6	1,707.1	220.1	1,482.7	190.5	19.7	7.7	4,201.5
	2007/08	731.6	1,524.9	381.2	2,007.1	237.1	29.7	9.4	4,921.1
	2008/09	889.7	1,348.9	560.8	2,564.0	283.7	39.7	11.1	5,697.9
	2009/10	1,016.1	1,141.6	779.5	3,207.5	330.3	49.5	12.8	6,537.4
Grand Total		3,658.2	7,673.8	2,043.5	10,288.3	1,185.6	148.4	47.5	25,045.3
%		14.6	30.6	8.2	41.1	4.7	0.6	0.2	100.0



**Annex 4b: Scenario 2 - HSDP-III Incremental Cost Estimate by Service Delivery Levels**

Nature of Expenditure	Fiscal Year	Health Services Delivery Level				Grand Total
		Health Services Extension Program	Health Center	Hospital	Administration	
Capital	2005/06	818.1	1,621.5	511.8	0.1	2,951.6
	2006/07	737.4	1,432.6	523.3	0.3	2,693.6
	2007/08	702.8	1,255.1	591.6	0.6	2,550.0
	2008/09	668.2	1,077.5	659.8	0.8	2,406.4
	2009/10	587.5	888.6	671.3	1.0	2,148.4
Recurrent	2005/06	216.5	287.5	228.4	3.4	735.9
	2006/07	442.2	585.0	476.5	4.2	1,507.9
	2007/08	687.3	904.1	774.4	5.2	2,371.1
	2008/09	943.6	1,234.0	1,107.6	6.3	3,291.5
	2009/10	1,225.4	1,596.2	1,560.1	7.3	4,389.0
Total	2005/06	1,034.6	1,909.1	740.2	3.5	3,687.4
	2006/07	1,179.6	2,017.6	999.8	4.5	4,201.5
	2007/08	1,390.1	2,159.2	1,366.0	5.8	4,921.1
	2008/09	1,611.9	2,311.5	1,767.4	7.1	5,697.9
	2009/10	1,812.9	2,484.8	2,231.4	8.3	6,537.4
Grand Total		7,029.1	10,882.2	7,104.8	29.2	25,045.3
%		28.1	43.4	28.4	0.1	100.0

Annex 4c: Scenario 2 - HSDP-III Incremental Cost Estimate by Source of Finance

Source of Finance		2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total	
							Amount	%
Government/Direct Budget Support	Per capita	20.9	22.0	24.2	26.8	30.1	24.8	
		1,524.5	1,651.1	1,874.2	2,134.0	2,467.4	9,651.2	38.5
	Capital	1,266.8	1,107.6	982.4	857.2	698.0	4,912.0	50.9
	Recurrent	257.7	543.5	891.8	1,276.8	1,769.5	4,739.2	49.1
Global Funds GFAMT, GAVI	Per capita	12.8	15.0	17.6	20.0	21.9	17.4	
		937.0	1,130.1	1,358.2	1,587.9	1,791.0	6,804.2	27.2
	Capital	731.2	716.7	733.8	751.0	736.5	3,669.2	53.9
	Recurrent	205.9	413.4	624.3	836.9	1,054.5	3,135.0	46.1
Other Sector Specific Funds: bilaterals, UN agencies	Per capita	14.2	14.4	15.5	16.6	17.7	15.7	
		1,033.8	1,085.1	1,197.5	1,322.5	1,447.0	6,085.8	24.3
	Capital	900.3	815.1	773.7	732.4	647.2	3,868.6	63.6
	Recurrent	133.5	270.0	423.8	590.1	799.8	2,217.3	36.4
NGO/Private Sector	Per capita	0.6	0.8	0.9	1.0	1.1	0.9	
		46.1	57.0	68.0	78.9	89.8	339.8	1.4
	Capital	31.2	27.2	23.2	19.3	15.3	116.2	34.2
	Recurrent	14.9	29.8	44.7	59.6	74.5	223.6	65.8
Out of Pocket Expenditure	Per capita	2.0	3.7	5.5	7.2	9.1	5.5	
		146.0	278.2	423.3	574.6	742.1	2,164.2	8.6
	Capital	22.1	27.0	36.8	46.5	51.4	183.9	8.5
	Recurrent	123.9	251.2	386.5	528.1	690.7	1,980.4	91.5
	Per capita	50.5	55.9	63.6	71.6	79.8	64.3	
Grand Total		3,687.4	4,201.5	4,921.1	5,697.9	6,537.4	25,045.3	100.0
	Capital	2,951.6	2,693.6	2,550.0	2,406.4	2,148.4	12,749.9	50.9
	Recurrent	735.9	1,507.9	2,371.1	3,291.5	4,389.0	12,295.4	49.1

**Annex 4d: Scenario 3 - HSDP-III Incremental Cost Estimates by Program Components**

Nature of Expenditure	Fiscal Year	HSDP Components							Total
		Health Service Delivery and Quality of Care	Access to Services: New Construction, Expansion and Transport	Human Resource Development	Strengthening Pharmaceuticals	IEC	Management, HMIS, M&E	Health Care Financing	
Capital	2005/06	292.5	2,091.8		1,087.8	83.5	0.1		3,555.8
	2006/07	280.6	1,788.9		1,155.5	69.6	0.3		3,294.8
	2007/08	300.4	1,521.3		1,290.7	55.6	0.6		3,168.7
	2008/09	320.1	1,253.8		1,426.0	41.7	0.9		3,042.5
	2009/10	308.2	950.8		1,493.7	27.8	1.0		2,781.5
Recurrent	2005/06	130.5	13.6	108.8	498.9	60.5	350.4	6.4	1,169.3
	2006/07	261.1	32.5	239.5	1,020.1	121.0	700.9	7.7	2,382.7
	2007/08	391.6	61.8	413.7	1,594.2	181.5	1,051.3	9.4	3,703.5
	2008/09	522.2	96.3	609.7	2,207.3	242.0	1,401.7	11.1	5,090.2
	2009/10	652.7	146.4	871.0	2,954.0	302.5	1,752.1	12.8	6,691.6
Total	2005/06	423.1	2,105.5	108.8	1,586.7	144.0	350.6	6.4	4,725.1
	2006/07	541.7	1,821.4	239.5	2,175.6	190.5	701.1	7.7	5,677.5
	2007/08	692.0	1,583.1	413.7	2,885.0	237.1	1,051.9	9.4	6,872.1
	2008/09	842.3	1,350.0	609.7	3,633.3	283.7	1,402.6	11.1	8,132.7
	2009/10	960.9	1,097.2	871.0	4,447.7	330.3	1,753.2	12.8	9,473.2
<b>Grand Total</b>		<b>3,460.0</b>	<b>7,957.1</b>	<b>2,242.6</b>	<b>14,728.3</b>	<b>1,185.6</b>	<b>5,259.4</b>	<b>47.5</b>	<b>34,880.6</b>
<b>%</b>		<b>9.9</b>	<b>22.8</b>	<b>6.4</b>	<b>42.2</b>	<b>3.4</b>	<b>15.1</b>	<b>0.1</b>	<b>100.0</b>

**Annex 4e: Scenario 3 - HSDP-III Incremental Cost Estimate by Service Delivery Levels**

Nature of Expenditure	Fiscal Year	Health Service Delivery Levels				Grand Total
		Health Services Extension Program	Health Center	Hospitals	Administration	
Capital	2005/06	816.9	2,122.3	616.3	0.1	3,555.8
	2006/07	737.3	1,871.6	685.5	0.3	3,294.8
	2007/08	703.9	1,620.9	843.3	0.6	3,168.7
	2008/09	670.4	1,370.2	1,001.0	0.9	3,042.5
	2009/10	590.8	1,119.5	1,070.2	1.0	2,781.5
Recurrent	2005/06	225.4	653.3	287.2	3.4	1,169.3
	2006/07	463.9	1,318.3	596.3	4.2	2,382.7
	2007/08	728.7	2,008.7	960.8	5.3	3,703.5
	2008/09	1,006.6	2,711.7	1,365.6	6.3	5,090.2
	2009/10	1,323.8	3,452.7	1,907.8	7.4	6,691.6
Total	2005/06	1,042.3	2,775.6	903.6	3.5	4,725.1
	2006/07	1,201.3	3,189.9	1,281.8	4.5	5,677.5
	2007/08	1,432.6	3,629.6	1,804.1	5.9	6,872.1
	2008/09	1,677.0	4,081.9	2,366.6	7.2	8,132.7
	2009/10	1,914.7	4,572.2	2,977.9	8.4	9,473.2
Grand Total		7,267.8	18,249.3	9,334.0	29.5	34,880.6
%		20.8	52.3	26.8	0.1	100.0

**Annex 4f: Scenario 3 - HSDP-III Incremental Cost Estimate by Source of Finance**

Source of Finance		2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total	
							Amount	%
Government/Direct Budget Support	Per Capita \$	28.3	34.0	40.8	47.7	55.3	41.2	
		2,065.9	2,558.8	3,155.3	3,793.0	4,530.4	16,103.4	46.2
	Capital	1,434.8	1,263.2	1,122.3	981.5	809.8	5,611.6	34.8
	Recurrent	631.0	1,295.7	2,032.9	2,811.5	3,720.6	10,491.8	65.2
Global Funds GFAMT, GAVI	Per Capita \$	15.5	18.2	21.2	24.0	26.4	21.0	
		1,131.0	1,366.4	1,637.9	1,911.6	2,160.4	8,207.3	23.5
	Capital	887.0	876.2	896.9	917.7	906.8	4,484.5	54.6
	Recurrent	244.0	490.2	741.0	993.9	1,253.7	3,722.7	45.4
Other Sector Specific Funds: bilaterals, UN agencies	Per Capita \$	17.6	18.0	19.4	20.9	22.2	19.6	
		1,288.6	1,355.0	1,500.8	1,661.8	1,816.0	7,622.2	21.9
	Capital	1,139.4	1,052.4	1,024.2	995.9	908.9	5,120.8	67.2
	Recurrent	149.1	302.6	476.7	665.9	907.1	2,501.4	32.8
NGO/Private Sector	Per Capita \$	0.8	0.8	0.9	1.0	1.1	0.9	
		55.1	62.9	70.6	78.4	86.2	353.2	1.0
	Capital	42.5	37.6	32.6	27.7	22.8	163.2	46.2
	Recurrent	12.7	25.3	38.0	50.7	63.3	190.0	53.8
Out of Pocket Expenditure	Per Capita \$	2.5	4.4	6.6	8.6	10.7	6.6	
		184.5	334.4	507.5	687.9	880.1	2,594.5	7.4
	Capital	52.0	65.6	92.6	119.7	133.2	463.1	17.8
	Recurrent	132.4	268.9	414.9	568.3	746.9	2,131.4	82.2
	Per Capita \$	64.7	75.5	88.9	102.2	115.7	89.4	
Grand Total		4,725.1	5,677.5	6,872.1	8,132.7	9,473.2	34,880.6	100.0
	Capital	3,555.8	3,294.8	3,168.7	3,042.5	2,781.5	15,843.3	45.4
	Recurrent	1,169.3	2,382.7	3,703.5	5,090.2	6,691.6	19,037.3	54.6

## Annex 5: HSDP-III Total Estimated Cost by Regions

### Scenario 1

'in Million Birr

	Federal	Tigray	Afar	Amhara	Oromyia	Somalia	Benishagul Gumuz	SNNP	Gambella	Harari	Dire Dawa	Addis Ababa	Total
2005/06	225.4	172.0	89.8	566.4	796.9	174.2	47.8	445.7	34.8	26.8	40.5	197.2	2,817.4
2006/07	258.9	197.6	103.1	650.7	915.5	200.1	54.9	512.1	40.0	30.7	46.5	226.6	3,236.8
2007/08	304.0	232.0	121.1	763.9	1,075.0	235.0	64.5	601.2	46.9	36.1	54.6	266.0	3,800.3
2008/09	352.7	269.2	140.4	886.2	1,247.0	272.6	74.8	697.5	54.5	41.9	63.3	308.6	4,408.7
2009/10	406.4	310.2	161.8	1,021.3	1,437.1	314.1	86.2	803.8	62.8	48.2	73.0	355.6	5,080.5
<b>Total</b>	<b>1,547.5</b>	<b>1,181.1</b>	<b>616.2</b>	<b>3,888.5</b>	<b>5,471.5</b>	<b>1,196.0</b>	<b>328.1</b>	<b>3,060.3</b>	<b>238.9</b>	<b>183.7</b>	<b>277.8</b>	<b>1,354.1</b>	<b>19,343.7</b>

### Scenario 2

'in Million Birr

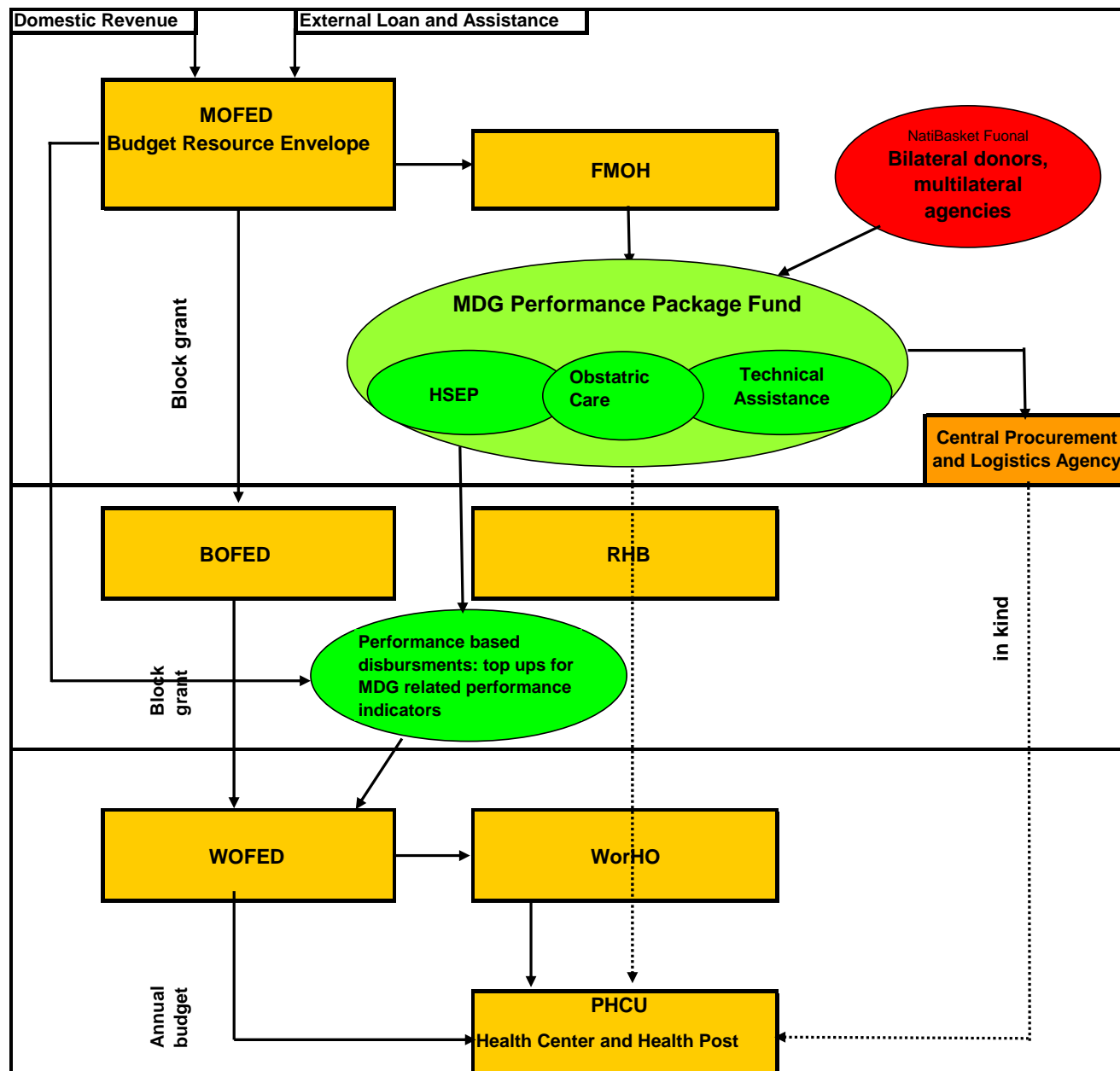
	Federal	Tigray	Afar	Amhara	Oromyia	Somalia	Benishagul Gumuz	SNNP	Gambella	Harari	Dire Dawa	Addis Ababa	Total
2005/06	325.7	248.6	129.7	818.4	1,151.5	251.7	69.1	644.1	50.3	38.7	58.5	285.0	4,071.1
2006/07	371.1	283.2	147.8	932.5	1,312.1	286.8	78.7	733.9	57.3	44.1	66.6	324.7	4,638.6
2007/08	434.6	331.7	173.1	1,092.2	1,536.8	335.9	92.2	859.5	67.1	51.6	78.0	380.3	5,433.1
2008/09	503.3	384.1	200.4	1,264.6	1,779.4	388.9	106.7	995.2	77.7	59.7	90.3	440.3	6,290.7
2009/10	577.4	440.7	229.9	1,450.9	2,041.5	446.2	122.4	1,141.9	89.2	68.5	103.7	505.2	7,217.5
<b>Total</b>	<b>2,212.1</b>	<b>1,688.3</b>	<b>880.9</b>	<b>5,558.4</b>	<b>7,821.3</b>	<b>1,709.6</b>	<b>469.0</b>	<b>4,374.6</b>	<b>341.6</b>	<b>262.6</b>	<b>397.1</b>	<b>1,935.6</b>	<b>27,651.0</b>

**Scenario 3**

'in Million Birr

	Federal	Tigray	Afar	Amhara	Oromyia	Somalia	Benishagul Gumuz	SNNP	Gambella	Harari	Dire Dawa	Addis Ababa	Total
2005/06	406.2	310.0	161.8	1,020.8	1,436.4	314.0	86.1	803.4	62.7	48.2	72.9	355.5	5,078.0
2006/07	488.1	372.5	194.4	1,226.6	1,725.9	377.2	103.5	965.3	75.4	57.9	87.6	427.1	6,101.7
2007/08	590.8	450.9	235.3	1,484.6	2,089.1	456.6	125.3	1,168.4	91.2	70.1	106.1	517.0	7,385.5
2008/09	699.2	533.6	278.4	1,757.0	2,472.3	540.4	148.3	1,382.8	108.0	83.0	125.5	611.8	8,740.3
2009/10	814.5	621.6	324.3	2,046.6	2,879.7	629.4	172.7	1,610.7	125.8	96.7	146.2	712.7	10,180.8
<b>Total</b>	<b>2,998.9</b>	<b>2,288.8</b>	<b>1,194.2</b>	<b>7,535.5</b>	<b>10,603.3</b>	<b>2,317.6</b>	<b>635.9</b>	<b>5,930.6</b>	<b>463.0</b>	<b>356.0</b>	<b>538.4</b>	<b>2,624.0</b>	<b>37,486.3</b>

## Annex-6 Making External Aid Work Better for Health Services Delivery and the MDGs





## **Annex-7 Emergency Preparedness and Response in health sector-HSDP III**

### **Issues**

With its dominant agrarian population, and traditional agriculture being the mainstay of the economy, dependence on the natural weather condition in addition to increasing population, poor health related infrastructure, inadequate health service coverage, and increment of internal displaced people for many reasons leads to very high vulnerability to disaster in Ethiopia.

The high burden of disease in the country is another factor contributing for the recurrence of disease outbreaks and also fuels the negative impact of disaster in the most vulnerable groups. The HIV/AIDS pandemic has further compromised the coping capacity and currently its contribution to food insecurity in the country has become a cause for serious concern. The need of establishment of an Emergency Preparedness and Response Team at federal level is the main pressing factor to enhance the Emergency Preparedness and Response at all level.

### **Challenges:**

Food insecurity is the driving force for the increasing vulnerability and deepening of the level of poverty, for the following reasons:

- The country will remain dependant on its backward agriculture as it attempts to transform the current system into a productive small-scale agriculture that assumingly will lead to self-sufficiency in food production in the short term and the development of industry in the long run.
- The recurrent drought will continue to marginalize more and more people
- The prediction of the impact of the global climatic change as has been indicated from various sources precludes that there is a looming large-scale crisis in food insecurity, draught in the coming decades especially in Sub-Saharan Africa.
- The high burden of disease in the country is also a factor contributing for the recurrence of disease outbreaks and also fuels the negative impact of disaster in the most vulnerable groups.
- Inability to secure adequate National Disaster Preparedness Fund.

### **Way forward**

**The most important issues that require immediate attention in Emergency Preparedness and Response of the Health sector include:**

- Establishing an emergency unit with in the FMOH to coordinate and guide the health emergency preparedness and response efforts in the country.
- Working with DPPC, to critically examine the current National Disaster Preparedness and Response Policy and make the necessary revision in the light of recent developments such as the Productive Safety Net Program, the establishment of the Coalition on food security etc.

- Having an emergency preparedness and response strategy for the health sector is another critical need. The role and responsibilities of the various actors in the field should be guided with an appropriate strategic document.
- Risk Mapping and vulnerability assessment is another area, which is not adequately treated. This valuable information if regularly updated can give the necessary direction and guidance to the various responses during and after emergencies.
- Developing a health and nutrition assessment methodology to feed into the annual humanitarian appeal process and linked with the water, agriculture and food processes.
- Strengthening the networking with key stakeholders is another important area, which requires an attention. The FMOH should be in a position to play the leading role in emergency response intervention.
- Strengthening the emergency preparedness and response capacities at all level.
- Research and Streamlining of food practices and lessons learnt into action.

## Objective

To capacitate 80% of woreda in the country to prepare and implement emergency preparedness and response plans there by strengthening the national capacity responding to emergencies.

## Strategies

- Establishing an emergency unit at FMOH and focal points in regions and Woredas respectively.
- Strengthening sectoral coordination mechanism at federal and regional level
- Having emergency preparedness and response strategies and guidelines in place.
- Regular risk mapping and vulnerability assessment
- Strengthening Intersect oral collaboration
- Strengthening the information system related to emergency
- Capacity building at all level

## Key Activities

- Staffing the emergency unit at the FMOH
- Maintaining and strengthening an emergency taskforce at federal level aiming at large participation from Government, UN and NGOs. Developing and maintaining a similar mechanism at regional level.
- Training of health professionals on emergency preparedness and response.
- Preparation and distribution of emergency health preparedness and response strategies and guidelines.
- Conducting risk mapping and vulnerability assessment in 80% of the woredas in the country.
- Establishment a comprehensive Database that covers all areas related to Emergency
- Provision of communication equipments, office materials and other essential items

- Preparation and implementation of emergency preparedness and response plans on annual bases
- Establish an emergency preparedness contingency stock of medicine for most probable disease out breaks at Federal and Regional level.
- Monitoring and evaluation
- Conduct operational research and streamline best practices.

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