Federal Democratic Republic of Ethiopia
Ministry of Health

## HEALTH SECTOR TRANSFORMATION PLAN-I

# ANNUAL PERFORMANCE REPORT


EFY 2009 (2016/17)

Version 1

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| | |
|---|---|
| **AA** | Addis Ababa |
| **AARHB** | Addis Ababa Regional Health Bureau |
| **ACT** | Artemisinin-based Combination Therapy |
| **AFRO** | African Regional Office |
| **AIDS** | Acquired Immunodeficiency Syndrome |
| **ALOS** | Average Length of Stay |
| **ANC4** | Antenatal Care Four |
| **APTS** | Auditable Pharmaceutical Transaction and Service |
| **ARM** | Annual Review Meeting |
| **ART** | Antiretroviral Therapy |
| **ARV** | Antiretroviral |
| **AVW** | African Vaccination Week |
| **AWD** | Acute Watery Diarrhea |
| **AYH** | Adolescent Youth Health |
| **CAR** | Contraceptive Acceptance Rate |
| **CASH** | Clean and Safe Health |
| **CBHI** | Community Based Health Insurance |
| **CBN** | Community Based Nutrition |
| **CBNC** | Community Based New Born Care |
| **CFR** | Case Fatality Rate |
| **CHD** | Community Health Day |
| **CINS** | Comprehensive and Integrated Nutrition Service |
| **CRC** | Compassionate Respectful and Caring |
| **CSA** | Central Statistical Agency |
| **CSS** | Child Survival Strategy |
| **CUC** | Catch-up campaign |
| **DBS** | Dry Blood Sample |
| **DM** | Diabetes Mellitus |
| **DP's** | Development Partners |
| **eCHIS** | Electronic Community Health Information System |
| **EDHS** | Ethiopia Demographic Health Survey |
| **EHAQ** | Ethiopian Hospitals Alliance for Quality |
| **EHRIG** | Ethiopian Hospital Reform Implementation Guideline |
| **EMR** | Electronic Medical Record |
| **EOS** | Enhanced Outreach Strategy |
| **EPI** | Expanded Program on Immunization |
| **ETB** | Ethiopian Birr |
| **EU** | European Union |
| **FMHACA** | Food, Medicine and Healthcare Administration and Control Authority |

| | |
|---|---|
| **FNA** | Fine Needle Aspiration |
| **GMP** | Growth Monitoring Program |
| **GOE'** | Government of Ethiopia |
| **HDA** | Health Development Army |
| **HAPCO** | HIV/AIDS Prevention and Control Office |
| **HCs** | Health Centers |
| **HCT** | HIV Counselling and Testing |
| **HEP** | Health Extension Program |
| **HEW** | Health Extension Workers |
| **HIT** | Health Information Technician |
| **HIV** | Human Immunodeficiency Virus |
| **HMIS** | Health Management Information System |
| **HRH** | Human Resource for Health |
| **HSDC** | Health Science Demonstration Centers |
| **HSTP** | Health Sector Transformation Plan |
| **HSTQ** | Health Service Transformation in Quality |
| **iCCM** | Integrated Community Case Management |
| **ICD** | International Classification of Disease |
| **IEC** | Information Education &Communication |
| **IESO** | Integrated Emergency Surgery &Obstetrics |
| **IFMIS** | Integrated Financial Management Information System |
| **IRS** | Insecticide Residual Sprayi |
| **IMNCI** | Integrated Management of Neonatal and Child Illness |
| **IUCD** | Intrauterine Contraceptive Device |
| **LLINs** | Long-Lasting Insecticide-treated Net |
| **LEEP** | Loop Electro Excision Procedure |
| **LQAS** | Lot Quality Assurance Sampling |
| **M&E** | Monitoring and Evaluation |
| **MARPs** | Most-At-Risk Population |
| **MDG** | Millennium Development Goal |
| **MDSR** | Maternal Death Surveillance and Response |
| **MFR** | Master Facility Registry |
| **mhGAP** | Mental Health Gap Action Programme |
| **MMR** | Maternal Mortality Ratio |
| **MNH** | Maternal &Newborn Health |
| **MOFEC** | Ministry of Finance and Economic Comission |
| **MOH** | Ministry Of Health |
| **MOI** | Ministry of Industry |
| **MPH** | Masters of Public Health |
| **MTCT** | Maternal To Child Transmission |
| **NBC** | New Born Care |
| **NCD** | Non-Communicable Disease |
| **NICU** | Neonatal Intensive Care Unit |

| | |
|---|---|
| **NMR** | Neonatal Mortality Rate |
| **NNP** | National Nutrition Programme |
| **NTD** | Neglected Tropical Diseases |
| **ODF** | Open Defecation Free |
| **OPV** | Oral Polio Vaccine |
| **OPD** | Out Patient Department |
| **ORS** | Oral Rehydration Salt |
| **OTP** | Outpatient Therapy |
| **PCV** | Pneumococcal Conjugate Vaccine |
| **PF** | Plasmodium Falciparum |
| **PHEM** | Public Health Emergency Management |
| **PMTCT** | Prevention of Maternal to Child Transmission of HIV |
| **PNC** | Post Natal Care |
| **PPP** | Public-Private Partnership |
| **PHCU** | Primary Health Care Unit |
| **PV** | Plasmodium Vivax |
| **QA** | Quality Assurance |
| **RDQA** | Routine Data Quality Assessment |
| **RDT** | Rapid Diagnostic Test |
| **RHBs** | Regional Health Bureau |
| **RMNCH** | Reproductive Maternal Neonatal Child Health |
| **RUTF** | Ready-to-Use Therapeutic Food |
| **SAM** | Sever Acute Malnutrition |
| **SALTS** | Saving Life through Safe Surgery |
| **SARA** | Service Availability and Readiness Assessment |
| **SBCC** | Social and Behavior Change Communication |
| **SDGs** | Sustainable Development Goals |
| **SLD'** | Second Line Drug |
| **SNNPR** | Southern Nations, Nationalities and Peoples Region |
| **SPA+** | Service Provision and Availability |
| **STI** | Sexual Transmitted Infections |
| **TB** | Tuberculosis |
| **TICs** | Treatment Initiating Centers |
| **TOT** | Training of Trainers |
| **TVET** | Technical Vocational Educational Training |
| **TWG** | Technical Working Group |
| **UN,** | United Nation |
| **UNFPA** | United Nations Population Fund |
| **USD** | United States Dollar |
| **UVP** | Utrovaginal Prolapse |
| **VAS** | Vitamin A Supplementation |
| **VPN** | virtual private network |
| **WHO** | World Health Organization |
| **WoHOs** | Woreda Health Office |

# KEY MESSAGE FROM THE MINISTER

H.E. PROF. YIFRU BERHAN MINISTER, MINISTRY OF HEALTH,
FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

As you all know, Ethiopia is one of the fast growing economies in the World with a vision to reach a middle income status by 2025. It is well recognized that this vision can only be realized if we have a healthy and productive population. That is why improving the health status of the country is one of the key priorities of the Government of Ethiopia in the past two decades. As a result of its robust health policy and innovative strategies, our country has made huge strides in increasing universal access to health services and improvements in health outcomes. All these gains were achieved in the process of building resilient and responsive health system that can address health issues in a sustainable, equitable and effective manner.

Despite the impressive advancements, we still have a lot to do in terms creating health systems that can withstand all adversities. Ethiopia is still one of the countries with a very high morbidity and mortality from triple burden of diseases. The quality of health care in terms of improving patient safety, effectiveness, and patient-centeredness is often inconsistent and unreliable. The health workforce shortage particularly in the field of medical specialty, low in-country capacity in pharmaceutical manufacturing, fragile regional collaboration in transboundary diseases and outbreaks, and climate change are few of the challenges that the country is facing.

To address existing and emerging challenges, the Government of Ethiopia has been implementing the first Health Sector Transformation Plan, which is part of the broader country Growth and Transformation Plan and aligned with the Sustainable Development Goals. This report covers the country's progress towards achieving the HSTP goals in all the six building blocks of the health system. As you can see from the report, this year's progress is characterized by moving from vision to concrete actions in most of the major transformation agendas. The report also calls for a need to accelerate our pace and renew our commitments to achieve the HSTP goals. I believe we will have the necessary support from all our development partners and important stakeholders in the health sector in the next three years implementation of the HSTP.

# CHAPTER 1

# INTRODUCTION


# INTRODUCTION

This Annual Performance Report represents the second year of the Health Sector Transformation Plan (HSTP) (2015/16-2019/20) performance, and mainly focuses on the progress made in the implementation of the Woreda-Based Annual Core Plan and on the overall health sector performance against the targets set for EFY 2009 (2016/17).

The performance report highlights the four pillars of HSTP: (i) Health Service Delivery; (ii) Quality Improvement and Assurance; (iii) Leadership and Governance; and (iv) Health System Capacity. It also covers the progress on the following Strategic Objectives of the health sector under these four Themes/pillars:

1. Improve health status;
2. Enhance community ownership;
3. Improve efficiency and effectiveness;
4. Improve equitable access to quality health services;
5. Improve health emergency risk management;
6. Enhance good governance;
7. Improve regulatory system;
8. Improve supply chain and logistics management;
9. Improve community participation and engagement;
10. Improve resource mobilization;
11. Improve research and evidence for decision-making;
12. Enhance use of technology and innovation;
13. Improve development and management of HRH;
14. Improve health infrastructure; and
15. Enhance policy and procedures.

- As one of the core agenda items at the ARM, the Annual Performance Report highlights progress, challenges, lessons learned and way forward for the health sector for the forthcoming year. In particular, the report provides information on:
- Overall priority health service coverage levels;
- Performance against target set in the core plan, using national and regional level indicators;
- Trends of achievements;
- Regional comparisons;
- Status of implementation of the health sector support systems as well as leadership and governance;

Financial report for EFY 2009, including health sector expenditure analysis and donor-expenditure analysis. This performance report is prepared based on data from HMIS/PHEM, CSA, application of accountability scorecard, etc. The Health Management Information System (HMIS) aggregated monthly, quarterly and annual institution-based reports for the EFY 2009, with some exceptions of data for certain program areas such as administrative reports and surveys undertaken by different institutions. Population figures are used based on the projection estimates for the fiscal year provided by the Central Statistical Agency (CSA) and conversion factors from the same source. Besides, simple measures of inequality ratio is applied for comparisons of equity stratifiers such as geography (regional) and age (adult/child) to show relative inequality (reflecting proportional differences) in health among subgroups. The report contains data represented in the form of tables, figures and maps that represent regional comparisons, geographical distributions, and trends over time of the indicators selected for monitoring the implementation of the second year of HSTP I.

Furthermore, consultations and iterative activities were made, involving Regional Health Bureaus (RHB), the various Directorates of the Federal Ministry of Health (FMOH), agencies accountable to the FMOH, and Development Partners (DP). The overall coordination and technical support was provided by a Committee led by the Policy and Planning Directorate (PPD) and a write-up team organized from FMOH and Development Partners.

This Annual Performance Report is divided into seven chapters:

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

**Chapter 2:** explains the status of the four health sector transformation agendas; and

**Chapter 3:** covers an overview of the sector performance for EFY 2009 with respect to health service delivery;

**Chapter 4:** explains the level of quality improvement and assurance on the health service delivery;

**Chapter 5:** deals with implementation status concerning leadership and governance;

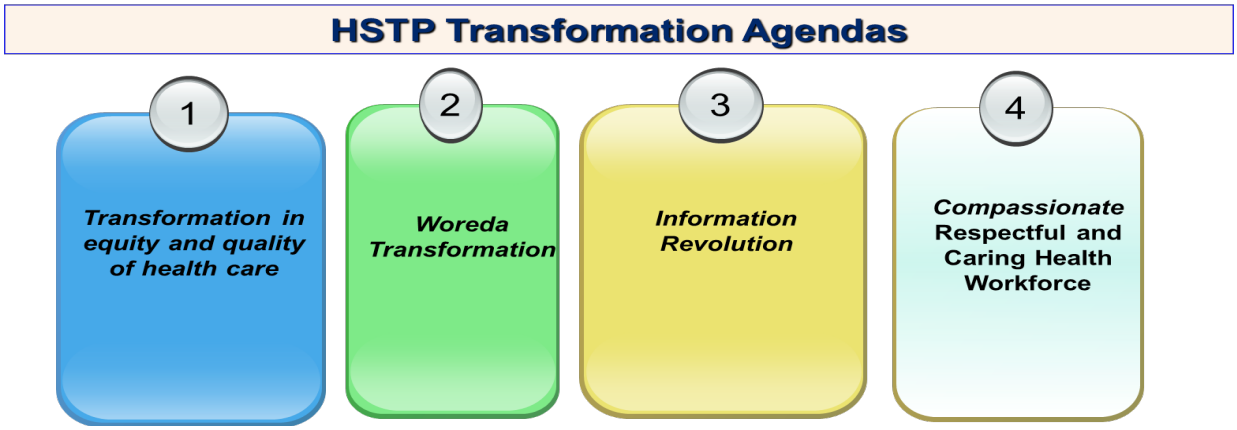
**Chapter 6:** details the performance in the area of health systems capacity;

**Chapter 7:** winds up the conclusion of the report.

# CHAPTER 2

# HEALTH SECTOR TRANSFORMATION AGENDAS PROGRESS

# HEALTH SECTOR TRANSFORMATION AGENDAS PROGRESS




## 2.1 EQUITY AND QUALITY OF CARE

Equity and quality of care, one of the four transformation agendas, is the core goal of the health sector transformation plan that aspires to build high performing health system. It consistently strives to provide safe, reliable, patient-centered and efficient health care to all citizens regardless of differences in personal characteristics including age, gender, socio-economic status and geographical location. A detailed roadmap with innovative strategies was developed to ensure that every Ethiopian is reached with essential, quality services.

Achieving equity and quality will not be easy and will not happen overnight— most important of all, it will require a movement. This movement requires strong and able leadership at all levels of the system, robust participation and support of the community to ensure quality and equity of health care. And to this end, the Health Service Quality Directorate has been established in the Federal Ministry of Health to harmonize and lead the activities being undertaken to ground the concept of quality in our health facilities. Similar structures are being established through the sector to organize and implement the strategic priority areas. The quality movement and the associated national initiatives need to gain momentum so that we can give the Ethiopian people the health care they need and deserve.

## QUALITY OF HEALTH CARE

Ethiopian National Healthcare Quality Strategy, which was launched in March 2016, builds on the plan laid out in HSTP to further align key stakeholders across prioritized interventions that will drive large-scale improvement in quality of care delivery over the next five years. This strategy provides a roadmap for addressing key quality challenges and for accelerating the improvement of health care quality nationwide. The ultimate aim is to consistently improve the outcomes of clinical care, patient safety, and patient-centeredness, while increasing access and equity for all segments of the Ethiopian population, by 2020. This is done by ensuring reliable, excellent clinical care, protecting patients, staff, and attendants from harm, and improving the efficiency of the delivery of care, while increasing access, equity and dignity of care for all segments of the Ethiopian population.

1. The four priority strategic areas to reach this aim, as outlined in the Ethiopian National Healthcare Quality Strategy are:

2. Develop an integrated approach to planning, improving, and controlling quality

3. Activate key constituencies to advance quality

4. Drive improvements in quality by explicitly linking Universal Health Coverage (UHC) strategy with quality

Support strong data systems and feedback loops as “backbone” of all improvement actions

## PROGRESSES IN THE IMPLEMENTATION OF NATIONAL QUALITY STRATEGY

### 1. DEVELOP AN INTEGRATED APPROACH TO PLANNING, IMPROVING, AND CONTROLLING QUALITY

In a series of consultative meetings held with the FMHACA, the Health Service Quality Directorate has harmonized the standards to be included in the EHSTG and HSTQ guiding documents for the minimum standards to be fulfilled by the hospitals. Other standards including WHO standards of care have also been incorporated into the guidelines to make them more comprehensive. Large scale quality improvement initiatives including, but not limited to Saving Lives through Safe Surgery (SaLTS) and Maternal and Newborn Health Quality of Care Network (MNH QoC Network) have been developed and are being implemented nationally using the Ethiopian Health Institute Alliance for Quality (EHIAQ) platform as a learning collaborative.

Hospitals have been capacitated with the necessary guiding tools and technical capabilities to perform a facility based gap analysis and undertake continuous quality improvement to fill the gaps identified with the support of regional health bureaus and Federal Ministry of Health. The former Ethiopian Hospital Alliance for Quality initiative has been currently reformed to Ethiopian Health Institutes Alliance for Quality initiative in order to incorporate a linkage and support system between hospitals and health centers. New initiatives like SaLTS, EHSTG and HSTQ as well as existing ones like MNCH and CASH have been included in the current platform.

The relevant national standards from FMHACA and international standards from WHO have been incorporated into the Ethiopian Hospital Services Transformation Guidelines and Ethiopian Health Sector Transformation in Quality Guidelines, which will serve as backbones for the implementation of the standards in the Hospitals.

**2. ACTIVATE KEY CONSTITUENCIES**

Existing forums and platforms like EHIAQ learning collaborative are being utilized to drive and demonstrate quality improvement activities throughout the nation. Through the alliance, hospitals were involved in cluster meetings, supportive supervision, mentoring and review meetings where they can learn from each other and strengthen their support systems. National Healthcare Quality Summits are an essential experience sharing venue where different essential stakeholders come together to join forces in an effort to harmonize the national quality movement. In 2009, the 3rd National Healthcare Quality Summit was held with the motto of "Unite around a Shared Vision for Quality".

Training for facility managers and frontline workers has been one of the essential capacity building activities undertaken by the Ministry. To date, over 2700 front line workers and managers were trained from all hospitals throughout the nation on quality improvement principles and national hospital standard guidelines (EHSTG and HSTQ). Capacity building trainings were also provided to staff from FMOH, RHB and FMHACA. Patient centered care is one of the essential domains of the Quality and Equity agenda we envision to have. In line with this the HSQD has included freedom of patients to access their records as one of the minimum standards to be adhered to by hospitals and service providers in the EHSTG. Service providers are expected to provide services with compassion and respect, this concept has been clearly set as a core component of the HSTQ.

Staff satisfaction is an important part of a well-functioning facility. Under the new guideline the hospitals have the obligation of performing staff satisfaction surveys and develop ways to act upon and improve the findings.

## 3. SUPPORT STRONG DATA SYSTEMS AND FEEDBACK LOOPS AS "BACKBONE" OF ALL QUALITY IMPROVEMENT ACTIONS

The Ministry identified 40 key performance indicators (KPIs) to assess the management and clinical process as well as outcome of services provided in hospitals. These indicators are reported from hospitals vertically to RHB's then to the FMOH. The indicators will be used to monitor and inform policy decisions on the quality of services being provided in the health sector.

Two-way feedback loop has been established to drive the communication between facilities and the health sector administration structures. Focal persons were assigned for all regions to facilitate the bi-directional information transfer. Hospitals held regular meetings in the EHIAQ platform to evaluate their performances with each other and against the national standards, and develop improvement plans. In addition, hospitals hold regular HDA meetings to monitor and improve their performance via facility specific indicators

As part of improving health service quality, MOH is working to improve the data use culture of health professionals through capacity building trainings. One of the main topics covered in a nationwide training provided to health professionals was the importance and utilization of data as a tool for performance improvement. However, there is still a need to supplement the ongoing activities by mentorship, supportive supervisions and continues capacity building sessions.

### PROGRESSES IN EQUITY OF CARE

Equity in health care is ensuring availability of the best care to all whereby the health care provided does not differ by any personal characteristics, including age, gender, socioeconomic status or place of residence, that are unrelated to a patient's reason for seeking care.

- In relation to implementation progress of Equity in Health Care, the following activities were performed during the EFY 2009.

- 59 (13 Somali, 9 Afar, 7 Gambella, 7 Benshangul Gumuz, 8 Amhara, 3 Tigray, 6 Oromia, and 6 SNNPR pastoralist zones) technical assistants deployed to DRS regions and 7 low performing Zones to improve the availability of skilled human resources

- Equitable health services plan of action for years 2016 – 2020 prepared

- Capacity building on Leadership and management training was conducted for 346 (179 SHM and 167 DHM) health managers' from DRS regions.

- 307 health centers and 1,998 health posts are constructed, equipped and supplied with essential equipment, medicines and supplies

## 2.2 WOREDA TRANSFORMATION

Effective implementation of Woreda transformation is considered as an engine to achieve of other transformational agendas. Woredas are the lower level government structure where policies and strategies are translated into action. Woredas are believed to be the hub of development. FMOH recognizes that enhancing the implementation capacity of Woredas can play a critical role in accelerating the country's developmental endeavors in general and the health sector plan in particular. Realizing Woreda transformation in the health sector will establish a strong and resilient health system by enabling Woredas to respond quickly to natural and manmade disasters, strengthen community ownership and fostering accountability and by enabling Service providers provide equitable, accessible and quality health services.

1. The Woreda transformation has three main expected outcomes:
2. Graduating Model Kebeles: this is achieved through organized community participation and engagement in the implementation of the health extension packages both at individual, village and community level and through strengthening the community health system.
3. Strengthening the performance of primary health care units (all health centers and health posts) in the Woreda and increase the client satisfaction by improving accessibility and quality of basic health services provision. This shall be accomplished by improving the skill, knowledge, behavior, ethics and capacity of the health managers and service providers.

Ensuring the enrollment of each household in the community based health insurance scheme.

During the last one year several activities were undertaken to implement the woreda transformation agenda. This includes preparation of woreda transformation manual, launching and familiarization of transformation agenda, and providing orientation in the concept and practical issue related to the transformation agenda for around more than 10,000 Health professionals from HCs and Woreda Health Offices. Using a clustering approach, over 34,000 HEWs were trained on Woreda transformation and its strategies (creating Model kebeles, second generation HEP, Health development army etc). In order to strengthen the linkages between health centers and health posts, FMOH has developed technical manual to guide health centers staffs on how to mentor HEWs, conduct supportive supervision and monthly performance reviews at the health center level.

Following the national launching program in April 2016, implementation started at the national level. Regional Health Bureaus also launched transformation agendas and started

implementation to the kebele level. The Federal Ministry of Health provided technical support and guidance to regions through supportive supervision, participating in the launching events and close follow-up.

To build the implementation capacity of Woreda Health Office and Health Center Heads, the Health Extension and Primary Health Services Directorate (HEPHSD) provided training for 102 Woreda health office heads and PHCU Directors on Transformational Leadership, Woreda Transformation, Information Revolution and Health Policies and Strategies.

As per the plan to give competency based training for Women Development Army leaders and certify them in level 1, the curriculum and teaching aids have been developed in collaboration with Federal TVETA. Master training of trainers and Training of Trainers were provided to HEWs and Woreda and Health Center staff. Financial support was provided to regions to cascade the training within their constituents. Regarding to the second generation HEP, the 16 HEP packages were amended to 18 HEP packages (by including newborn health, communicable diseases, neglected tropical diseases, mental health and institutional sanitation; as well as merging some related packages) and its implementation framework and guidelines were developed. Besides, FMOH has conducted assessment of the quality of health posts and availability of level 4 HEWs in order to support planning for second generation HEP. The infrastructural design of health posts for the implementation of second generation HEP was also conducted.

The Ministry has conducted a quick assessment in the agrarian regions (Tigray, Amhara, Oromia, SNNPR) and Urban Administrations (Dire Dawa, Harar, and Addis Ababa) to understand the status of implementation of woreda transformation and HEP.

- In relation to Community Based Health Insurance, the following major progresses have been made:
- A total of 377 woredas are enrolled in CBHI scheme, out of this 248 woredas are providing the necessary health services to their respective CBHI members
- Out of the total 9,540,917 eligible members in the 377 Woredas enrolled for CBHI, 36% registered as members in the CBHI program
- Total revenue collected from CBHI members in EFY2009 was 593,790,260 Birr
- Proclamations drafted for CBHI, including amendment of SHI Proclamation in the EFY2009
- Implementation guidelines, CBHI Implementation Manual, CBHI Clinical Manual and CBHI Data Management Manual were prepared, printed and distributed to CBHI schemes

## 2.3 PRODUCING COMPASSIONATE RESPECTFUL AND CARING HEALTH WORKFORCE

Compassionate and respectful care is fundamental to the practice of all health care professions. A growing body of evidences demonstrates that compassionate care is associated with improved health outcomes, increased patient satisfaction, better adherence to treatment recommendations, fewer malpractice claims, and reduced healthcare expenditure.

- The National Health Sector Transformation Plan, launched in 2015, has recognized that creating a compassionate respectful and caring (CRC) health workforce is a major pillar to improve the quality of health care services. This has led to a renewed focus on how to improve the health workforce performance including responsiveness, timeliness and patient centeredness of health care services. The Ministry has developed a national CRC implementation guideline to address this national agenda. The national CRC implementation guideline framed out a number of initiatives including developing standardized in-service training. Below are some of the major activities that have been carried out in 2009 EFY.
- The training needs assessment into CRC practices conducted by FMOH revealed reluctance among health care providers to priorities technical knowledge in the area. This was despite acknowledging the critical role of such care in the wellbeing of patients and their families. This finding brought to light the urgent need for tailored training aimed at improving the attitudes and skills of health care providers in regard to Compassionate and Respectful Care.
- The National CRC implementation guideline was developed and distributed all over the country. In addition, a standardized national CRC training manual has been developed and printed. A Compassionate and Respectful Health Care (CRC) is now included in the National Technical Vocational and Education Training (TVET) curricula. Equally, the establishment of National, Regional and Institutional councils has been agreed, MoU document developed and circulated. Addis Ababa city administration, Amhara and the South Nations Nationality and People Regions have established and leading the way. Similarly, Oromia region has established a Case Team to lead the program.
- Nationally, 137 health professionals received ToT in five rounds on CRC. FMoH allocated 25,000,000.00 birr for 21 in service training centers and they are providing basic CRC training across the country. Pre-deployment CRC orientation is provided to all health graduates in the country.

- National compassionate, respectful and caring Facebook page (@CRChealthworforce) was created and two documentaries were produced and posted on the Ministry's website. Majority of health institutions in the country organized CRC sensitization workshops.

## 2.4 INFORMATION REVOLUTION

The Information Revolution is one of the four transformation agendas of the Health Sector Transformation Plan (HSTP). The objective of the Information Revolution is to transform and enhance the culture of data use to positively impact population health and health-system performance through evidence-based decision making at all levels of the health system. Maximizing the availability, accessibility, quality, and use of health information will positively impact quality and equity of healthcare delivery in the country.

To achieve this, FMOH has developed a national Information Revolution Roadmap based on two pillars of focus with actionable and measurable interventions for each. Pillar 1 is comprised of interventions to enhance the culture of information use for decision making. This cultural shift is supported by Pillar 2, the implementation and scale up of prioritized health information systems and tools.

The Information Revolution is cascaded down to the Regional and Woreda levels to allow the initiative to be implemented throughout all levels of the health sector. Each Regional Health Bureau (RHB) has developed a plan for implementation of the Information Revolution, ensuring alignment within the framework of the national HSTP strategy.

### PROGRESS OF THE INFORMATION REVOLUTION

This section highlights major accomplishments of the Information Revolution in the 2009 EFY.

### CONNECTED WOREDA

The Connected Woreda program implementation strategy has been developed. The connected woreda program is designed to measurably operationalize the Information Revolution agenda at the woreda and health facility levels. The Connected Woreda allows for health data to be collected, shared and used in a timely, equitable and transparent manner among and between points of service throughout the Woreda and primary health care unit (PHCU) with linkages to the regional and national health systems, thereby improving health worker performance and the quality of care. Improving data quality and information use are the core components of the connected woreda program and it leverages supporting capacity and digital tools that tie back to the pillars of the Information Revolution: strengthened data culture and digitalization of health information systems.

### CAPACITY BUILDING AND MENTORSHIP PROGRAM (CBMP)

The Capacity Building and Mentorship Program, which was launched in May 2017, has an end goal of improving data quality and information use through strengthening health workforce capacity and motivation to collect, analyze, and use information at the frontline and program levels. This national program is being implemented by five universities and their consortium members distributed in five major clusters throughout the country.

## DHIS -2 CUSTOMIZATION AND ROLLOUT

FMOH has been working towards transition to DHIS-2 as a national health management information system platform. The Ministry is customizing the software based on the requirements of the Ethiopian health system and building capacity towards strengthening local ownership and sustainable implementation. The new system is expected to harmonize upstream data collection and downstream data use across all levels of the health sector. It is also expected to facilitate more structured and harmonized data collection processes and strengthen information use at all levels. A DHIS-2 rollout roadmap and costed work plan has also been developed.

## ELECTRONIC COMMUNITY HEALTH INFORMATION SYSTEM

The Federal Ministry of Health is developing a new mobile-based electronic Community Health Information System. The eCHIS is the national digital Community Health Information System. The system intends to capture data on the Health Extension Program (HEP) and other community-level services, as well as utilize this data to improve HEP performance, community health outcomes, and Health Extension Workers (HEW) support across Ethiopia. This system is designed to be a single platform to meet the needs of urban, agrarian and pastoralist population. The eCHIS upon completion will consist of five components: 1) Health Extension Mobile Application, 2) Reporting and Analysis Portal, 3) System Management Portal, 4) eCHIS Database and 5) Clinical Portal.

## THE NATIONAL HEALTH DATA DICTIONARY

The National Health Data Dictionary (NHDD) is the authoritative source for indicator and data standards within the health system. The NHDD harmonizes data definitions from multiple programs and facilitates mapping of definitions. The Ethiopian NHDD is currently populated with indicators and data definitions from the HMIS Data Recording and Reporting Guidelines, the National Classification of Diseases (NCoD), and Community Health Information System (CHIS) Guidelines; mappings to ICD-10, SNOMED-CT, and CIEL international standards.

## THE MASTER FACILITY REGISTRY

The *Master Facility Registry (MFR)* is a digital resource that allows FMOH to manage and share common health facility identifiers and related data such as location, facility type, infrastructure, available equipment, human resources, and services. These shared identifiers are essential to understanding the distribution and availability of health service delivery, disease prevalence, and resource consumption and allocation throughout the health system. The MFR has been loaded and is now functionally live with initial datasets imported from SPA+, SARA, and eHMIS. The MFR includes information necessary for use in planning the construction or upgrading of new facilities and distribution of resources to ensure optimal coverage of health services.

## HEALTHNET

FMOH in partnership with Ethio Telecom is working to improve ICT Infrastructure and Connectivity at health facilities throughout the country. The plan is to connect more than 3000 health centers, hospitals and health offices to a government-supported multiprotocol label switching (MPLS) virtual private network (VPN). The connectivity will provide health facilities 2 – 15 mbps bandwidth. This connectivity provides an enabling mechanism to create connected facilities and Woredas.

Accordingly, FMOH has conducted series of discussions on the plan with Ethio Telecom and get a service with highly subsidized price. Ethio Telecom has started the work by conducting IP plan and site survey for 1684 facilities for the implementation. The FMOH paid subscription fee of around ETB 30 million for the service. For the implementation of the Health Net, Regional Health Bureaus are conducting detailed assessment and currently Addis Ababa and SNNPR have completed the assessment. As major component of the Health Net program, the capacity of the main data center of FMOH was successfully upgraded.

### TELE-MEDICINE AND TELE-EDUCATION

Telemedicine is another priority area of the Ministry to facilitate delivery of health care services and other consultations from a remote location. It has already been started in some specialty care services with the support of various kinds of telemedicine technology. In EFY 2009, FMOH has planned to implement Telemedicine in 60 hospitals (new) and to strengthen the existing telemedicine services implemented in previous years. Accordingly, a total 7 servers and 63 desktop computers were distributed for the hospitals that have started telemedicine services. In addition, a consultative workshop was conducted with a total of 80 participants drawn from 60 selected hospitals, 9 referral hospitals and 11 regional health bureaus. Currently, preparatory work for the implementation of telemedicine services in 60 remote hospitals is underway.

Moreover, during the fiscal year, a total of 403 tele-consultation services were provided in hospitals that have telemedicine services.

### ELECTRONIC MEDICAL RECORDS (EMR)

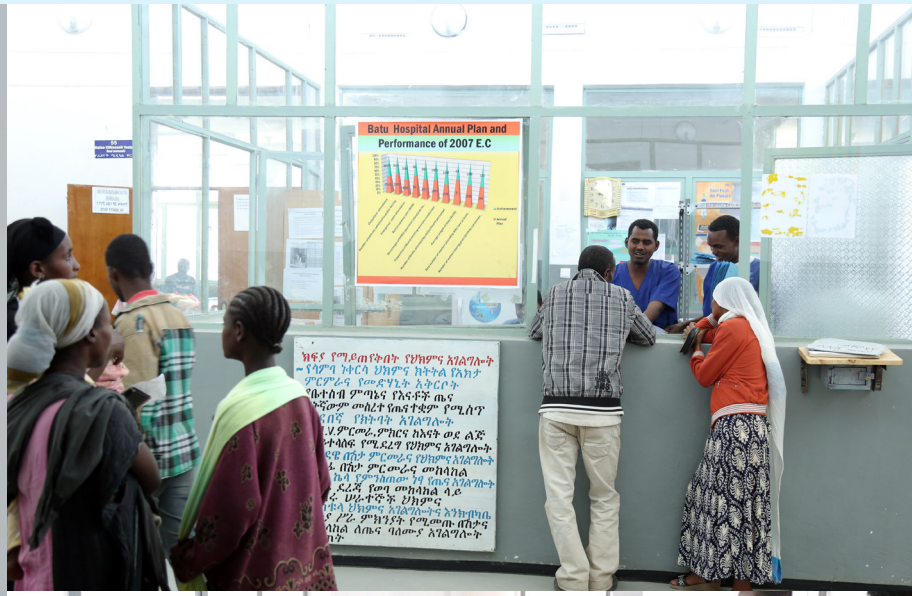
FMOH has planned to implement EMR at 80 hospitals and health centers in the EFY 2009. Accordingly, the 80 facilities are carefully selected from all the 9 regions and 2 city administrations and preparatory activities are currently underway. To date, full electronic medical record is implemented in 6 hospitals and 12 health centers in six regions. In addition, the registration module is implemented in 165 hospital and 1005 health centers in 10 regions.

### ETHIOPIAN HEALTH DATA ANALYTICS PLATFORM

The Ethiopian Health Data Analytics Platform (EHDAP) integrated data from various data sources, such as Tulane, JSI, PHEM, SPA, and more into one platform. The EHDAP also allows users to query these multiple datasets with intuitive, easy-to-use analytical tools that save countless hours of manual manipulation of data. All in all, EHDAP allows simultaneous querying across multiple data sources and supports data-driven decision-making across the Ethiopian health system.

# CHAPTER 3

# HEALTH SERVICE DELIVERY




# HEALTH SERVICE DELIVERY

## 3.1 HEALTH EXTENSION AND PRIMARY HEALTH SERVICE

The Health Extension Program (HEP) is a community health system designed primarily to deliver disease prevention, health promotion and selected high-impact curative services at the community and household level. The program aspires to increase accessibility of primary health care to less privileged households and communities. The philosophy of HEP is reaching every household with key messages and high impact interventions through community health workers (i.e. health extension workers—10$^{th}$ grade complete with one year training in primary health care) to increase awareness of communities and bring attitudinal change, and resultantly enable households and communities to produce their own health like they do produce crops and raise livestock. The most important tenet of the program is forging strong community engagement and ownership of the program through raising their awareness, behavioral change communication, community organization, and mobilization with their full participation, using locally available technologies and skills, and indigenous wisdom eventually adoption of healthy lifestyles.

The utilization of primary health services in the country has been greatly improved since the launching of the program in 1997 (2003). The DHS show that utilization of vaccination services, preventive and promotive maternal and child health services and those targeted against common communicable diseases has shown fast increase since 2005. Ethiopia has registered impressive results in the last decade in reducing maternal and under-five mortality, morbidity attributed to malaria, TB, diarrhea, and pneumonia and HIV/AIDS. The HEP was first designed to provide 16 packages of largely health promotive and diseases preventive health services at health post level, outreach, during home visits. Gradually, the packages of health services of the program have been expanded to accommodate additional curative health services.

The Health Development Army (HDA), which is also referred to as Women Development Army (WDA), was launched in 2011 to further strengthen the HEP and sustain the gains the country has registered. It is participatory engagement of women's groups to disseminate health information and facilitate uptake of critical health services. The HDA leaders are selected from model families and they complement the work of HEWs with network of 1:5 and 1:30 households.

Contemporary with advancements in socioeconomic status of communities, change in demographic trends, epidemiologic transition, urbanization, the need for more comprehensive and quality service has increased. To match these changes and adequately transform the quality

and equity of health care delivery in Ethiopia, the government has revised the HEP and has been providing one year additional training to the HEWs and produced 9858 second generation (level-IV) HEWs so far. The Ministry aspires to stay abreast of the needs of the communities through continually shaping the HEP.

## IMPLEMENTATION OF HEALTH DEVELOPMENT ARMY (HDA)

The main objective of the HDA is to augement the effort of the HEP of furthering communty engagegement in the implementation of the program and therby enable communities to produce its own health through infleucing health determinants with a strong ownership and leading role in implementation of health programs. This requires an organized social movement fueled by technical and knowledge-based inputs provided primarily by the HEWs.

Remarkable achievements have been gained in health sector since the start of HDA, particularly in the past three years. In 2009 EFY, to further strengthen HDA, an ignition document was prepared building on past lessons and common action plan was developed and have guided the implementation of HDA related activities. In the budget year, the coverage of households with full implementation of health extension packages was 5,553,105 (38%), and 5,051 (30%) kebeles have been declared open deification free which is far below the target set for 2009 EFY.

To further enhance community participation and ownership, building the capacity of health development army team is has been considered pivotal. To this end, health extensions package competency training curriculum was developed to train health development army team leaders based on technical and vocational training implementation guide. Implementation manual was developed and piloted in two woredas. With the goal of scaling up the training to all regions, experience sharing workshop was conducted with all regional representatives and discussion was held on the findings of the pilot. Moreover, regions identified woredas for a phased scale up of level one training in their respective regions and a total of 412 health professionals received training of trainers.

## CHALLENGES

- Lack of proper follow up by leaders at all level
- Insufficient support for Cascading training by Regional Health Bureaus

## WAY FORWARD

- Expanding women development army competency based training in all regions
- Cascade training for Women Development Team leaders
- Conducting advocacy at all level to gain support from leaders
- Strengthening inter-sectoral collaborations
- Documenting best practices and scaling up

## RURAL HEALTH EXTENSION PROGRAM

The HEP has been instrumental in taking primary health services to communities and thereby in increasing access to and use of maternal and child health and, disease prevention and control since 1997 E.C. With the objective of increasing the responsiveness of HEP to the contemporary health needs of the communities, a comprehensive assessment on the performance of the Health Extension Program was conducted in selected high and low performing zones/woredas of four agrarian regions (SNNP, Oromia, Amhara, and Tigray) and Addis Ababa and Dire Dawa city administrations. Extensive desk review and qualitative interview of key informants and focused grouped discussion and in-depth interview of community members were the methods. The findings of the assessment were presented for high level discussion and for decision to revitalize health extension program.

## URBAN HEALTH EXTENSION PROGRAM

With the objective of strengthening the urban HEP, revised national urban HEP implementation manual was distributed to regions and city administrations. Furthermore, sensitization of the program was conducted for 1,295 health managers from all regions. Integrated refresher training was provided for 4,500 urban HEWs on three modules namely SBBC, WASH, and RMCH.

In the fiscal year, national conference on urban HEP was conducted in Addis Ababa with participation of political leaders, policy makers and other key stakeholders. In the conference, lessons and program experiences from different professions and backgrounds in urban health were shared.

## CHALLENGES

- Lack of strong follow up by leadership at each level
- Low community engagement and weak intersectoral collaboration

- Lack of commitment in some health extension workers
- Lack of motivational packages
- Lack of standardized data collection and reporting tool

**WAY FORWARD**

- Finalize the HEP Re-optimization document and its implementation
- Strengthen Integrated Refresher Training for Urban Health Extensions workers
- Strengthening advocacy to gain commitment from leaders at all level
- Strengthening intersectoral collaborations
- Conducting urban health conference
- Strengthening urban primary Health care reform implementations
- Strengthening UHEPs performance and program evaluation system and roll out community based health information system.
- Revisiting Health Development Army (HDA) implementation, monitoring and evaluation manuals

**HYGIENE AND SANITATION**

**URBAN HYGIENE & SANITATION**

To further enhance the implementation of revised integrated Urban Hygiene & Sanitation Strategy, different advocacy and sensitization efforts were made and Memorandum of Understanding (MoU) has been signed between important stakeholders.

With the objective of improving latrine coverage in urban areas, design revision and bill of quantity was made for communal, public latrines and public showers. The revised design and bill of quantity have been shared to all regions in order to help regions guide the construction of latrines and showers they have planned to construct in small towns. Additionally latrine technology option manual was finalized in consultation with respective stakeholders.

## SANITATION MARKETING

In the fiscal year, for the establishment of sanitation market centers in Woredas different activities were undertaken and MoU was signed among key actors and aligned implementation plan was developed. The ministry supported regions in establishing enterprises and cascading the training. In general, 103 woredas were selected and 57 enterprises were established from all regions and as a result, 12,982 slabs were produced and sold from 31 established enterprises.

To improve Menstrual Hygiene Management (MHM) of women's, reusable and high quality locally produced and imported sanitary pads was piloted among girls in 22 woredas at 47 schools, working places and residential areas.

## CHALLENGES

- Slipping back of ODF kebeles
- Weak follow up and leadership at Kebele level
- Lack of inter-sectoral collaboration
- Lack of locally suitable sanitation technologies

## WAY FORWARD

- Strengthen the engagement of the health development army at community level
- Conducting advocacy on the Community Led Total Sanitation and Hygiene (CLTSH) implementation approach at each level
- Strengthening multi-sectoral collaboration
- Expansion of sanitation marketing at all levels and availing locally suitable materials at low price for the community.

## HEALTH EDUCATION AND COMMUNICATION

The role of social behavior change communication in improving demand for health services has been appreciated these days much more than ever. The ministry of health has made great strides to enhance the capacity of the health system to implement effective social behavioral change

communication interventions. In EFY 2009, health and health system literacy implementation guideline, was developed with the participation of multidisciplinary experts. This guideline is intended to guide activities of the health system to create awareness on health and health system literacy at community level.

In addition, a guideline for health communication material development was finalized and 14,500 copies were distributed to regions. A familiarization workshop was organized and TOT was provided to staff from FMOH, Regional Health Bureaus and Federal Hospitals as part of the capacity building exercise for the new guideline.

The urban family health card was revised using findings from an assessment conducted on its utilization and emerging health issues such as drug abuse and addiction, non-communicable diseases, and environmental hygiene and sanitation. Moreover, communication quality assurance guidelines were prepared to help program experts develop contextual communication materials which is suitable for the community.

**OTHER ACTIVITIES**

- Family health guidelines were prepared and 112,740 printed copies were distributed to SNNP and Amhara regions
- Training support toolkit was developed and tested to support rural HEWs to provide training on HEP packages for Health Development Army
- Technical support was provided for Somalia and Addis Ababa city administration in creating awareness and social mobilization on Acute Watery Diarrhea (AWD)
- Different Information, Education, Communication (IEC) materials were distributed for people with hearing and visual impairments in collaboration with programs.
- Advocacy and distribution of printed copies of the National Health Promotion and Communication Strategy (2016-2020) were conducted.

**CHALLENGES**

- Shortage of trained human resources on health education and communication at each level.
- Absence of integration of health and communication into different health strategies

- Lack of focus on using guidelines, strategies on health education and communication.

**WAY FORWARD**

- Recruit and train health education and communication professionals at each level;
- Ensure the utilization of national heath promotion and communication strategy and related guidelines;
- Ensure integrated M&E activities related to health education and communication

## 3.2.REPRODUCTIVE, MATERNAL, NEONATAL, CHILD, ADOLESCENTS AND YOUTH HEALTH SERVICES

The Government of Ethiopia is committed to improve and maintain the health status of women, neonates, children, adolescent, and young people.

In response to the need to provide guidance for implementing initiatives stipulated in the HSTP pertaining to reproductive health, a National Reproductive Health Strategy for the years 2016-2020 was developed and endorsed. This strategy reaffirms the ministry's commitment to sustain the momentum by setting targeted and measurable agendas to improve the health of women, children and youth. It builds on lessons learnt during implementing numerous solutions and those initiatives currently being implemented and is developed in a way to readily assimilate new and emerging developments, and serve the health needs of all Ethiopians with high impact.

The implementation strategy encompasses (I) improving maternal and newborn health (MNH), (ii) improving family planning, (iii) improving adolescent and youth reproductive health, (iv) prevention and management of reproductive organ health problems, and (v) addressing the social determinants of reproductive health through improving equitable access to the full spectrum of essential and quality health services to mothers, neonates, children, adolescents and youth.

**REPRODUCTIVE AND MATERNAL HEALTH SERVICES**

**REPRODUCTIVE & MATERNAL HEALTH IMPACT INDICATORS FROM EDHS**

Ethiopia has registered remarkable progress in past two decades in improving the health service coverage and health status of the population. The country showed notable progress in reduction of maternal Mortality, Child mortality Infant mortality and Neonatal mortality. There was also a sharp increment in Life expectancy and decline on Total fertility rate.

## MATERNAL MORTALITY

The Ethiopian DHS showed that maternal mortality ratio has been reduced by 39% from 676 in 2011 to 412 per 100,000 live births in 2016. This remarkable decline in maternal mortality should be maintained and accelerated to reach the HSTP target of 199/100,000 live births MMR in 2020.

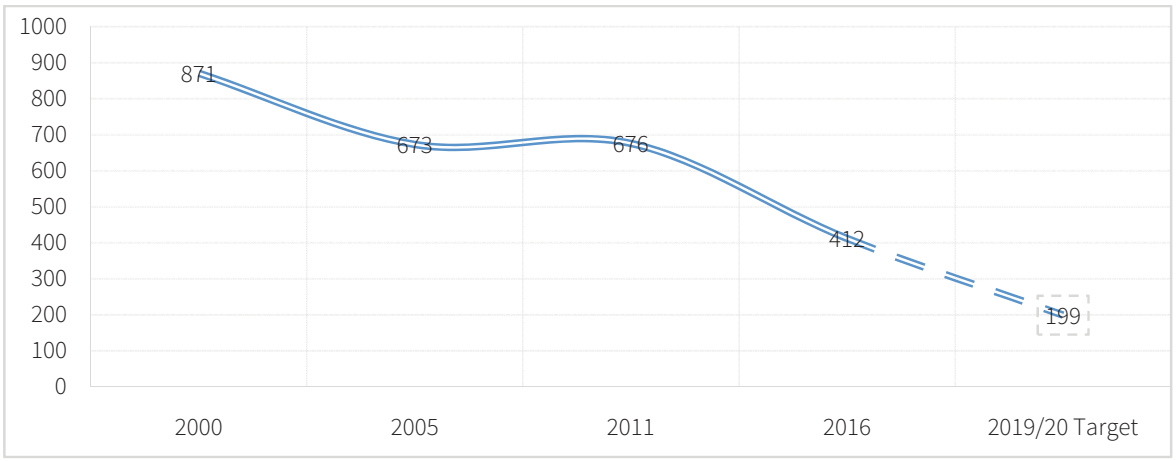



Figure 1: Trends in Maternal Mortality Ratio, 2009 EFY

## CONTRACEPTIVE PREVALENCE AND TOTAL FERTILITY RATE

The contraceptive prevalence rate (any method) among married women in Ethiopia has sharply increased from 8% in 1997 (2000) to 36% in 2009 (2016). In order to achieve the HSTP target (i.e. 55%) within the remaining three years, the CPR has to be raised by an average of five percent per annum (figure 2). Parallel to the increase in CPR, the fertility rate in three years prior to surveys has been reduced from 5.5 in 1997 (2000) to 4.6 children per woman in 2009 (2016).

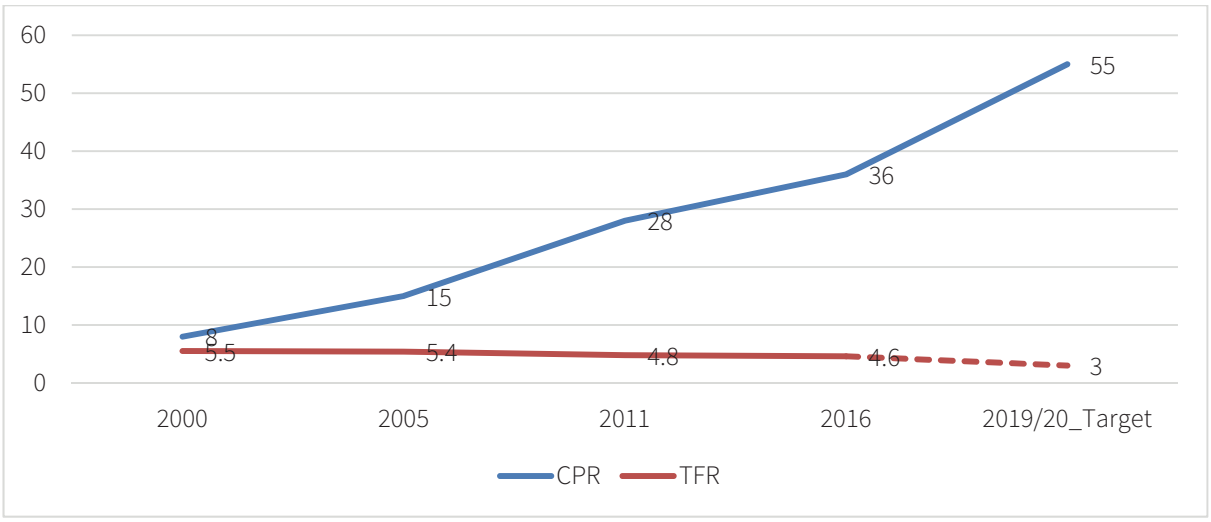



Figure 2: Trend in married Contraceptive Prevalence Rate, 2000-2016, Ethiopia

## MATERNAL HEALTH INDICATORS PERFORMANCE FROM ROUTINE HMIS

In past two years of implementation period of the HSTP, an increment in the performance of the reproductive and maternal health indicators has been observed. Figure 3/table 1 illustrates that the trend in the performance of the health sector towards achieving the maternal health HSTP targets is impressive.

Table 1: Maternal Health Indicators performance in past three years

| INDICATORS | 2007 EFY Baseline | 2008 EFY | 2009 EFY | 2009 EFY TARGET | 2019/20 TARGET |
|---|---|---|---|---|---|
| Contraceptive Acceptance Rate | 70% | 71% | 71% | 83% | |
| Antenatal 4+ care coverage | 68% | 76% | 77% | 88% | 95% |
| Percentage of deliveries attended by skilled health personnel | 61% | 73% | 71% | 87% | 90% |
| Early Postnatal care coverage | 90% | 89% | 82% | 90% | |
| Percentage of pregnant women counseled and tested for PMTCT | 93% | 95% | 92% | 97% | |
| Pregnant women tested positive for HIV who received ART prevent (MTCT) | 65% | 62% | 58% | 91% | 95% |

## CONTRACEPTIVE ACCEPTANCE RATE

In 2009 budget year, 13,430,829 (71%) women in reproductive age received family planning service. Three regions, Amhara (93%), Oromia (76%), and SNNP (75%) have performed above national average whereas, Afar (40%), Addis Ababa (36%), Gambella (26%) and Somali (13%) has performed below the national average and their baseline (figure 3). The lower performance of Addis Ababa is mainly due to lack of reporting by private health facilities. The report further indicates that there is wide disparity in CAR performance among regions, with a range of 80% among the high performing (Amhara) and low performing (Somali) regions.

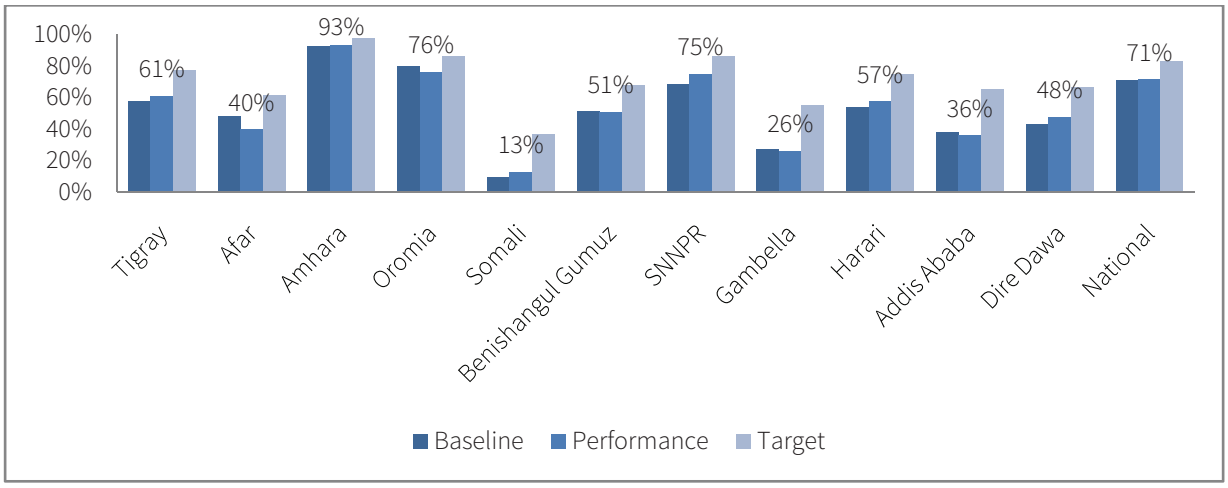



Figure 3: Contraceptive Acceptance Rate by Region, 2009 EFY

## FAMILY PLANNING METHOD MIX

Over half of family planning users prefer injectable methods (54%), followed by implants (26%), oral contraceptives (13%) and IUCD (3%). Out of the 3,932,131 long-term family planning method users, 3,504,186 (89%) use implants and the remaining 427,945 (11%) use IUCD. There is significant increment in the uptake of long term family planning methods from the total users. To further improve the long-term methods use, 241 number of level IV HEW were trained on IUCD and two rods implant insertion and removal service provision. The Ministry is planning to scale up this task shifting in the coming years. In addition to this, immediate post-partum FP service was started focusing on Postpartum IUCD scale up.

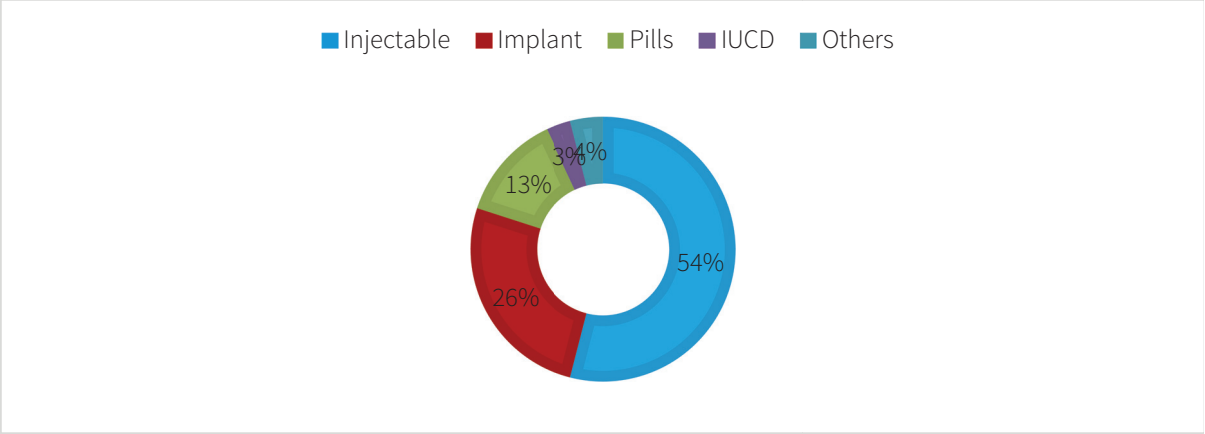



Figure 4: Family Planning Method Mix, 2009 EFY

## ANTENATAL CARE COVERAGE
## ANC 4+ PERFORMANCE

Pregnant mothers should have at least four antenatal visits in their pregnancy to identify and manage pregnancy related complications.

In 2009 EFY, from a total of 3,172,455 pregnant mothers who were expected to receive antenatal care service, 2,429,905 (77%) received ANC-4 service.

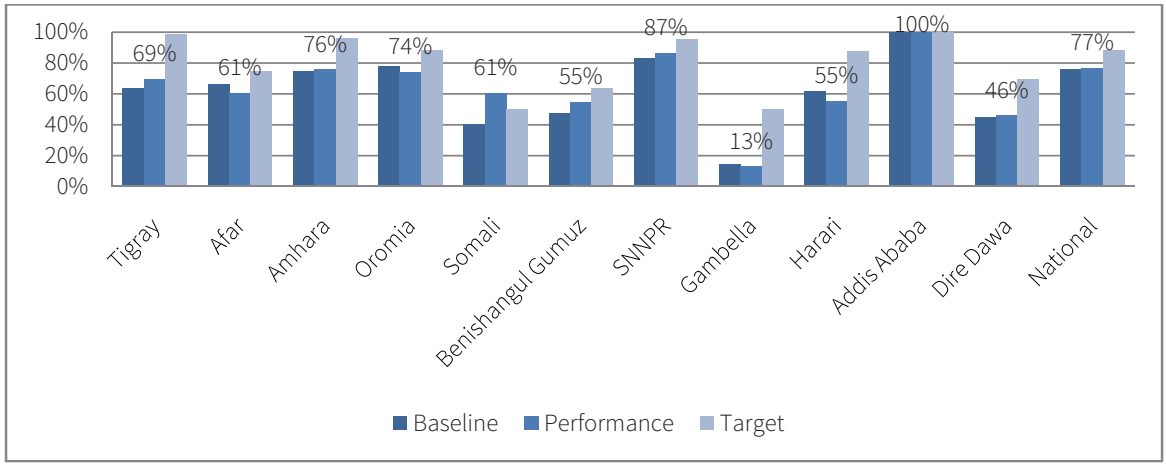



Figure 5: Comparison of Baseline, Performance and Target of Antenatal Care Coverage 4+ by Region, 2009 EFY

The above graph shows that the ANC-4 performance ranges from 13% in Gambella region to (100%) Addis Ababa. In comparison, Amhara, SNNP, and Oromia regions performed above the national average (figure 5). Early pregnant mother's identification using the health development army has been a major strategy employed to increase the percentage of mothers receiving ANC-4+. Pregnant mothers are expected to have syphilis screening during their ANC visit. However, only 45% of pregnant mothers were screened for syphilis from those who accessed any ANC visits at health facility in 2009 EFY.

## SKILLED DELIVERY ATTENDANCE

In the 2009 fiscal year, 2,253,541 (71%) of pregnant women were reported to have delivered at health facility assisted by skilled health personnel. The national performance shows slight decrement from 2008 baseline (73%) and was far below the HSTP 2009 target (87 %) (Figure 6).

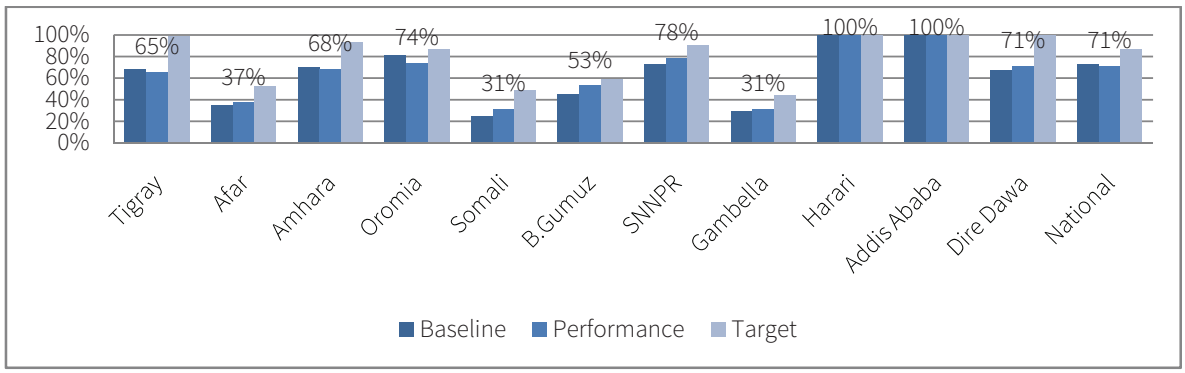
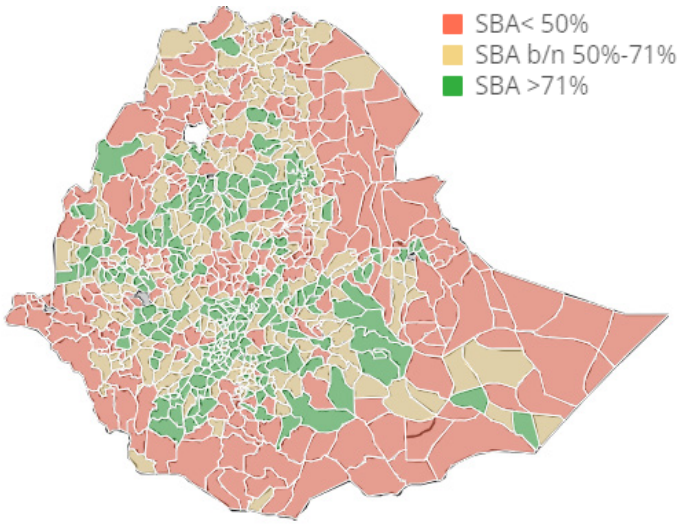



Figure 6: Proportion of deliveries attended by skilled health personnel, 2009 EFY

Looking in to regional performance, percentages of women delivered at health facilities with skilled attendance in Addis Ababa, Harar, SNNPR and Oromia regions were above the national average, while, Afar, Somali and Gambella have lowest coverage. The skilled delivery assistance ranged from 31% in Gambella and Somali regions to 100% in Harar administration and Addis Ababa city (figure 6).




The map shows distribution woredas by their skilled delivery coverage. Proportion of woredas with less than 50% skilled delivery coverage was high in Gambella (100%), Somali (83%), Afar (82%), and Benishangul-Gumuz regions. This indicates that there should be focus in these regions to narrow the performance gap

Figure 7: Woreda level distribution of delivery attended by skilled health personnel, 2009 EFY

The progress made so far in improving skilled delivery attendance has been impressive and the engagement of Health Development Army (HDA) has been the engine for the achievement. In order to improve the quality of obstetric service, Basic Emergency Obstetric and Neonatal Care (BEmONC) training was provided for health workers.

## POSTNATAL CARE

Early Postnatal Care is one of key interventions to prevent maternal and neonatal deaths. In 2009 EFY, 2,587,669 (82%) mothers received early PNC service of which 1,542,353 (49%) of mothers get the service in the first two days (48 hours) after delivery.

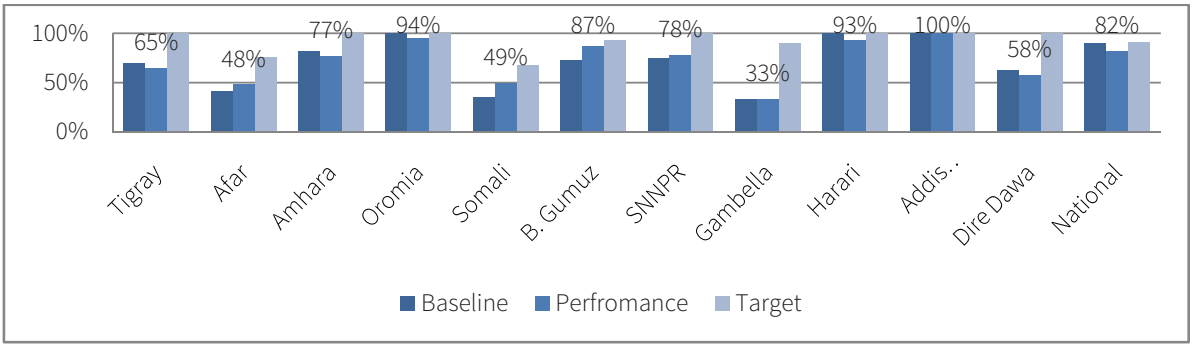



Figure 8: Early Postnatal care performance by regions, 2009 EFY

Postnatal Care coverage in the regions ranged from 33% in Gambella to 100 % in Addis Ababa. All regions except Addis Ababa did not meet their annual target and Tigray, Amhara, Oromia, Gambella and Dire Dawa have shown slight decrement from the baseline.

## CESAREAN SECTION

In 2009 EFY, percentage of women delivered by cesarean section at national level was 4% which is close to last year performance. Largely urban areas, Addis Ababa (25%), Harari (21%) and Dire Dawa (16%) have the highest Cesarean Section rate among regions. In the remaining largely rural regions, Cesarean Section rate ranged between 2% and 5%, which is far below the acceptable standard of 15%.

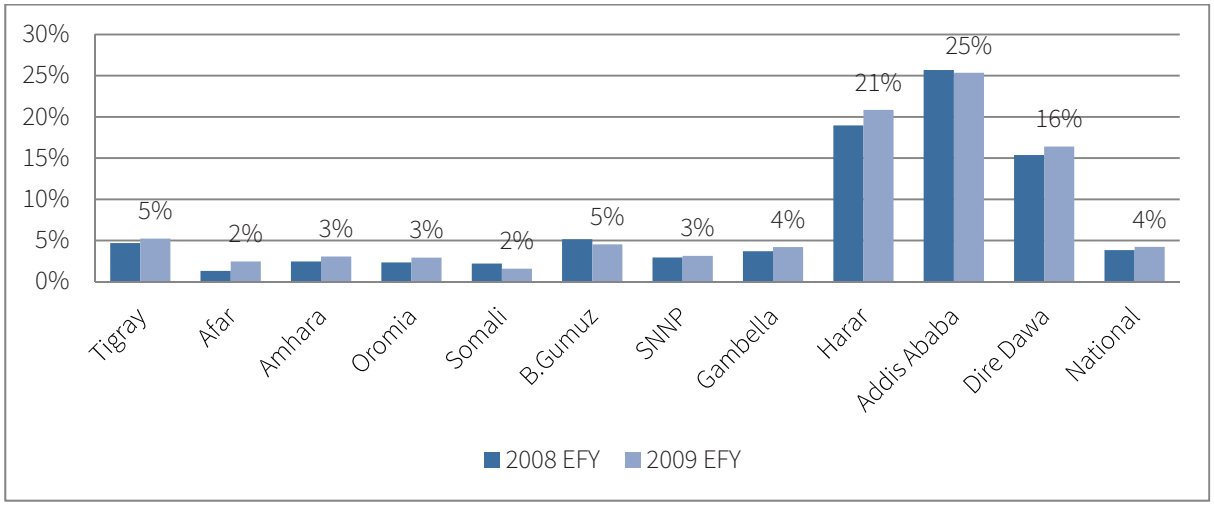



Figure 9: Cesarean section rate, 2009 EFY

## SAFE ABORTION SERVICE

Safe abortion services have been implemented with the aim of reducing maternal mortality, with close monitoring and enforcement of the laws making the necessary adjustments. In 2009, a

total of 245,208 women received comprehensive abortion care services, of which 21,733 were under the age of 18. Therefore, it is necessary to reinforce the reproductive health services for teenagers by implementing Adolescent and Youth Reproductive Health (AYRH) guidelines.

## STILL BIRTHS

Still birth rate serves as a proxy indicator to measure quality of obstetric service provided for pregnant mothers from conception to delivery time. Most stillbirths are avoidable, as evidenced by the low stillbirth rate for developed countries of 3 per 1000 births in contrast to the stillbirth rate of 28 per 1000 births in sub-Saharan Africa. Nationally, there were a total of 24,141 still births in 2009 EFY, 10 still birth per 1000 births attended at health facility and nearly similar rate to the 2008 EFY rate. The still birth rate reported ranges from 7 in SNNPR to 62 in Harari per 1000 births.

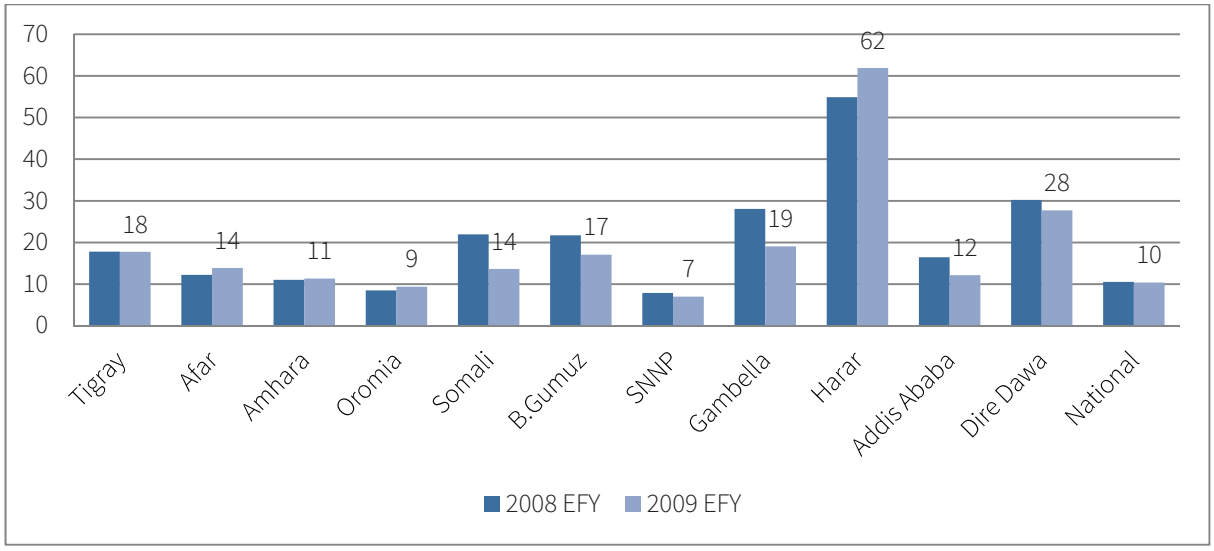



Figure 10: Still birth rate, 2009 EFY

## MATERNAL DEATH SURVEILLANCE AND RESPONSE (MDSR)

Delays in health care seeking, accessing (transport) and receiving care at health facilities during obstetric emergencies are major contributing factors for maternal death both at community and facility level.

According to 2009 EFYMDSR report, 7% of maternal deaths were reported nationally which has a slight increment from last year 535 (5 %) from UN estimate for 2008 EFY. However, it is far below from expected maternal deaths as per the UN estimate for the fiscal year.All regions have reported lower number of maternal deaths as compared to the regional estimated maternal deaths.

Table 2: Maternal Deaths through PHEM/MDSR System by Region, 2009 EFY

| Region | Expected MD/year as per UN estimate | Number of Maternal Deaths reported | Percent of maternal deaths reported |
|---|---|---|---|
| Tigray | 732 | 46 | 6% |
| Afar | 216 | 11 | 5% |
| Amhara | 2,964 | 258 | 9% |
| Oromia | 5,112 | 476 | 9% |
| Somali | 756 | 9 | 1% |
| Benishangul Gumuz | 144 | 25 | 17% |
| SNNPR | 2,760 | 62 | 2% |
| Gambella | 48 | 6 | 13% |
| Harari | 32 | 8 | 25% |
| Addis Ababa | 324 | 45 | 14% |
| Dire Dawa | 60 | 26 | 43% |
| **National** | **13,148** | **972** | **7%** |

The MDSR report showed that direct and indirect causes account for 83.3% and 16.7% of maternal deaths, respectively. Hemorrhage (35.4%) is the leading cause of maternal death followed by hypertension disorder during pregnancy (13.3%) and anemia (12.9%). The data showed that more needs to be done such as, expansion of C/S service, blood transfusion and EmONC at health facility level to reduce the maternal deaths. Also the MDSR review shows the delay one, which is delay in seeking care, account for half of the total maternal deaths which needs capitalizing the engagement of health development army in early pregnant mothers identification and linking with health facilities for accessing maternal health services.

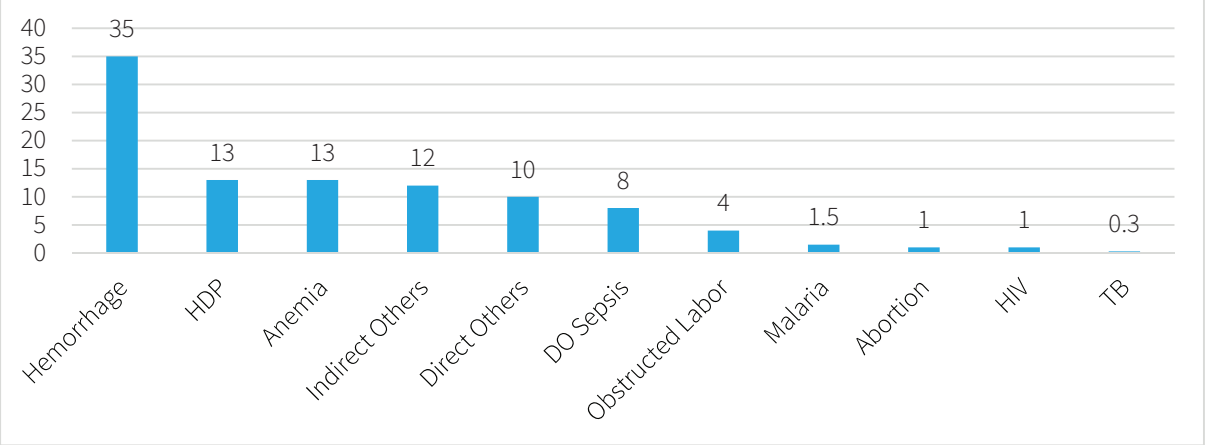



Figure 11: Cause of maternal death, 2009 EFY

## PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV TESTING RATE

Nationally, there were 28,727 estimated HIV positive mothers in 2009 EFY of which 16,871 (58%) mothers received ARV to prevent HIV transmission from mother to child. From the total mothers 40% of them were newly diagnosed in the fiscal year and the remaining, 60% were known HIV positive and linked to PMTCT. The performance is far below the national target 91% and has slight decrement from 2008 EFY performance (62%). To improve the PMTCT service 50 HIV hot spot areas were identified and comprehensive quality improvement package implementation was started.

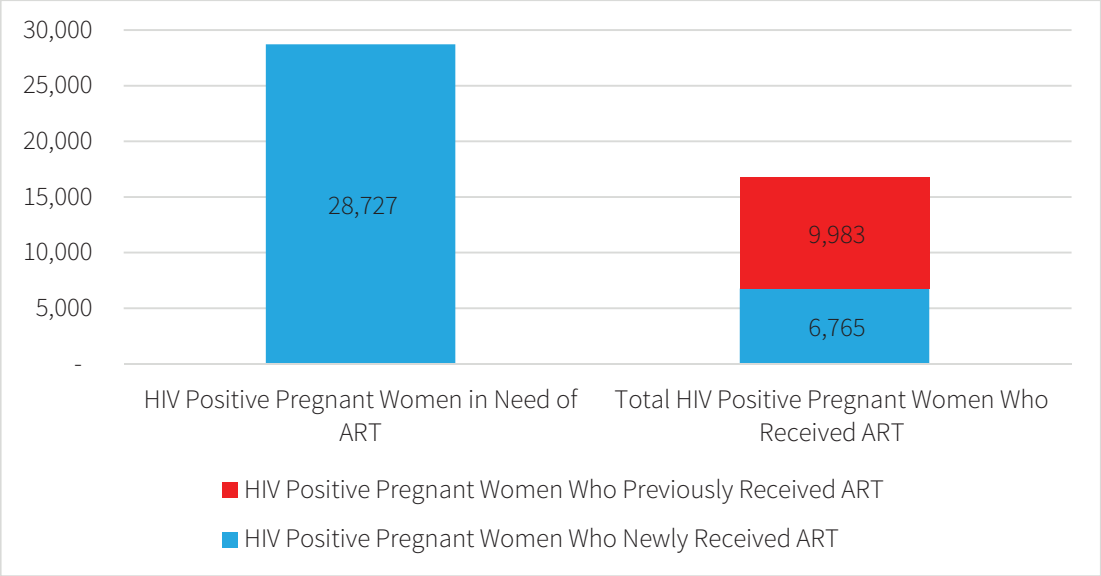



Figure 12: Status of Pregnant Women Tested Positive for HIV Who Received ART, 2009 EFY

## OTHER ACTIVITIES

## FISTULA AND UTERO VAGINAL PROLAPSE (UVP) SERVICES

A total of 1743 women with fistula cases and 473 women with UVP cases received treatment free of charge. Job aids on fistula and UVP were distributed for health care workers and HEWs. Moreover, a number of TV spots that focus on where to get fistula and UVP treatments were aired in different TV channels.

## ADOLESCENTS AND YOUTH-FRIENDLY HEALTH SERVICES

Adolescents and youth constitute 33.8% of the total population of Ethiopia. National adolescent and youth strategy document specifies as they are challenged with a wide range of problems, including poor health status with high substance abuse. Nearly one of eight (13%) adolescent girls are anemic and 36% are chronically malnourished (BMI<18.5). More than half (51%) of

adolescent and youth consumed Khat with high regional variation; about 46% of them consume alcohol six or more times per month; and 4.4% of adolescents are cigarette smokers. Moreover, the prevalence of road traffic accidents among young people aged 15-29 years is 2.7%,

In response to the above problems, the National Adolescent and Youth Health (AYH) strategy was developed to initiate a strategic framework for tackling the full range of adolescent and youth health. The current strategy aims to improve the overall health status of adolescents and youth in Ethiopia and contributes toward realization of their full potential in national development. The strategy has undergone a paradigm shift from sexual and reproductive health services to the overall adolescent and youth health services including nutrition, substance use, mental health, injury, gender-based violence, harmful traditional practices, non- communicable diseases and other services that contribute to the overall health and development of adolescents. By 2020, the strategy targets to reduce morbidity and mortality of adolescent and youth by 50%, to reduce maternal mortality among adolescent and young women by 50%, to reduce the incidence of HIV among adolescent and youth from 0.2% to 0.001% and reduce unintended pregnancy from 12.5% to 3%.

**SCHOOL HEALTH STRATEGY**

In collaboration with Ministry of Education, a school health program framework and school health service packages have been developed. The package included ten important services packages (SBCC and life skill, nutrition services, WASH, vaccination and immunization, SRH, HIV/STIs, mental and substance use disorders, non-communicable disease and injuries, common childhood infection and infestations and school health preparedness, readiness, response and recovery in emergency during education). These packages are going to be implemented at schools from pre-primary to tertiary level of education. As a pilot, the program will be implemented in Amhara and Tigray regions through the health extension program by deploying one extra health extension worker who will be mainly responsible to implement the SHP packages at schools.

**CHALLENGES**

- Delay of procurement of medical equipment
- Delayed re-imbursement for hospitals providing free services to improve maternal health

**WAY FORWARD**

- Facilitate procurement order and process through frequent communication and strengthening the system
- Program integration for effective and efficient use of resources
- Deliver BeMoC assessment results per each facilities and users for action

## NEONATAL AND CHILD HEALTH SERVICES

Ethiopia has registered tremendous success in meeting MDG 4 (reducing child mortality) three years earlier than scheduled (2015). The successive Ethiopian demographic health surveys buttresses that Ethiopia has sustained the huge gains in terms of reducing under-five mortality since 2000. The surveys show that under-five mortality with five years prior to the surveys has declined from 166 in 2000 to 67 per 1000 livebirths in 2016. However, the decrease in neonatal mortality has not been as much as the decrease in post-neonatal and child mortality and has been relatively stagnant for over a decade. Neonatal mortality has declined by 41% from 49 in 2000 to 29 in 2016 whereas the under-five mortality has declined by 60% during the same period. Subsequently, the share of neonatal mortality among total under-five mortality has increased from 29% in 2000 to 43% in 2016. Regrettably, more than two thirds of neonatal deaths are caused by few easily preventable conditions; mainly infections, neonatal conditions and malnutrition.

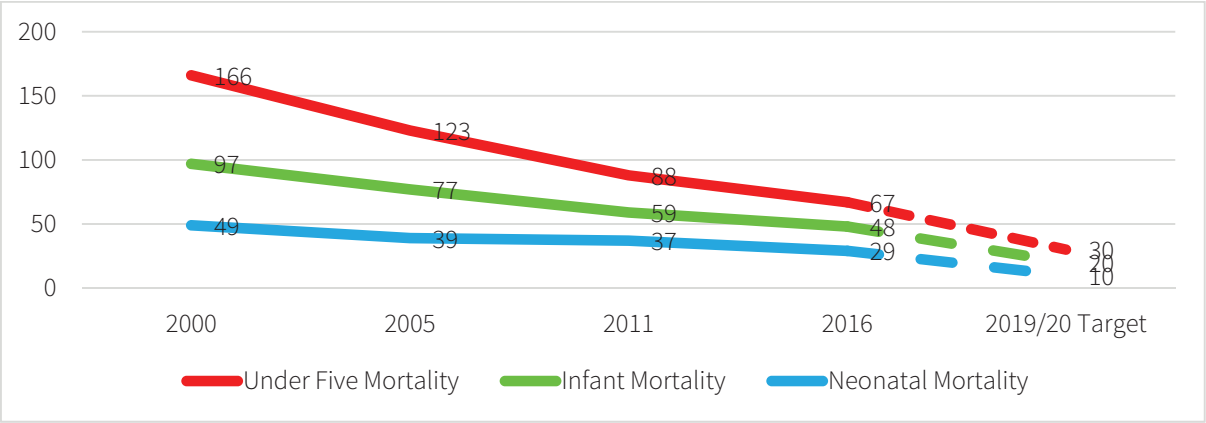



Figure 13: Under five, Infant and Neonatal Mortality (2000-2016 EDHS)

In order to realize the child health targets set in the HSTP and SDGs, the country has been implementing National Newborn and Child Survival Strategy (CSS) (2015-2020) and aspires to reduce under-five mortality to at least 30 /1,000, infant mortality rate to 20/1000, and NMR to 10/1,000 live births, by 2020. The guiding principles for implementation of the strategy are: increasing equitable access to quality service through enhancing community engagement, empowerment, and ownership; and efficient use of resources. To this end, implementation of proven highly effective interventions, encouraging innovation of solutions to improve quality of care, replicating them across regions, informing the process with strong monitoring and evaluation of programs and documentation and dissemination of learnings are outlined as critical components of the strategy.

The major initiatives articulated in the HSTP and detailed out in the national CSS were expanding community and facility based Integrated Management of Neonatal and Childhood Illnesses (IMNCI), establishing new-born corners and Neonatal Intensive Care Units (NICU), strengthening the immunization program, forging strong program management, and implementing context

tailored and effective child health interventions. The performance of the health sectors in terms of implementing these initiatives in 2009 EFY is described below.

### EXPANDED PROGRAM ON IMMUNIZATION

In 2009, the national plan for coverage of pentavalent-3, pneumococcal conjugate vaccine (PCV)-3 immunization, measles and fully vaccination of surviving infants were 99%, 99%, 98% and 97% respectively. The routine health information system showed that in the fiscal year, pentavalent-3, PCV-3, measles and fully vaccination coverage were 97%, 96%, 93% and 91%.

Figure 15 illustrates that the national 2009 EFY targets for the four vaccination coverage indicators were not achieved and a slight decrement (by 1%) from 2008 EFY performance has been observed in three indicators except coverage of fully vaccinated children that remained the same.

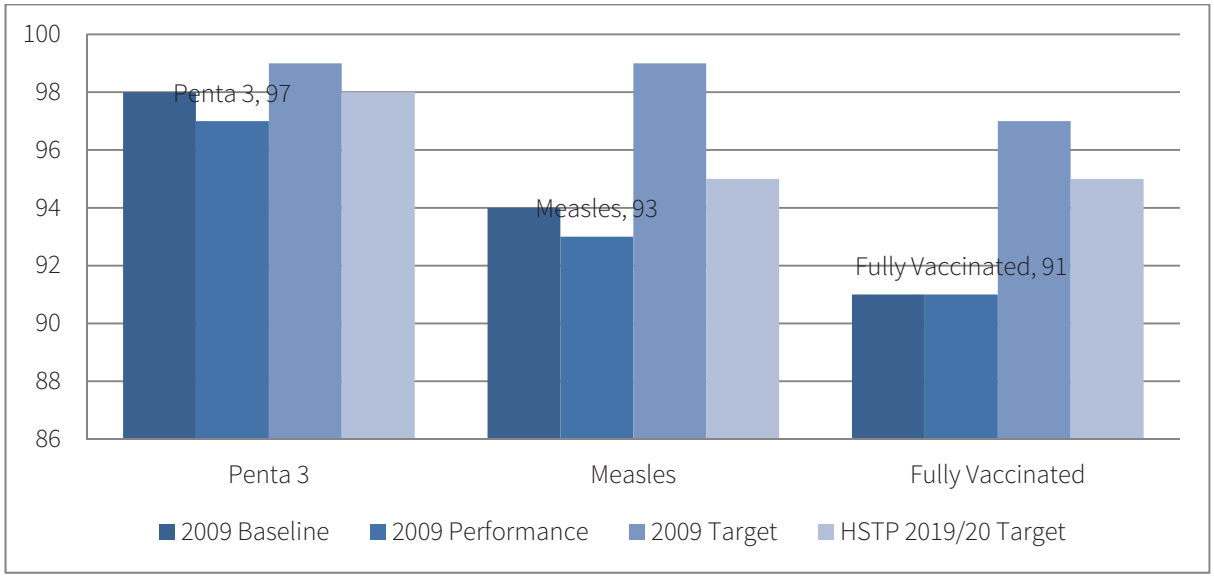



Figure 14: Performance in child vaccination coverage indicators, 2009 EFY

### REGIONAL PENTAVALENT-3 VACCINATION COVERAGE

The annual HMIS report showed that in 2009 EFY, the regional pentavalent-3 coverage ranged from 78% in Dire Dawa city administration to 100% in Addis Ababa, Harar, Benishangul-Gumuz, and SNNP regions. Only the four regions, Addis Ababa, Harari, Benishangul-Gumuz, and SNNP regions, were able to achieve their target for 2009 EFY, with the highest target-performance gap observed in Dire Dawa (22%), Gambela (18%), Tigray (11%) and Afar (11%) (Figure 15).

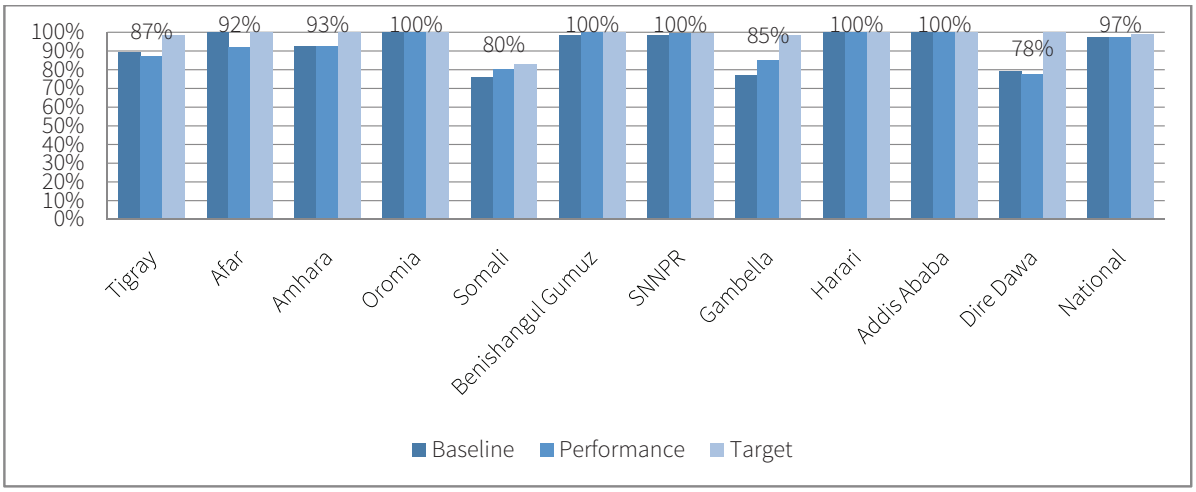



Figure 15: Pentavalent-3 vaccination Coverage by Region, 2009 EFY

## REGIONAL PNEUMOCOCCAL CONJUGATE-3 VACCINATION COVERAGE

In the fiscal year, 100% of eligible children in Benishangul-Gumuz , Harari and Addis Ababa were vaccinated with PCV-3. The PCV-3 coverages of Tigray, Afar, Somali, Gambela, and Diredawa were below the national average. Only three regions, Tigray (12%), Oromia (24%) and SNNP (20%) regions, were able to increases their PCV-3 coverage from last year performance, whereas five regions have performed below their baseline. The highest drop in performance was observed in Somali (21%) and Gambela (17%) regions (figure 16)

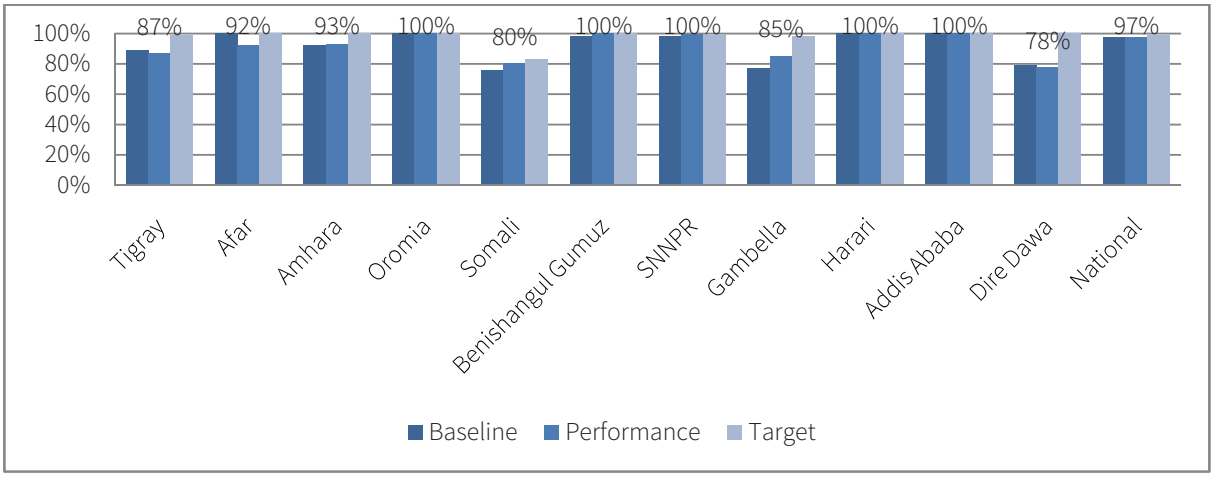



Figure 16: PCV-3 vaccination Coverage by Region, 2009 EFY

## REGIONAL MEASLES VACCINATION COVERAGE

At the national level, measles vaccine coverage for EFY 2009 was 94%. The coverage ranges from 75% in Somali region to 100% in Addis Ababa. In addition to Addis Ababa, Oromia (95%),

Benishangul Gumuz (96%), and SNNP (97%) regions have performed above the national coverage (94%). Five regions were able to raise their measles coverage from their baseline with the highest increase observed in Gambella region (15%), whereas, the drop in measles coverage was observed in four regions with the highest drop registered in Afar region (6%). Only Harar, Addis Ababa city and SNNP regions were able to achieve their measles coverage target while the rest didn't achieve their target set for the fiscal year (figure 17).

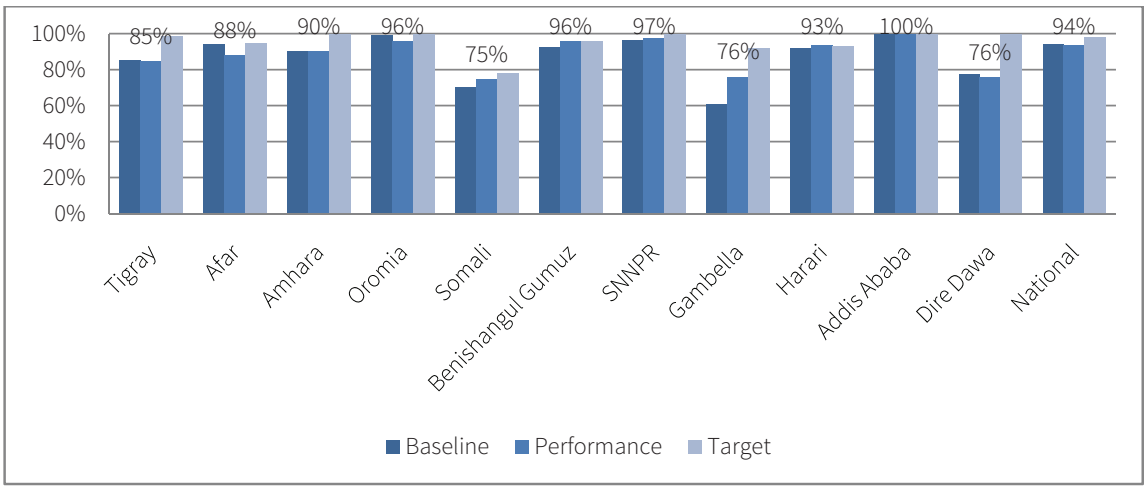



Figure 17: Measles vaccination Coverage by Region, 2009 EFY

## REGIONAL FULLY VACCINATION COVERAGE

The proportion of surviving infants fully vaccinated in 2009 EFY at national level was 91% and the regional performance ranges from 70% in Gambella and Somali regions to 100 % in Addis Ababa. Increment in coverage of fully vaccinated surviving infants was observed in five regions with the highest increase registered in Gambela region (15%). A drop in coverage of fully vaccinated children was observed in Afar (3%), Oromia (3%) and Dire Dawa (2%). Only Addis Ababa city and Benishangul-Gumuz regions were able to achieve their fully vaccination coverage target for the fiscal year (figure 18).

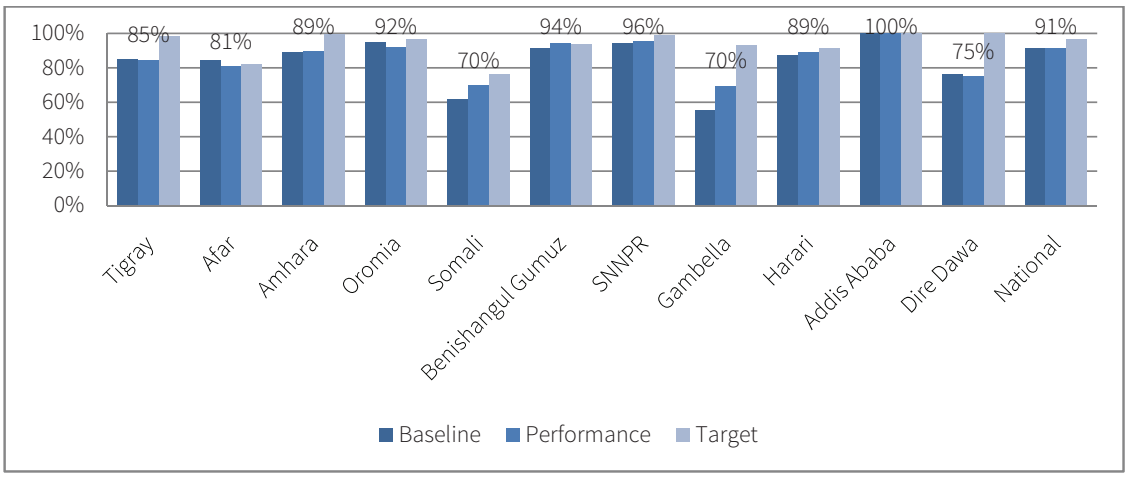



Figure 18: Full Vaccination Coverage by Region, 2009 EFY

In the fiscal year, the national pentavalent-1 to measles drop-out rate has increased from 9% in 2008 EFY to 10% in 2009 EFY. All regions, except Tigray, Amhara, Addis Ababa, and SNNP, have dropout beyond the national acceptable range (>10%). The highest pentavalent-1 to measles drop-out rate was observed in Somali and Gambella regions (22%) and the lowest dropout rate was registered in SNNP region (5%). Worsening of dropout rate, i.e., increment in drop-out rate, was observed in Oromia (2%) and Dire Dawa (2%), while reduction in drop-out rate was observed in total of seven regions with the highest reduction observed in Gambella region (figure 19).

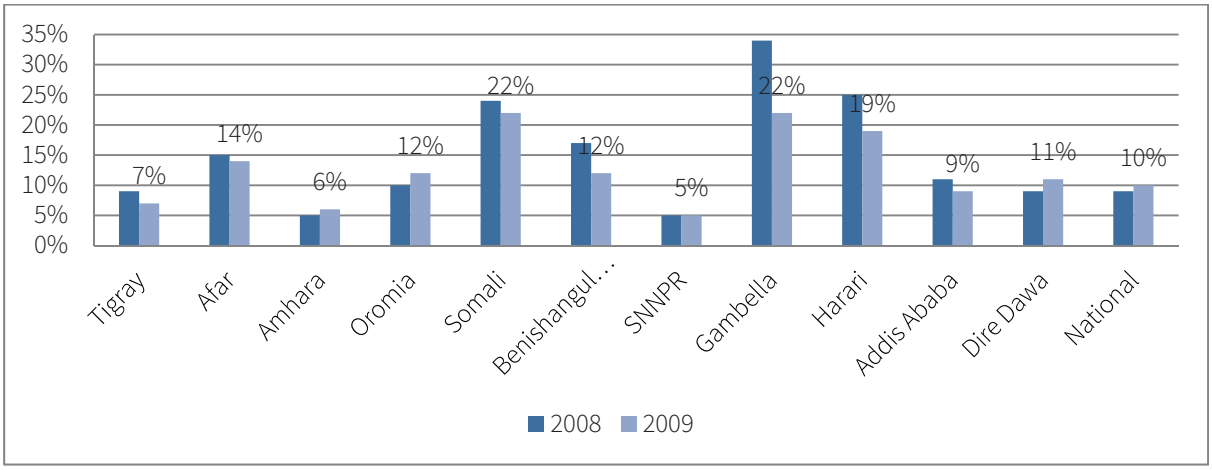



Figure 19: Pentavalent-1 to measles drop-out rate by region, baseline and performance, 2009 EFY

## WOREDAS WITH PENTAVALENT-3 VACCINATION COVERAGE ABOVE 80%

In the fiscal year, about three out of four woredas in the country have achieved more than 80% pentavalent-3 vaccination coverage which is slightly lower than last year's performance (75%). The proportion of woredas with more than 80% pentalent-3 coverage ranges from 44% in Dire Dawa administration and Somali region to 92% in SNNP region. In addition to Diredawa administration and Somali region, the proportion of woredas with less than 80% pentavalent-3 vaccination coverage in Tigray (58%), Oromia (73%), Gambela (50%) and Harari (67%) was lesser than the national average (74%). An increase in the proportion of woredas with this indicator was observed in four regions that ranged from 4% in SNNP to 23% in Afar region whereas drop in this indicator was observed in four regions that ranged from 7% in Tigray to 15% in Oromia (figure 20).

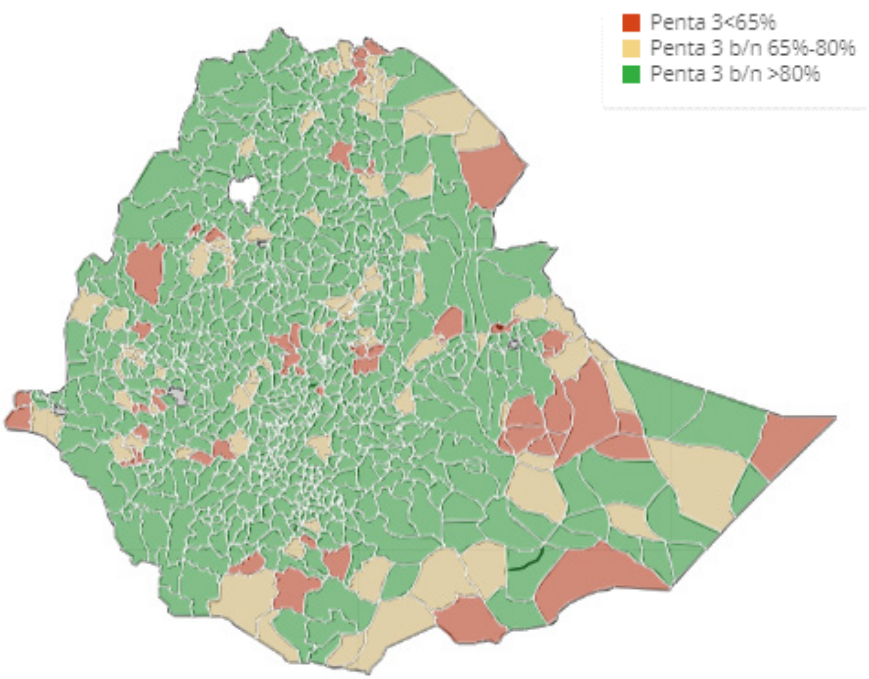



Figure 20: Proportion of woredas with more than 80% pentavalent-3 vaccination coverage by region, 2009 EFY

## MAIN EPI ACHIEVEMENTS IN 2009 EFY

- Polio free status documentation of Ethiopia was accepted by WHO.
- WHO acknowledged Ethiopia as the 42nd nation to have eliminated neonatal tetanus through intensified efforts
- Vaccination of public health care workers providing clinical services with hepatitis-B vaccine in the country has been initiated.
- The 7th round African vaccination week (AVW) was hosted in the country and social mobilization activities were organized to build on demand creation and community ownership
- Human papilloma vaccine (HPV) demonstration project was wrapped up successfully and therefore, GAVI IRC has approved the HPV national rollout application.
- The National Immunization Technical Advisory Group (NITAG) has been established and engaged in major immunization related decision making

## CHALLENGES

- Late and incomplete reporting of EPI activities and poor data use practice at local level
- Over-reporting of vaccinations through the HMIS (as demonstrated through comparison with the DHS 2016 findings)
- Suboptimal cold chain and fridge tag utilization
- Lack of strong trainees database post-training follow up that resultantly led to inadequate learning and skill transfer among health care providers

- Weak supply chain management particularly in proper stock management that usually led to lower level stock visibility
- Suboptimal quality and equity of services
- Lack of clear guidance in immunization target setting (denominator) in major cities and towns of regions and city administrations.

**WAY FORWARD**

- Establishment of coordination platforms at regional, zonal and woreda level for smooth implementation and rapid response
- Enhance coordination among stakeholders in the implementation of the program in developing regional states
- Stride to improve data quality and use at point if data generation
- Monitor the program by giving emphasis on disease specific outcome/impact monitoring
- Give due focus on pocket areas and population groups unimmunized; private facilities
- Periodic intensification of routine immunization (PIRI) in low performing districts
- Finalize the preparatory activities for MCV2 introduction in 2010 fiscal year
- Finalize the preparation of Polio legacy plan and start implementing the transitioning of polio eradication activities to government routine immunization program
- Standardize Immunization target setting in major cities and towns of regions and city administrations.
- Contextualize and implement the revised African regional RED/C guide in the national context
- Implement vaccine transition

**THE MANAGEMENT OF NEWBORN, NEONATAL AND CHILDHOOD ILLNESSES**

The activities related to neonatal and child health service provision were categorized into two as community and facility based activities. The facility based interventions include expansion of Essential Newborn Care (ENC) Services; strengthening & establishing Neonatal Intensive Care Units at hospitals; establishing skill laboratories at selected hospitals; expanding IMNCI services; and enhancing the quality of neonatal and child health care. Expanding and strengthening implementation of integrated community case management (iCCM) and community based newborn care (CBNC) were the major community based interventions implemented within the fiscal year.

Major focus was also given on availing essential commodities and equipment crucial for saving the lives of newborns and children to health facilities. These include ORS and Zinc dispersible tablet for diarrhea, Amoxicillin dispersible tablet for pneumonia, Amoxicillin and Gentamycin for possible serious bacterial infection for newborns, and other program related drugs. To ensure the uninterrupted supply of live saving newborn and child health commodities, preparations were made for integration of the commodities' supply system into the integrated pharmaceutical logistics system (IPLS).

## FACILITY BASED ACTIVITIES

- A total of 1316 health workers were trained in ENC, of these, 195 were drawn from health facilities who had not started ENC service before.
- Level two Neonatal Intensive Care Units (NICU) service was initiated in 80 hospitals in the fiscal year. To this end, a total of 121 physicians and 347 nurses were trained in NICU; 135 incubators, 128 phototherapy machines and 278 neonatal beds were distributed. In order to further expand NICU and NBC services, readiness assessment was conducted in additional 120 hospitals and 175 health centers respectively. Assessment to identify factors influencing the quality of neonatal and child health services was conducted in collaboration with local universities. At the end of the fiscal year, the total number of hospitals with NICU facility in the country has reached 190.
- In order to strengthen strengthening skill laboratories, an assessment was conducted at selected nine teaching hospitals and equipment was distributed to these hospitals based on the needs identified.

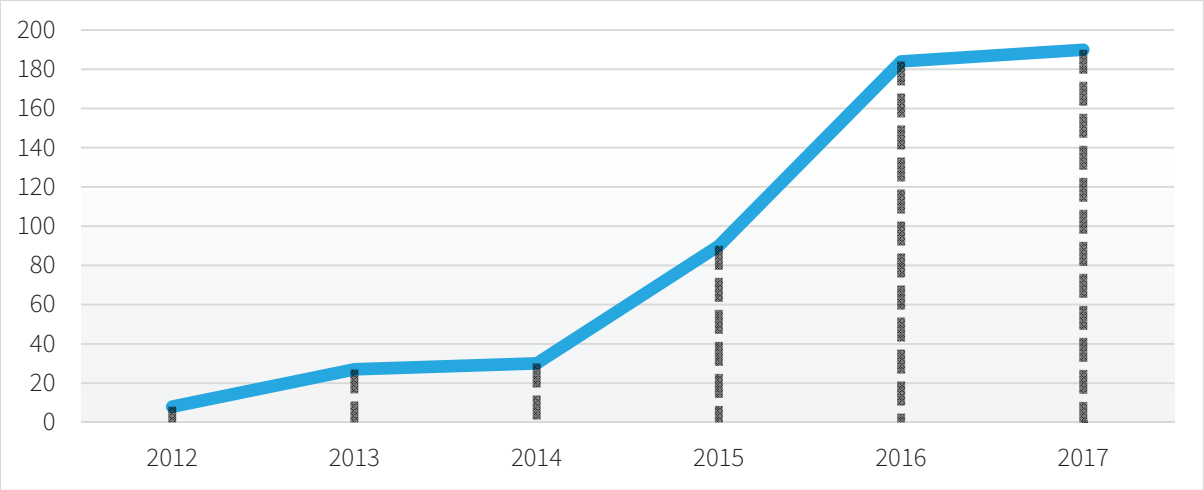



Figure 21: Trends in the number of hospitals with NICU facilities, 2009 EFY

*Percentage of Health Facilities Providing Integrated Management of Neonatal and Childhood Illnesses (IMNCI)*

With the intention to expand access to IMNCI services, FMoH and RHBs have been striding to increase the number of health facilities providing IMNCI services. With the fiscal year, 986 health workers were trained on IMNCI, and supplies were distributed to the health facilities. Consequently, the cumulative number of health facilities (hospitals and HCs) providing IMNCI service increased from 3,302 in 2008 to 3778 in 2009 EFY (Table 3).

Table 3: Cumulative number of health facilities providing IMNCI by Region, 2009 EFY

| Regions | Cumulative Number of HFs Providing IMNCI (2008 EFY) | Cumulative Number of HFs Providing IMNCI Service (2009 EFY) |
|---|---|---|
| Tigray | 239 | 240 |
| Afar | 84 | 90 |
| Amhara | 821 | 893 |
| Oromia | 1047 | 1391 |
| Somali | 208 | 217 |
| Benishangul-Gumuz | 39 | 41 |
| SNNPR | 715 | 740 |
| Gambella | 29 | 33 |
| Harari | 10 | 12 |
| Addis Ababa | 94 | 104 |
| Dire Dawa | 16 | 17 |
| **National** | **3302** | **3778** |

Improving the quality of and demand for iCCM/CBNC services and ensuring the sustainability of interventions were the priority initiatives of the FMoH. In collaboration with partners, the ministry has developed a three years Quality Improvement and Transition Plan (QITP) through consultations with the relevant stakeholders for the implementation of the project. In addition, with the intention to accommodate new recommendations and lessons learned from implementation of the project for four years, the ministry spearheaded the development of integrated iCCM/CBNC implementation guidelines.

### INTEGRATED COMMUNITY CASE MANAGEMENT (ICCM)

In the fiscal year, a gap filling training was provided to a total of 2144 HEWs and 182 health workers. In order to initiate iCCM in Afar and Somali regions, a total of 106 HEWs and 49 health workers in Afar, and 881 HEWs and 133 health workers in Somali region were trained in iCCM. In addition, 678 registers prepared in local languages were distributed to Somali and Afar regions. Post training supportive supervision was provided to 64 HPs in Afar and 614 HPs in Somali regions that started providing iCCM services in the fiscal year. Consequently, the cumulative number of HPs providing iCCM services in rural and pastoral woredas has increased from 15,551 (94%) in 2008 EFY to 16,367(99.42 %) in 2009 EFY.

### COMMUNITY BASED NEWBORN CARE MANAGEMENT (CBNC)

In the fiscal year, health posts in eight Afar woredas and 10 Children's Investment Fund Foundation (CIFF) supported woredas have started providing CBNC services, and with that the cumulative number of woredas implementing CBNC has risen to 577. Similarly, the cumulative number of HPs providing CBNC has increased from 13,789 in 2008 EFY to 14136 (97.6%) in agrarian woredas

of the four regions, namely Amhara, SNNP, Oromia, and Tigray regions in 2009 EFY. Baseline assessment to initiate CBNC in Gambella was conducted.

**CHALLENGES**

The major challenges that the health sector faced while implementing child health related activities were:

- Shortage of human & financial resources
- Low demand and low utilization of child health services
- Weak ownership and sustainability of interventions by the health system
- High attrition rate of health professional
- Weak supply chain management
- Suboptimal quality of CBNC/ICCM services
- Vital child health program indicators were not captured by routine HMIS report
- Irregularity of supportive supervision

**WAY FORWARD**

- Design and initiate specialty curriculum for NICU nurses
- Strong mobilization of resources and aligning activities with development Partners
- Strengthen community based demand creation activities
- Integrating child health program into existing monitoring and evaluation tools
- Integration of child health commodities in to IPLS in 2010 EFY
- Implementation of the 3-years national quality improvement and transitional strategy & plan for ICCM/CBNC
- Integration of child health indicators into the revised national HMIS indicators pool
- Expansion and preparation to establish level 3 NICU in 80 hospitals selected from all regions
- Improve quality In IMNCI services

**NATIONAL NUTRITION PROGRAM**

Ethiopia revised national nutrition plan I (NNP I) and prepared (NNP II) for the period of 2016-2020 to realize “Seqouta declaration” and meet the target set for 2020. The NNP II implementation is coordinated by National coordinating body as it needs multi sectoral interventions at all level. The main interventions under NNP II include optimal breastfeeding, optimal complementary feeding, mitigation and prevention of micronutrient deficiencies, WASH, deworming, food

fortification and management of acute malnutrition. Accordingly, the following activities were carried out in the fiscal year.

### GROWTH MONITORING AND PROMOTION

FMOH has worked on the integration of Enhanced Outreach Service (EOS/EEOS) program into the routine HEP as a way of making VAS sustainable. Accordingly, the FMOH has developed a transition plan for EOS and Community Health Day (CHD) to make Vitamin A supplementation, deworming, and nutritional screening delivery mechanism part of the routine HEP.

Currently, services have been provided through EOS in four developing regions (Afar, Benishangul Gumuz, Gambella, and Somali), CHD in two agrarian regions (SNNPR and Oromia), and routine delivery in 406 woredas of Amhara, Tigray, Oromia (142 woredas), SNNPR (68 woredas), Addis Ababa, Dire Dawa, and Harari.

### GROWTH MONITORING UNDER 2 CHILDREN

Growth monitoring is expected to be done for all under two children monthly to check their nutritional status and provide age appropriate service. In 2009 EFY, nationally the GMP performance at month of Sene (June) is 47% from the total eligible under two children. Addis Ababa, Tigray, Amhara and SNNP regions performed above the national average, while Afar, Somali B.Gumuz and Gambela have very low performance.

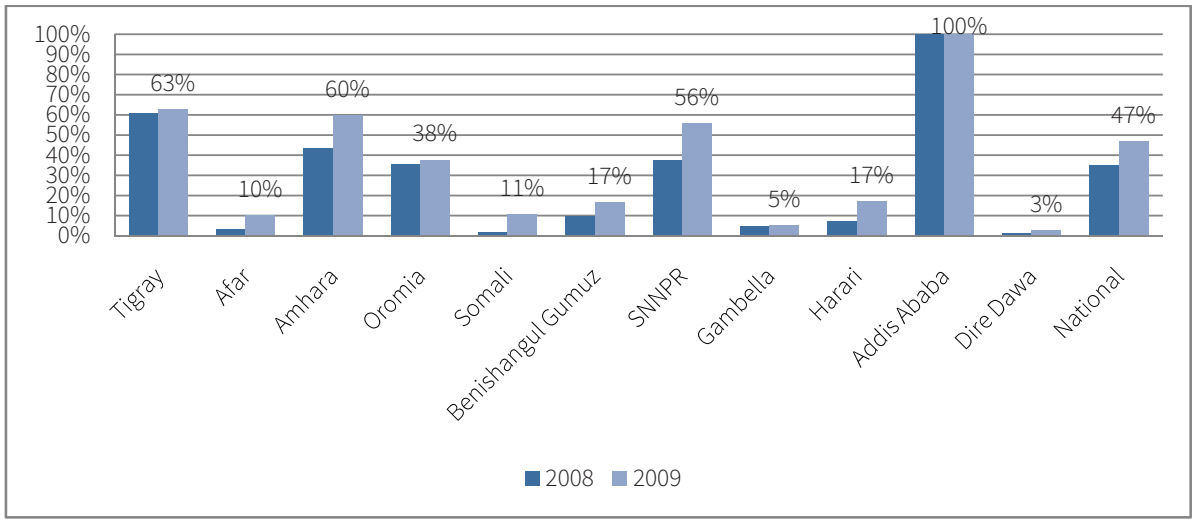



Figure 22: Growth monitoring under 2 children

### VITAMIN A SUPPLEMENTATION

The national VAS coverage among children aged 6-59 months declined from 77% in EFY 2007 to 58% in EFY 2009, and far below the national target. Wide differences were observed across regions ranging between 65% in SNNPR to 98.0% in Afar and Somali Regions. These wide performance gaps exist mainly because of differences in the implementation and reporting across regions

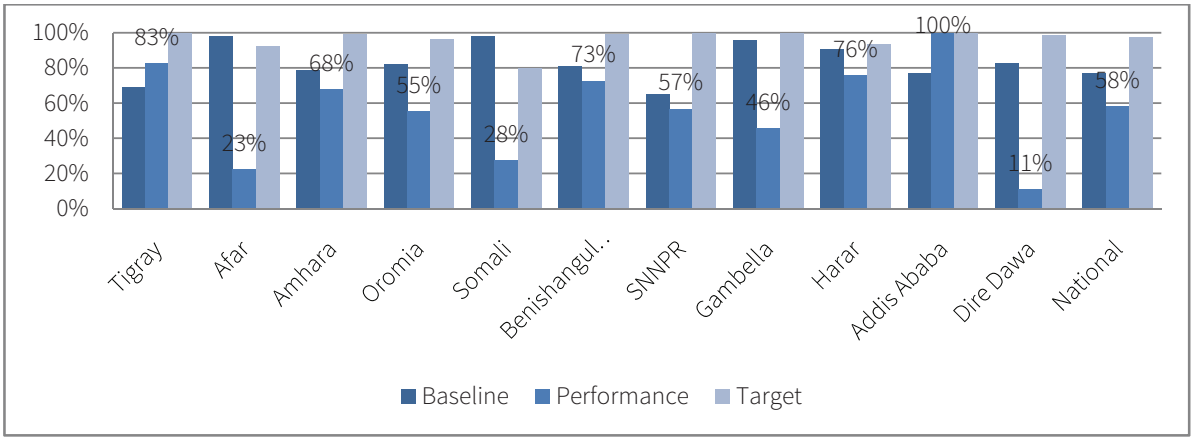



Figure 23: Comparison of Baseline, Performance and Target of Coverage of 6-59 Months Children Supplemented with Vitamin A by Region

## COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION

In EFY 2009, FMOH in collaboration with nutrition development partners implemented the following key activities:

- Command post established at national and sub-national levels;
- Sensitization document developed and workshop conducted to all regions;
- Monthly nutrition screening conducted to all hotspot woredas;
- Intensive supportive supervision conducted to Afar, Somali, SNNPR, Oromia, Amhara, and Tigray regions (two to three months);
- 70 epidemiologists trained on the management of acute malnutrition and deployed to Afar and Somali regions for more than six months;
- More than 300 HWs trained on the management of acute malnutrition and deployed to Afar ( in three months); and
- More than 15,000 sites are providing Outpatient Therapeutic Program (OTP) and 4000 Stabilizing Center established and capacitated.
- Out of 116,217 severely malnourished children who were treated in EFY 2009, 84% of them recovered, 4% defaulted, and 0.8% died.
- Compared to 2008 EFY, the number of acute malnutrition cases in EFY 2009 dropped by 69%. The number of community-based management sites of acute malnutrition (CMAM) increased to more than 20,000 health facilities in order to prevent and control the incidence.

## COMPREHENSIVE AND INTEGRATED NUTRITION SERVICES (CINS)

A comprehensive and integrated nutrition services package (CINS) is an approach that links all nutrition programs (CBN, CMAM, EOS/CHD, and MAIYCN) to service delivery at facility levels. At this juncture, CINS is a CBN plus program in which it uses the opportunity of the monthly Growth Monitoring (GMP) of a child for nutrition screening, Management of MAM/SAM, Vitamin A supplementation, deworming, and counseling on the maternal, adolescent, infant, and young child nutrition services. Therefore, a child assessed for GMP will also be assessed for severe acute malnutrition and receive comprehensive nutrition services.

The National Nutrition Program (NNP) places a critical importance on the CINS to prevent children from different forms of malnutrition through comprehensive and integrated nutrition services at facility and community levels. CINS implementation was started in EFY 2008 in 406 woredas through transition of the EOS/CHD to routine HEP. In those woredas, mothers/caregivers with children under two years of age were weighed monthly and counseled based on the children nutritional status.

## SALT IODIZATION

In EFY 2009, a total of 5,880,000 quintals of iodized salt was produced in Afdera, Dobi, Gudusbo and other sites and distributed throughout the country. Due to lack of modern iodization technology and delay in establishing proper Quality Assurance/Quality Control (QA/QC) mechanisms, there was an iodization quality gap that needed enforcement of the salt regulation. This quality-related concerns can be corrected through strengthening the enforcement of salt regulation. Hence, it remained as one of the main focus areas of EFY 2010.

The cost recovery scheme to make potassium iodate supply self-reliant and sustainable has been continued to be made marked progress in EFY 2009. So far, the program was totally independent from external donations. Over all 400 quintals of Potassium Iodate was distributed for local iodized salt producers. The national food fortification steering committee meets twice a year and five years food fortification strategic plan has been developed. The central salt iodization facility assessment was done jointly with MOI, FMHACA, and local salt producers.

## SEQOUTA DECLARATION" IMPLEMENTATION

The "Seqouta Declaration" is a high commitment initiative from GOE to end hunger and malnutrition in under two years' children by 2030 through improvements in nutrition to propel sustainable development. The major achievements in 2009 were capacitating the program

delivery unit with human resources. Some of the achievements of EFY 2009 from the program delivery unit include:

- Establishment of Program Delivery Unit (PDU) at federal and regional level
- Advisors recruited at both phase one implementation regions (Tekeze basin); Amhara and Tigray
- Knowledge and technology transfer visits conducted at Israel and Kelamino (Tigray) by PDU, federal and regional implementers.
- Evidence review, stakeholder mapping and planning workshop conducted.
- Steering committee established at both federal and regional level.
- Stakeholder consultation conducted.

**OTHER ACTIVITIES**

The following activities were also carried out to strengthen the NNP in EFY 2009.

- The first draft food and nutrition policy revised, communicated at various forums and ready for endorsement by council of ministers;
- The NNP II (2016 to 2020) has been developed and implementation has started;
- Blended Integrated Nutrition Learning Module (BINLM) national ToT finalized in all regions and cascading to facility level conducted in most regions
- School nutrition service package developed and ready for piloting in schools from selected woredas
- An advocacy was conducted to religious leaders on nutrition of pregnant and lactating women, and of children

**CHALLENGES**

- Limited awareness on nutrition among decision makers, managers, health workers and NNP implementing sectors
- Lack of nutrition specific interventions integration both with in sector and across sectors.
- Weak system on integration of nutrition supplies procurement, storage, and distribution mechanisms;
- Weak multi-sectoral nutrition coordination and linkage at regional, zonal, and woreda levels;
- Lack of budget and appropriate professional allocation for nutrition sensitive interventions in signatory sectors;

- Lack or weakness in recruiting nutrition human resources at all levels (carrier structure for nutrition in health sector recently accepted and not yet in NNP implementing sectors);
- Unclear role and accountability of sectors for nutrition;
- No clear data collection, analysis, interpretation, utilization, and feedback mechanism for NNP implementing sectors on nutrition;
- Nutrition specific indicators collected through HMIS are not adequate to support and use for all nutrition specific and sensitive programs.
- Transition of Nutrition commodities and Supplies to PFSA delayed
- Interruption and weak distribution of deworming
- Forecasting problems based on population figures
- No strong monitoring tools; HMIS do not address nutrition indicators sufficiently
- Nutrition is not well addressed in Family Health Folder
- Low Coverage of Vitamin A, Deworming and Nutritional screening in routine woredas
- Combined Adult-child MUAC is inconvenient to take measurement for adults

**WAY FORWARD**

- Improve the first 1,000 days and adolescent nutrition;
- Improve nutrition of patients with communicable and non-communicable or life-style related disease;
- Strengthen nutrition sensitive interventions in order to sustainably reduce under nutrition;
- Strengthen the implementation of baby-friendly hospital initiatives in selected hospitals;
- Strengthening the transition of VAS, deworming, and nutrition screening through EOS to CHD and CHD to HEP;
- Improve the management of SAM and MAM;
- Strengthen multi-sectoral nutrition coordination and linkage;
- Strengthen the implementation of Seqouta declaration and work on resource mobilization;
- Strengthen awareness creation activities on nutrition policies, strategies , programs, and implementation guidelines;
- Strengthen nutrition supplies management system;

- Strengthen nutrition information platform for evidence-based decision making;
- Strengthen the implementation of nutrition-sensitive intervention across sectors;
- Support the nutrition workforce development, recruitment and career structure;
- Strengthen nutrition development coordination; and
- Build the capacity of nutrition workforce in NNP signatory sectors.

## 3.3. PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

### HIV/AIDS PREVENTION AND CONTROL

HIV/AIDS is one of the top priorities of HSTP. According to the "HIV related estimates and projections for Ethiopia-2016,"the adult (15-49 years) HIV prevalence is estimated at 1.2% (0.8% in males and 1.4% in females) and the estimated number of new adult and children HIV infection in 2016 is 21,731 and 5,557 respectively.

### HCT SERVICE

HIV testing is the critical first step in identifying and linking PLHIV to the treatment cascade and it also provides an important opportunity to reinforce HIV prevention among the negatives.

In 2009 EFY, a total of 7,721,556 people were tested for HIV and received their results that accounts for 57% of the annual target.

Table 4: HIV Tests In HCT Services by Region, 2009 EFY

| Region | Number of Persons Tested who received results | | HIV+ | |
|---|---|---|---|---|
| | 2008 EFY | 2009 EFY | 2008 EFY | 2009 EFY |
| Tigray | 494,932 (49%) | 509,863 (50%) | 3,072 (0.62%) | 4,797(0.9%) |
| Afar | 142,306 (46%) | 198,763 (64%) | 2,108 (1.48%) | 1,251 (0.6%) |
| Amhara | 1,990,347 (66%) | 1,723,844 (57%) | 12,517 (0.63%) | 12,763 (0.7%) |
| Oromia | 3,032,374 (65%) | 2,693,661 (58%) | 10,951 (0.36%) | 13,783 (0.5%) |
| Somali | 176,833 (37%) | 163,695 (24%) | 789 (0.45%) | 271 (0.2%) |
| Benishangul Gumuz | 49,428 (27%) | 94,304 (52%) | 412 (0.83%) | 567 (0.6%) |
| SNNPR | 2,126,259 (82%) | 1,621,461 (63%) | 4,281 (0.2%) | 5,669 (0.3%) |
| Gambella | 25,011 (26%) | 67,397 (69%) | 1,061 (4.24%) | 2,075 (3.1%) |
| Harari | 64,986 (71%) | 45,984 (100%) | 271 (0.42%) | 267 (0.6%) |
| Addis Ababa | 272,671 (65%) | 493,648 (68%) | 9,146 (3.35%) | 12,956 (2.6%) |
| Dire Dawa | 110,232 (89%) | 108,936 (100%) | 689 (0.63%) | 853 (0.8%) |
| **National** | **8,485,379 (65%)** | **7,721,556 (57%)** | **45,297 (0.53%)** | **55,252 (0.72%)** |

Tigray, Somali, and Benishangul Gumuz Regions were below the national average and Harari and Dire Dawa met their 2009 EFY target. Overall, HIV testing has decreased by 8% when compared to

last year performance while the HIV positivity yield has increased by about 22%. It is important to note that these numbers reflect HIV tests performed. The major reason for the low performance in the budget year is related to shortage/poor distribution of diagnostic test kits.

## ANTIRETROVIRAL TREATMENT

The number of persons requiring ART stands at 718,498 (653,412 adults and 65,088 Children) in 2009 EFY out of which 426,472 (59%) are currently receiving treatment. Adult PLHIVs are almost twice more likely to be on ART than Children, 405,002 (62%) and 21,470 (33%), respectively. Regarding regional performance, Afar, Oromia, Somali, SNNP and Gambella regions have currently on ART coverage below the national average while Somali region's coverage is extremely low at 7%.

Table 5: Trend showed that currently on ART and % change

| Region | Total (Adult and Children) | | | |
|---|---|---|---|---|
| | 2009 Eligible | Baseline 2009 | performance 2009 | % from eligible |
| Tigray | 64,797 | 37091 | 39,333 | 61% |
| Afar | 10,664 | 4017 | 4,671 | 44% |
| Amhara | 204,481 | 123210 | 130,708 | 64% |
| Oromia | 185,516 | 95448 | 102,983 | 56% |
| Somali | 27,758 | 2068 | 1,806 | 7% |
| Benishangul Gumuz | 4,379 | 3504 | 4,071 | 93% |
| SNNPR | 68,971 | 32428 | 35,550 | 52% |
| Gambella | 11,463 | 3791 | 5,028 | 44% |
| Harari | 4,529 | 3858 | 4,205 | 93% |
| Addis Ababa | 127,619 | 82332 | 83,566 | 65% |
| Dire Dawa | 8,321 | 6074 | 6,494 | 78% |
| OGAs | | | 8,057 | |
| **National** | **718,498** | **393,821** | **426,472** | **59%** |

*90-90-90 Status*

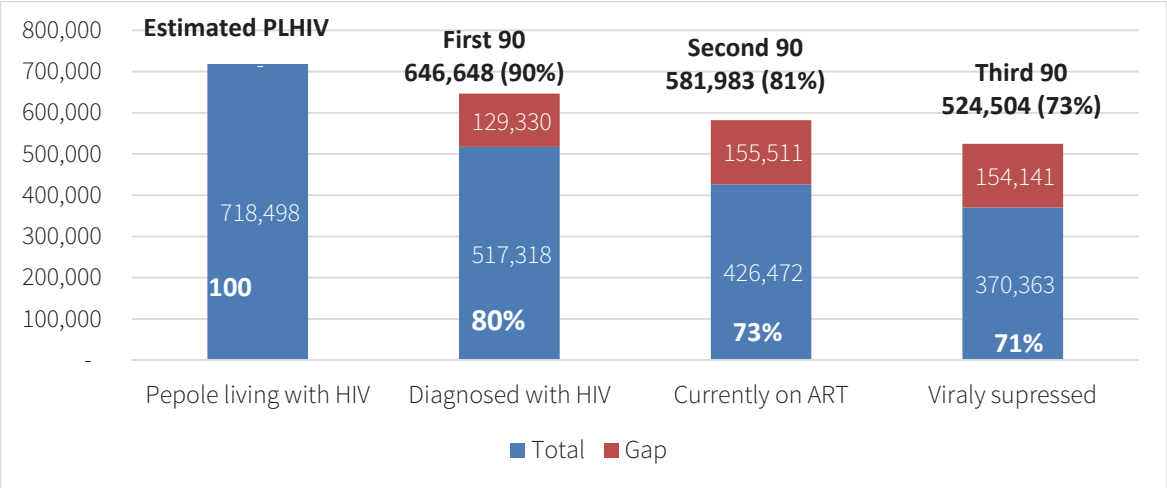



Figure 24: IV care continuum for EFY 2009 illustrating the 90-90-90 targets and performance

- *Numerator for first 90 is calculated using EDHS 2011 report which states that 72% of identified HIV positives were previously tested for HIV and received their results. Data to be updated when EDHS 2016 for HIV is released.*
- *Numerator for second 90 is the number of PLHIV who are currently on ART, HMIS report*
- *Numerator for third 90 by applying the proportion of people suppressed among those tested to those on currently on ART (UNAIDS recommendation). According to EPHI, a total of 174,810 (87%) clients have viral load < 1000 copies/ml out of 201,293 tests performed accounting for a viral load testing coverage of about 47%.*

To meet the 90-90-90 target set for the year 2020, the FMOH adopted the targeted testing approach that aims to raise the proportion of people who know their HIV status to 90% in 2020 through an appropriate approach that increases the community demand for testing and by focusing on the most at-risk populations for better yield. In line with this first 90, efforts are also underway to put 90% of people diagnosed with HIV on ART at existing ART sites with further expansion. In the same token, to meet the third 90, the FMOH is working to strengthen the regional laboratory with further expansion to perform viral count for patients who are on ART.

Additionally, FMOH and FHAPCO as well as RHB and development partners have conducted several other activities which includes:

- Various social mobilization activities conducted with the aim of Revitalization of multisectoral HIV/AIDS response.
- Revitalization of HIV/AIDS governance bodies at all level starting from the national AIDS council was done with the objective of strengthening the response
- Catch-up campaign (CUC) plan implemented at more than 200 selected high burden towns with the objective of increasing the cumulative number of currently on ART clients by 80, 230 i.e. from 391,844 to 472,074, and ensure retention. Moreover, the campaign was aimed to be achieved through provision of targeted HIV testing and counseling service to 2,733,034 which will help to achieve the first 90 by improving the HTC yield and improving number of HIV positives who know their status.
- Based on the CUC report 2,564,140 were tested and 35,602 (1.4%) were HIV positive (as of end of Sene/2009 EFY); this potentially contributed to the increment in overall positivity yield of HTC by 0.02%. In addition 1.5 million brochures and 50,000 posters were distributed to vulnerable people for awareness creation.
- 291,961 STI cases were treated using STI syndromic approach. To strengthen syndromic approach 30,000 revised guide lines, 30,000 wall charts and 10,000 desk reference were distributed.
- A total of 148,074,763 condoms were distributed in the current EFY out of which 73,041,476 condoms were distributed to individuals who are most at risk for HIV

(MARPs) including commercial sex workers, mobile workers, long distance truck drivers.

**CHALLENGES**

- Irregular supportive supervision at all levels;
- Irregularity in distribution of rapid diagnostic kits;
- Delay in maintenance of CD4 count machines;
- Lack of continuity in routine viral load monitoring;
- Weak coordination mechanisms among agencies and RHBs;
- Inadequate participation on multisectoral responses to HIV/AIDS;
- Poor data quality in viral count reports of patients on ART

**WAY FORWARD**

- Refocus on primary HIV prevention interventions
- Maintain regularity of supportive supervision and integrate with other programs;
- Create mechanisms to ensure regular provision of condoms and other supplies;
- Ensure expansion and on-time maintenance of CD4 count machines;
- Strengthen implenetation of routine viral load monitoring;
- Create coordination mechanisms for agencies and RHBs;
- Revitalize consensus with all stakeholders on multi-sectoral responses to HIV/AIDS and strengthen the follow-up;
- Innovation around reaching MARPs with different HIV/AIDS services.

**TUBERCULOSIS AND LEPROSY PREVENTION AND CONTROL**

Tuberculosis (TB) is among major public health problem throughout the world. Ethiopia is among the 30 countries with TB, TB/HIV, and Multi-Drug resistant TB (MDR-TB) burden with annual estimated TB incidence of 192 /100,000 populations and TB mortality rate of 26 per 100,000 population for 2015 according to WHO 2016 report (Figure 26). The Prevalence of Leprosy has sharply declined from 19.8 per 10,000 populations in 1983 to 0.3 per 10,000 populations in 2016, following the introduction of Multi Drug Therapy (MDT) since 1983. Cognizant of this, the Government of Ethiopia has given due attention to the control and prevention of TB and Leprosy and indicated as the priority health programs in the country's HSTP.

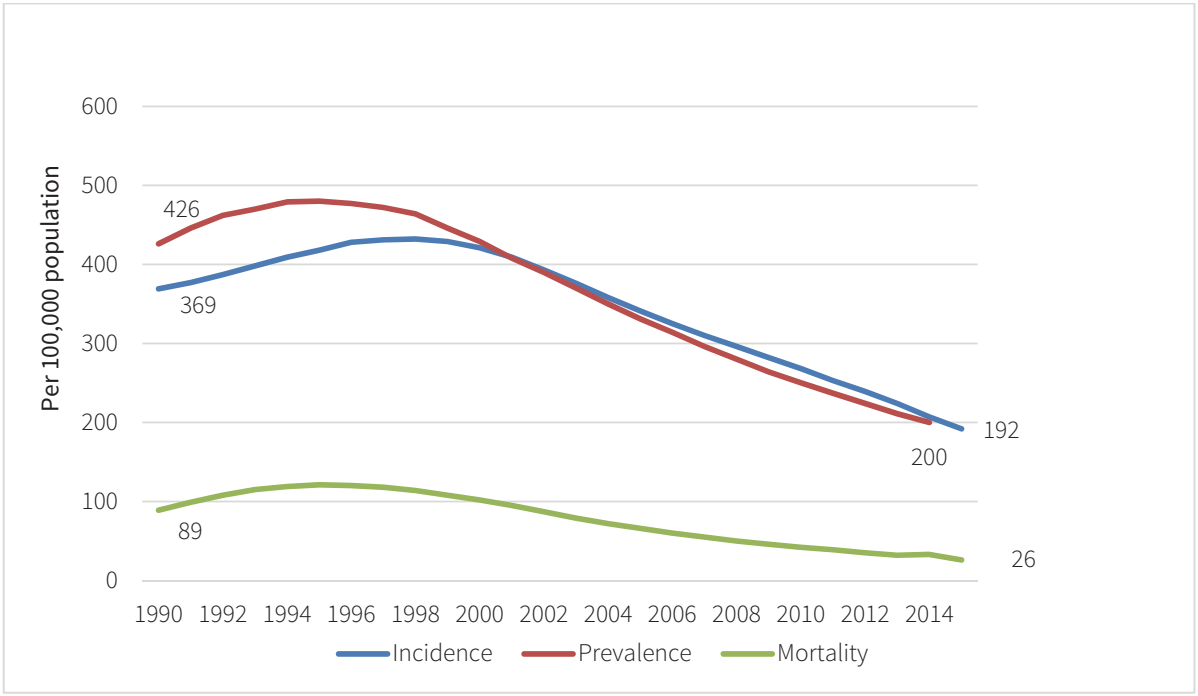



Figure 25: TB incidence, prevalence and mortality rate 1990-2015 (WHO 2016 report)

## TB PREVENTION AND CONTROL

### TB CASE NOTIFICATION

In EFY 2009, a total of 116,105 all forms TB cases were reported nationally making a TB case notification rate of 123 per 100,000 population which is lower than that observed in EFY 2008 (136 per 100,000 population). Out of notified all forms of TB cases in EFY 2009, 40 % of the cases were bacteriological confirmed new and relapse, 29 % were clinically diagnosed new, and 31% were extra pulmonary new TB cases. Previously treated TB cases account for 4.2% of the total TB cases detected in EFY 2009.

The TB case notification rate in the fiscal year showed huge variation among regions that ranges from 88 TB cases per 100,000 populations in Somali region to 368 per 100,000 in Dire Dawa. Addis Ababa, Gambella, and Dire Dawa reported TB case notification rates of more than 200/100,000; whereas, Amhara, Oromia, Somali, Benshangul Gumuz and SNNP regions reported a TB CNR of less than the national Average (Figure 26).

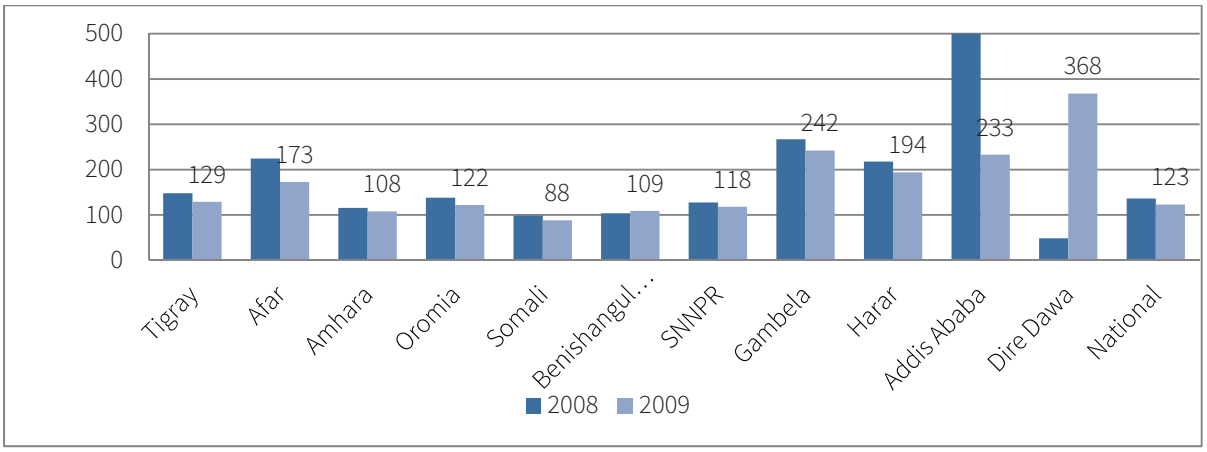



Figure 26: Comparison of Baseline and Performance of TB Case Notification Rate by Region (EFY 2009)

## TB CASE DETECTION RATE

In EFY 2009, the TB case detection rate was 64%, which is above last year performance (61%) but below the target set for the year (85%). Differences were observed across regions, ranging from 48% in Somali region to 100% in Gambella, Harari, Addis Ababa, and Dire Dawa. Except the five regions (Afar, Gambella, Addis Ababa, Harari and Dire Dawa), the rest did not achieve their targets set for the year (Figure 27).

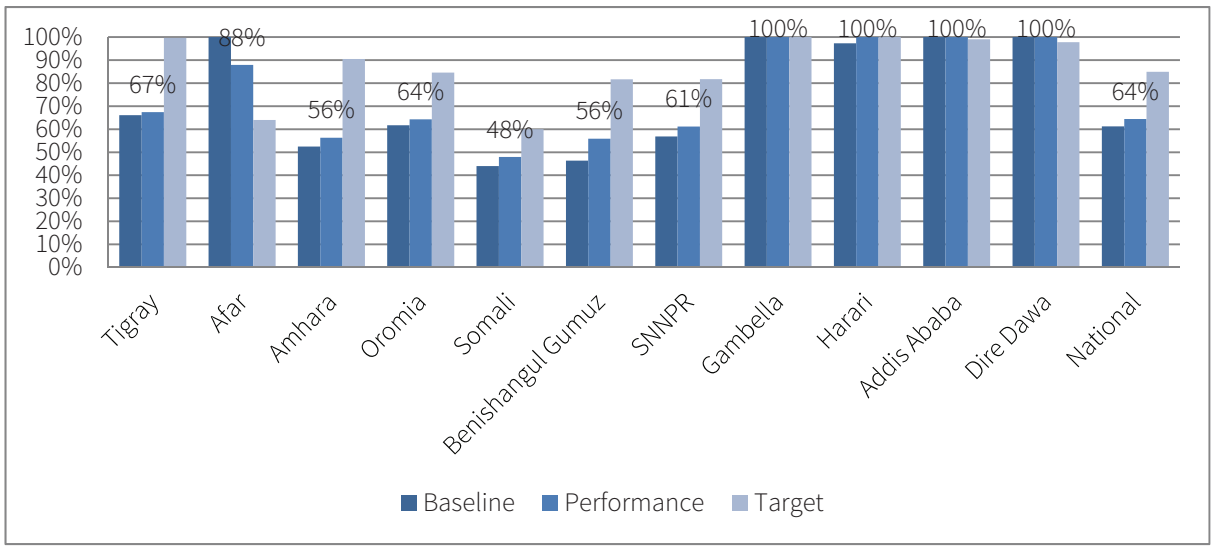



Figure 27: Comparison of Baseline, Performance and target of TB Case Detection Rate by Region (EFY 2009)

Due to sub-optimal implementation of community based TB activities in most of the regions, the contribution of HEWs in TB detection in 2009 EFY was 24 %, which is by far lower than the 2008 performance (34%).

## TB TREATMENT OUTCOMES

### TB TREATMENT SUCCESS RATE

Treatment success rate (TSR) for bacteriologically confirmed pulmonary TB cases is slightly better than last year's performance at 94%. The 2009 HMIS report shows that TSR of Afar (74%), Gambella (78%), and Somali (82%) are below the WHO recommended rate of 85%. Amhara, Oromia, SNNP and Harari regions performed above the national average (figure 28).

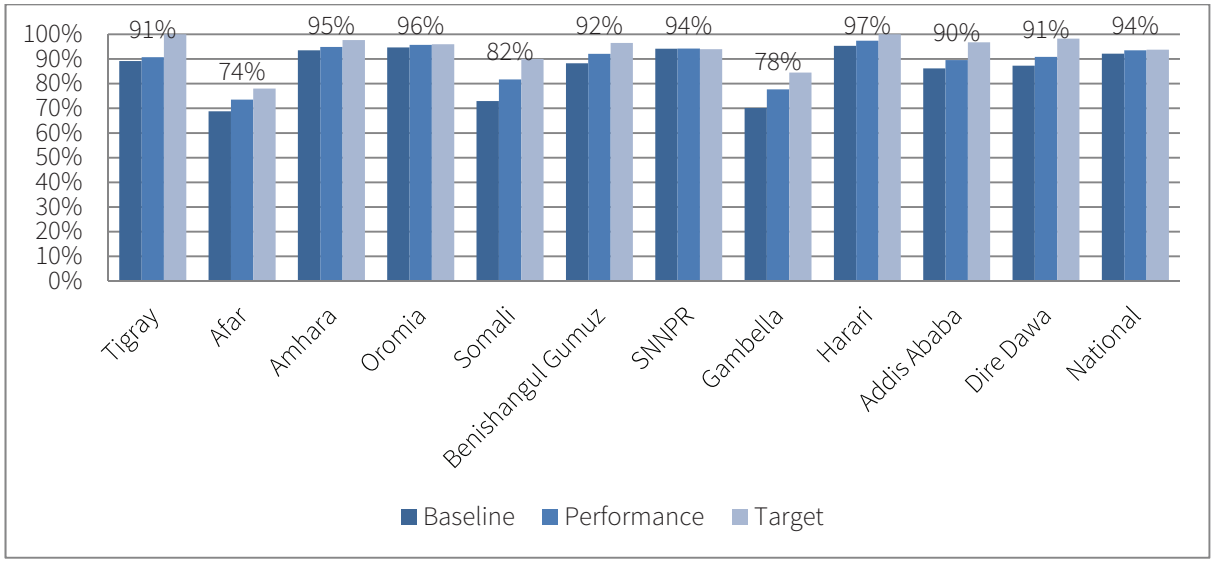



Figure 28: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2009)

### TB CURE RATE

TB cure rate has increased from 81.2% in EFY 2008 to 85% in EFY 2009. However, it was below the target set for the year (92%). High TB cure rate was observed in Harari (96%), Oromia (91) and Amhara (91%) regions, while the lowest cure rate was observed in Somali (53%), Gambella (53%), and Afar (54%) regions. The TB treatment Success- cure rate difference in those three regions are 29%, 25% and 20%, respectively. Apart from data quality problems observed during external program review , availability of laboratory supplies and equipment including functional microscope and laboratory expert, and commitment of healthcare provider and TB patients' compliance to laboratory follow up could be the possible reasons for low performance of cure rate of the aforementioned regions.

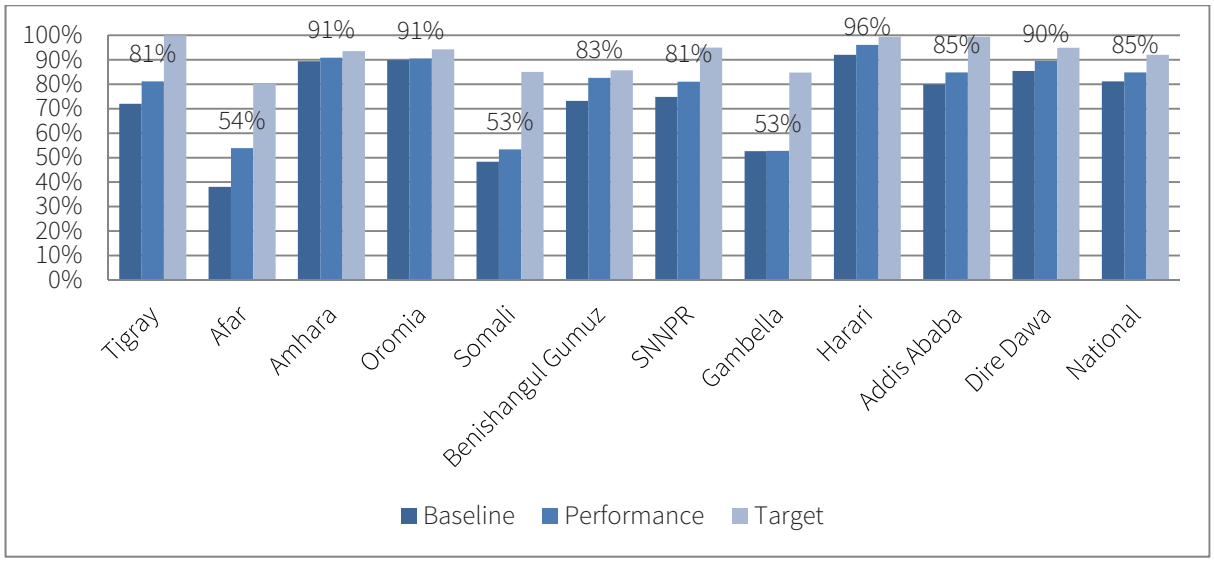



Figure 29: Comparison of Baseline, Performance, and Target of the TB Cure Rate by Region (EFY 2009)

## DRUG RESISTANT TB

In 2009 EC, a total of 706 RR/MDR-TB cases are diagnosed and enrolled to second line anti TB drug; the treatment success rate of MDR TB reached 71.3%. Currently, 165 functional GeneXpert machines are available in different health facilities. Among this 16 machines are on a pilot study to determine viral load for HIV positive patients. In addition to these, 142 GeneXpert machines are on the process of procurement for the same purposes. As per the strong recommendation of WHO, the program is switching the conventional microscopy method to LED fluorescent microscopy to diagnose TB. Accordingly, 280 LED fluorescent microscopes are on procurement process in addition to the existing 700. Regular technical supports including external quality assessment have been provided for the health facilities which are providing TB laboratory services. To improve and strengthen access of TB culture, DST service and sputum sample referral system in a country, tripartite agreement was made between Ethiopian Public Health Institute, Regional health Bureaus and Ethiopia Postal Service Enterprises.

So far, a cumulative total of 3,767 MDR TB patients were enrolled in second line drug (SLD) treatment.

Table 6: Rifampicin Resistance /MDR-TB Patients put on Second Line Drugs by Region, EFY 2009

| Regions | EFY 2009 RR/MDR-TB Patients put on Second Line Drugs |
|---|---|
| Tigray | 100 |
| Afar | 16 |
| Amhara | 121 |
| Oromia | 178 |
| Somali | 5 |
| Benishangul-Gumuz | 0 |
| SNNP | 92 |
| Gambela | 2 |
| Harari | 9 |
| Addis Ababa | 139 |
| Dire Dawa | 43 |
| National | 706 |

In EFY 2009, there were a total of 48 health facilities providing DR TB treatment services and an additional four health facilities are in process to start the service in the coming year. Gene Xpert machine is placed in 161 health facilities and a total of 200 laboratory professionals are trained on GeneXpert machines. In addition, the construction of two culture and DST diagnostic laboratories are completed out of the three planned for EFY 2009.

To expedite the process of referral linkage on TB case detection, the Ethiopia Postal Service is contributing in transporting samples from health facilities to the diagnostic sites. Furthermore, to widen FNA cytology service for extra pulmonary tuberculosis in health facilities, procedural documents (manual and SOP) were prepared; and training were provided for 15 health care providers to scale up the service to 15 additional hospitals.

Since the national TB program has introduced new anti DR-TB drug in Bishoftu hospital in 2016, the program is scaled up in to two additional federal (ALERT and St Peter) hospitals to give service for patient who are not eligible to be treated with the then standard DR-TB treatment. To supplement the service, new anti DR TB drug implementation guidelines were prepared and training on the newly revised DR TB treatment guideline were provided for 90 health care providers working at DR treatment initiating center. A national-level DR TB clinical review committee was formed to provide advisory and decision-making services on proper new anti DR TB drug utilization.

As part of TB case finding in TB Key population, the TB program is integrated with IMNCI program and piloting is in progress in 30 health facilities in Addis Ababa.

The national TBL program has reviewed TBL program guideline to included global recommendation on clinical and programmatic management of TB, TB/HIV and DR TB. National strategic plan of TBL program is revised as per midterm external program reviewers' recommendation.

## LEPROSY PREVENTION AND CONTROL

### LEPROSY CASE DETECTION

Among communicable diseases, leprosy is the leading cause of permanent physical disability. Notable achievements observed in reducing the prevalence of the disease is achieved, especially after the introduction of Multiple Drug Therapy (MDT). However, the annual national case-detection remains constant between 3000 - 4000 cases. In EFY 2009, a total of 3,101 new leprosy cases were detected which was slightly higher than EFY 2008 (3,096) (Table 7).

Table 7: Comparison of Baseline and Performance of Leprosy Cases Detected by Region (EFY 2009)

| Region | 2008 Baseline | 2009 performance |
|---|---|---|
| Tigray | 100 | 57 |
| Afar | 38 | 25 |
| Amhara | 1128 | 847 |
| Oromia | 1879 | 1508 |
| Somali | 0 | 14 |
| Benishangul-Gumuz | 53 | 87 |
| SNNPR | 290 | 241 |
| Gambella | 80 | 64 |
| Harari | 6 | 7 |
| Addis Ababa | 223 | 231 |
| Dire Dawa | 20 | 33 |
| National | 3817 | 3114 |

### PROPORTION OF GRADE II DISABILITY AMONG NEW LEPROSY CASES

Grade II disability among new leprosy cases for EFY 2009 is 12.9%, which is close to meeting the 12% national target and showed improvement from EFY 2009 baseline, which was 13.6%. All regions have shown progress in reducing grade II leprosy disability compared with 2008 performance except Afar, Gambella and Addis Ababa. However, the problem remains prevailing in Addis Ababa (36.4%), and Gambella (30.2%).

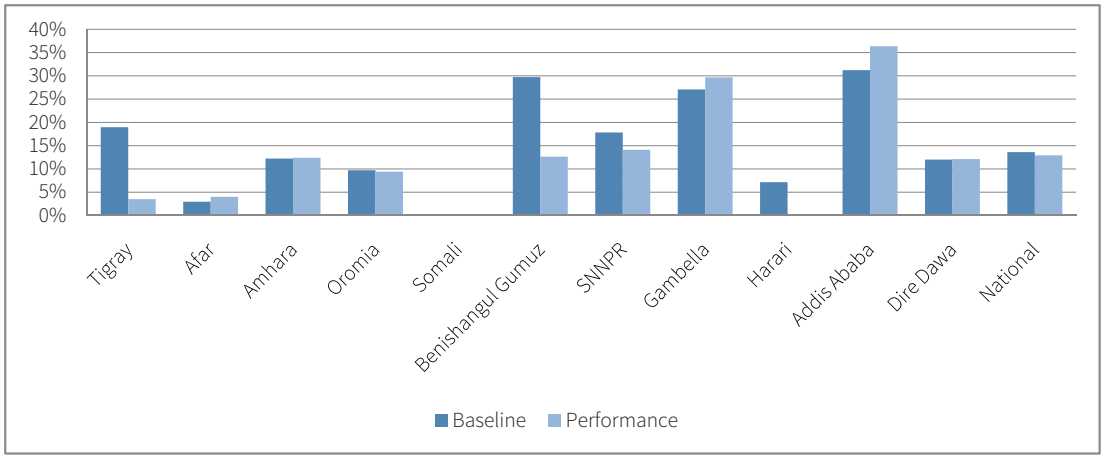



Figure 30: Comparison of Baseline and Performance of Leprosy Grade II Disability by Region (EFY 2009)

**CHALLENGES**

- Slow progress in the implementation of community TB care;
- GeneXpert service utilization and reporting system is far below optimal, monitoring system is not satisfactory;
- Weak sample referral system for presumptive DR –TB cases;
- DR case finding is far below target and data quality problem and;
- Delay in utilization and liquidation of GF grant.

**WAY FORWARD**

- Enhance community participation and engagement in TB service;
- Strengthen TB/DR-TB diagnostic services and M&E;
- Strengthen sample referral network;
- Improve TB program management capacity at all levels; and
- Close follow up and support on enhancement of GF fund utilization and liquidation.

**MALARIA PREVENTION AND CONTROL**

For EFY 2009, like the previous years, the major activities planned for malaria prevention and control focused on expanding vector control and strengthening malaria case detection and treatment. In particular, increasing the availability and use of Long-Lasting Insecticidal Nets (LLINs) as well as implementing Indoor Residual Spraying (IRS) are powerful vector control tools for reducing malaria transmission. Furthermore, access to care for suspected malaria cases and appropriate diagnostic testing and therapeutic management at all points of care are needed to ensure that all patients with malaria receive prompt and effective treatment.

**NUMBER OF MALARIA CASES AND DEATHS**

Malaria is an acute parasitic illness mainly caused by Plasmodium falciparum and Plasmodium vivax in Ethiopia. In EFY 2009, the total number of laboratory confirmed plus clinical malaria cases were 1,747,251 with 14 % decrease from total cases reported in 2008 EFY. As it is displayed in the figure below, the total number of laboratory confirmed plus clinical malaria cases were a bit higher in 2008 EFY due to the effect of climate abnormality (El Nino). In particular, the monthly trend showed an increase number of malaria cases in month October to December of the fiscal year reaching the high in October, whereas the malaria cases decreased from month January to May reaching the lowest in February.

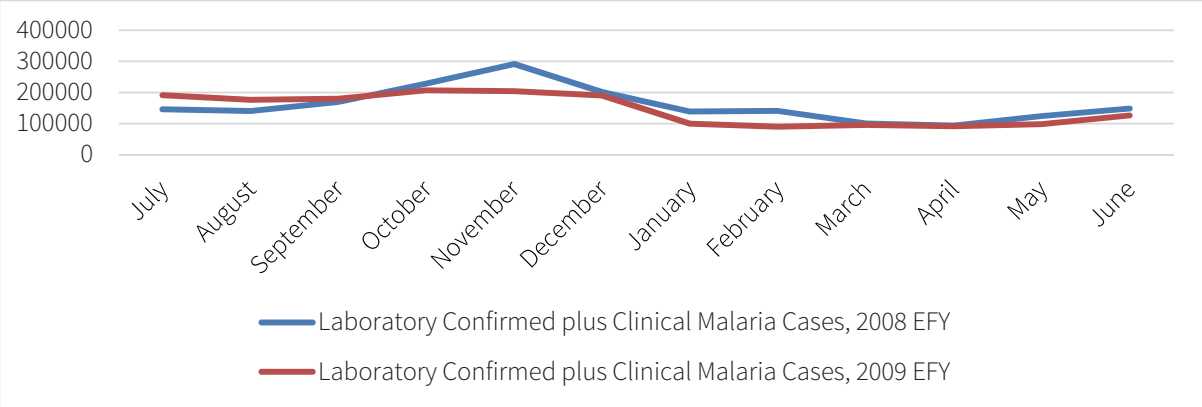



Figure 31: Trend in Laboratory Confirmed Plus Clinical Malaria Cases by Month (EFY 2009)

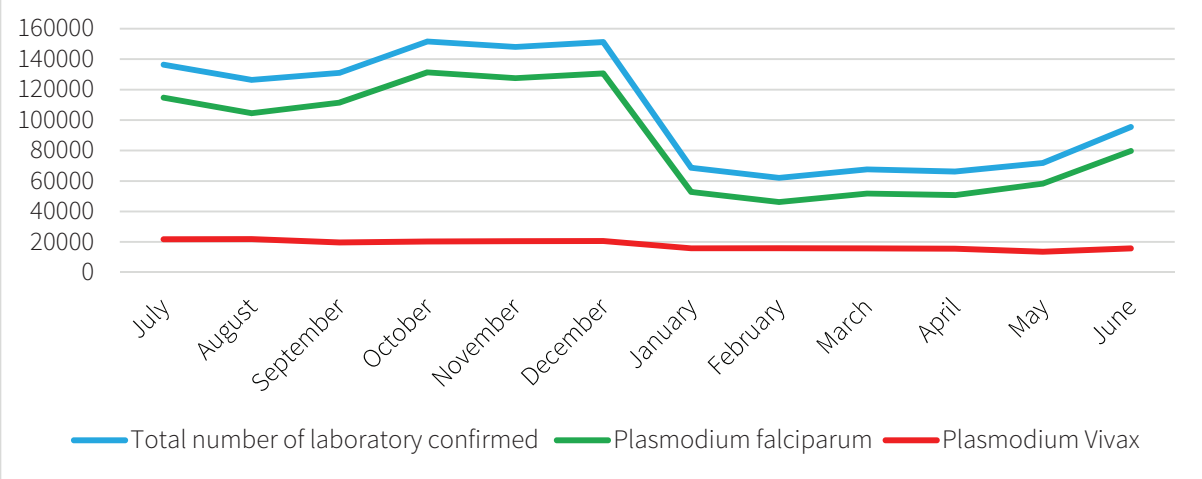



Figure 32: Trend in Laboratory Confirmed Malaria Cases, Plasmodium falciparum Malaria Cases, and Plasmodium vivax Malaria Cases by Month (EFY 2009)

WHO recommends all malaria cases to be confirmed with either microscopy or rapid diagnostic tests (RDT). Out of the total 1,747,251 malaria cases reported in the fiscal year, 1,276,371 (73%) were confirmed by either microscopy or rapid diagnostic tests (RDT).

Out of the confirmed malaria cases 1,059,829 (61%) were Plasmodium falciparum (PF) and 216,542 (12%) were Plasmodium vivax (PV). When we look at the trend with regard to parasite type over the years, Plasmodium Falciparum (PF) is steadily increasing while Plasmodium Vivax (PV) is decreasing.

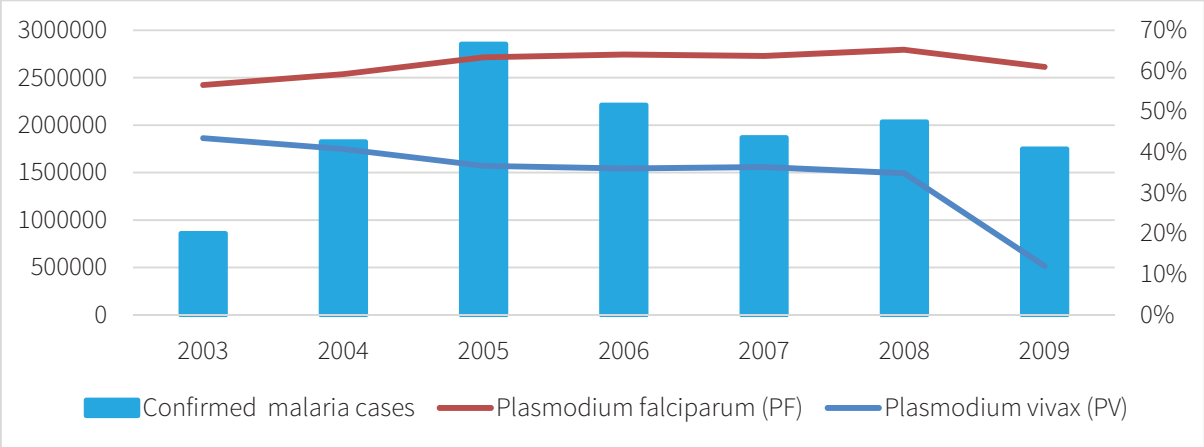



Figure 33: Trend in Laboratory Confirmed Malaria Cases, Plasmodium falciparum Malaria Cases, and Plasmodium vivax Malaria Cases by Year (EFY 2003-2009)

In EFY 2009, the highest number of laboratory confirmed plus clinical malaria cases was reported from Amhara (394,989 cases) followed by SNNP (355,208), and Tigray (297,291 cases) (Table 7).

Table 8: Distribution of Laboratory Confirmed plus Clinical Malaria Cases and deaths by Region (EFY 2009)

| Region | Population at risk | Cases | | | Death | | |
|---|---|---|---|---|---|---|---|
| | | Number | Percent | Incidence per 100,000 at risk population | Number | Percent | CFR (%) |
| Tigray | 3,892,723 | 295,811 | 7.60% | 7599 | 68 | 18% | 0.02% |
| Afar | 1,917,396 | 133,516 | 6.96% | 6963 | 4 | 1% | 0.00% |
| Amhara | 16,322,282 | 394,503 | 2.42% | 2417 | 22 | 6% | 0.01% |
| Oromia | 23,965,001 | 168,777 | 0.70% | 704 | 58 | 16% | 0.03% |
| Somali | 5,067,475 | 155,715 | 3.07% | 3073 | 22 | 6% | 0.01% |
| Benishangul Gumuz | 843,401 | 199,548 | 23.66% | 23660 | 10 | 3% | 0.01% |
| SNNPR | 12,661,876 | 270,741 | 2.14% | 2138 | 126 | 34% | 0.05% |
| Gambela | 432,554 | 105,145 | 24.31% | 24308 | 53 | 14% | 0.05% |
| Harari | 192,740 | 11,197 | 5.81% | 5809 | 2 | 1% | 0.02% |
| Addis Ababa | 334,877 | 11,071 | 3.31% | 3306 | 5 | 1% | 0.05% |
| Dire Dawa | 215,198 | 11,227 | 5.22% | 5217 | 4 | 1% | 0.04% |
| **National** | **63,495,055** | **1,757,251** | **2.77%** | **2768** | **374** | **100.00%** | **0.02%** |

During this year, a total of 374 deaths were recorded in the same period, with a Case Fatality Rate (CFR) of 0.02%. A total of 3.1 million doses of artemisinin-based combination therapy (ACT), 40,000 vials of Artesunate injection, 196,000 chloroquine syrup, 830,173 doses of Chloroquine and 5.7 million RDTs were distributed to respective regions for malaria prevention and control.

## HOUSEHOLDS COVERED WITH INDOOR RESIDUAL SPRAY (IRS)

With regards to vector control, 5.8 million unit structures were sprayed in the budget year; this makes total coverage 97%, in targeted areas, which is an increase from last year at 91.8%.

## LONG-LASTING INSECTICIDAL NET DISTRIBUTION

In EFY 2009, a total of 2.8 million LLINs were distributed for replacement of worn out LLIN. In addition 676,873 LLIN were distributed for specific woredas affected by the El Nino disaster.

## OTHER ACTIVITIES

- Revision of national malaria strategic plan, NMSP 2017-2020.
- Malaria elimination road map was launched in selected 239 Districts
- Malaria indicator survey (MIS) 2015 disseminated.
- Malaria program review, MPR 2017 conducted
- Submission of The Global Fund malaria full review funding request application for 2018-2020.

## CHALLENGES

- Gaps in IRS operation quality;
- Sub-optimal of LLIN utilization; and
- Inadequate malaria prevention and control in investment areas and development corridors.

## WAY FORWARD

- Improve quality of IRS operation;
- Promote proper utilization of LLIN;
- Strengthening Malaria prevention and control in investment area and development corridors

## 3.4. PREVENTION AND CONTROL OF NEGLECTED TROPICAL DISEASES

Eight neglected tropical diseases (NTDs) require serious attention since they are among the main impediments for poverty reduction and some are targeted for elimination by 2020. A national task force for NTDs, involving FMOH and partners, oversees coordination of intervention strategies.

A fast track strategy is instituted so as to enable the elimination of blinding trachoma before the global target of 2020 and has cleared more than 60% of the backlog of around 700 thousand cases. The Ethiopian Onchocerciasis Elimination Expert Advisory Committee is also established that would provide state-of-the art technical guidance so that the country achieves onchocerciasis elimination by 2025. In the reporting fiscal year 2009, over 13.8 million people took drugs for the prevention of onchocerciasis and the program was able to interrupt transmission of Onchocerciasis in Metema focus after 12 years of annual mass drug administration. A total of 17.7 million children received deworming service for Soil Transmitted Helminthiasis in 468 Woredas and schistosomiasis treatment was provided for 4.6 million people in the first round of the year.

Lymphatic Filariasis treatment was given for more than 3.5 million people and integrated hydrocele and lymphedema prevention and control service for LF and Podoconiosis was expanded to 41 Woredas in four endemic regions (Amhara, Benishangul Gumuz, SNNP, and Oromia) through training of 266 health workers in addition to conducting burden assessment for detection and registration of lymphedema patients in 93 highly endemic Woredas.

Leishmaniasis treatment has been provided to 2,499 Visceral leishmaniasis patients in 24 health facilities located in the six regions of the country namely Tigray, Amhara, Somali, SNNP, Oromia and Afar.

Coordination of NTD and WASH programs has been started at federal and regional level. A 3-day capacity building workshop was provided for federal and regional NTD and WASH program implementers and stakeholders. Similarly WASH-NTD integration consultative workshops were conducted in regions having high NTD burden.

**CHALLENGES**

- Incomplete mapping for some NTDs resulting in gaps for comprehensive planning and action;
- Inadequate coordination and co-implementation of WASH and NTD interventions impeding efficient use of limited resources;
- Limited resource for morbidity management
- Inadequate surveillance system for effective monitoring of progress;
- Limited community mobilization; and

**WAY FORWARD**

- Complete the mapping of NTDs;
- Strengthen coordination and co-implementation of interventions at federal and regional levels;
- Strengthen the surveillance system nationwide;
- Advocate for multi-sector engagement and promote community mobilization; and
- Promote partnership and resource mobilization.
- Advocacy for coordination and integration of NTDs into WASH programs at all levels

## 3.5. PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

Non-Communicable Diseases (NCDs) is growing fast in Ethiopia. According to the 2015 STEPS survey findings, excess consumption of salt, not being engaged in regular physical activity and khat consumption are among the major risk factors attributed to the rise of the problem. Considering the vast amount of financial resources required to treat NCDs and the limited capacity that the country has, emphasis has to be put on strengthening primary prevention of NCDs.

Policy and strategy documents have been collected from sector ministries and situational analysis conducted in selected sector ministries and report compiled. A synopsis of the NCD Multi-sectoral response was also developed. In 2009 EFY, awareness raising on NCDs risk factors was conducted through print and electronic media. In collaboration with public relations directorate, awareness raising messages were developed on hypertension, rheumatic heart disease and diabetes mellitus and transmitted through radio and television. Integrated refresher training manual was developed this year for Urban Health Extension Program on NCDs and risk factors.

**HYPERTENSION AND DIABETICS CONTROL**

Training on Hypertension was conducted for 62 health professionals from 12 hospitals and 36 HCs and 6 RHBs. Training on diabetes was also conducted in 81% of these selected health facilities. These 12 hospitals are currently providing services on DM and Hypertension with enhanced quality. A total of 216 HPs from the selected 36 HCs were trained on hypertension diagnosis and treatment; the required tools were also supplied to these HCs (including screening and treatment registers).

Integration of hypertension diagnosis and treatment within those 36 health centers started about 10 months ago. The total number of individuals screened for hypertension in 6 months period (from November 2016 to June 2017) at both facility and community levels is 188,862. Among the total individuals screened 47,633 (25%) individuals were found with raised BP; out of these 8,877 were enrolled to care.

### RHEUMATIC HEART DISEASE

A pilot project is being implemented on RHD prevention and control in 2 hospitals and 6 health centers in collaboration with AAU. Training manual was developed on RHD and 23 health professionals from 14 hospitals have been trained. Program specific supportive supervision was subsequently conducted in 30 HFs and 5 RHBs in 5 regions.

### CANCER CONTROL

In order to address the huge burden of cancer, FMOH continued implementation of cancer service, including radiation therapy expansion program in five regional university hospitals. Currently three of the five centers have competed construction of bunkers and radiotherapy machines are being imported. Cancer chemotherapy drugs were availed at subsidized cost to Black Lion hospital and few other sites in the country. To improve access to chemotherapy of cancer service, FMOH renovated one health center in Lideta sub-city and inaugurated the center after fully equipping it with the necessary equipment, furniture, and medicines. This helped decrease the waiting time of patients to get treatment from six months to one month.

To facilitate screening and treatment of cervical cancer, 118 cryotherapy machines were procured and distributed to 118 health facilities and health care providers were trained.

Currently, 200 health facilities are providing VIA screening and cryotherapy treatment and more than 52,000 women were screened in 2009. In addition, LEEP service was scaled up from five to fifteen hospitals. The FMoH is working to scale up VIA screening and cryotherapy treatment into 823 districts. To this effect, awareness creation activities were conducted for 70 participants from all regions of different sector in collaboration with Ministry of women and child affairs and the necessary supplies are under procurement.

### HEPATITIS

Hepatitis B and C are major causes of morbidity and mortality in Ethiopia. They are major causes of chronic liver disease and liver cancer. FMOH is keen in the prevention and treatment of these infections. To that effect, the FMOH has prepared training material on Hepatitis management and developed a five-year strategic action plan. As per the plan, screening, diagnosis and treatment of HBV and HCV has been initiated in 7 hospitals in the regions and 18 public and private hospitals

in Addis Ababa. To date, 42,214 individuals received screening test for HBV (either with RDT and/or ELISA) and 17,579 individuals were screened for HCV with RDT.

Regarding treatment, about 929 and 346 patients have been and/or are on treatment for HBV and HCV respectively.

The FMOH has officially launched Hepatitis B vaccination of Healthcare Workers nationwide and has plan to provide this vaccine to over 450,000 health workers, health facility waste handlers and health science students who will be joining the health workforce will be receiving the vaccine.

**MENTAL HEALTH**

Mental health problems are also a major cause of suffering, loss of productivity, and death. The FMOH has been implementing the first mhGAP Program scale up for the past three years by integrating the service at the PHCU level in all regions and city administrations of the country. A total 405 midlevel health professionals from 244 health centers were trained in mental health services.

So far, only 13,035 patients were reported to be diagnosed and treated for mental illnesses. These cases are reported from health centers that developed their own reporting template in consultation with their respective training institutions. Among other reasons, recording and reporting related problems were incriminated for the observed lower performance.

To integrate mental health services into HIV/AIDS services, training manual was prepared for HIV/AIDS case managers, endorsed as a national document and distributed to regional health bureaus, universities, health science colleges, and key partners. Furthermore, national ToT was conducted for 36 health professionals drawn from regional health bureaus, Ministry of Defense and Federal Police Administration.

**EYE CARE**

The burden of eye problems in Ethiopia is huge. About 1.2 million people are blind and 2.7 million people are living with low vision.  Ethiopia, with over 3% of the global blindness burden carries disproportionately high burden of blindness and low vision. Cataract, trachoma refractive error and glaucoma are the leading causes of blindness in Ethiopia.

An eye health advisor was recruited and started supporting NCD case team. The national TWG is revitalized and is working to harmonize work plans by the different stakeholders. A multi-year strategic plan (2016-2020) on eye health that contains the three pillars of vision 2020: disease control, Infrastructure and human resource is operational.

To address the current backlog of cataract cases, the FMoH is redesigning its strategy as only few cases were being operated as compared to the backlog; in addition, supplies to address the huge burden is currently under procurement.

To make the screening more accessible to those in need of care, the Ministry has trained around 240 teachers in the capital Addis Ababa. Training of Ophthalmic nurses in BSc level has been stared in four of the government higher educational institutions/Universities. Preparatory works are also underway for "the second blindness and visual impairment" survey to be conducted in 2018 to get up-to-date data on blindness and visual impairment as it has been more than 10 years since the 1st survey was conducted.

**OTHER ACTIVITIES**

- mhGAP implementation review meeting was conducted with Regional Health Bureau's program owners and 6 (six) university hospitals
- World Health Day is celebrated with the theme "Depression: let's talk", with Panel discussion at the event and different awareness creation activities
- Interviews were also conducted with various TV and radio stations on mental health
- World kidney day was celebrated the same year with the theme 'let us keep our kidneys healthy' by preventing obesity and screening for hypertension; urine analysis was also conducted for 3,000 participants free of charge.
- World "No Tobacco Day" was commemorated and awareness-raising messages were transmitted through TV on health effects of tobacco use.
- A National Consultative conference was conducted in Addis Ababa on Prevention and Control of NCDs in which different papers were presented on NCDs.
- A panel discussion was held on nutrition and NCDs and awareness raising messages transmitted through television.
- The second National Epilepsy Week was celebrated in Bench Maji Zone, SNNPR where papers and articles were presented, panel discussion and press conference were also held.
- Eye health events (world site day and glaucoma week) was celebrated with vision screening activities and eye health key messages, brochures and Radio spots prepared.

**CHALLENGES**

- Low awareness amongst HCWs towards NCDs and risk factors;
- Low awareness of the community on NCDs;
- Lack of NCD focal points in most of RHBs;

- Absence or inadequacy of expertise and regional centers on cancer, heart disease, and other NCDs management;
- Quantification and procurement of NCD supplies is not being conducted holistically;
- Poor data capturing and reporting system;
- Weak or non-existent multisectoral collaboration to address NCD risk factors;
- Weak supportive supervision at regional level; and facilitation of the trainings and follow ups
- Limited number of national and international partners working on NCDs.

**WAY FORWARD**

- Develop multi-sector NCD Strategic Plan 2017-2020;
- Work on creating regional buy-in of the NCD programme
- Develop national cancer treatment protocols and decentralize service;
- Conduct national quantification exercise on NCDs;
- Finalize and launch National Mental Health Strategic Plan
- Conduct intensive awareness campaign on NCDs and their risk factors nationwide

## 3.6 .PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE

Public Health Emergency Management (PHEM) aims to improve how the health system deal with existing and evolving disease epidemics, malnutrition, and natural disasters of national and international concern. It is designed to ensure rapid detection of any public health threats, preparedness related to logistic and fund administration, and prompt response to and recovery from various public health emergencies. Therefore, the strategies were set towards an effective early warning, preparedness, response, recovery and rehabilitation system.

**EPIDEMIC PREVENTION AND CONTROL**

**MEASLES**

In EFY 2009, a total of 2,237 laboratory confirmed and epidemiologically linked measles cases were reported nationally from a total of 4709 suspected cases with 13 deaths and CFR of 0.6%. When compared to last EFY 2008 (12,477 cases), there is a sharp decrement by 1, 0240 (457%) but the CFR remains the same. From the total cases reported, Amhara Region accounts for the highest number of cases (30.1%) followed by Oromia Region (29.8%), Somali Region (23.9%) and Addis Ababa (7.7%). The CFR was high in Oromia Region (1.3%) and SNNPR (0.8%). Looking at the incidence rate, the highest annual incidence rate per 100,000 populations was reported from Somali Region (10.9), Addis Ababa (5.1) and Amhara Region (3.2).

Table 9: Distribution of Suspected Measles Cases and Deaths

| Region | Confirmed Cases | Percent | Incidence/100,000 | Number of Deaths | CFR |
|---|---|---|---|---|---|
| Addis Ababa | 172 | 7.7 | 5.1 | 0 | 0.0 |
| Afar | 11 | 0.5 | 0.6 | 0 | 0.0 |
| Amhara | 674 | 30.1 | 3.2 | 2 | 0.3 |
| Benishangul Gumuz | 4 | 0.2 | 0.4 | 0 | 0.0 |
| Dire Dawa | 0 | 0.0 | 0.0 | 0 | NA |
| Gambella | 5 | 0.2 | 1.2 | 0 | 0.0 |
| Hareri | 0 | 0.0 | 0.0 | 0 | NA |
| Oromia | 667 | 29.8 | 1.9 | 9 | 1.3 |
| SNNPR | 133 | 5.9 | 0.7 | 1 | 0.8 |
| Somali | 535 | 23.9 | 10.9 | 1 | 0.2 |
| Tigray | 36 | 1.6 | 0.7 | 0 | 0.0 |
| **National** | **2237** | **100.0** | **2.4** | **13** | **0.6** |

As shown in the figure below there is very sharp decrement of confirmed measles cases in the 2009 EFY compared to 2008 EFY.

In EFY 2009, the monthly trend of laboratory and epidemiologically confirmed measles cases show a similar trend to EFY 2008 from July to February and a sharp decrease during month of June.

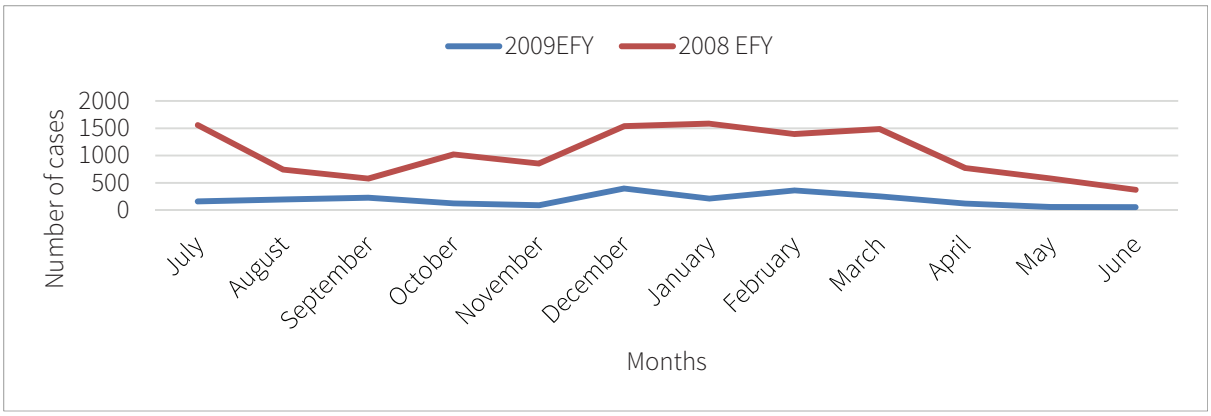



Figure 34: Trent in Suspected Measles Cases and Deaths

## DYSENTERY

In EFY 2009, a total of 320,700 dysentery cases were reported from all regions, an increment by 14,106 (4.39%) from EFY 2008. The majority of the cases were reported from Amhara (27.9%) and Oromia (25.4%), followed by Tigray (12.9%) and SNNPR (12.1%), while Dire Dawa (0.4%) accounts for the lowest case report. Benishangul Gumuz Region was the most affected (incidence rate per 100,000 populations of 1238) followed by Tigray and Gambella Regions.

Table 10: Distribution of Suspected Dysentery Cases and Deaths

| Region | Cases | | | Deaths | | |
|---|---|---|---|---|---|---|
| | Number | Percent | Incidence Rate (per 100,000 population) | Number | Percent | CFR |
| Addis Ababa | 22722 | 7.09 | 654 | 0 | 0.00 | 0.00 |
| Afar | 8967 | 2.80 | 469 | 0 | 0.00 | 0.00 |
| Amhara | 89477 | 27.90 | 407 | 0 | 0.00 | 0.00 |
| Benishangul-Gumuz | 13197 | 4.12 | 1238 | 0 | 0.00 | 0.00 |
| Dire Dawa | 1239 | 0.39 | 327 | 0 | 0.00 | 0.00 |
| Gambella | 3453 | 1.08 | 792 | 0 | 0.00 | 0.00 |
| Harari | 1303 | 0.41 | 660 | 7 | 36.84 | 0.54 |
| Oromia | 81430 | 25.39 | 223 | 3 | 15.79 | 0.00 |
| SNNPR | 38932 | 12.14 | 199 | 5 | 26.32 | 0.01 |
| Somali | 18371 | 5.73 | 323 | 0 | 0.00 | 0.00 |
| Tigray | 41609 | 12.97 | 812 | 4 | 21.05 | 0.01 |
| **National** | **320700** | **100.00** | **333** | **19** | **100.00** | **0.01** |

The monthly trend of dysentery cases are slightly similar with 2008 EFY with increment during the rainy seasons.

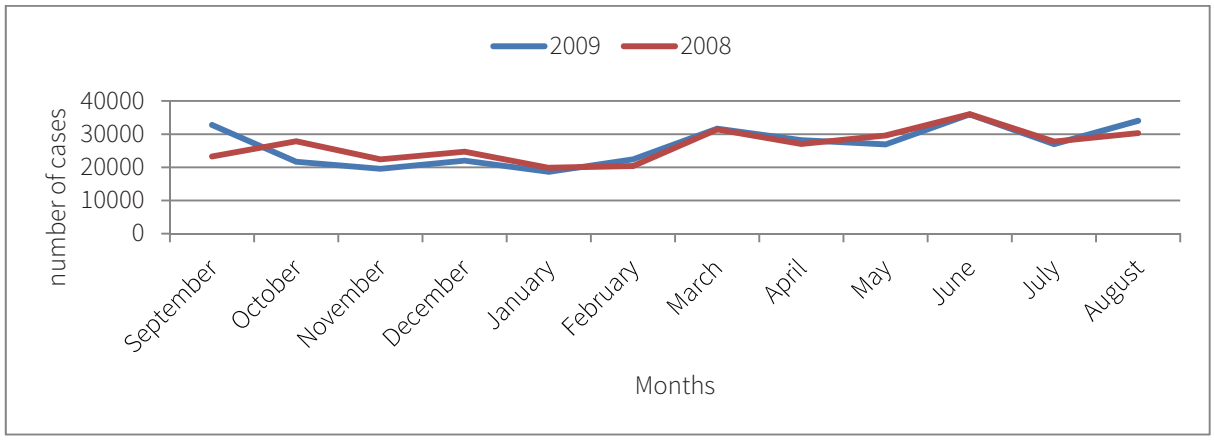



Figure 35: Trends of Suspected Measles Cases and Deaths

## SUSPECTED MENINGITIS

A total of 1,865 suspected meningitis cases were reported in 2009 EFY, which is with increment of 15.8% (294 suspected cases) as compared to 2008 EFY. High numbers of suspected cases were reported from SNNPR (39.8%) followed by Oromia Region (23.1%) and Amhara Region (12.6%). A total of 73 deaths were reported with a case fatality rate of 3.9%. The higher case fatality was due to suspected meningitis was in Gambella Region (28.6%) followed by Tigray Region (7.1%). On other hand, the incidence rate per 100,000 population is 2/100,000 at national level with the highest incidence rate in Gambela Region (14/100,000) followed by SNNPR (3.8/100,000) and Addis Ababa (3.7/100,000).

Table 11: Distribution of Suspected Meningitis

| Region | Cases | | | Deaths | | |
|---|---|---|---|---|---|---|
| | Number | Percent | Incidence Rate (per 100,000 population) | Number | Percent | CFR |
| Addis Ababa | 127 | 6.81 | 4 | 5 | 6.85 | 3.94 |
| Afar | 56 | 3.00 | 3 | 3 | 4.11 | 5.36 |
| Amhara | 234 | 12.55 | 1 | 10 | 13.70 | 4.27 |
| Benishangul-Gumuz | 29 | 1.55 | 3 | 1 | 1.37 | 3.45 |
| Dire Dawa | 1 | 0.05 | 0 | 0 | 0.00 | 0.00 |
| Gambella | 63 | 3.38 | 14 | 18 | 24.66 | 28.57 |
| Harari | 0 | 0.00 | 0 | 0 | 0.00 | 0.0 |
| Oromia | 430 | 23.06 | 1 | 10 | 13.70 | 2.33 |
| SNNPR | 742 | 39.79 | 4 | 21 | 28.77 | 2.83 |
| Somali | 127 | 6.81 | 2 | 1 | 1.37 | 0.79 |
| Tigray | 56 | 3.00 | 1 | 4 | 5.48 | 7.14 |
| National | 1865 | 100.00 | 2 | 73 | 100.00 | 3.91 |

The monthly trend of suspected meningitis show an increment in October to December, March and June to August as compared to 2008 EFY.

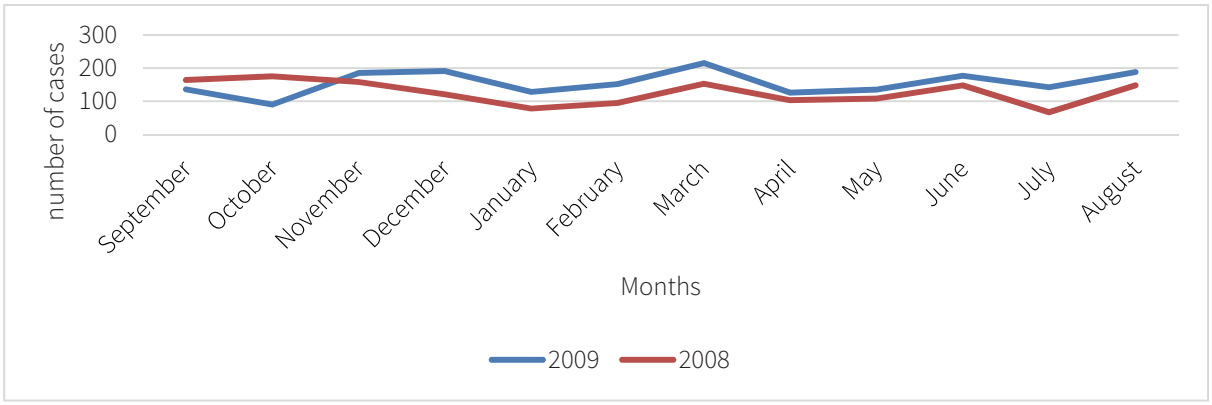



Figure 36: Trends of Suspected Meningitis

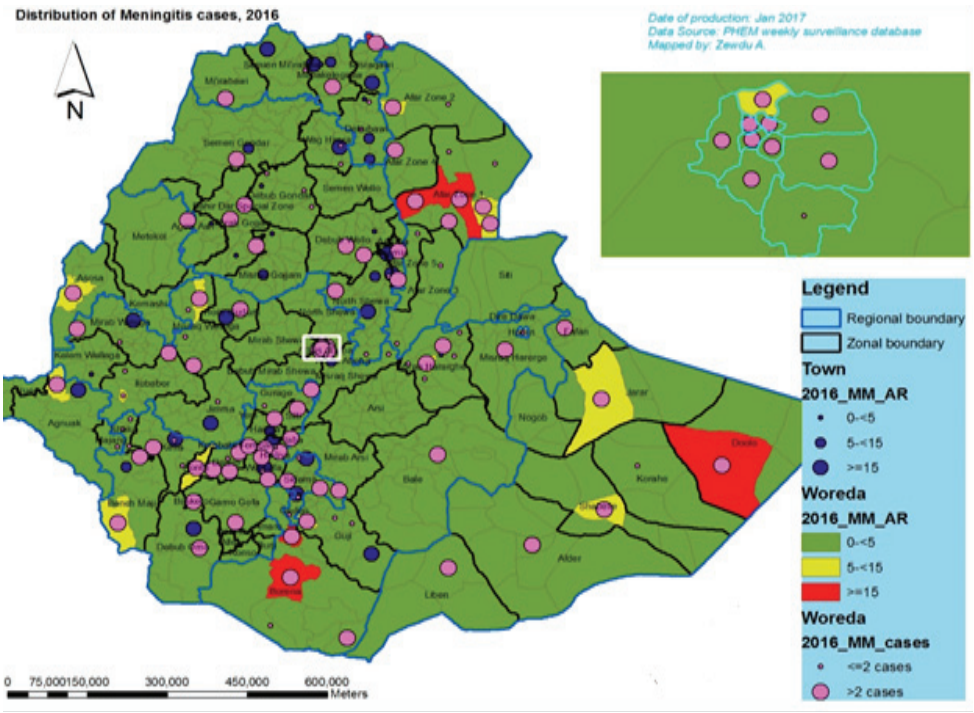



Figure 37: Distribution of Meningitis Cases

## ANTHRAX

In 2009 EFY, a total of 676 anthrax cases were reported with CFR of 1.0%. As compared to last year there was an increment of 14.9% (101 suspected cases). The highest proportion of cases was reported from Amhara Region (53.1%) followed by Tigray Region (18.2%), while highest CFR was from Somali Region (1.8%) followed by SNNPR (1.4%).

Table 12: Distribution of Suspected Anthrax

| Region | Cases | | | Deaths | | |
|---|---|---|---|---|---|---|
| | Number | Percent | Incidence Rate (per 100,000 population) | Number | Percent | CFR |
| Addis Ababa | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Afar | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Amhara | 359 | 53.11 | 2 | 4 | 57.14 | 1.11 |
| Benishangul-Gumuz | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Dire Dawa | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Gambella | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Harari | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Oromia | 10 | 1.48 | 0 | 0 | 0.00 | 0.00 |
| SNNPR | 72 | 10.65 | 0 | 1 | 14.29 | 1.39 |
| Somali | 112 | 16.57 | 2 | 2 | 28.57 | 1.79 |
| Tigray | 123 | 18.20 | 2 | 0 | 0.00 | 0.00 |
| **National** | **676** | **100.00** | **1** | **7** | **100.00** | **1.04** |

The monthly trend has slightly similar trend from September to November and April to August with a sharp increment in December as compared to 2008 EFY.

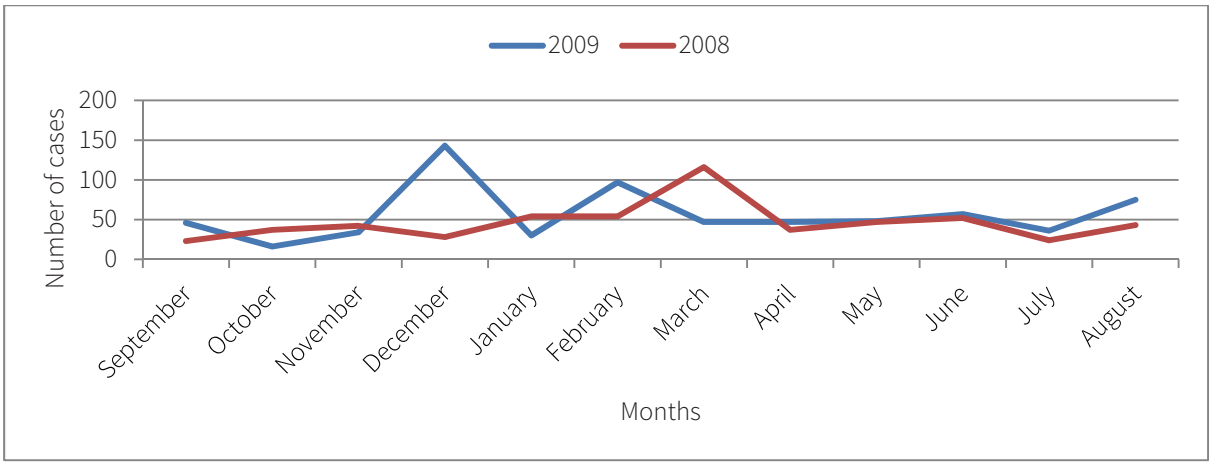



Figure 38: Trends of Suspected Anthrax

## RABIES

A total of 3,521suspected rabies cases were reported with 30 deaths, which showed an increment of 28.5% (1,003 suspected cases). The highest proportion of cases were reported from Tigray Region (49.9%) followed by Amhara Region (38.2%). The incidence rate at national level is 4 per 100,000 population with the highest incidence rate in Tigray Region (34/100,000 population) followed by B/Gumuz Region (8/100,000 population).

Table 13: Distribution of Suspected Rabies

| Region | Cases | | | Deaths | | |
|---|---|---|---|---|---|---|
| | Number | Percent | Incidence Rate (per 100,000 population) | Number | Percent | CFR |
| Addis Ababa | 29 | 0.82 | 1 | 5 | 16.67 | 17.24 |
| Afar | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Amhara | 1345 | 38.20 | 6 | 10 | 33.33 | 0.74 |
| Benishangul-Gumuz | 82 | 2.33 | 8 | 2 | 6.67 | 2.44 |
| Dire Dawa | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Gambella | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Harari | 0 | 0.00 | 0 | 0 | 0.00 | 0.00 |
| Oromia | 275 | 7.81 | 1 | 10 | 33.33 | 3.64 |
| SNNPR | 32 | 0.91 | 0 | 2 | 6.67 | 6.25 |
| Somali | 2 | 0.06 | 0 | 0 | 0.00 | 0.00 |
| Tigray | 1756 | 49.87 | 34 | 1 | 3.33 | 0.06 |
| **National** | **3521** | **100.00** | **4** | **30** | **100.00** | **0.85** |

The monthly trend is similar to 2008 EFY with the exception of peak cases in the month of September, December to January and June to August of 2009 EFY.

## OTHER ACTIVITIES

### POLIO AND NNT

Ethiopia was accepted as Polio Free Country after a verification visit from ARCC in EFY 2009. Similarly, the county also was validated on the elimination of maternal and neonatal tetanus and become one of the 42 countries that eliminated MNE in the same fiscal year.

National Non Polio AFP rate was 2.5 in EFY 2009 more than the pervious year rate (2.4). Afar (NP Polio AFP rate: 1.4) and Harari (NP Polio AFP rate:0 / Silent) showed the lowest performance and not yet met the minimum target set (2/100,000 <15 population). Further more, the national stool adequacy rate was 92% which was more than last year's achievement (90%) and the target (>80%) in the same period.

Different trainings/workshops were organized in the fiscal year. Among these trainings/workshops the following were the major ones:

- To strengthen public health surveillance system in detecting, reporting, investigating and responding for an emergency and any other public health threat timely, a total of 324 Woreda PHEM officers were trained on FETP-Frontline basic level training;
- To establish a multispectral and multi-disciplinary rapid response team for effective management of public health emergencies, a total of 56 Regional PHEM, Clinicians from hospitals, experts from environmental protection agencies, regional laboratory Hospital Staffs, IOM and Red Cross and Fire and Emergency on rapid response.
- To strength the malaria surveillance and response system and to support the malaria elimination program, a total of 550 PHEM officers trained on malaria surveillance.
- To introduce the prenatal surveillance and to strength the MPDSR surveillance system, a total of 104 regional PHEM and MCH officers were trained TOT level MPDSR.

One of the other major activities under PHEM is to produce guidelines, manuals and SOPs that helps the public health emergency system. In EFY 2009 the following manuals and guidelines were produced.

- Rapid Response Team Manual
- Event Based Surveillance Manual
- Community Based Surveillance Manual
- Yellow Fever Guideline
- Rabies Guideline
- Anthrax Guideline

- Public Health Low Enforcement manual
- EOC manual

With regard to surveillance and response of public health emergencies (immediately/weekly reportable diseases) 572 weekly feedback and 52 weekly PHEM epidemiology reports were produced with 91% report completeness and 89% of report timelines.

In the fiscal year, more than 25 Rapid Response Teams (for AWD-11RRT,Drought and Malnutrition-4 RRT, malaria outbreak-2 RRT, Genie worm-2 RRT, Rabies -1RRT,for unknown disease in Ethio-Somali 2 RRT and for IDP 5 RRT) were deployed for checking and to give alerts and warning to the general public regarding potential public health emergencies or disasters. And by mobilizing the government and partners resources it was responded rapidly and effectively to the outbreaks happening like the current AWD outbreak by distributing necessary logistics such as 67 CTC kits, more than 400,000 water treatment chemicals, over one million ORS and Ringer lactate.

One of the major achievements in EFY 2009 was the introduction of the PHEOC in the national PHEM at EPHI. An emergency operations center (EOC) is a physical location for the coordination of information and resources to support incident management activities. EOC used as a platform for effective management of PHEs by creating; a multi sectoral, multidisciplinary and multi-agency technical and resource collaboration among local and international stakeholders. When an outbreak or event happened EOC activates for unified command, control and coordination system for preparedness and response activities though the Incident Management System. The national EOC has direct link with the EPHI and the Ministry of Health, it is managed under the Director General of EPHI. A strategic direction for the operation of the EOC is given by Minster of Health and EPHI senior managements.

**CHALLENGES**

- Low completeness and timeliness of reporting from some regions;
- Inadequate data utilization, especially at lower levels;
- Limited capacity of laboratory for timely confirmation of outbreaks; and
- Staff turnover, especially at national and regional levels.

**WAY FORWARD**

- Implementation of electronic surveillance system and regular supportive supervision;
- Strengthen data documentation through training of PHEM officers and data managers; and
- Provide training on data analysis and reporting to lower level.

# CHAPTER 4

# QUALITY IMPROVEMENT AND ASSURANCE

# QUALITY IMPROVEMENT AND ASSURANCE

## 4.1. QUALITY IMPROVEMENT

### HOSPITAL REFORM

### ETHIOPIAN HOSPITALS ALLIANCE FOR QUALITY (EHAQ) INITIATIVE

In EFY 2009, Ethiopian Hospitals Alliance for Quality (EHAQ) initiative has been implemented by forming a joint forum with high performing (LEAD) hospitals in their catchment. The forum was organized every quarter and identified annually awardee hospitals with best performance (delivered highest quality of health services) at national level. In order to improve quality of clinical care in university and federal hospitals, a consultative forum have been organized, LEAD hospitals with plan of action have been identified and the process of implementation is currently being monitored.

### ETHIOPIAN HOSPITAL REFORM IMPLEMENTATION GUIDELINES (EHRIG) REVISION

The Ethiopian Hospital Services Transformation Guidelines (EHSTG) builds on and expands the Ethiopian Hospital Reform Implementation Guidelines (EHRIG) and is consistent with the Health Sector Transformation Plan (HSTP). The EHSTG focuses on selected management and clinical functions, including new individual service specific chapters for Emergency Medical, Outpatient and Inpatient Services, Nursing and Midwifery, Maternal, Neonatal and Child Health, Federal and Teaching Hospitals' Management and Clean and Safe Hospital (CASH).

During 2009 EFY, supportive supervision was conducted at 20 LEAD hospitals based on EHSTG, SaLTS, CASH initiatives and QI activities. The national EHSTG performance was 53% ranging from 14 % on rehabilitative and palliative care service management to 73% in monitoring and reporting system based on data of the 19 chapters (Figure 39 excluding federal and teaching hospitals management chapter).

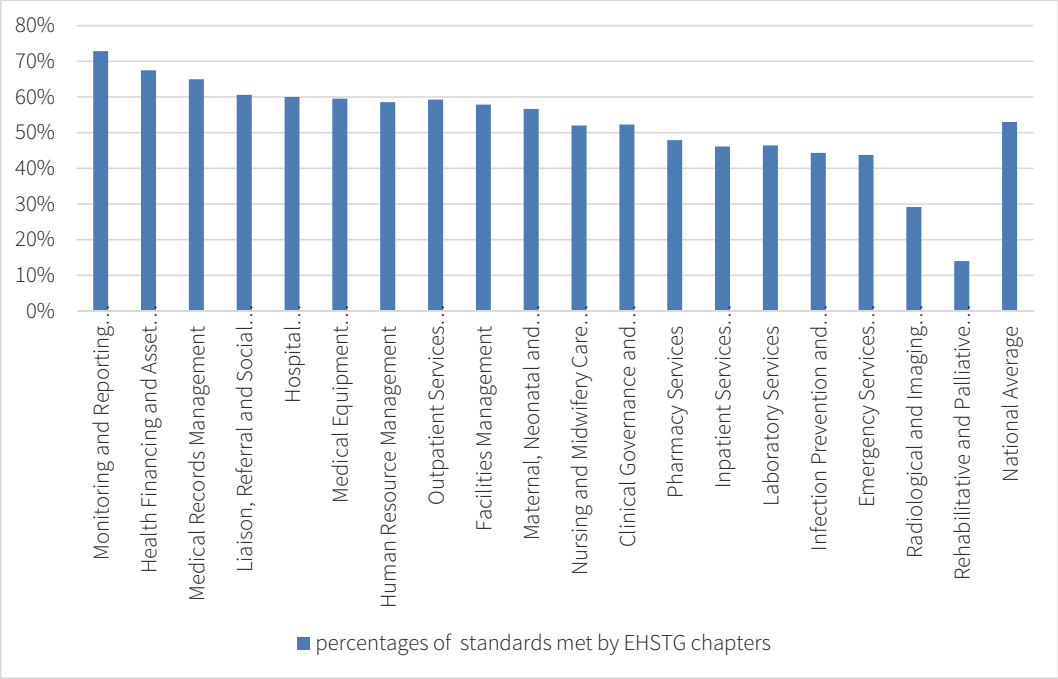



Figure 39: National EHSTG performance, EFY 2009

## SAVING LIFE THROUGH SAFE SURGERY (SALTS)

The SaLTS initiative is a one of the flagship initiative launched by the Federal Ministry of Health aimed to make essential and emergence surgical and anesthesia care available and accessible to all segments of the population of Ethiopia. It is a large initiative in which basic and emergency surgical services have been launched in all hospitals of the country including task-shifting to middle-level healthcare professionals through short or medium-term competency based trainings.

In EFY 2009, a national technical working group was established and held consecutive meetings for the development of the national SaLTS five-year strategic plan. The SaLTS baseline assessment tool was also developed and hospital readiness for the implementation of safe surgery was assessed using the tool. Based on the identified gaps, hospitals are designing a quality improvement project.

In the fiscal year, monitoring and evaluation framework was developed and national SaLTS indicators were set to measure and evaluate the surgical services at all levels of the health system.

Surgical teams composed of a surgeon, anesthesia provider, scrub nurse and hospital CEO/ medical director from hospitals across all regions were trained on “transforming surgical care through SaLTS” for three-days. In addition, FMoH has procured Operation Theater Equipment and handed over them to all regions which then were distributed to hospitals.

## CLEAN AND SAFE HOSPITALS (CASH) INITIATIVE

Providing health services with cleanliness and safety maintains the comfort and satisfaction of customers as well as health service providers. In this regard, in EFY 2009, training on CASH / IPPS was organized for more than 2,000 participants (health professionals and leaders) from different hospitals. In addition, best practices on CASH implementation was documented along with experts from Michigan University on the clean, comfortable, safe and effective prevention of contamination.

## IMPROVING NURSING SERVICES INITIATIVE

In order to standardize nursing services, in EFY 2009, training was organized to 2,300 participants, 12 professionals from each hospital with different level of profession (managers, medical directors, quality service coordinators, matrons, department coordinators and directors/ managers) including participants from regional health bureau on nursing standards. On the other hand, five private hospitals that have agreed to implement the directive also provided the training to their respective medical staff.

## CLINICAL SERVICES GOVERNANCE

Clinical Governance is a system of advanced standardization and decentralization of clinical services. Currently, it is very important to enable hospitals to make effort to ensure that the communities have role in fulfilling quality standards, fulfilling the needs of the community, always improving and controlling health care services and generally in ensuring the welfare of the people. In this regard, in 2009 EFY, a clinical management draft directive document was prepared.

## HEATH CENTER REFORM

The FMoH has been implementing initiatives to ensure universal health care coverage with the highest possible quality and equity as its priority. Creating high performing PHCUs by implementing EHCRIG and providing quality and equitable health care at PHCUs through implementing comprehensive, evidence based and integrated primary care clinical guideline at all HCs (PHCG), and transforming PHCU service delivery and care through fostering collaborative learning via the EPAQ were the strategies implemented to ensure universal primary health care coverage. In addition, the FMoH has selected 80 HCs, i.e. 1HC/Zone, to serve as national incubation centers where repackaged service components will be tested, adopted and expanded. Having these HC at each zones would be instrumental to foster the propagation of reform in the country.

## ETHIOPIAN PRIMARY CARE ALLIANCE FOR QUALITY

Building on the experience of rapid expansion of EHRIG and changes in packages of the Hospital collaborative learning, FMoH adopted the concept of EHAQ to Health centers where the woreda health office plays central role in coordinating this collaborative network of HCs in its Woreda/ catchment to select a lead HCs that guides other members to learn from its best practices and serves to facilitate experience sharing and collaborative learning at the Woreda and the clusters in each Woreda collectively will be learning hubs at a national level.

## PRIMARY HEALTH CARE CLINICAL GUIDELINES FOR ETHIOPIA (PHCG)

Another nationwide initiative planned for implementation is the primary clinical care guideline that aims to standardize the clinical service delivery at health centers through provision of a comprehensive, practical, easy to use, integrated, and provider focused clinical care. Currently, the final draft of the guide has been prepared and it has four pillars namely guideline development, training, health systems strengthening and monitoring, evaluation, regular updates and knowledge management.

## HEALTH CENTER REFORM IMPLEMENTATION STATUS

During the budget year, financial and technical support on health center reform was provided to all Regions. After HC reform training given, preliminary assessment was conducted in the Benishangul and Afar Regions. On top of that, Regions have started sending quarterly reports HC reform implementation status. Accordingly, HC reform implementation at national level reached 46 %, with regional performance ranging from 78% in Tigray to 33 % B. Gumuz (Somali Region didn't start the implementation yet.)

The Health Center Reform Implementation Guidelines has been translated into Oromiffa language and implemented by Oromia Regional Health Bureau. Similarly, the reform document has also been translated into Somali and has been implemented by the Regional Health Bureau.

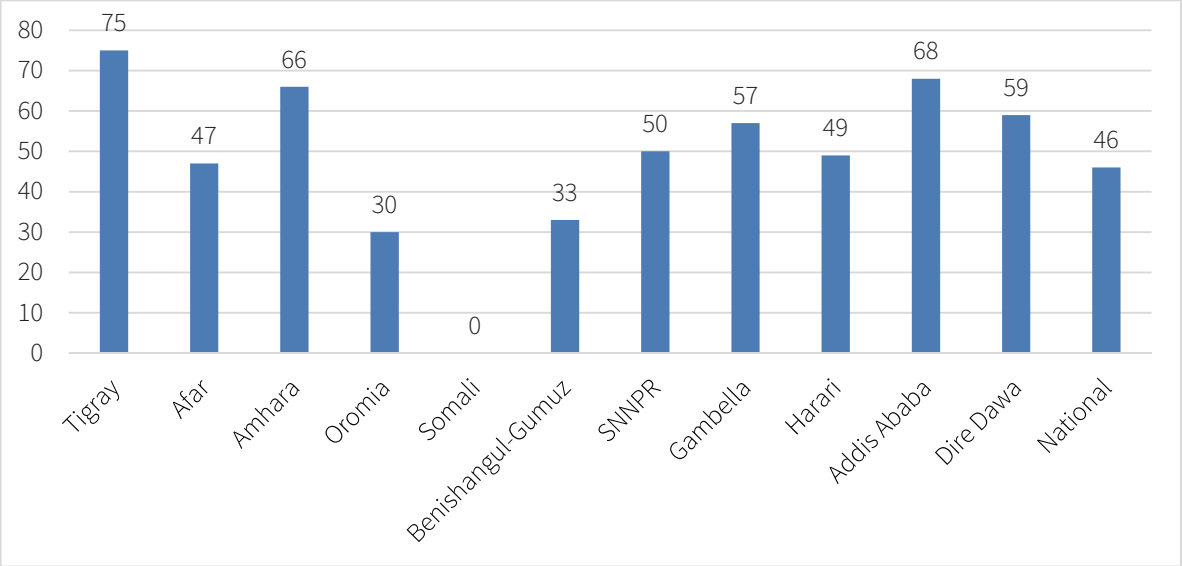



Figure 40: Ethiopia health center reform implimentation status

## 4.2 EMERGENCY SERVICES

### PRE-HEALTH FACILITY EMERGENCY MEDICAL SERVICES

In EFY 2009, in collaboration with Fire and Emergency Management Authority and other partners, FMOH organized two rapid response and preparedness to emergencies drill/training at Jan-Meda. In line with emergency response, a directive document was prepared on natural and manmade Emergency Response Team and a one-day workshop was conducted. Around 4 hospitals (Black Lion, Alert, Saint Paul, and Abet) have established an Emergency Response Team. In order to improve emergency preparedness and response, a national guideline on the National Emergency Response Unit was prepared and a one-day forum was conducted for a mix of health professionals.

### INTENSIVE CARE MEDICAL SERVICES

In order to improve of the hospital services and to reduce sickness and death of people in hospitals, particular attention has been given on the availability of human and necessary medical equipment in important health care services like intensive care units. In EFY 2009, Assela, Axum, Durame, Dilla and Yirgalem hospitals have been provided with important medical equipment. Similarly, Adama, Dil Chora and Assosa hospitals have been technically supported by anesthesiologists and ICU specialists to initiate ventilation service in respective ICU unit. Besides, in St. Peter's hospital the ICU unit was strengthen by providing necessary medical training.

Training was provided for 252 professionals from 13 hospitals on adult ICU management. In addition, 19 health professionals from three hospitals were trained on Neonatal ICU management.

Nine months of hospitalization report were collected from a total of 20 hospitals. The reports show from a total of 4,275 patients admitted to ICU, 2,541 (59.4%) were recovered and 1,249 (29.2%) were died.

**BLOOD SAFETY**

At health facilities, utmost efforts were exerted to improve the supply of blood and reduce deaths caused by blood loss. Mass media campaign and consultative forums have been created to enhance the awareness of the community on voluntary blood donation and related issues.

In EFY 2009, it was planned to collect 202,000 units of blood. The actual performance for the year is 169,744 units (83.6%), from which 168,776 units (99.4%) were collected from voluntary donors. The National Blood Bank has collected 70,000 units of blood samples, from which 55004 units (78.6%) were collected from voluntary blood donation. Out of the total voluntary blood donation, 36524 units (66.4%) were collected by the mobile blood collecting team and 18480 units (33.6%) were collected at Central level.

## 4.3. NATIONAL LABORATORY SYSTEM

With regard to Laboratory Quality Management System (LQMS) implementation, a total of 120 health centers were participating in LQMS/SLIPTA program. Baseline assessment and training were conducted for 60 laboratories. To this end, external SLIPTA audit was done for 12 laboratories and awarded to 3 star by ASLM. Similarly, 5 laboratories achieved ISO accreditation and another 3 laboratories maintained their ISO15189 accreditation.

In EFY 2009, in line with International External Quality Assessment Scheme (IEQAS), a total of 334 Laboratories participated with 28 different Parameters of Laboratory disciplines and 18 Participated in EID/VL.On the other hand, in the budget year, national external quality assessment was conducted for health facilities with different testing types (HIV/RDT, GeneXpert, Malaria test). In this regard, slide bank was established for malaria EQA.

A total of 393 curative maintenance services were provided with 78% response rate.and a total of 145 preventive maintenance services were provided.

In line with laboratory testing expansion/technology replacement, a total of six new EID/Vl sites were established, one EID/VL site was being established; a total of 100 old FACScount CD4 machines were replaced by FACSpresto; 30 old Heamatology Machines were also replaced and 48 GeneXpert Machines put into service in the fiscal year.

## 4.4 CLINICAL SERVICES

### OPD ATTENDANT PER CAPITA

In 2009 EFY, total of 70,510,347 OPD visits were made at health facilities, which is an average of 0.7 OPD visit per person per year. This achievement has 17% increment from 2008 EFY performance. The graph below shows all regions have a slight increment from their baseline and Tigray, Amhara, Harar, AA and Dire Dawa performed above the national average. Nationally, OPD attendance per capita showed wide variation ranging from 0.2 in Somali to 1.8 in Tigray.

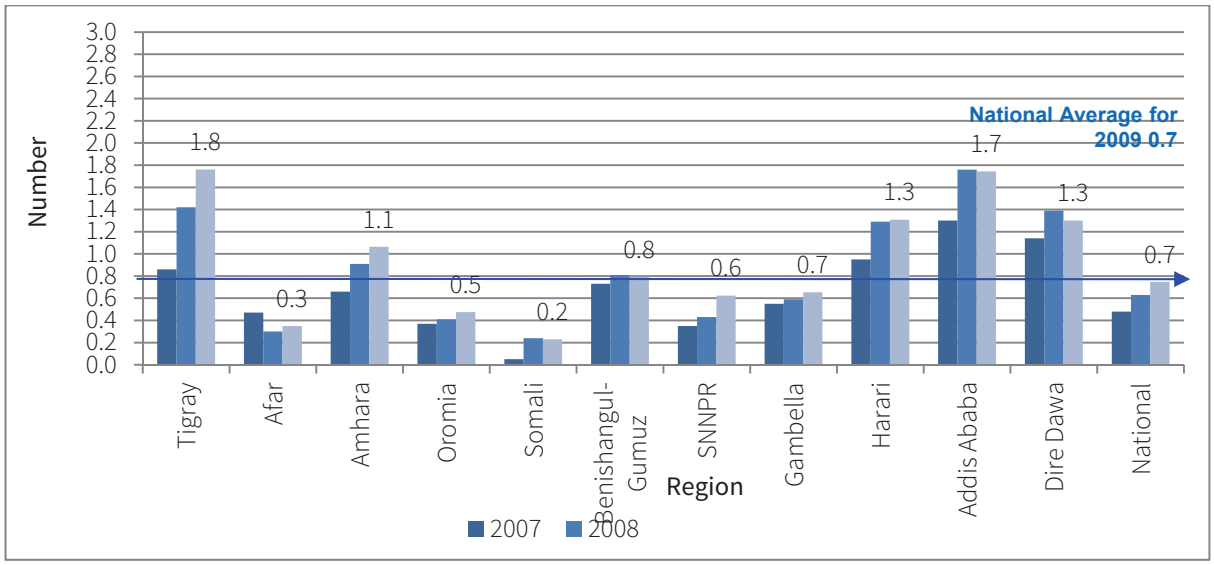



Figure 41: Comparison of Baseline and Performance of OPD Attendance Per Capita by Region (EFY 2009)

### AVERAGE LENGTH OF STAY

In EFY 2009, there were a total of 1, 022,362 inpatient discharges with an average length of stay (ALOS) of 4 days which is the same with 2008 performance. Variations were observed across regions, between 2.9 days ALOS in Afar region and 4.7 days ALOS in Addis Ababa (Figure 44).

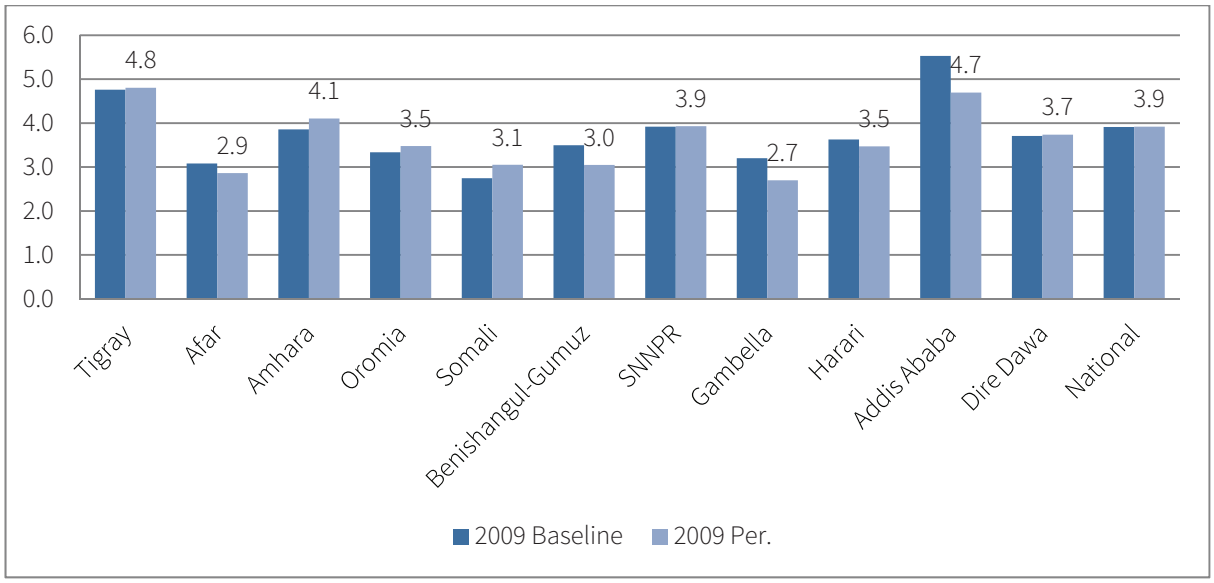



Figure 42: Average Length of Stay by Region, EFY 2009

## BED OCCUPANCY RATE

In EFY 2009, the Bed Occupancy Rate (BOR) was 40% with slight increment from baseline performance. Variations were observed across regions, between 17% in Afar region and 46% in Addis Ababa.

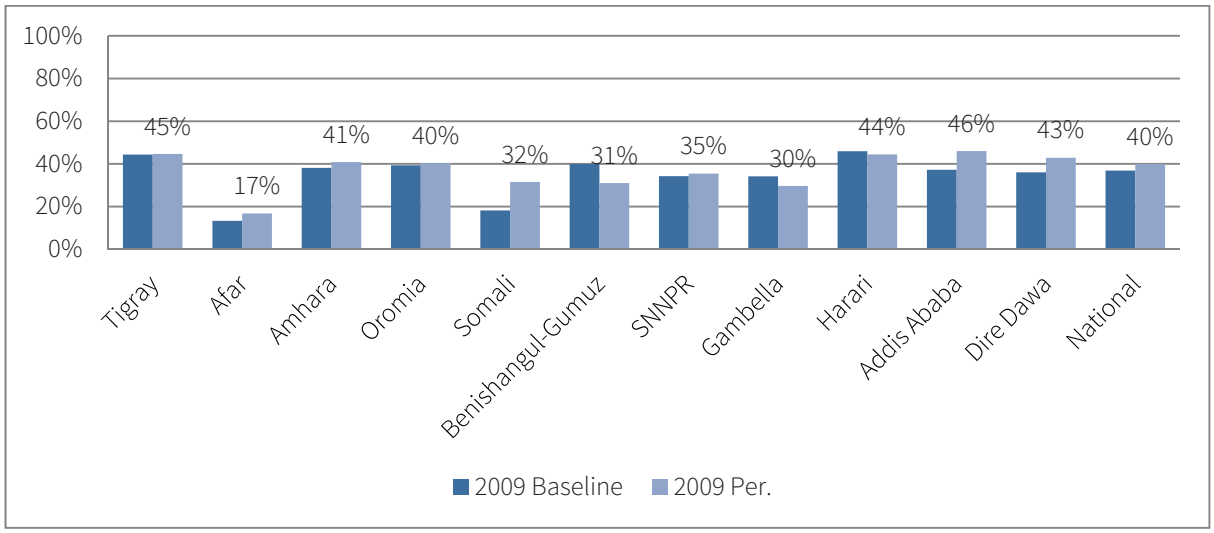



Figure 43: Bed Occupancy Rate by Region, EFY 2009

# CHAPTER 5
# LEADERSHIP AND GOVERNANCE


# LEADERSHIP AND GOVERNANCE

## 5.1 EVIDENCE BASED DECISION MAKING (EBDM)

A comprehensive annual health sector plan for EFY 2009 was prepared and reconciled with regions and partners based on the harmonization and alignment principles. To ensure successful implementation of the HSTP, particularly to strengthen evidence-based decision making, the EFY 2009 annual plan was prepared with the aim of sustaining the percentage of woredas with a comprehensive and integrated plan at 100%, increase the completeness and timeliness of the reports to 100%, and increase the percentage of health facilities implementing health data quality assessment (LQAS) to 100%. Based on this, the performance of the EFY 2009 is presented as follows.

### THREE ONE (ONE PLAN, ONE BUDGET AND ONE REPORT)

A woreda-based planning approach applied to prepare the health sector annual plan where the plans originated from the woredas  further consolidated by zones and regions. After aligning the target with the national plan and budget cleaning, it was printed and distributed for use. The resource gap for the full implementation of the plan was also analyzed and presented to important stakeholders.  In a bid to sustain the planning exercise conducted through balanced score card at the federal level, various need based capacity building training were provided to hospitals and agencies.

Moreover, a detailed plan was developed based on the planned activities of the fiscal year and budget allocated for EFY 2009 for the sector.

### ROUTINE DATA COLLECTION AND AGGREGATION

### STRENGTHENING OF HEALTH INFORMATION SYSTEM AND ENSURING QUALITY

Although improvements have been made on the use of health data during decision-making processes, more must be done to bring the required data use culture and practice for improving health system and health program performance.  Innovative approaches are being tested and implemented to change culture of information use at all levels in the health system including the initiatives to create connected woreda, capacity building and mentorship program by engaging universities, human-centered design and innovation lab concepts, etc.

In addition, the Ministry is working to strengthen the data quality assurance mechanisms by implementing Data Quality Reviews and implementing tailored response to data quality review outputs. One of the major initiatives includes further expanding the data quality verification process to the community levels in a bid to combat data falsification.

## REVISION OF NATIONAL HMIS INDICATORS

FMOH has been reviewing and revising the existing core HMIS indicators of the health sector to accommodate tracking progress on the implementation of HSTP, SDGs, new program initiatives and other international needs. A TWG has been set up and all the program directorates have submitted their indicator needs. A national consultative workshop is convened to present the revised key HMIS indicators with the objective of soliciting inputs and further refine indicators. Finally, a total of 131 indicators were selected, out of which 33 are new, 29 indicators are modified, and 69 indicators remain unchanged from the previous set of indicators. Following the indicator revision, a national master ToT has been conducted for six days.

The revised set of indicators has been presented to the management and approved. All the data collection tools and registers have been revised, including customization of DHIS2 based on the new indicators.

## COMMUNITY HEALTH INFORMATION SYSTEM

The Federal Ministry of Health has conducted a formative assessment in the use of the family folder in the agrarian regions. The results of the assessment have been compiled and areas of improvement identified to serve as inputs during the planned redesign of the family folder. In EFY 2009, the urban CHIS training manual was prepared and piloted in selected urban sites of the country. Similarly, a customized paper-based CHIS including recording instruments were developed for the pastoralist setting. TOT and financial support were provided to the regions to cascade the training at the lower levels.

## DISEASE LIST UPDATE (ICD 10)

The existing disease list category has been in the process of revision in the previous fiscal years. In EFY 2009, the revised disease list was pilot tested by providing training for a total of 200 health professionals drawn from different health facilities in Addis Ababa. The lessons learned are documented for wider scale implementation.

## CAPACITY BUILDING

It was planned to provide pre-service training for students of higher learning institutes before their deployment to their duty station. During the fiscal year, 35 Gondar University health informatics graduates were given training on the national health policy, transformation plan, BSC, reform activities at FMOH, health information system and related topics. Moreover, 5300 health professionals graduated from various universities were trained on HSTP.

## PERFORMANCE MONITORING AND COORDINATION

Quarterly, bi-annual, annual, and strategic transformation plans, a performance evaluation, and health equity reports were prepared. The following reports are distributed to all relevant stakeholders.

- Quarterly health sector report was prepared and disseminated to all stakeholders.
- The EFY 2008 Annual Performance Report was prepared and shared with participants during the annual review meeting.
- The EFY 2008 annual finance utilization report and the EFY 2009 finance utilization action plan were prepared and submitted.

## SUPPORTIVE SUPERVISION

To review regional plan and performance of its implementation, integrated supportive supervision was conducted on selected 20 zones/sub-cities, 78 woredas, 26 hospitals, 81 HCs, 162 HPs and 324 HHs in all the nine regions and two city administrations. The supervision was made by a team composed of members from House of Peoples Representative, Prime Minister's Office, FMOH, Regional Health Bureaus, agencies under FMOH, and professionals from Development Partners. Assessments conducted during the supervision include: the status of Health Development Army in achieving the stated goals, health services quality and equity, health sector governance, and evidence-based decision-making at all levels. Technical supports on the identified gaps were provided on site at all levels (from Kebele command post to regional health bureau) and action plan was shared during the debriefing sessions at the end of the supervision.

Moreover, to improve data quality and information use at national level, integrated supportive supervision was conducted in all regions and city administrations by a team composed of members from FMOH, Regional Health Bureaus and Development Partners. A total of 165 health

institutions from all levels were covered during the supervision and data verification. On site technical support was provided on the identified gaps and written feedbacks were provided for management.

## HEALTH AND HEALTH RELATED SURVEYS

### ETHIOPIAN DEMOGRAPHIC AND HEALTH SURVEY (EDHS)

The 2016 Ethiopia Demographic and Health Survey (EDHS) is the fourth Demographic and Health Survey conducted in Ethiopia. It was implemented by the Central Statistical Agency (CSA) at the request of the Federal Ministry of Health (FMoH). The primary objective of the 2016 EDHS is to provide up-to-date estimates of key demographic and health indicators. The EDHS provides a comprehensive overview of population, maternal, and child health status in Ethiopia.

EDHS provides valuable information on trends in key demographic and health indicators over time. The information collected through the 2016 EDHS is intended to assist policymakers and program managers in evaluating and designing program and strategies for improving the health of the country's population. Additionally, the 2016 EDHS included a health facility component that recorded data on children's vaccinations, which were then combined with the household data on vaccinations.

### SERVICE AVAILABILITY AND READINESS ASSESSMENT (SARA)

The 2016 Service Availability and Readiness Assessment (SARA) for Ethiopia was conducted to assist the health sector in assessing and monitoring service readiness and capacity at region and health facility levels on a regular basis. The SARA provides key information on the state of the health system in terms of service availability and readiness of the facilities to provide key information for measuring progress in health system strengthening over time by generating a summary index that represents "readiness to provide key MNCH and other health related services".

### ETHIOPIAN EMERGENCY OBSTETRIC AND NEWBORN CARE (EMONC) ASSESSMENT

The primary objective of the 2016 EmONC assessment was to provide up-to-date information for policy-makers, planners, researchers and program managers, which would allow guidance in the planning, implementation, monitoring and evaluation of maternal and newborn services in the country.

The 2016 EmONC assessment collected information on the topics of infrastructure, human resources for maternal and newborn health, essential drugs, equipment and supplies, facility service statistics, emergency obstetric and newborn signal functions, providers' knowledge of maternal and newborn care, health provider supervisory support and motivation, maternal and newborn referral, maternity waiting homes and chart reviews for the partograph, Caesarean sections, women who survived obstetric complications, maternal deaths, and newborn complications. The indicators presented in the preliminary report selected findings from some but not all topics. Generally, findings are presented for the national and nine regional states and two city administrations. In addition, data are also provided by urban and rural location of facilities, and managing authority. Findings from the assessment indicate marked improvements in infrastructure, utilization of services, and health outcomes in the past eight years.

## OPERATIONAL RESEARCH

Scientific information is paramount in order to give quality health services, design appropriate intervention programs and draw workable policy. Operational research is performed in the health sector in order to identify and study priority problems of public health importance and produce evidence that would help decision-makers to improve the services, and develop realistic health sector policies and strategies. Ethiopian Public Health Institute (EPHI) is mandated to conduct problem solving research so as to deliver scientific information as inputs for evidence-based decision making on strategy, program and policy development. In EFY 2009, more than 32 operational researches were completed by EPHI. The following major operational researches were conducted focusing on infectious and noninfectious diseases, health system, and nutrition.

- Case based surveillance for HIV in Ethiopia;
- National TB/HIV sentinel surveillance (July 2015-June 2016);
- End term review of implementation of the national strategic plan for the elimination of mother-to-child transmission of HIV, 2013-2015;
- Sentinel surveillance of sexually transmitted infections based on syndromic case reporting, (July 2015-June 2016);
- Pre-treatment antiretroviral drug resistance study among HIV-1 patient in Ethiopia;
- First-line TB multiple drug resistance (XDR-TB) Survey;
- TB-Molecular Epidemiology;
- National TB prevalence survey on vulnerable groups: prisoners, homeless, health care workers , alcohol, drug and tobacco users;
- Evaluation of Schistosomiasis/STH diseases monitoring and control program;
- Biomarker study on patients with onchocerciasis disease;

- Onchocerciasis disease sentinel surveillance;
- Malaria rapid diagnostic Test (RDT) Kits evaluation;
- Study on insecticide resistance management of malaria mosquitoes;
- National Emergency Obstetric & new born care needs assessment (EmONC);
- Maternal and child health care midline evaluation in one hundred selected woredas of the four populous regions of the country;
- Optimizing the use of health extension program (OHEP). Baseline survey has been completed;
- Ethiopian international tobacco use survey;
- Improving Antenatal Care Services Utilization in Ethiopia: an evidence–based policy brief;
- Community based non-communicable diseases (NCD) national survey;
- Evaluation of 1000 PLUS nutrition Intervention in selected Woredas of Ethiopia: a cross-sectional baseline survey;
- Sustainable under-nutrition reduction in Ethiopia (SURE) program evaluation (2016-2019): Cross-sectional baseline survey;
- Sustainable under-nutrition reduction in Ethiopia (SURE) program: Process evaluation;
- Evidence-based decision-making in formulating nutrition policy and program in Ethiopia: A qualitative study exploring barriers and facilitators; and
- Quality and safety of edible oils in Addis Ababa.

## 5.2. REGULATORY SYSTEM

It is widely recognized that establishing a fully functional regulatory system ensures adherence to national health and health related standards and regulations by all state and non-state actors. The objective is to ensure safety and quality in the delivery of health and health related services, products, and practices.

The strategic initiatives to improve regulatory system in EFY 2009 includes:

(a) Excelling food and medicine post-marketing surveillance;

(b) Ensuring third party quality assurance certification for locally produced and imported foods;

(c) Implementing zero back log of food and medicine dossier evaluation and pre-market quality test;

(d) Strengthening risk and audit based post licensing inspection;

(e) Strengthening health professionals' ethics and competency regulation;

(f) Ensuring the quality and standard of health services);

(g) Enforcing facilities to implement internal quality assurance system;

(h) Strengthen narcotic drugs, psychotropic substances and tobacco control; and

(i) Building the health regulatory sector with competent and ethical professionals qualified with regulatory science;

(j) Ensure general public and stakeholders' ownership of combating illegal food and medicine trade and health care services;

(k) Improving the health regulatory sector organizational structure;

(l) Implementing ISO based quality management system to be regulatory center of excellence;

(m) Excelling pharmacovigilance system and others

The following section describes the performance of the sector in implementing strategic initiatives to improve the regulatory system in EFY 2009.

## ENHANCING THE CONTROL OF FOOD QUALITY AND SAFETY

Registration and licensing of food items is one of the activities toward enhancing the control of food quality and safety. Hence, a total of 58 food items (43 food supplements, 7 infant formulas, and 8 child formulas), were evaluated and registered. This performance accounts to 75.5 % of what was planned for the fiscal year.

Concerning licensing inspection of food establishments, a total of 839 licenses were issued for manufacturers, exporters, importers, and distributors. In addition, 15,647 licenses were issued for retailers. This accomplishment was more than 100% of what was planned for the fiscal year.

Similarly, post-licensing inspection was conducted at 1186 (88.6%) food manufacturers, importers, and distributors as well 99,994(105%) food retailers. The performance of the newly implemented internal quality system on food manufacturers, importers and distributors was 44% at federal level and 6.3% at the regional level. This low performance is mainly because of low awareness of the new system by the implementing organizations.

Furthermore, post-marketing test was conducted for edible oil, juices, peanut butter, pasteurized milk and child food. Of the 215 PMS samples, 112 were in compliance with the standard while the remaining 103 samples failed. In addition, consignment test was conducted for 13 items by the food laboratory, BLESS and conformity assessment laboratory. Of the total of 650 consignment samples, 536 were found to comply to the standard while 114 failed.

In the fiscal year under review, a total of 1,408,005 tons of food and 87,402 tons of food raw materials were given import permits after checking their quality and safety.

## ENHANCING THE CONTROL OF HEALTH SERVICE INPUTS

FMHACA is currently implementing a "zero backlogs" strategy for medicine registration and licensing. Under this initiative, 805 (out of 800 planned) market authorization certificates were issued after inspecting compliance to requirements.

Regarding inspection and licensing of the health input establishments, a total of 25 health input manufacturing and 339 import and distribution licenses were issued during the fiscal year. In addition, 555 (48.8%) new licenses were issued for medicine retail outlets. This low performance is attributed to low number of applications for new licenses. 83 (98.8%) GMP inspections for foreign manufacturers have been conducted. Inspection of 272 (89.15%) import and distributors and 4036(85.5%) retail outlets were carried out. The performance of the newly implemented internal quality system on manufacturers, importers and distributors was evaluated as satisfactory, with an accomplishment of more than 100% at the federal level.

Medicine Quality Control includes Physicochemical, Microbiology and condoms tests for post-market and consignment purposes. In relation to consignment, the performance for condom test was 53.7% while the same for physicochemical was 20.5%. The low performance was due to the low number of samples submitted to the lab since tests for all the samples were done. The performance for the post-market test was encouraging as FMHACA has performed 69 types of medicines out of the planned 53. The medicines include those for Mothers and Children, antimalarial, antineoplastic and medicines for opportunistic infections. This performance is achieved because the focus given to the medicine quality control as a flagship and the support provided by branch laboratories after building their capacities.

The value of imported medicine, medical supplies, raw materials and lab reagents was 6.8 Billion Birr, 2.00 Billion Birr, 906.3 Million Birr and 2.16 Billion Birr respectively

Significant achievements were also registered for import permit (100%) and proper use control (74.8%) of Narcotic Drugs, Psychotropic Substances and Precursor Chemicals.

## ENSURING HEALTH PROFESSIONAL COMPETENCE AND ETHICS

Nationwide 22, 948 **(94%)** new health professionals were registered and licensed to practice their respective profession. There was good performance in the renewal of professional license that amounts 11,870 **(84%)** nationally. At the federal level, there is still a significant gap in the renewal of licenses since those who are practicing in the public sector are not forced to renew.

From a total of 150 public complaints received nationwide, 58 cases got decisions while the remaining cases are still under investigation.

## ENSURING HEALTH SERVICE QUALITY

One of the strategies to ensuring health service quality is issuance of certificate of competence for Health facilities. The performance of issuance of certificate of competence was 69.8%. 17 Specialty Centers and 4 Comprehensive specialized hospitals have received new license during the past fiscal year. Besides, 5485 facilities including public health facilities were licensed at regional level.

The performance of post-licensing inspection at the federal level was found to be 84.9%. 31 Specialty Centers, 7 general hospital and 10 comprehensive specialized hospitals were inspected during the fiscal year. The performance was low as more attention was given to pre-licensing inspection. On the other hand, regions inspected 15016 facilities in post-licensing that makes up 95% of the performance. Besides, 72 health facilities were supported to establish internal quality system.

## HYGIENE, ENVIRONMENTAL HEALTH, AND CONTROL OF COMMUNICABLE DISEASES

The regulatory activity at the federal level on the health related facilities was good. Performance on proper allocation and control of tobacco free areas was 94.2%. Aggregated performance in the regions on the control of health related facilities was 154,541 facilities, which is 88% of the plan.

Various measures were taken on different facilities based on the results of the inspections. This includes, 3803 pharmaceutical facilities (manufacturer up to retail outlet), health facilities, food facility (manufacturer up to retail outlet) and health related facilities received warning, pending and revocation depending on the severity of their cases. Similarly, health products that worth Birr 39,821,316.00 (medicine = 38,900,000.00, medical equipment = 355,932.00 and cosmetics = 565,384.00) and 3233.9 tons of food items were detained and properly disposed for not meeting the country's quality standards, expired dates, and unfit for use

## STRENGTHENING DEVELOPMENT AND IMPLEMENTATION OF LEGAL INSTRUMENTS

With regard to development and revision of directives and requirements, 6 directives and 2 standards were developed. The new standards and directives include: good manufacturing practices for food manufacturers, food pre-license, food registration, education and training on ethics of professionals. Moreover, standards of telemedicine and regulatory requirement of medical centers at different organization have been done. Likewise, regulation on Iodized salt and payment for a committee served the authority has been revised.

## IMPROVING COMMUNITY OWNERSHIP FOR THE REGULATORY SECTOR

In order to improve the community ownership of the regulatory sector, various online and recorded messages were broadcasted through federal and regional television and radio channels

in areas of universal salt iodization, Tobacco, bottled water, edible oil, circulation and control of illegal medicines and food, health professional ethics. Consequently, 23 live discussions were conducted.

**STRENGTHENING THE PARTICIPATION AND PARTNERSHIP OF COMMUNITY AND STAKEHOLDERS**

Planning and performance review of the regulatory sector was accomplished by involving the public wing. Accordingly, performance review and discussions have been conducted with regional regulatory bodies, media forum and public wings on EFY 2009 performance and the strategic plan for EFY 2010. Moreover, awareness creation activities were conducted targeting a total of about 1.5 million people through the established regional structure on annual nations and nationalities festival at Harar city.

**CHALLENGES**

- Shortage of human resources in terms of number, capacity and professional mix
- Weak collaboration/integration with stakeholders especially at lower level
- Weak regulatory information system leading to problems of handling information in more integrated and organized way,
- Disparity among regions on structural setup
- Shortage of budget and resources like vehicle for inspection

**WAY FORWARD**

- Finalize and implement the newly designed organizational structure
- Strengthening HDA;
- Strengthen collaboration through joint planning and execution
- Strengthening community regulatory ownership activities;
- Align and integrate health regulatory system from top to bottom level;
- Strengthening resource mobilization for health regulatory sector.

## 5.3. GENDER, YOUTH AND PEOPLE WITH DISABILITY MAINSTREAMING

Gender, youth and people with disability mainstreaming in the health sector has been implemented with the objective of promoting gender equality and empowerment of women, youths and people with disability on the utilization of health services.

Based on previous years' experiences and achievements, the EFY 2009 plan gave emphasis to further enhance the awareness of gender mainstreaming, empowerment and increase

involvement and participation of women in the health sector. Accordingly, activities that enhanced equitable access to health services by mainstreaming issues of women, youth and people with disability were prioritized and given considerable attention.

**Institutionalizing Issues of Women, Youth and People with Disability:** during the fiscal year all guideline and strategic documents prepared under the FMOH were thoroughly reviewed to mainstream the issue of women, youth and people with disability. For example, the guideline prepared by Maternal and Child Health Directorate on adolescents and youth reproductive health strategy was reviewed. Moreover, adolescent health and education strategy document was prepared.

**Mobilization and Awareness Creation Activities:** activities to raise public awareness of the health of women, youth and people with disability were conducted using social media and further awareness activities were conducted during the celebration of International Women's Day (March 8). During the event, about 500 copies of a magazine were distributed for women and youth. Moreover. social media was used to enhance the awareness of the community on women and youth, including sharing to the public messages on preparation of communication activities, training and sexual violence guideline preparation, resource mobilization, international day on anti-sexual violence motto and agenda preparation, international women's day motto, 10 months performance review made with public wings, sign language and women's leader training.

**Enhance empowerment of women in the health sector:** There are a various activities that were implemented to promote women to leadership positions within FMOH. The key factor that promotes this initiative is to conduct strong advocacy and communication activities. As a result, the participation of women in the leadership positions increased within the Ministry. At regional level, training was provided for 100 leaders on "leadership and decision making skills" in order to strengthen leadership capacity. Moreover, as vital empowerment processes a training provided on self-confidence and team building for 279 female employees from FMOH mainly those who serve in administration and support positions. A total of 285 staff from federal agencies and hospitals were also trained on the revised family law. In addition to the training, educational empowerment support was provided for female and male employees at degree and TVET levels ranging from full tuition fee coverage to partial sponsorship.

**Create favorable condition to provide health services:** during the fiscal year, Disability mainstreaming manual was prepared with concerned bodies and launched for health sector leaders, officers and stockholders, and distributed for regional health bureaus. To address health service challenges for persons with hearing impairment, sign language training was given for 100 health sector professionals and workers. In addition, four sign language dictionaries were distributed for federal hospitals. As a result of these efforts, a total of40 individuals with disability (hearing impairment) provided health services without any communication barriers. Moreover,

Standard operating procedures for response and preventing of sexual violence system manual was launched for more than 800 participants that attended the health sector annual review meeting.

In addition, training on sexual violence was provided for 150 professionals drawn from all regions and universities. St. Paul hospital has provided services for a total of 61 victims of sexual violence (58 females and 3 males). Similarly, at the clinic of Jugo hospital, Harari region, has provided services for a total of 218 victims (214 females and 4 males).

**CHALLENGES**

- Inaccessibility of hiring professionals for the development of sexual violence strategic document;
- Low level of commitment, ownership and support from to women and youth affairs structures at all level.
- Difference in structure and human resource capacity across regions and federal agencies to work constantly and effectively as per the plan;

**WAY FORWARD**

- Promote and strengthen frequent supportive supervision;
- Capacitate the woman and youth structures on documentation, capturing best practices and lessons learned; and
- Bridge the gaps in understanding and attitudes for women empowerment initiatives.

# CHAPTER 6
# HEALTH SYSTEM CAPACITY


# HEALTH SYSTEM CAPACITY

## 6.1 HEALTH INFRASTRUCTURE

### HEALTH INFRASTRUCTURE DEVELOPMENT

This strategic objective encompasses the expansion and standardization of health and health related facilities. It involves (a) Development of standard design of health infrastructures; (b) Construction, maintenance, renovation, and rehabilitation of health facilities; (c) Equipping and furnishing of health facilities; (d) Availability of adequate utilities (water, sanitation facilities, and power installations); (e) Enhancing medical equipment management and maintenance; and (f) Developing basic ICT infrastructure, use, and innovations.

### CONSTRUCTION, MAINTENANCE, RENOVATION, AND REHABILITATION OF HEALTH FACILITIES

### CONSTRUCTION OF HEALTH POSTS

In the EFY 2009, it was planned to maintain a linear increase in the construction of health posts. The cumulative number of functional health posts increased to 16,660 in 2009 EFY from that of 16,480 in EFY 2008 **(**Table 13). In EFY 2009, PV solar installations were made for 457 HPs.

Table 14: Cumulative number of Functional Health Posts by Region, EFY 2009

| Region | Cumulative Number of HPs Functional in EFY 2009 |
|---|---|
| Tigray | 712 |
| Afar | 325 |
| Amhara | 3342 |
| Oromia | 6797 |
| Somali | 1,026 |
| Benishangul Gumuz | 402 |
| SNNPR | 3874 |
| Gambela | 118 |
| Harari | 30 |
| Dire Dawa | 34 |
| **National** | **16,660** |

### EXPANSION OF HEALTH CENTERS

The cumulative number of functional health centers increased to 3,622 in EFY 2009 from that of 3562 in EFY 2008. In the year under review, a total of 156 HCs were either under construction or completed but not functional.

With regards to regional distribution, Oromia, Amhara, and SNNPR accounted for 1,383 (38%), 841 (23%), and 726 (20%), respectively (Table 14). In EFY 2009, PV solar installations were made for 116 health centers.

Table 15: Number of Functional and Under Construction Health Centers by Region, EFY 2009

| Regions | Available | Functional | Under Construction and completed but not Functional |
|---|---|---|---|
| Tigray | 213 | 211 | 2 |
| Afar | 94 | 94 | 4 |
| Amhara | 841 | 841 | 23 |
| Oromia | 1441 | 1383 | 58 |
| Somali | 204 | 189 | 15 |
| Benishangul Gumuz | 40 | 40 | 14 |
| SNNPR | 742 | 717 | 25 |
| Gambela | 28 | 27 | 1 |
| Harari | 8 | 8 | 0 |
| Addis Ababa | 98 | 97 | 14 |
| Dire Dawa | 15 | 15 | 0 |
| **National** | **3724** | **3622** | **156** |

## CONSTRUCTION, REHABILITATION, AND EXPANSION OF HOSPITALS

### FEDERAL HOSPITALS

**The construction of the new Emanuel General Hospital**: phase one of the construction, which includes an inpatient department with 161 bed capacity, has been completed and pre-provisional acceptance was done. And the second phase of the hospital, administrative office building construction progress has been reached 80% of physical progress.

**Alert Hospital G+6 Apartment Building**: has been completed and pre-provisional acceptance been made.

**St. Peter Hospital G+6 Apartment Building**: The progress of construction of two blocks (each with 36 flats with two bed rooms and four flats with three bed rooms) is ready for pre-provisional acceptance with progress of 97% physical performance.

### Regional Hospitals

As illustrated in Table 15 below, a total of 266 functional hospitals were available in EFY 2009. In EFY 2008 a total number of functional hospitals were 241. On the other hand, in EFY 2009 it was reported from regions that a total of 125 hospitals are under construction and completed but not functional.

Table 16: Number of Functional and Under Construction Hospitals by Region (EFY 2009)

| Regions | Available | Functional | Under Construction and completed but not Functional |
|---|---|---|---|
| Tigray | 39 | 31 | 8 |
| Afar | 6 | 6 | 1 |
| Amhara | 68 | 68 | 27 |
| Oromia | 78 | 68 | 20 |
| Somali | 12 | 10 | 2 |
| Benishangul Gumuz | 2 | 2 | 4 |
| SNNPR | 78 | 63 | 29 |
| Gambela | 4 | 3 | 1 |
| Harari | 2 | 2 | 0 |
| Addis Ababa | 11 | 11 | 3 |
| Dire Dawa | 2 | 2 | 1 |
| **National** | **302** | **266** | **96** |

## OTHER PROJECTS

**Blood Bank Buildings**: the ongoing construction of the Gondar, Jigjig and Arba-Minch regional blood bank offices had reached on average more than 95% performance levels, of which Arba Minch Blood Bank building construction is already completed. Likewise the recently started (EFY 2009) Nekemte regional blood bank has reached 35%. Moreover, the performance of the construction of federal budget supported 12 Mini blood banks on average has reached 81%. Specifically, the construction of 4 projects from Tigray, Oromia, and Amhara regions has been completed.

**Adama G+7 Anti-Malaria Center**: The process of construction has been underway and the progress has reached about 80%.

## CHALLENGES

- Limited capacity of contractors and RHBs contract administration;
- Dalliance in health facility construction due to shortage of professionals as well as important engineering software; and
- Poor follow-up on regional health facility projects

## WAY FORWARD

- Strengthen the capacity of contractors and/or mobilization of qualified contractors
- Strengthen collaboration with RHB on contract management

## 6.2 HUMAN CAPITAL AND LEADERSHIP

This strategic objective includes: (a) human resource planning and (b) human resource development. The main focuses of this strategic objective for EFY 2009 is to promote patient-centered, respectful, and compassionate care by all professionals, and to increase the intake of physicians and integrated emergency surgery and obstetrics officers

In EFY 2009 it was planned to (a) Develop national minimum competency for public health training; (b) Enroll 2084 new medical students; (c) introduce residency matching program nationwide (d) Support the provision of educational materials and instructors to medical schools; (g) Enroll 500 trainees in level 4 midwifery program and 1,500 trainees in degree program; (h) Develop new standards and curriculum for the training of health extension professionals; (j) Enroll 280 students in emergency and ambulance service training; (k) Identify and document health professionals' public health competencies; (l) Expand Field epidemiology training program in 8 universities and standardize and institutionalize service trainings. The implementation of each activity is presented in detail below.

### PRE-SERVICE TRAINING

### MEDICAL EDUCATION TRAINING

In EFY 2009, 2500 new students were enrolled in 28 medical schools. In the year under review, a total of 933 Physicians were deployed, increasing the total number of physicians deployed throughout the country to 7,503. In EFY 2009, physician to population ratio has reached 1: 17,000 population, which is way below WHO standard for developing countries (1 physician to 10,000 population).

Table 17: Number of Medical Students by Year of Study and University (EFY 2009)

| University | 1st year | 2nd year | 3rd year | 4th year | 5th year | 6th year | Total |
|---|---|---|---|---|---|---|---|
| Addis Ababa | 290 | 357 | 322 | 299 | 332 | 272 | 1872 |
| Arba Minch | 94 | 144 | 108 | 174 | 104 | 88 | 712 |
| Arsi | | 171 | 98 | 134 | 118 | 76 | 597 |
| Bahir Dar | 131 | 215 | 155 | 125 | 222 | 146 | 994 |
| Gondar | 249 | 289 | 366 | 393 | 224 | 236 | 1757 |
| Haromaya | 156 | 164 | 249 | 305 | 200 | 192 | 1266 |
| Hawasa | 269 | 217 | 295 | 369 | 283 | 157 | 1590 |
| Jimma | 244 | 371 | 310 | 361 | 310 | 286 | 1882 |
| Mekelle | 271 | 222 | 242 | 289 | 195 | 210 | 1429 |
| St. Paul | 170 | 148 | 128 | 169 | 111 | 93 | 819 |
| Adigrat | 101 | 133 | 93 | 92 | 34 | 0 | 453 |
| Wachamo | 50 | 94 | 58 | 57 | 39 | 0 | 298 |
| Debre Tabor | 59 | 62 | 57 | 46 | 0 | 0 | 224 |
| Axum | | 0 | 49 | 23 | 61 | 39 | 172 |
| Wollo | | 41 | 48 | 60 | 53 | 0 | 202 |
| DebreMarkos | | 67 | 41 | 73 | 50 | 0 | 231 |
| DebreBirhan | | 0 | 48 | 50 | 62 | 46 | 206 |
| Ambo | | 0 | 46 | 29 | 78 | 70 | 223 |
| Wollega | | 14 | 41 | 60 | 60 | 0 | 175 |
| Wolayitasodo | | 0 | 52 | 35 | 95 | 65 | 247 |
| Medawolabu | | 28 | 17 | 62 | 45 | 0 | 152 |
| Dilla | | 33 | 16 | 47 | 58 | 33 | 187 |
| Dire Dawa | | 0 | 24 | 39 | 56 | 45 | 164 |
| Adama Hospital | | 29 | 56 | 26 | 0 | 0 | 111 |
| Yekatit 12 Hospital | | 0 | 72 | 52 | 76 | 56 | 256 |
| Yirgalem Hospital | | 0 | 52 | 46 | 56 | 50 | 204 |
| Wolkite | 70 | 70 | 0 | 0 | 0 | 0 | 140 |
| Jigjiga | 78 | 92 | 55 | 0 | 0 | 0 | 225 |
| Myung sung A.A | | 28 | 26 | 27 | 17 | 0 | 98 |
| Bethel A.A | | 138 | 122 | 76 | 38 | 24 | 398 |
| Gambi A.A | | 18 | 22 | 11 | 9 | 8 | 68 |
| Hayat A.A | | 0 | 236 | 163 | 136 | 109 | 644 |
| Sante A.A | | 59 | 100 | 0 | 0 | 0 | 159 |
| Adama A.A | | 0 | 50 | 45 | 64 | 28 | 187 |
| **TOTAL** | **2232** | **3224** | **3654** | **3737** | **3186** | **2329** | 18342 |

Medical Education Quality Improvement training was given to staff from quality assurance units of 13 newly established medical schools as a move to strengthen HSDC centers and improve the quality of training programs. In addition, training curriculum was developed by joint technical teams established from all newly established medical schools.

## LEVEL "V" ANAESTHESIA TRAINING

Anaesthetists play a critical role in the provision of emergency surgery at primary hospital and HC levels. In order to increase access to the services of nurse anaesthetists, in EFY 2006 the FMOH trained and deployed 96 Level V nurse anaesthetists, 126 in EFY 2007 and 159 in EFY 2008, Besides this program 226 BSc anaesthesia trainees were graduated out of 226 graduates 36 were sponsered by RHBs and deployed and 190 graduates will deploy within the next month. Currently, a total of 381 level V nurse anaesthetists were graduated and deployed by RHB at defferent health facilities which provide surgical services. (Table 17), while 1226 trainees are attending Bachelor of Science Program both generic and post basic programm in 17 Universities and 02 HSC. In order to strengthen the learning and teaching process, 2000 spinal needle,24 Pulse oximeter, portable with accessories, 200 Stethoscope, binaural, complete, 20 Resuscitator, hand-operated, adultset, 6 Monitor bed side, 200 Sphygmoaneroid adult and 5 Oxygen Concentrator were dispatched to HSCs and universties with aneasthesia training In addition, FMOH and partners conducted pre-deployment training, joint supportive supervision, and transfer of budget per student to health science collages. In addition, 4000 log books were prepared, printed and distributed to 17 universties and 2 health science colleges, 1085 anaesthesia learning modules and 90 pocket guides distributed to 4 health science colleges for level V trainees.

Table 18: Number of Anaesthesia Trainees in BSC Program( generic and post basic ) by University and Year of Study (EFY 2009)

| s/ no | University/College | Number of students EFY 2009 | | | | |
|---|---|---|---|---|---|---|
| | | Year I | Year II | Year III | Total | Number graduated in EFY 2009 |
| 1 | Addis Ababa | 44 | 30 | 50 | 124 | 26 +20 P.B(sponsored by Amhara,Oromya and SNN-PR RHBs) |
| 2 | Gondar | 55 | 65 | 33 | 153 | 31 |
| 3 | Jimma | 30 | 31 | 28 | 89 | 27 |
| 4 | Dilla | 18 | 20+12 (PB) | 15 | 65 | 15 |
| 5 | Wolayita Sodo | 18 | 16 | 12 | 46 | |
| 6 | Mekelle | 33 | 25 +12(PB) | 41 | 111 | 23 |
| 7 | Debre Tabor | 22 | 20 | 20 | 62 | 14 |
| 8 | Dire Dawa | 23 | 20 | 32 | 75 | 29 |
| 9 | Hawassa | 22 | 20 | 20 | 62 | 12 |
| 10 | Axum | 24 | 22 | 20 | 66 | 13 |
| 11 | Arba Minch | 35 | 25 | 22 | 82 | |
| 12 | Menelik II HSC | 15(PB) | 15 | | 30 | 16 ( sponsored by A.A RHB) |
| 13 | Arsi | 15 | 22 | 12 | 49 | |
| 14 | Debre Berhan | 15 | 15 | | 30 | |
| 15 | Wachamo | 25 | 30 | | 55 | |
| 16 | Wollo | 19 | 25 | | 44 | |
| 17 | Ambo | 10(PB) | 12 (PB) | | 22 | |
| 18 | Harar HSC | 20(PB) | 25(PB) | | 45 | |
| 19 | Bahir dar university | 16(PB) | --- | | 16 | |
| TOTAL | | 459 | 447 | 335 | 1226 | 226 (190 generic &36 PB) |

*N.B: PB means post basic (upgrading) program*

Based on the gap identified durining JSS, a total of 11 anaesthetists were deployed for aneasthesia schools. Effective teaching skills for preceptor and technical updating trainings were provided to anaesthesia teachers.

In colaboration with FMOE and partners, Clinical Practice Syllabi for BSc Degree in Anesthesia Program Professional Attachments were developed for generic and post basic training and sent to universties and HSCs .

## HEALTH EXTENSION WORKERS

A critical component of the program is to enhance the knowledge and skills of health extension workers to deliver quality health service to the community by providing in- service training and career development education. The aim of HEW upgrading program is to improve the quality of health extension services at community and household levels.

Table 19: Regional Distribution of HEWs Enrolled for the Replacement and Upgrading Program (EFY 2009)

| Region | Cumulative number of HEW's EFY 200 | Number of Level III replacement HEWs Enrolled in EFY 2008 | Urban Health Extension Workers EFY 2009 | Number of level IV upgrading HEWs Enrolled in EFY 2008 |
|---|---|---|---|---|
| Tigray | 1988 | 1100 | 288 | 600 |
| Afar | 419 | 366 | 20 | 33 |
| Amhara | 8288 | 4839 | 955 | 2494 |
| Oromia | 15669 | 10186 | 1448 | 4035 |
| Ethio.Somali | 2563 | 1412 | 60 | 1091 |
| Ben-Gum | 103 | 3 | 69 | 34 |
| SNNPR | 7990 | 5989 | 774 | 1227 |
| Gambella | 583 | 448 | 19 | 116 |
| Harari | 895 | 636 | 66 | 190 |
| Addis Ababa | 1250 | - | 1250 | - |
| Dire Dawa | 130 | 5 | 87 | 38 |
| **National Total** | **39878** | **24914** | **5036** | **9858** |

In EFY 2009, 9858 level III HEWs were enrolled to be upgraded to level IV. Level III replacement training has been continuing in line with the upgrading program in all regions. Accordingly, a total of 24914 HEWs enrolled in EFY 2009.

### EMERGENCY MEDICAL TECHNICIANS / PARAMEDICS TRAINING

FMOH initiated the pre-service Emergency Medical Technicians /Paramedic Training program with the aim of improving pre-hospital emergency care in managing all emergencies. In EFY 2009, 505 students were enrolled in six training institutions.

### HEALTH INFORMATION TECHNICIANS TRAINING

The training program essentially focuses on addressing the critical shortage of skilled human resources in data recording, analysis, and reporting as well as in use of information for evidence-based decision making both at the point of data collection and also at the various levels of the national health care system. In EFY 2009, a total of 1736 HIT students were enrolled for the training program.

Table 20: Training Program of Health Information Technicians by Region (EFY 2009)

| Region | Number of Health Science College/ TVET | Student Enrolled in EFY 2009 |
|---|---|---|
| Tigray | 2 | 120 |
| Afar | 1 | 50 |
| Amhara | 5 | 250 |
| Oromia | 3 | 300 |
| Somali | 3 | 60 |
| Benishangul G. | 1 | 30 |
| SNNPR | 4 | 500 |
| Gambela | | 0 |
| Harari | 1 | 26 |
| Addis Ababa | 2 | 400 |
| Dire Dawa | | |
| TOTAL | 22 | 1,736 |

## BIOMEDICAL TECHNICIAN TRAINING

The biomedical technician level 4 training program was started in collaboration with Debre Markos University and Human Bridge College in EFY 2007 & EFY 2008 respectively. In EFY 2009, additional 241 new students were enrolled, making the total number of students in training 671.

Table 21: Enrolment of Biomedical Technician Level IV (EFY 2009)

| Region/ Institution | 2007 Enrollment | 2008 Enrollment | 2009 Enrollment | Total |
|---|---|---|---|---|
| Tigray | 44 | 18 | 29 | 91 |
| Afar | 10 | 7 | 8 | 25 |
| Amhara | 32 | 32 | 44 | 108 |
| Oromia | 46 | 36 | 68 | 150 |
| Somali | 5 | 17 | 21 | 43 |
| Benishangul Gumuz | 4 | 6 | 10 | 20 |
| Gambela | 5 | 6 | 10 | 21 |
| SNNPR | 31 | 25 | 40 | 96 |
| Harari | 1 | 1 | 6 | 8 |
| Addis Ababa | 56 | 27 | 0 | 83 |
| Dire Dawa | 4 | 0 | 2 | 6 |
| Federal Hospitals (Alert, St. Paul, St. Peter, Amanuel) | 4 | 2 | | 6 |
| Gondar University Hospital | 3 | 3 | | 6 |
| Federal Prison Police | 3 | 0 | 3 | 6 |
| Human Bridge College | 2 | 0 | | 2 |
| GRAND TOTAL | 250 | 180 | 241 | 671 |

## NURSING SPECIALTY INITIATIVES

The new nursing specialty training initiative started focuses on Nursing Specialty Training in neonatal nursing, emergency and critical care, operating theatre, pediatrics, and surgical nursing. The –training approach aimed at responding to the current human resources gap and current and future demand by the country nursing specialty initiatives also supportive supervision and material support.

Table 22: Total Enrolment of Nursing Specialty (EFY 2007 -2008-2009)

| S/no | Enrolled in EFY (2007 & 2008) | | | | Enrolled in EFY 2009 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ECCN | NN | OTN | ECCN | N,N | OTN | Surge | Ped | spy | TOTAL |
| 1 | Mekelle | 26 | 27 | 33 | | | | | | | |
| | Axum | | | | | 15 | | 15 | | | 30 |
| 2 | Bahirdar | 20 | 0 | 0 | 20 | 15 | | 20 | 20 | | 75 |
| | Wolli | 33 | 31 | 30 | 18 | 12 | 15 | 20 | 20 | | 85 |
| | Gondar | 32 | 27 | 30 | 15 | 15 | 15 | 15 | 15 | | 75 |
| | D/Tabor | 0 | 36 | 0 | | 18 | | | 20 | 12 | |
| | D/Berhan | 0 | 0 | 0 | | 15 | | 15 | 15 | | 35 |
| 3 | Dilla | 0 | 10 | 0 | 12 | 15 | | | 12 | | 39 |
| | Hawasa | 26 | 0 | 0 | 15 | | | 15 | | | 30 |
| | WollaytaSodo | 32 | 32 | 10 | 10 | 10 | 10 | 10 | 10 | | 50 |
| 3 | St Paul | 52 | 36 | 60 | 20 | 20 | 20 | 20 | 20 | | 100 |
| | AAU | 8 | 7 | 0 | | | | | | | |
| | Menelik II | 40 | 40 | 40 | 20 | 20 | | | | 30 | 70 |
| 4 | Arsi | 0 | 20 | 17 | | 12 | 12 | | | | 20 |
| | Ambo | 15 | 0 | 0 | 15 | | | | | 15 | 30 |
| | Haromaya | 28 | 25 | 0 | 15 | 10 | | | | | 25 |
| | Wollega | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 75 |
| | Jimma | 0 | 40 | 20 | | 11 | 10 | | | | 21 |
| 5 | Harar H/s/c | 20 | 0 | 0 | 20 | | 20 | | | | 40 |
| 6 | Jigjig | 0 | 15 | 0 | | | 15 | | | | 15 |
| | | 347 | 361 | 255 | | | | | | | 840 |

Total enrolment in EFY 2009 in different nursing specialities is 840, which is by far larger than the same for previous years.

## FIELD EPIDEMIOLOGY TRAINING

As part of the capacity building for training institutions, budget support was given to eight universities and 38 field based training centres, and 100 trainers from universities and regional health bureaus received skill enhancement trainings. Martial support, 4 TOT training and mentorship the performance reached 79%.

Table 23: Number of Field Epidemiology Trainees in MPH Program by University and Year of Study (EFY 2009)

| University/ College | Number of Residents on training (2009 EFY) | | | No of Residents Graduated | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Year I | Year II | Total | 1st batch | 2nd batch | 3rd batch | 4th batch | 5th batch | 6th batch | 7th batch (EFY 2009) | Total |
| Mekelle | 18 | 17 | 35 | 13 | 22 | 15 | 16 | 16 | 16 | 16 | 114 |
| Jimma | 42 | 22 | 64 | 22 | | | | | | | |
| Hawasa | 25 | 16 | 41 | 16 | | | | | | | |
| Haromaya | 51 | 5 | 56 | | | | | | | | |
| Gondar | 55 | 10 | 65 | 10 | | | | | | | |
| St. Paul's HMMC | 15 | 10 | 25 | 10 | | | | | | | |
| Addis Ababa | 10 | 10 | 20 | 6 | | | | | | | |
| Bahir Dar | 29 | 12 | 41 | 12 | | | | | | | |
| **Total** | **245** | **102** | **347** | **89** | **22** | **15** | **16** | **16** | **16** | **16** | **114** |

Total number of residents enrolled in field epidemiology in EFY 2009 was 245, making the total number currently on training 694. Total number of field epidemiology graduate who have joined the health workforce in the last seven years is 114, including 16 graduate who joined the health workforce in EFY2009.

## MIDWIFERY PROGRAM

In EFY 2009, a total of 1120 midwives graduated and deployed in the health sector. As part of capacity building full skill lab equipment's were distributed for 10 Universities based on RMNCH competency using HERQA minimum standard. For 33 midwifery teaching institutions, student logbooks were distributed.

Table 24: Midwife Degree Graduates by Universities, EFY 2009

| Son. | University | Total Number of graduates |
|---|---|---|
| 1 | Addis Ababa | 30 |
| 2 | Ambo | 44 |
| 3 | Jimma | 43 |
| 4 | Arsi | 36 |
| 5 | Jigjiga | 29 |
| 6 | Wachamo | 40 |
| 7 | MizanTepi | 36 |
| 8 | Wollega | 55 |
| 9 | Hawasa | 40 |
| 10 | Axum | 41 |
| 11 | Arba Minch | 40 |
| 12 | Adigrat | 43 |
| 13 | DebreBirhan | 44 |
| 14 | Gondar | 81 |
| 15 | Debremarkos | 35 |
| 16 | Haromaya | 26 |
| 17 | Mekelle | 25 |
| 18 | Wollo | 43 |
| 19 | Semera | 30 |
| 20 | D/tabor | 50 |
| 21 | Metu | 45 |
| 22 | Bahirdar | 50 |
| 23 | Dilla | 16 |
| 24 | Wolaita | 28 |
| 25 | Wolkite | 34 |
| 26 | Medawolabo | 45 |
| 27 | Diredawa | 37 |
| | TOTAL | 1120 |

## IN-SERVICE TRAINING

### IN-SERVICE TRAINING STANDARDIZATION AND INSTITUTIONALIZATION

FMOH is working to provide need-based, standardized, and institutionalized in-service trainings (IST) to ensure sustainability and ownership of health program trainings as part of the human capital development in the health sector. Standardizing in-service training ensures the quality of the trainings and institutionalizing them will help to ensure sustainability in the country by linking

training to the local facility. In line with this, the following key achievements were carried out in EFY 2009; two additional IST centers have been selected and assessed based on the regional demand and the total number of IST centers increased to 52. To this end, FMOH developed 36 different training manuals, IST implementation guideline, and review and approval checklist. In past five years, IST centers have organized and conducted in-service training courses for 49, 275 health care providers of which 22,354 (45%) provided in 2009 EFY using the national standardized training packages. In addition the cumulative income generated by the IST centers in past five years reached 150,013,238 ETB of which 73,132,456 ETB collected in 2009 EFY.

## NATIONAL LICENSING EXAMINATION

The goal of the National Licensing Examination is to protect the public through standardized assessment of all health professionals irrespective of where they are trained. It serves as a powerful quality assurance tool by providing structured and informative feedback on curricula. It ensures that only competent health care professionals are granted a license to practice in the health sector. It was launched in EFY 2007 and started with four major health care cadres, namely; nursing, anesthesia, public health, midwifery and medicine. So far, the exam has reached the above mentioned four professions with a plan to include two more professions (pharmacy and laboratory) and skill assessment for selected cadres. In EFY 2009, a total of 10,653 graduates from five disciplines both from public and private institutions have taken the National Licensing Examination.

Table 25: Number of Graduates who sat for Licensure Examination in EFY 2009

| S.N | Profession | Number of examinees | | Total |
|---|---|---|---|---|
| | | Public institutions | Private institutions | |
| 1 | Anesthesia | 96 | ** | 96 |
| 2 | Midwifery | 1110 | 75 | 1166 |
| 3 | Public Health Officer | 1199 | 2902 | 4101 |
| 4 | Nursing | 1134 | 2195 | 3329 |
| 5 | Medicine | 1854 | 107 | 1961 |
| | **Total** | **5393** | **5260** | **10653** |

*** Anesthesia program not allowed in PRIVATE institutions*

## DEPLOYMENT

The FMOH has been engaged in establishing a human resources database to carry out equitable deployment of health manpower, especially those that are in short supply. Accordingly, 933 general practitioners, 1,137 health officers, 78 anesthetists, 1,121 BSc nurses, and 1039 midwives and other health professionals have been deployed during EFY 2009 (Table 25).

Table 26: Number of Health Personnel Deployed by Occupation (EFY 2009)

| Occupation | Number of Health Professionals Deployed |
|---|---|
| General Practitioner | 933 |
| Health Officers | 1137 |
| Optometrists | 45 |
| Anesthetists | 78 |
| Biomedical Engineering | 111 |
| BSC Nurse | 1121 |
| Midwives | 1039 |
| Pharmacy | 309 |
| Radiology Technology | 18 |
| Psychiatry | 106 |
| Total | 4897 |

## 6.3 PHARMACIUTICAL SUPPLY SERVICE

Establishing and strengthening pharmaceutical and logistics management system that helps detailed analysis of pharmaceuticals in terms of items available in stock and used, their financial transaction system and that ease the drug auditing process at health facility level and at all levels of the health system remains a top priority.

Lack of transparent and accountable pharmaceutical and logistics management system that is free from any form of corruption and fraud, has been identified as one of key challenges/ bottleneck, and an issue of good governance and cause of public grievance.

### AUDITABLE PHARMACEUTICALS TRANSACTIONS AND SERVICES

Cognizant of the existing situation, and with the objective of creating a transparent and accountable drug management system and improving the pharmacy service and pharmaceuticals auditing process ,in the past years, ministry of health has been implementing Auditable pharmaceutical transaction and service (APTS) system at various places, and Successful results have been achieved. The implementation of APTS, facilitated evidence based forecasting of pharmaceuticals, supported continuous availability of pharmaceuticals, minimized miss management of drugs and medical supplies, helped to institutionalize transparent and accountable pharmaceutical and logistics management system.

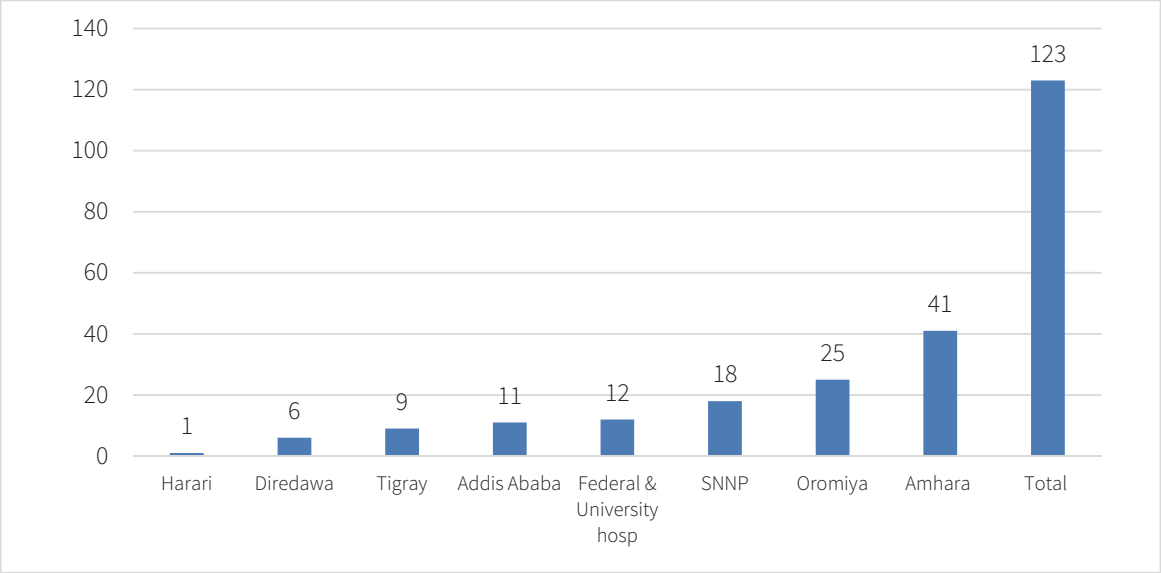



Figure 44: Hospitals that implement Auditable pharmaceutical transaction and service (APTS)

In 2009 EFY, nationally there are 123 Hospitals that implement Auditable pharmaceutical transaction and service (APTS) system. To facilitate smooth implementation of the system capacity building trainings has been given to health professionals who came from various hospitals from Oromia region. Follow up supportive supervision and mentoring program has been intensified to lay fertile ground for the smooth implementation of the system in Gambela, Afar, Ethiopia Somali, Gambela and Benishangul and Gumuz regions.

## PHARMACEUTICALS SUPPLY CHAIN MANAGEMENT

Based on the experience gained from previous years, In 2009 EFY, Cold Chain transition plan was implemented in Adama, Jimma, Nekimi and Negele Borena branch offices of Oromia region and in Hawasa Branch office of SNNP region. It was also partially implemented in Ethiopia Somali region. PFSA Jigjiga branch office will soon start implementing the Adaptable pharmaceutical transaction system (APTS) system.

In the past few years, encouraging results have been registered with regards to improving the availability of quality and affordable pharmaceuticals (drugs, medical equipment and medical supplies),establishing and institutionalizing transparent and accountable pharmaceutical management system and in enhancing skills, knowledge and implementation capacity of health professionals at various levels of the health system. .

## FORECASTING, QUANTIFICATION, AND ESSENTIAL DRUGS AVAILABILITY

Transparent, accountable and effective procurement and distribution of pharmaceuticals and medical supplies system plays a pivotal role in the proper functioning of health system and evidence based decision making processes. Timely forecasting and quantification is a foundation for effective and timely procurement and distribution, proper stock management, follow level of implementation of key pharmaceutical supply system indicators.

During the year under review, a list of vital and essential drugs and medical supplies was prepared and distributed to health facilities in order to facilitate timely forecasting and quantification of 2010 EFY planning. Based on information received from health facilities and branch offices, forecast for the coming three years and one year procurement plan was finalized. Procurement of pharmaceuticals for the 2010 EFY from local manufacturers' pharmaceuticals (worth ETB 1.06 billion) and from international pharmaceuticals (worth ETB 1.71 billion) is underway. As of Ginbot 30, 2009 (June 7), the national vital and essential pharmaceuticals stock status has been on average reached 60%.

For the first time in Ethiopia, essential medicines, health and laboratory supplies and medical equipment for tertiary hospitals and specialty centers have been defined and integrated into one list with the recognition that all three are integral to the diagnosis and appropriate treatment of diseases. All in all, a total of 862 medicines (2253 medicines with different dosage form), 1158 medical equipment items, 946 medical supplies and 947 laboratory reagents and chemicals have been listed. Also the National Pharmaceuticals Procurement List includes both PFSA Pharmaceuticals Procurement List and Health insurance drug list.

**PHARMACEUTICALS PROCUREMENT AND DISTRIBUTION**

Pharmaceutical Fund and Supply Agency (PFSA) planned to procure pharmaceuticals, medical supplies, and equipment worth of ETB 8.56 billion (ETB 3.96 Recurrent budget and ETB 4.60 billion for health programs). Of the planned target, it procured pharmaceuticals, medical equipment and medical supplies worth of ETB 6.84 billion (ETB 3.74 billion for recurrent budget and ETB 3.10 billion for health programs), which accounts for80% of the planned procurement in the year.

In addition, pharmaceuticals, medical supplies and equipment worth of ETB 5.17 billion were donated by Development partners and received by the Agency. Altogether, ETB 12.5019.billion worth of pharmaceuticals (drugs, medical equipment and medical supplies) have been supplied through PFSA during the year under review.

With regards to distribution, it was planned to distribute pharmaceuticals worth ETB 22.00 billion in EFY 2009. However, only pharmaceuticals, medical supplies and equipment worth of ETB 13.56 billion have been distributed (61.6% of the planned distribution) in the year.

In 2009 EFY, ETB 1.38 billion and ETB 1.02 billion were collected from procurement and distribution fee and credit sales respectively.

**STRENGTHENING THE PRODUCTION CAPACITY OF LOCAL PHARMACEUTICALS AND MEDICAL SUPPLIES MANUFACTURERS**

In 2009 EFY, it was planned to procure ETB 1,261,301,058 worth of pharmaceuticals and medical supplies from local pharmaceuticals and medical supplies manufacturers. However, out of the planned target, local manufacturers were able to supply to the Agency only ETB 799,492,018

worth of pharmaceuticals and medical supplies which is 63.38% of the planned target for the year.

**STRENGTHEN AND ENHANCE SYSTEM FOR ADVANCED PHARMACEUTICALS AND MEDICAL SUPPLIES AND WAREHOUSE MANAGEMENT**

Joint efforts were made to design and implement a strategy that will shorten long port clearance process and facilitate smooth and timely distribution of pharmaceuticals. As per the new initiative, pharmaceuticals will be distributed to their respective destinations sites immediately as soon as they reached their first storage area (dry port). Accordingly, encouraging results have been demonstrated. For the first time, pharmaceuticals cleared within 10 days of their arrival at point of entry (dry ports). Medical equipment, vaccines and supplies that require very big storage spaces (ITN) directly distributed to health facilities as soon as they reached their storage places first entry point i.e. dry port.

During the year under review, to further facilitate and enhance fast procurement and distribution of pharmaceuticals, joint plan was prepared and MoU was signed with Oromia and Amhara Regional health bureaus. Furthermore, separate agreement was also signed with health facilities from the two regions to further facilitate the procurement and distribution of medical equipment. As in previous years, pharmaceuticals (drugs, Medical equipment's and medical supplies) have been procured through international bidding process.

In 2009 EFY, an integrated pharmaceutical logistics system was further strengthened. Accordingly distribution of program drugs and supplies was done through this system together with other pharmaceuticals and medical supplies. As in previous years, in EFY 2009, efforts were also made to minimize wastage rate and enhance proper utilization of drugs and medical supplies by redistributing pharmaceuticals with highest stock and slow moving items. A task force was established that will assess the situations and come up with solutions and recommendations to minimize wastage rate with a focus on pharmaceuticals and medical supplies with short life spans (less than six months). Accordingly, transfer process of pharmaceuticals worth ETB 17.63 million has been initiated and effectively utilized.

**PROMOTION OF RATIONAL DRUG USE**

To promote the rational use of drugs, various activities including advocacy, public education on rational drug use was undertaken, using print media and radio spots.

In order to increase the public awareness on appropriate use of medicines, a total of 104 radio spots were prepared and transmitted on various programs and in different languages. Various print materials such as quantification manuals, clinical pharmacy assessment report and stock cards have been distributed.

**CHALLENGES**

- Shortage of foreign currency to timely procure and distribute pharmaceuticals,
- Delay in bidding process
- Shortage of ART drug

**WAY FORWARD**

- Strengthen early forecasting and timely distribution system,
- Strengthen participatory planning process

## 6.4 RESOURCE MOBLIZATION AND UTILIZATION

The HSTP recommends for proactive approach in the mobilization of resources from domestic and international sources through increasing the health budget from treasury, establishment and strengthening of risk pooling mechanisms, collection of revenues by health institutions, strengthening international health partnerships and enhancement of pooled funding; public-private partnerships and maximizing collaboration with national and international civil society organizations and NGOs.

The following section summarizes major activities carried out in relation to resource mobilization and utilization in the fiscal year.

**HEALTH CARE FINANCING**

One of the most important factors limiting access to quality health care service in Ethiopia is lack of adequate resources. To alleviate this chronic under-financial limitation, in 1991 E.C. the health care financing reform program was endorsed by the Council of Ministers and allowing health facilities to establish their respective Governing Boards/Management committee and retain and utilize their internal revenue, systematize the fee waiver and exempted health services, outsource of non-clinical services, establish private wing in the health facility.

Therefore, in EFY 2009, the following health care financing implementation progresses were documented.

**STRENGTHENING HEALTH FACILITIES GOVERNING BOARD/MANAGEMENT COMMITTEE**

In the fiscal year, various trainings focusing on strengthening the technical and managerial capacity of board members were provided for a total of 86 facility board members from Afar and also for a total of 118 officials (3 University Hospitals Presidents, 37 Board members and 78 Executive Committee members).

In addition, three day training on financial management was provided for a total of 51 finance staffs from 10 University Hospitals in order to strengthen the financial management capacity of the respective hospitals.

In the fiscal year, a total of 238 hospitals and 3,255 health centers have established governing Board/ Management Committee.

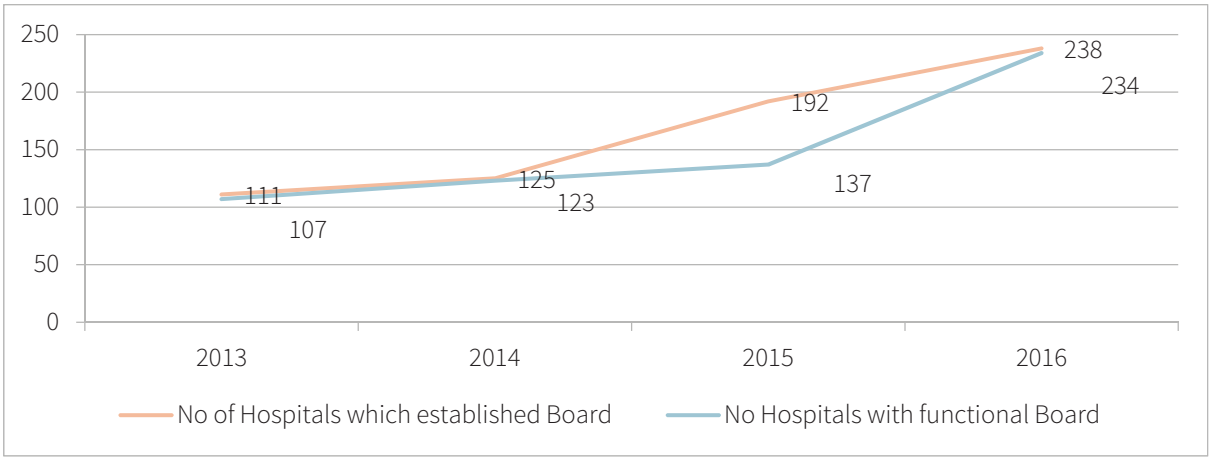



Figure 45: Trend of established Board in Hospitals (EFY 2006 - 2009)

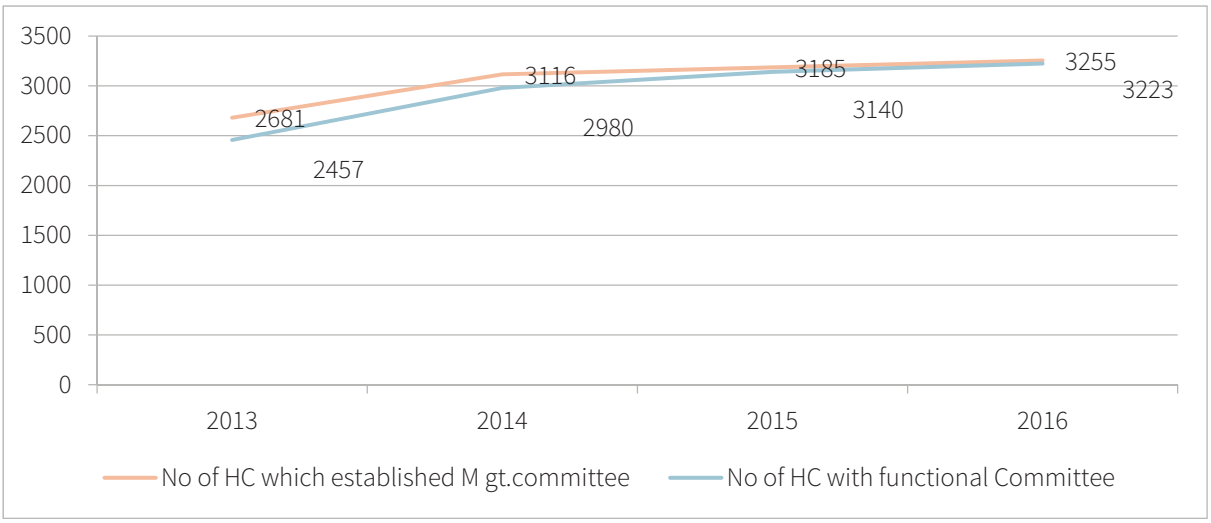



Figure 46: Trend of established management committee in Health Centers (EFY 2006 -2009)

## REVENUE RETENTION AND UTILIZATION FOR QUALITY IMPROVEMENT

In EFY 2009, a total of 253 hospitals and 3,329 health centers were retaining and utilizing their respective internal revenue. And, as the field level assessment clearly reveals in most health facilities the revenue generated was utilized for the procurement of drugs and medical equipment.

Table 27: Number of Health Facilities Retaining and Utilizing, (EFY 2009)

| No | Region | Number of Facilities Retaining and Utilizing Internal Revenue | | |
|---|---|---|---|---|
| | | Hospitals | Health Center | Total |
| 1 | Tigray | 36 | 232 | 258 |
| 2 | Afar | 6 | 28 | 34 |
| 3 | Amhara | 66 | 820 | 886 |
| 4 | Oromia | 65 | 1,366 | 1,431 |
| 5 | Somali | 4 | 0 | 4 |
| 6 | Benishangul Gumuz | 2 | 38 | 40 |
| 7 | SNNP | 53 | 719 | 762 |
| 8 | Gambela | 1 | 9 | 10 |
| 9 | Harari | 1 | 8 | 9 |
| 10 | Addis Ababa | 6 | 94 | 100 |
| 11 | Dire Dawa | 2 | 15 | 17 |
| 12 | Federal Hospitals | 11 | | 11 |
| | **Total** | **253** | **3,329** | **3,582** |

## FEE WAIVER SYSTEM FOR ENHANCED EQUITY OF ACCESS TO HEALTH SERVICES

A fee waiver is a right conferred to indigents to obtain health services in health facilities at no direct charge or at reduced price. The main purpose of the fee waiver system is to ensure equity in access to health services by increasing access of the poor. In EFY 2009, out of 751,989 screened beneficiaries 745,768 of them got the necessary health services. And, for realizing this out of total budget of ETB 83,775,597 was earmarked from government budget and ETB 29,098,875 utilized.

## PROVISION OF EXEMPTED SERVICES

Exempted health services are those services that are rendered free of charge to all community irrespective of level of income. By reason of being of public health nature that widely affects the general public and have substantial contribution in improving the health seeking behavior of the society. Accordingly, services such as diagnosis, treatment and follow-up of TB, prenatal, delivery and postnatal services, immunization; HIV Voluntary Counselling and Testing, Prevention of HIV/AIDS transmission from mother to child, Leprosy management, epidemic follow-up and control, fistula management and malaria treatment are some the services that are provided to general public free of charge. Even though most of the health facilities have been providing the necessary exempted services, lack of adequate resources leading the health facilities to drain their internal revenue and the limitations of some health facilities in keeping the records of exempted service beneficiaries are the major challenges which demand the coordinated effort of all stake holders.

## ESTABLISHING PRIVATE WING AND OUTSOURCING OF NON-CLINICAL SERVICES

Having the major objectives of reducing the attrition of highly qualified health personnel through increasing their motivation and also to mobilize additional resources to the health facilities through availing alternative choices of care for the community, health facilities are allowed to establish a private wing. Furthermore, out sourcing of non -clinical services is also the other component of the reform program which is designed for its comparative advantages of increasing the quality of health services through enabling health facilities to focus on their core business and also to gain quality and efficiency through accessing that expertise who are not available in the facilities. Accordingly, health facilities are allowed to outsource construction, printing, maintenance, catering, gardening, security and other similar non -clinical services.

In EFY 2009, a total of 58 hospitals were running their respective private wing and 127 of them have out sourced some of their non-clinical services such as security, food for patient , maintenance and so on.

Table 28: Number of Hospitals Opened Private Wing and Outsourcing Non Clinical Service

| No | Region | No of Hospitals with private wing | No of Hospitals out sourced non-clinical services |
|---|---|---|---|
| 1 | Tigray | 12 | 5 |
| 2 | Afar | - | - |
| 3 | Amhara | 4 | 21 |
| 4 | Oromia | 26 | 43 |
| 5 | Somali | 2 | - |
| 6 | Benishangul Gumuz | 2 | 2 |
| 7 | SNNP | - | 41 |
| 8 | Gambela | 1 | 1 |
| 9 | Harari | - | 1 |
| 10 | Addis Ababa | 5 | 6 |
| 11 | Dire Dewa | 1 | 2 |
| | **Total** | **58** | **127** |

## USERS' FEE REVISION

Compared to the budget allocated from government treasury, the user's fee charged in government health facilities have been very small and remained unchanged for a long time. Cognizant of this, the health care financing strategy endorses the health services charges at government health facilities to be revised and set based on a cost-sharing principle. For realizing this, some regions such as Oromia and Amhara are working to revise their respective health facilities user's fee .In addition to these, MOH is also on the verge of finalizing the Federal Hospitals user's fees. Coupled with the complexity of the task, the lack of competent personnel are some of the major challenges regions are facing.

## HEALTH PARTNERSHIP COORDINATION

### STRENGTHENING PUBLIC PRIVATE PARTNERSHIP IN HEALTH

The government of Ethiopia believes that the private sector will play a critical role in three areas: tertiary care provision, local pharmaceutical manufacturing and human resources for health (HRH), where the aim is to set up long-term training arrangements. And, to realize these, various tasks which aim at establishing and strengthening the right regulatory framework for the private sector were performed.

In EFY 2009, PPPH guideline and users guide which stipulate the modalities through which the private sector and MOH establish the partnership have been prepared and submitted to MOFEC. In addition to this, to identify the major gaps which calls for the participation of the private sector through PPPH modalities, a pre-feasibility study was conducted on 11 hospitals selected from Federal and Addis Ababa City Administration.

### CHSOS COORDINATION

In EFY 2009, in the presence of senior officials from Ministry of Health and Charity and Society agency and ChSOs representatives a MOH-ChSOs joint health forum was conducted. The major challenges raised on the meeting were translated in to action plan and a MOU was developed and submitted to the attention of senior officials. In addition to this, 1mid-term and 7 terminal evaluations were conducted on a total of ChSOs and also 52 new project proposals were appraised and 41 of them were endorsed for implementation.

### BILATERAL COOPERATION

Different bilateral cooperation tasks and agreements which focus on strengthening the health care service delivery of Ethiopia with different countries were performed. Accordingly, the necessary bilateral agreement on health was signed with South Korea, Russia, Saudi Arabia, Iran, Sudan, South Sudan, and Palestine. In addition to these, Ethio-Sudan and Ethio-Djibouti Joint border Commission Meetings were held by reviewing the previous agreements and approving the future joint plan. To co-ordinate and monitor the implementation status of bilateral agreements a technical working group representing members from different agencies was also established.

### HEALTH INSURANCE

Considering the strategic importance of health insurance in enhancing the country's progress towards the attainment of the Universal Health Coverage, in the EFY 2009 the following activities were implementation in line with community based and social health insurance.

## COMMUNITY BASED HEALTH INSURANCE

In the EFY 2009, various activities focus on increasing CBHI membership base and coverage through conducting an all-out awareness creation and sensitization programs, registering new members and improving members' contribution were planned and implemented. From these an all -out effort, currently the CBHI program coverage has reached in to a total of 377 woredas. And, out of them 248woredas are providing the necessary health services to their respective CBHI members. And, out of the total 9,540,917 eligible members 3,474,569 of them have joined the CBHI program.

Considering the strategic importance of creating community ownership in sustaining the implementation of the CBHI program, CBHI General Assembly meeting were organized in a total of 225 CBHI woredas in the EFY 2009. In addition, various forms of training addressing the very importance of CBHI were provided for a total of 18,217 women development army and 904 community based (CBO) and Faith Based organizations (FBOs) representatives.

Table 29: CBHI membership and contribution status (EFY 2009)

| No | Region | Total CBHI Woredas | Woreda that started service provision | Eligible Population | CBHI members and contribution status | | | | Total family members | Total contribution collected ( 2009 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Paying Members | Indigents | Total members | Enrol-ment rate % | | |
| 1 | Tigray | 36 | 18 | 869,405 | 216,362 | 56,681 | 273,043 | 31% | 1,175,309 | 35,453,220 |
| 2 | Amhara | 111 | 102 | 2,921,390 | 1,320,385 | 236,530 | 1,556,915 | 53% | 7,321,829 | 220,205,400 |
| 3 | Oromia | 142 | 102 | 3,938,246 | 632,627 | 363,348 | 995,975 | 25% | 4,390,157 | 219,507,840 |
| 4 | SNNP | 76 | 49 | 1,810,442 | 573,166 | 72,569 | 648,636 | 36% | 2,846,971 | 118,623,800 |
| | | **365** | **271** | **9,539,483** | **2,742,540** | **729,128** | **3,474,569** | **36%** | **15,638,789** | **593,790,260** |

In order to achieve the goals set in the second HSTP, 15 CBHI Woredas were selected as center of excellence Woredas in the regions that have been implementing CBHI program to improve membership registration and health service utilization. The regional distribution of the selected Woredas vary in accordance with the size of each region where 5 Woredas are selected in Oromia, 5 in Amhara, 3 in SNNP and 2 in Tigray.

On the other hand, the four developing regions have initiated CBHI program. Three pilot Woredas were selected in Benishangul Gumuz Region and the CBHI directive was endorsed by the regional council. A number of trainings were provided on CBHI for various actors in the woredas and preparatory activities are underway to establish the schemes. Similarly, three pilot Woredas were also selected in Gambella Region and the CBHI directive was endorsed by the

RHB. Approval of the regional cabinet is awaited to further enhance CBHI preparatory activities in the region. In Ethio Somali and Afar regions the CBHI directive was approved after a series of consultations with the regional cabinets and RHBs.

**OTHER ACTIVITIES**

With regard to preparation of implementation guidelines, CBHI Implementation Manual, CBHI Clinical Manual and CBHI Data Management Manual were prepared, printed and distributed to CBHI schemes. Similarly, directives for Recruitment, Promotion and Transfer of employees of the agency; Vehicle and Fuel Utilization of the agency vehicles; Incentive Payment for Kebele CBHI Executives; Establishment of CBHI Regional Pool and proposal for Human Resource Structure of CBHI Schemes were also prepared in EFY 2009.

Assessment studies were conducted by branch offices of the agency on availability of drugs and laboratory services in health facilities. The findings show that essential drugs were not available for about 2 to 5 months during the year, and in general there were shortages of drugs and laboratory reagents in most of the health facilities.

During EFY 2009, CBHI data management manual was prepared and training was provided to EHIA branch offices and CBHI schemes on its implementation. Accordingly, quarterly reports were prepared as per the contents of the manual and distributed to concerned bodies.

Considering the strategic importance of Medias in diffusing the necessary information and knowledge to the wider community, various spots addressing the very importance of CBHI were aired through local and National radio and Television programs. In addition to these, five CBHI documentary films addressing the success stories of regions, different newspapers, leaflets and broachers were produced and distributed to the community also up loaded on the agency web site

Networking of the EHIA head office with five branch offices with ICT infrastructure was planned, of which three branches (Adama, Sebeta and Debre Berhan) have already linked with the woreda net. Networking of the remaining two branches (Addis Ababa and Finfinnee) with the head office is under way.

Moreover, procurement of equipment for IT infrastructure development and related studies have been conducted. Specification for IT equipment such as video conferencing, biometric attendance machine, laptops and tablet computers have been prepared. Website of the EHIA has been established and started operation. Similarly, database for claim management has been prepared.

**SOCIAL HEALTH INSURANCE**

In EFY 2009 several preparatory tasks were carried out to include segments of the community in formal sector in to health insurance scheme. Accordingly, the tasks of clearing the data and

information on the quantity and man power of those eligible private organizations is under process.

In addition to these, consultative meeting on social health insurance was conducted in the presence of 45 higher officials who were represented from the Ethiopian Teachers union and Ethiopian labor union federation and Confederations.

To automate the social health insurance membership registration and follow up process, the task of developing a management information system software and implementation manual of the scheme are on the verge of completion. Besides these, various Social health insurance implementation manuals and guide lines were also drafted and are ready for testing.

**CHALLENGES**

- Lack of CBHI legal framework (proclamation and regulation);
- Delay in approving the CBHI scale up directive by regions which in turn pose difficulties to establish CBHI schemes in new woredas;
- Lack of proper leadership/ownership in some regions and woredas;
- Poor data management and reporting by CBHI schemes which hindered informed decision making;
- Sluggish in ID card preparation and distribution by CBHI schemes;
- Loss of financial vouchers and deficit reporting by Kebele executives in some CBHI schemes, and not doing financial auditing timely; and
- Shortages of drugs, laboratory equipment and technicians, pharmacists, etc., in health facilities under contract with CBHI schemes and referring beneficiaries to private providers.

**WAY FORWARD**

- Developing draft CBHI proclamation and started consultation workshops to enrich it;
- Conducting review meetings and plan alignment activities at all levels including regional and Woreda government structures and stakeholders;
- Revising of the agency structure is underway to replace it by a new structure;
- Continuing capacity building is being provided to CBHI schemes and branch offices of the agency on data management and reporting after data management system manual is developed and distributed; and
- Providing interim tailored solutions to problems encountered (support ID preparation, auditing, etc.).

## 6.5 FINANCIAL/EXPENDITURE MANAGEMENT AND CONTROL

In order to ensuring efficient and effective utilization of financial resources, a consistent and strong financial/expenditure system have been in place in the EFY 2009. In the fiscal year, two financing streams (government budget and donor grants funds) were used by FMOH. From government a total of ETB 265,661,293 million has been allocated for capital and operating budget (excluding federal hospitals and agencies).

For grants management, FMOH has exerted its maximum effort to collect all the agreed upon donor funds, utilizing and liquidating all grants revenues with the target of zero level efficiency loss. In effect, ETB 4.79 billion (85%) was collected from donors, and ETB 3.73 billion was liquidated including the carried forward left over balance from EFY 2008. To this end, the FMOH has been closely working with and supporting all the implementing regions/city administrations, federal agencies, and other federal level health institutions to strengthen grant management systems and practices.

All the necessary financial audit services was carried out for both financing streams to ensure accountability for proper utilization of financial resources in compliance with the prevailing financial management proclamations, regulations, directives, policies, and procedures.

As it was documented in the previous year, the clean audit opinion has been achieved for all audits for both government and donor grants in EFY 2009. FMOH has also been using the quarterly internal audit to ensure the health of internal control systems and practices with the objective to have strong, reliable, and transparent systems in place.

### INTEGRATED FINANCIAL MANAGEMENT INFORMATION SYSTEM

IFMIS, an oracle-based financial application, have been deployed in 21 selected sites throughout the country including FMOH for a powerful financial management system. For the system, a team composed of seven individuals has been fully involved in supporting the day-to-day operations of the Ministry's Directorates in utilizing the system for their regular activities. The Ministry has successfully implemented all nine modules. Currently, all the directorates of FMOH are using the system for their daily operations (especially inventory and fixed asset).

### PUBLIC BUDGET ALLOCATION

This section explains the amount of budget subsidized by the federal government to the health sector activities performed at regional level. The estimate was out of the total public budget in EFY 2009 by the government. The source of data is MoFEC.

## PERCENTAGE SHARE OF THE PUBLIC HEALTH BUDGET ALLOCATION FROM THE TOTAL BUDGET

In EFY 2009, the percentage of total budget allocated for the health sector at regional level was 10.7%, which was lower than in EFY 2008 (11.3%) (Figure 49). This was due to a decrease in the capital budget allocation in some regions. However, there was an increment on the per capita health allocation from ETB 156.31in the previous fiscal year to ETB 188.76 in the current fiscal year. The regional block grant budget allocated to the health sector ranged from 6.9% in Harari to 13.2% in Benshangul Gumuz Regions in the same year. Five regional states (Tigray, Afar, Amhara, SNNP and Gambela) and one city administration (Addis Ababa) has made increment in the percentage share of their health budget from EFY 2008. However, there was a decrease in the remaining four regional states (Oromia, Somali, Benshangul Gumuz, and Harari) and one city administration (Dire Dawa).

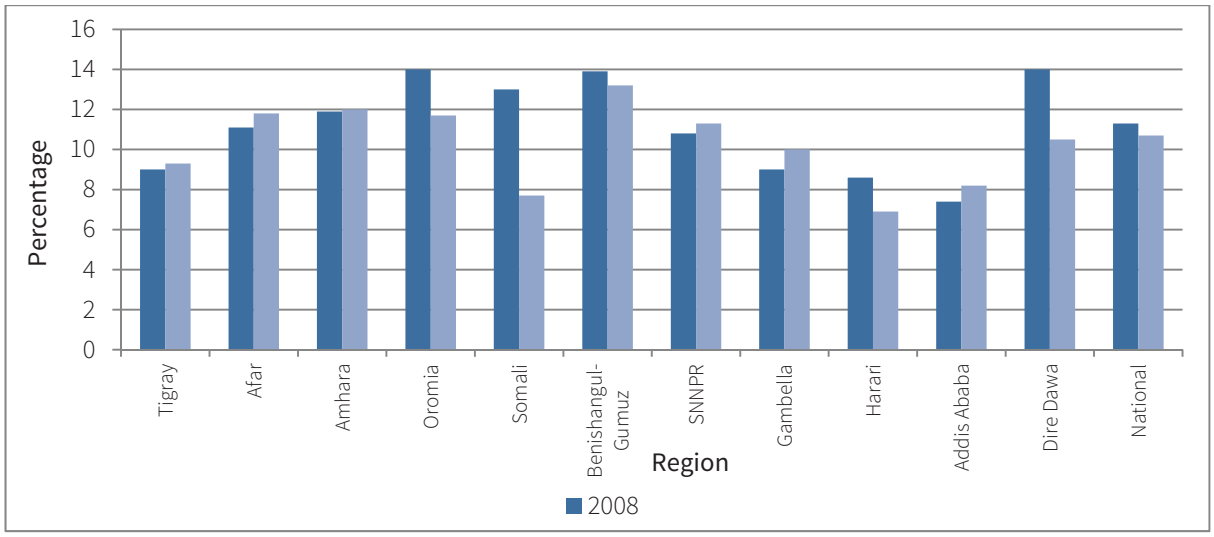



Figure 47: Distribution of the Percentage of Total Budget Allocated in the Health Sector by Region (EFY 2008 and 2009)

## DEVELOPMENT PARTNERS' CONTRIBUTION TO THE HEALTH SECTOR

The major source of funding for the Ethiopian health sector is financial contribution from development partners. The following section shows how much was contributed and disbursed by DPs to the health sector in EFY 2009.

## PROPORTION OF EACH DONOR'S CONTRIBUTION AS COMPARED TO THE TOTAL DP DISBURSEMENT

In EFY 2009, a total amount of USD 257.48 million was committed and a total amount of USD 218.41 million (84.8%) was disbursed using channel two modality to the health sector. This was still lower than the previous three years commitments and disbursements.

Table 30: Commitment and Disbursement of Funds by Development (EFY 2009)

| S.N | Source of Fund | Commitment (in USD in EFY 2009 | Disbursement in USD in EFY 2009 | Percentage of Disbursement |
|---|---|---|---|---|
| 1 | SDG Performance Fund | | | |
| | DFID | 48,305,478 | 55,991,250 | 116% |
| | Spanish Aid | 1,115,500 | 1,043,900 | 94% |
| | Irish Aid | 5,019,751 | 4,720,022 | 94% |
| | Italian Cooperation | 1,673,250 | 1,560,824 | 93% |
| | Netherlands Embassy | 11,000,000 | 10,808,128 | 98% |
| | UNICEF | 500,000 | | 0% |
| | World Bank | 6,000,000 | 8,278,443 | 138% |
| | GAVI | 19,190,000 | 19,189,980 | 100% |
| | EU | 9,658,125 | 9,476,031 | 98% |
| | **Total** | **102,462,104** | **111,068,578** | **108%** |
| 2 | Bilateral Partner | | | |
| | DFID (RIF) | 9,272,727 | 9,272,727 | 100% |
| | CDC | 1,881,818 | 1,881,818 | 100% |
| | **Total** | **11,154,545** | **11,154,545** | **100%** |
| 3 | UN Organization | | | |
| | UNICEF | 3,222,795 | 3,222,795 | 100% |
| | UNFPA | 300,633 | 300,633 | 100% |
| | WHO | 10,767,913 | 10,767,913 | 100% |
| | **Total** | **14,291,341** | **14,291,341** | **100%** |
| 4 | Global Fund | | | |
| | Malaria | 58,158,139 | 35,438,320 | 61% |
| | TB | 29,792,722 | 19,647,964 | 66% |
| | HSS | 21,755,398 | 18,973,877 | 87% |
| | **Total** | **109,706,259** | **74,060,161** | **68%** |
| 6 | GAVI and GSF | | | |
| | GAVI- MEASES - OPC | 7,842,989 | 7,842,989 | 100% |
| | Global Sanitation | 1,088,952 | 1,088,952 | 100% |
| | **Total** | **8,931,941** | **8,931,941** | **100%** |
| 7 | Foundation | | | |
| | CIFF | 6,576,145 | 6,576,145 | 100% |
| | End Fund | 1,904,597 | 651,961 | 34% |
| | **Total** | **8,480,742** | **7,228,106** | **85%** |
| | **Grand Total** | **255,026,932.00** | **226,734,672.00** | **89%** |

In the fiscal year, 89% of the committed amount by DPs have been disbursed. Some of the DPs have also contributed beyond their committed amount for new needs emerged in the middle of the year (such as Emergency Response).

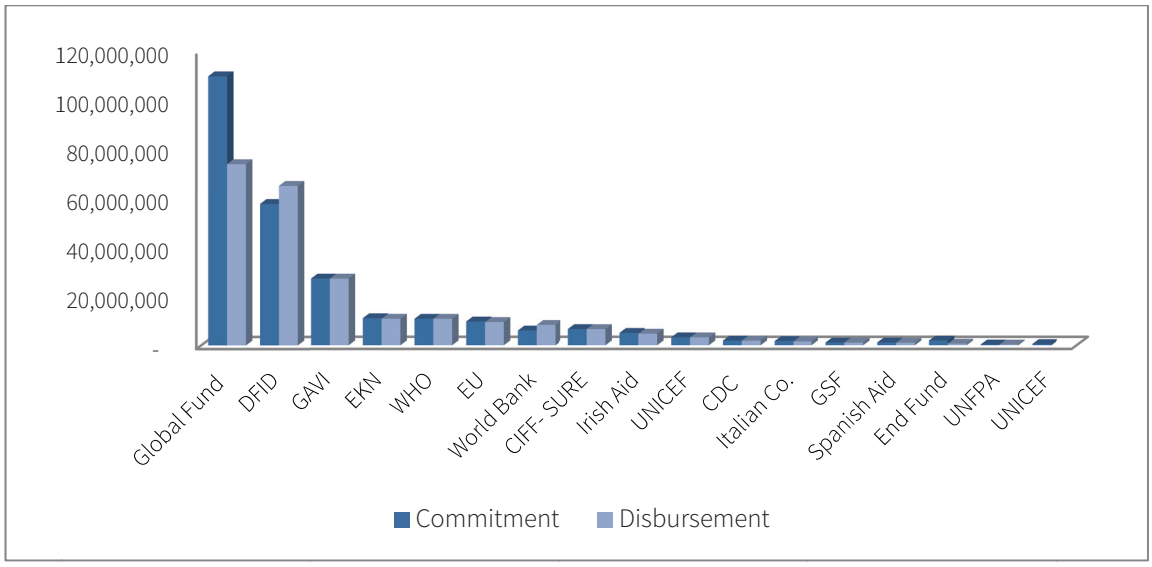



Figure 48: Distribution of Amount Committed and Disbursed by Development Partner (EFY 2008)

From total disbursements to FMOH by development partners in the budget year, Global Fund's share was 33% (USD 74.06 million). It remained the largest contributor to health sector, followed by DFID 29% (USD 65.26 million) and GAVI 12% (USD 27.03 million). Netherland's Embassy (4.8%), WHO (4.7%), European Union (4.1%), World Bank(3.6%), CIFF (3.0%), Irish Aid (2.1%), UNICEF (1.4%), CDC (0.8%), Italian Cooperation (0.7%), Spanish Aid (0.5%), End Fund (0.3%) and UNFPA (0.1%).

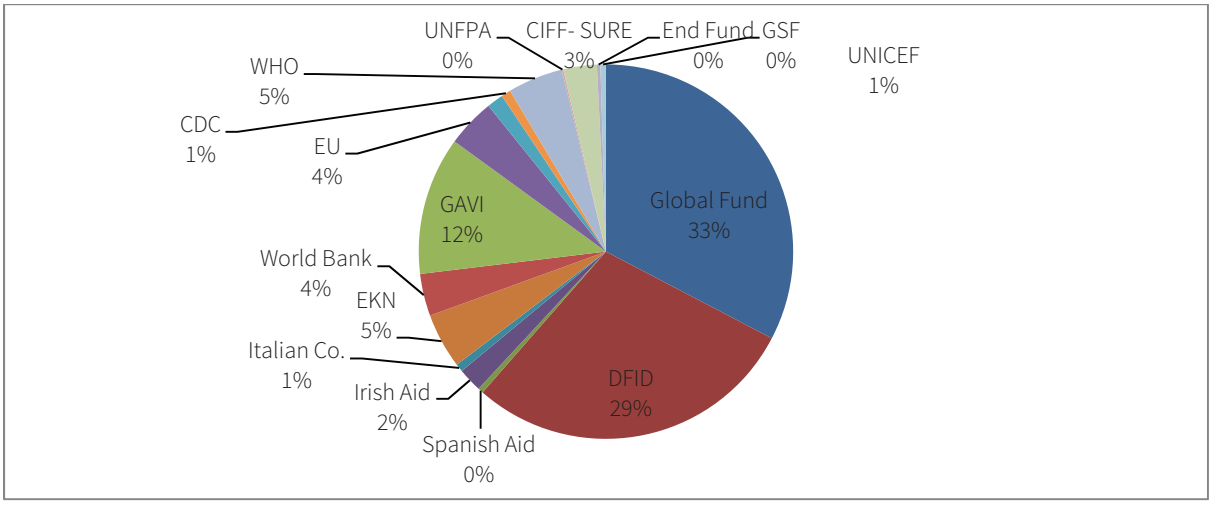



Figure 49: Proportion of disbursements to FMOH

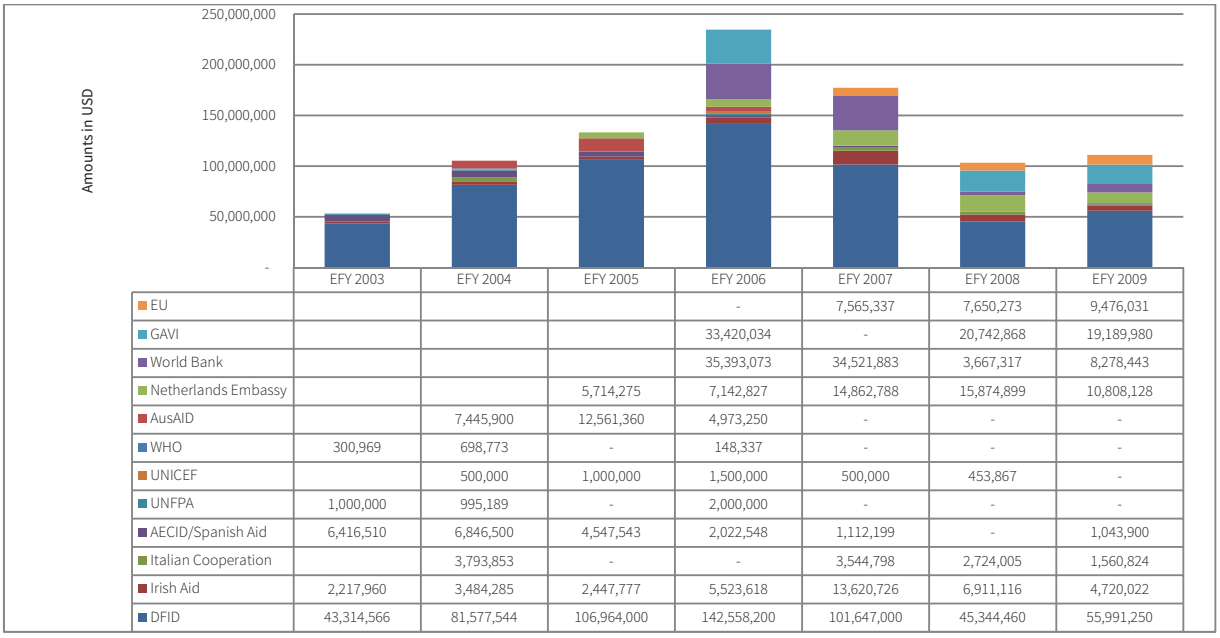
In this report, channel three contributors are not included in the above financial contribution by DP's. It is known and clear that there is a considerable amount of resources provided by U.S. partners using channel three modality which are not directly monitored by FMOH.

## SDG PERFORMANCE FUND

In the Joint Finance Arrangement of Sustainable Development Goals Performance Fund, it is stated that SDG Fund is a pooled funding mechanism managed by the FMOH using the Government of Ethiopia procedures. In the framework of the Ethiopia IHP compact, it provides flexible resources, consistent with the 'one plan, one budget, and one report' concept, to secure additional finance to the Health Sector Transformation Plan. It is one of the GoE's preferred modalities for scaling up Development Partners assistance in support of HSTP.

In EFY 2009, the budget commitment to SDG PF by contributors was USD 102.46 million; however, a total amount of USD 111.07 million was disbursed to SDG PF in the same period. This accounted for 108% DP's disbursement in the fiscal year. At this end, the amount budget disbursed exceeds the amount of budget committed was due to two development partners (DIFD and World Bank) disbursed more than what they planned and the fluctuation of currency exchange during disbursement. The EFY 2009, there was increment by 7.4% from the previous fiscal year (USD 103.37 million).

Similar to previous years, DFID was the major contributor to SDG PF in EFY2009 as well, accounting 50.4% of the total amount disbursed by DPs to SDG PF; followed by GAVI (17.3%), Netherlands Embassy (9.7%), EU (8.5%), World Bank (7.5%), Irish Aid (4.2%), Italian Cooperation (1.4%) and Spanish Aid (0.9%) . In this fiscal year, WHO, UNFPA and Aus Aid did not committed resource to SDG PF; however, UNICEF's commitment was left to use the funds directly to transfer a vendor for service delivery.




| | EFY 2003 | EFY 2004 | EFY 2005 | EFY 2006 | EFY 2007 | EFY 2008 | EFY 2009 |
|---|---|---|---|---|---|---|---|
| EU | | | | - | 7,565,337 | 7,650,273 | 9,476,031 |
| GAVI | | | | 33,420,034 | - | 20,742,868 | 19,189,980 |
| World Bank | | | | 35,393,073 | 34,521,883 | 3,667,317 | 8,278,443 |
| Netherlands Embassy | | | 5,714,275 | 7,142,827 | 14,862,788 | 15,874,899 | 10,808,128 |
| AusAID | | 7,445,900 | 12,561,360 | 4,973,250 | - | - | - |
| WHO | 300,969 | 698,773 | - | 148,337 | - | - | - |
| UNICEF | | 500,000 | 1,000,000 | 1,500,000 | 500,000 | 453,867 | - |
| UNFPA | 1,000,000 | 995,189 | - | 2,000,000 | - | - | - |
| AECID/Spanish Aid | 6,416,510 | 6,846,500 | 4,547,543 | 2,022,548 | 1,112,199 | - | 1,043,900 |
| Italian Cooperation | | 3,793,853 | - | - | 3,544,798 | 2,724,005 | 1,560,824 |
| Irish Aid | 2,217,960 | 3,484,285 | 2,447,777 | 5,523,618 | 13,620,726 | 6,911,116 | 4,720,022 |
| DFID | 43,314,566 | 81,577,544 | 106,964,000 | 142,558,200 | 101,647,000 | 45,344,460 | 55,991,250 |

Figure 50: MDG/SDG Performance Fund Disbursement (EFY 2002 - 2009)

## IMPLEMENTATION PROGRESS OF THE SDG PERFORMANCE FUND

In EFY 2009, there were identified gaps which are financed by SDG PF based on the annual comprehensive plan and in line with eligible expenditure stated on JFA. Like the previous period, in EFY 2009, the major funding areas are presented below, together with the budget.

Table 31: Areas of Support Funded by SDG Performance Fund (EFY 2009)

| Area of focus | Budget allocated for 2008 in USD | Budget allocated in percentage |
|---|---|---|
| Public Health Commodity Procurement | 121,475,624 | 34% |
| Maternal Health | 67,292,470 | 19% |
| Child Health Services | 44,135,967 | 12% |
| Prevention and Control of Communicable and Non Communicable Diseases | 32,714,217 | 9% |
| Health Service Delivery | 3,038,167 | 1% |
| Health System Strengthening | 81,997,921 | 23% |
| Health Extension Program | 2,773,609 | 1% |
| Miscellaneous | 1,705,146 | 0% |
| **Total SDG PF Expenditure** | **355,133,122.33** | **100%** |

As represented in the above table, the highest budget is allocated to Public Health Commodity Procurement (34%) under which medical equipment and pharmaceuticals are procured. Health System Strengthening follows in amount taking 23% of the budget and Maternal New-born Health and Nutrition is the third largest program area receiving the 31% of the annual budget of SDG PF.

## IMPLEMENTATION AREAS OF THE SDG PERFORMANCE FUND

In EFY 2009, following the Joint Financing Arrangement guidelines, the underfunded priority areas were financed using the SDG PF to strengthen the overall health system and provision of public health goods, for the improvement of maternal and child health and prevention and control of communicable and non-communicable diseases. In addition, during the middle of the year, resources were allocated for the Emergency Response by reprogramming some of the SDG-PF activities. The following section explains the implementation status of SDG PF in EFY 2009 by program area.

## HEALTH EXTENSION PROGRAM

In addition to the implementation of Woreda transformation, revitalizing the Health Extension Program has been commenced, 2nd generation Health Extension workers program packages implementation manuals and guidelines were prepared during the year. Furthermore, the Health Development Army strengthening was continued.

### MATERNAL AND NEWBORN HEALTH AND NUTRITION

The program of reimbursing health facilities that provide free delivery services has continued in this fiscal year. In addition, SDG-PF has filled the gap identified in the availability of the Iron Folate in the country by procuring through procuring agency. In EFY2009, one of the significant investments of the SDG-PF was on Family planning. Required supplies were procured and distributed for Health Facilities.

### CHILD HEALTH SERVICES

Child Health Service has been supported by the SDG PF for the implementation of routine immunization program costs in the year. In addition, the procurement of NICU medical equipment for 80 hospitals, the procurement of the 6,000 solar direct drive refrigerators and child health pharmaceuticals delivery were covered by the SDG-PF.

### PREVENTION AND CONTROL OF COMMUNICABLE AND NON COMMUNICABLE DISEASES

The pool fund mainly used for malaria prevention works by procuring the required chemicals which were distributed to Regional Health Bureaus to support areas identified as development corridors that need malaria prevention activities.

### HEALTH SYSTEM STRENGTHENING

Enhancing the human skill is determinant for the achievement of the HSTP target and the transformation agendas. Trainings to upgrade the Health Extension workers to Level IV and replacing Level III, Biomed technician Level IV, Anesthesia Level V were supported by this fund. Moreover, the construction of Operating Theaters in all regions has been intensified in the year using SDG PF. The procurement and installation of solar PV in the selected remote health centers and health posts has been implemented. As part of Health System Strengthening the Community Based Health Insurance has received the fund to subsidies the contribution of the community and to support on motor cycles' procurement.

### EMERGENCY RESPONSE

During the year there were emergencies that require the response of the Ministry's and Development Partners particularly in Somali Region in relation to the draught in East Africa. SDG PF was used to support the procurement of measles vaccine for the affected area, to manage Acute Watery Diarrhea and to assist the region by human resource and organizing Case Treatment Center as well as to avail nutritional supplies and to do health promotion and social mobilization.

Likewise, SDG PF also used to support the system by HSTP Transformation Agendas.

# CHAPTER 7

# CONCLUSION


# CONCLUSION

In EFY 2009, despite all the hurdles posed by various emergency situations, the health sector has performed with notable gains. However this encouraging performance is also characterized by a rather slow progress towards the targets set for the year.

With the intention to keep the HEP in alignment to contemporary healthcare needs, FMoH made critical decisions to strengthen the program. The training of second generation HEWs has been continued in the fiscal year. To reinforce community engagement and support to HEWs, the FMoH has designed a competency-based training curriculum, pilot tested, and decided to scale-up the training to about three million HDA leaders. The urban health extension program and urban hygiene and sanitation programs were also major focal areas in the fiscal year. Numerous initiatives were launched under the HEP that need to be sustained and implemented with a renewed rigor in the coming fiscal years.

Various interventions targeted to improve maternal, neonatal and child health status were implemented in the fiscal year. Accordingly, school health has been prioritized as a strategy to reach children, adolescents and youth for primary health services. It is estimated that almost one-third of the population in Ethiopia is comprised of students enrolled at all levels of the education system and school health is considered crucial to reach this segment of the population and their families with critical health services.

The EDHS 2016 results reaffirmed the significant reduction in child mortality in Ethiopia. In order to further tackle the leading causes of under-five mortality, in particular, neonatal mortality, IMNCI and iCCM/CBNC services were expanded in EFY 2009. A quality improvement and transition plan developed to further expand and ensure institutionalization of the services. The plan will be used to guide the efforts to expand the IMCI, iCCM/CBNC, and NICU services in the upcoming year.

Additional achievements during the fiscal year include the acceptance of Ethiopia's polio free status documentation, the finalization of the human papilloma vaccine demonstration, preparations for MCV2 vaccination and hepatitis-B vaccination for health workers. Regarding routine immunization activities, the coverage of pentavalent-3, PCV-3, measles, and fully vaccination coverage have remained relatively constant (above 90%) as the previous year's performance.

During the fiscal year, the importance of inter-sectoral collaboration for the realization of NNP II was greatly appreciated. Accordingly, the majority of nutrition-related activities involved multiple sectors and has been spearheaded by the national nutrition coordination body, chaired by the FMoH. The main interventions conducted in the fiscal year were primarily poised to improve optimal breastfeeding, optimal complementary feeding, mitigation and prevention of micronutrient deficiencies, WASH, deworming, food fortification and management of

acute malnutrition. In addition to the routine activities of growth monitoring, vitamin-A supplementations, salt iodization, Comprehensive and Integrated Nutrition Services (CINS) was also emphasized as a key strategy to tackle the majority of nutritional disorders among children.

Despite a sharp increase in maternal health service coverage from the previous fiscal years and the ambitious target, the coverage of majority of maternal services has shown little progress in the 2009 fiscal year. It was possible to sustain at least last year's performance on national CAR, ANC-4+, skilled delivery coverage, C/S and stillbirth rates. However, a slight drop in performance in early PNC and PMTCT indicators were observed during the fiscal year.

Maternal death surveillance and response was a key activity in the fiscal year. A total of 972 maternal deaths were reported and audited, which is far below the expected number of maternal deaths. The analysis of the maternal death showed that hemorrhage, pregnancy induced hypertension and anemia were the leading causes.

The efforts to reduce HIV transmission and provide care support for people who know their status showed slowdown in national performance and regional variation achievements. In the fiscal year, about three out of four people knew their HIV positive status, of which two-thirds were put on HAART. Strengthening HIV primary prevention, focusing on MARPS and improving the clinical care quality will be the major focus areas in the upcoming years.

Several efforts to strengthen TB and leprosy control interventions were implemented in the fiscal year. While the programs have been successful in the previous years, there were challenges related to multi drug resistance. The national tuberculosis notification rate has shown a slight decrease; however, the case detection rate and treatment outcome indicators showed increment from the previous year's performance. Priority focus areas for the upcoming years will include strengthening community engagement, enhancing diagnostic capacities and improving TB and Leprosy program management capacity.

Major malaria interventions during the fiscal year include expanding vector control and strengthening malaria case detection. In order to control vectors, 5.8 million (97%) unit structures were covered with IRS and a total of 2.8 million LLITN were distributed. Enhancing utilization of LLITN and effective targeting of areas for IRS will be the major focus areas for the upcoming years.

Prevention and control of neglected tropical diseases and non-communicable diseases were significant priorities in the fiscal year. In order to address the increasing burden of non-communicable diseases, the FMoH carried out many programmatic designs and changes.

Strong leadership and governance at all levels are necessary to ensure that resources are devoted to the health sector to provide adequate healthcare access and improve health outcomes. In 2009 EFY, the FMoH with Regional Health Bureaus (RHBs) jointly monitored the implementation of the HSTP on a quarterly basis. In addition, Joint Steering Committee (JSC) meetings with RHBs, quarterly Joint Consultative Forum (JCF) meetings with Development Partners (DP), and Joint Core Coordinating Committee (JCCC) meetings were held regularly to deliberate on priority issues in the health sector.

To strengthen evidence-based decision making and to adequately monitor the progress of HSTP implementation, the national health indicators were revised and a total of 131 indicators were selected, of which 33 are new. Twenty-nine indicators are modified and 69 indicators remain unchanged from the previous set of indicators. FMOH has also been working towards transitioning to DHIS-2 as a national health management information system platform. Similarly, The FMoH is developing a new mobile-based electronic Community Health Information System to support reporting and service delivery by HEWs. Moreover, in order to identify and study the priority problems that are of public health importance and to produce evidence that would assist decision-maker, the FMoH conducted operational research in the health sector focused on HIV/AIDS, TB, malaria, immunization, traditional medicine and nutrition.

The health workforce is fundamental to health systems. Clinical care without caring, respectful and compassionate health professionals cannot be truly patient centered. In EFY 2009, 2,232 new students were enrolled in 28 medical schools. Annual enrollment in medical schools increased to 18,342 in EFY 2009. Similarly, a total of 933 physicians were deployed in the health sector, increasing the total number of physicians deployed to 7,503 and expanding the physician-population ratio to 1 per 17,000.

Expansion of HCs plays a pivotal role for the achievement of universal health coverage. Expanding, equipping, furnishing, maintaining and managing health facilities are one of the priorities of HSTP. In EFY 2009, total cumulative number of available health centers reached 3,622. However, despite remarkable achievements in regards to improving access to the population, challenges still exists that need to be addressed to make HCs functional.

With the aim of accelerating progress and building momentum towards realizing the HSTP targets, the FMoH identified four transformation agendas and reviewed all health programs with focus on the four agendas. There has been a huge drive to improve quality and equity of care; ensure woreda transformation; produce a compassionate, respectful and caring health workforce and realize the Information Revolution. Thus far, quality has been given due attention and the national quality framework has been developed and rolled-out. Encouraging results have been registered in hospital and health center reform activities that need to be scaled up in the coming years. Implementation of the transformation agendas revealed that woreda transformation is a long term process. To date, despite progress on each of the components of the woreda transformation, no single woreda has been entirely transformed. The Information Revolution has also demonstrated concrete progress in transforming the routine and population based data sources, but a poor culture of information use and data quality remain one of the major challenges of the health sector.

In most cases, the health sector performance in 2009 EFY is characterized by sustaining previous year's gains or slight progresses in most of the HSTP strategic objectives. The observed steady progresses compared to the annual targets are mainly attributed to the primary attention awarded to improving health care quality as well as the efforts exerted to use a better quality routine data. Overall, the report indicates that numerous initiatives were launched during the fiscal year that will need to be sustained and implemented with renewed rigor in the coming fiscal years.

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