ETHIOPIA HEALTH SECTOR

DEVELOPMENT PROGRAMME

HSDP III

2005/06 – 2010/11 (GC)

(1998 – 2003 EFY)

Mid-Term Review

VOLUME I

COMPONENT REPORT

By the Independent Review Team

05th May – 5th June 2008

Final Report

Addis Ababa, 12th July 2008

ETHIOPIA HEALTH SECTOR DEVELOPMENT PROGRAMME

MID-TERM REVIEW OF HSDP III

5TH MAY TO 5TH JUNE 2008

Programme:	Ethiopian Health Sector Development Programme (HSDP III)
Executing Agencies:	Federal Ministry of Health and Regional Health Bureaus
Evaluation:	Mid-Term Review (MTR) HSDP III.
Period reviewed:	July 2005-December 2007 (EFY July 1998 - Dec 2000)
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All team members were selected on the basis of their professional expertise and participated as individuals. There were 9 international and 38 national consultants. Some members only participated part-time. The following institutions provided staff/consultant support for this evaluation: FMOH (12), UNICEF (13), UNFPA (3), WHO (5), Italian Cooperation (2), EHNRI (1), HAPCO (1), Tulane University (2), ABT Associates (1), JSI (1), Pathfinder (1), SC-UK (1), and freelance (3). The evaluation was partly funded through the Health Pooled Funds (Technical Assistance component).As an *independent* review team, the opinions and suggestions mentioned in this report are solely the responsibility of the authors and do not in any way commit or imply the agreement of the FMOH or any of the other stakeholders operating in the Ethiopian health sector.

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Abbreviations and Acronyms

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health
AEPHCC	Accelerated Expansion of Primary Health Care Coverage
AIDS	Acquired Immune Deficiency Syndrome
AWD	Acute Watery Diarrhoea
AYRH	Adolescent Youth and Reproductive Health
AYRHS	Adolescent Youth and Reproductive Health Strategy
ARM	Annual Review Meeting
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ACT	Artemisin-Based Combination Therapy
BEmONC	Basic Emergency Obstetric and Neonatal Care
BCC	Behavioural Change Communication
BOFED	Bureau of Finance and Economic Development (Regions)
CDR	Case Detection Rate
CSR	Cataract Surgical Rate
CJSC	Central Joint Steering Committee
CDC	Centre for Disease Control
CRDA	Christian Relief and Development Association
CSRP	Civil Service Reform Programme
CSO	Civil Society Organization
CHP	Community Health Promoter
C-IMCI	Community Integrated Management of Childhood Illnesses
CBHI	Community-Based Health Insurance
CBN	Community-Based Nutrition
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CAR	Contraceptives Acceptors Rate
CPR	Contraceptives Prevalence Rate
CYP	Couple of Years Protection
DHS	Demographic Health Survey
DFID	Department for International Development (UK)
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
DAG	Development Assistance Group
DCI	Development Cooperation Ireland
DPT	Diphtheria, Pertussis and Tetanus Vaccine
DOTS	Directly Observed Treatment Short Course
DPPA	Disaster Prevention and Preparedness Agency
DPPC	Disaster Prevention and Preparedness Commission
DACA	Drug Administration and Control Authority
DTC	Drug and Therapeutic Committees
EWS	Early Warning System
EmONC	Emergency Obstetrics Neonatal Care
EOS	Enhanced Outreach Strategy
EHSP	Essential Health Service Package
ENA	Essential Nutrition Actions
ESHE	Essential Services for Health in Ethiopia
ETB	Ethiopian Birr
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EHNRI	Ethiopian Health and Nutrition Research Institute
EPI	Expanded Programme of Immunization
EQC	External Quality Control
FBO	Faith Based Organization

FHI	Family Health International
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FGM	Female Genital Mutilation
FMIS	Financial Management Information System
FEFO	First Expired-First Out
GP	General Practitioner
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GHI	Global Health Initiatives
GHP	Good Hygienic Practices
GOE	Government of Ethiopia
GC	Gregorian Calendar
HHRI	Health and Health Related Indicators
HCF	Health Care Financing
HCSS	Health Commodity Supply System
HEC	Health Education Centre
HEPR	Health Emergency Preparedness and Response
HEEC	Health Extension and Education Centre
HEP	Health Extension Programme
HEW	Health Extension Workers
HMIS	Health Management Information System
HPF	Health Pooled Fund
HPN	Health Population and Nutrition
HSDP	Health Sector Development Programme
HCT	HIV Counselling and Testing
HAPCO	HIV/AIDS Prevention and Control Office
HHM	HSDP Harmonization Manual
HIV	Human Immunodeficiency Virus
HRMIS	Human Resource Management Information System
HRD	Human Resources Development
HRH	Human Resources for Health
ICT	Information Communication Technology
IEC	Information, Education and Communication
ITN	Insecticide Treated Net
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IRT	Integrated Refresher Training
IDA	International Development Association (World Bank)
IHP	International Health Partnership
IUD	Intra-Uterine Device
IFA	Iron/Folic Acid
JICA	Japan International Cooperation Agency
JSI	John Snow Incorporated
JCCC	Joint Core Coordinating Committee
JRM	Joint Review Mission
UNAIDS	Joint United Nations Programme on HIV/AIDS
LMIS	Logistics Management Information System
MPS	Making Pregnancy Safer
MVA	Manual Vacuum Aspiration
MNMM	Maternal and Neonatal Mortality and Morbidity
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonatal Child Health
MNH	Maternal Neonatal Health
MSF	Médecins Sans Frontières (Doctors without Borders)
MAPP-E	Medical Association of Physicians in Private Practice
MTR	Mid-Term Review

MDG	Millennium Development Goal
MOCB	Ministry of Capacity Building
MOE	Ministry of Education
MOFED	Ministry of Finance and Economic Development
M&E	Monitoring and Evaluation
MDR	Multiple Drug Resistance
NDP	National Drug Policy
NHA	National Health Accounts
NHCS	National Health Communication Strategy
NNP	National Nutrition Policy
NNS	National Nutrition Strategy
NGO	Non Governmental Organization
NORAD	Norwegian Agency for International Development
NHC	Nucleus Health Centre
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Salts
OPD	Out Patient Department
PHAST	Participatory Hygiene and Sanitation Transformation
PLWHA	People Living With HIV/AIDS
PPF	Performance Package Fund
PFSA	Pharmaceutical Fund and Supply Agency
PLMP	Pharmaceutical Logistics Master Plan
PSLD	Pharmaceutical Supply and Logistic Department
PHARMID	Pharmaceuticals and Medical Supplies Import and Distribution
PAMIS	Physical Assets Management Information System
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PPD	Planning and Programming Department
PSI	Population Services International
PNC	Postnatal Care
PRSP	Poverty Reduction Strategy Paper
PEPFAR	President's Emergency Plan for Aids Relief
PMTCT	Prevention of Mother to Child Transmission
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PLMS	Procurement and Logistics Management System
PAP	Programme Action Plan
PBS	Protection of Basic Services
PER	Public Expenditure Review
PFM	Public Finance Management
PPP	Public Private Partnership
RDT	Rapid Diagnostic Test
RDU	Rational Drug Use
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
RTC	Regional Training Centre
RH	Reproductive Health
RDF	Revolving Drug Fund
RNE	Royal Netherlands Embassy
SC-UK	Save the Children UK
STI	Sexually Transmitted Infection
SHI	Social Health Insurance
SNNPR	Southern Nations Nationalities and Peoples Region
SP	Special Pharmacy
SCMS	Supply Chain Management System
SAFE	Surgery, Antibiotic, Face washing and Environmental Improvement
SDPRP	Sustainable Development and Poverty Reduction Programme
SIDA	Swedish International Development Agency
SSSC	Support Systems Steering Committee

TVET	Technical and Vocational Education Training School
TOR	Terms of Reference
TT	Tetanus Toxoid
TFP	Therapeutic Feeding Programme
TFR	Total Fertility Rate
TBA	Traditional Birth Attendant
TOT	Training of Trainer
TB	Tuberculosis
U5MR	Under Five Mortality Rate
UN	United Nations
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commission for Refugees
USAID	United States Agency for International Development
USD	United States Dollar
USI	Universal Salt Iodization
VCT	Voluntary Counselling and Testing
VCHW	Volunteer Community Health Worker
WASH	Water Sanitation and Hygiene
WORHO	Wereda Health Office
WJSC	Wereda Joint Steering Committee
WOFED	Wereda Office of Finance and Economic Development
WRA	Women of Reproductive Age
WFP	World Food Programme
WHO	World Health Organization
ZHD	Zonal Health Department
ZOFED	Zonal Office of Finance and Economic Development

Conversion Rate:

1 USD = 9, 56 Birr (May/June EFY 2001, GC 2008)

1 Euro = 14, 96 Birr (May/June EFY 2001, GC 2008)

Calendars

The Ethiopian Fiscal Year / EFY (or Ethiopian Calendar / EC) refers to the Ethiopian Fiscal Year, starting on 7th July in the European calendar. Currently, June 2008 corresponds with the end of EFY 2000. The overall correspondence between Ethiopian and European fiscal years is given in the table below, based on the Gregorian and Ethiopian Calendars:

Table 1.1 Gregorian and Ethiopian Calendars

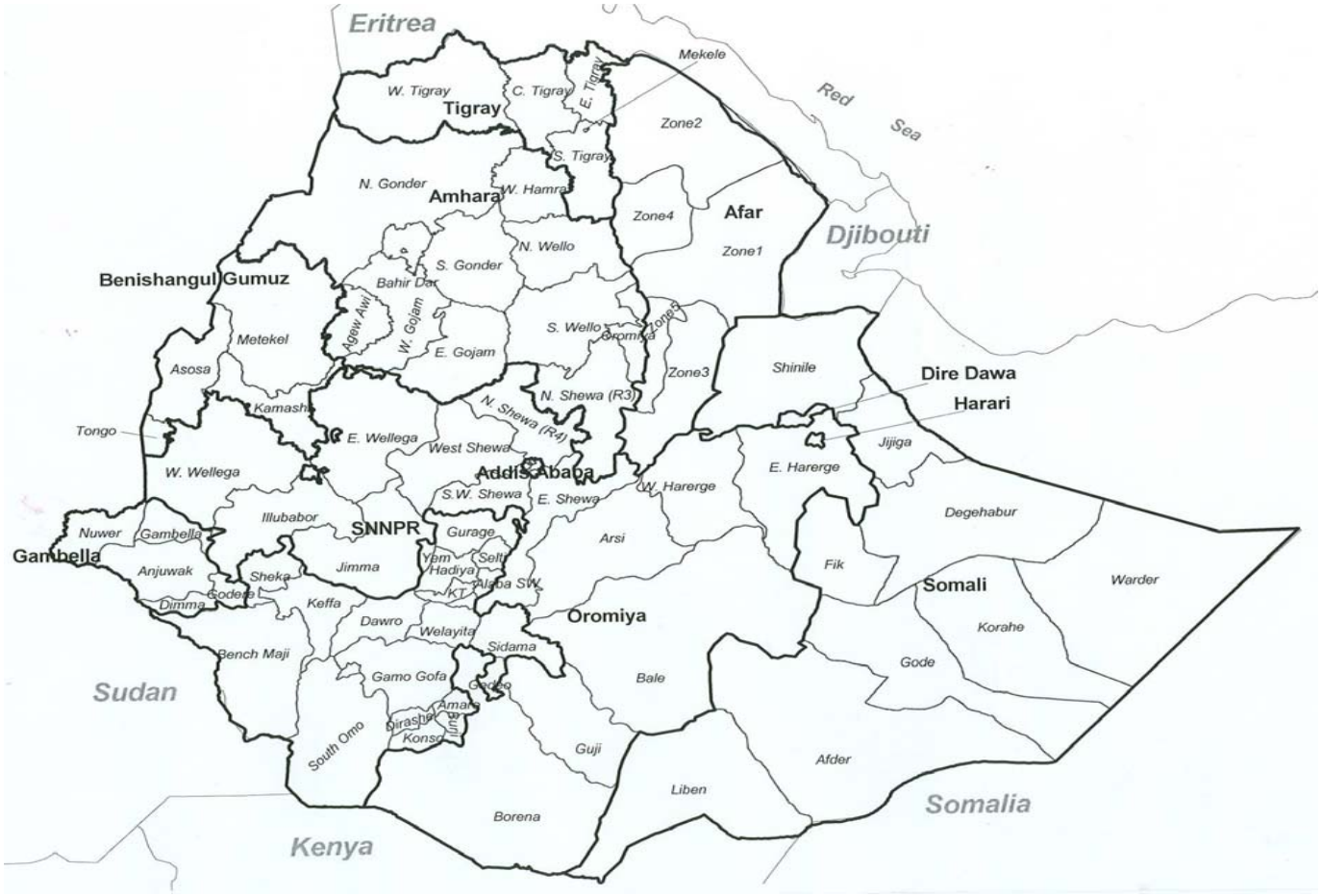
Gregorian (GC)	Ethiopian (EC)	HEALTH DEVT HSDP YEARS	NAT DEVT PLANS	HEALTH POLICY
1992/93	EFY 1985			
1993/94	EFY 1986			1993 HEALTH POLICY OF THE TRANSITIONAL GOVERNMENT
1994/95	EFY 1987			
1995/96	EFY 1988			
1996/97	EFY 1989	BASELINE		
1997/98	EFY 1990	HSDP I	i-PRSP	
1998/99	EFY 1991			
1999/00	EFY 1992		PRSP	
2000/01	EFY 1993		SDPRP	
2001/02	EFY 1994			
2002/03	EFY 1995	HSDP II		
2003/04	EFY 1996			
2004/05	EFY 1997			
2005/06	EFY 1998	HSDP III	PASDEP	
2006/07	EFY 1999			
2007/08	EFY 2000			
2007/08	EFY 2001			
2008/09	EFY 2002			
2009/10	EFY 2003			
2010/11	EFY2004			
2011/12	EFY 2005			
2012/13	EFY 2006			
2013/14	EFY 2007			

EFY = Ethiopian Fiscal Year; GC = Gregorian Calendar; EC = Ethiopian Calendar

National Level Indicators, June 2008 (2000 EC)

Serial No.	Category	Indicators	Baseline HSDP III EFY 1997	Target HSDP III EFY 2003	Current Status MTR EFY 1999	Comments
1	Input	Government budget allocation to the health sector: ETB	1,643 million	3,250 million	3,920 million (in EFY 2000)	The HSDP III target is to double the share of health as a proportion of total Government budget (domestic spending and direct budget support), the baseline is given as an absolute amount rather than a percentage.
2		Total per capita health expenditure (GOE):	Birr 19.10 (USD 2,0)	Birr 91.70 (USD 9,60)	Birr 28.00 (USD 3)	The HSDP III target is to increase total per capita health expenditure from USD 5.6 to USD 9.6. This can only be determined through a National Health Account. Per capita public health expenditure is estimated at ETB 28 (USD 3)
3	Process	Ratio of budget allocation to utilization/expenditure	85%	NA	78%	No target was set for this indicator in HSDP III but an increase in utilization is desirable. There is a high level of utilization in the recurrent budget but less in the capital budget, mainly due to the multi-year nature and delays in capital expenditure.
4		Essential drug stock-out rate Essential Drug Availability	NA NA	0% 100%	Improving	HSDP III sets a target for essential drug availability to increase from 75% to 100%. During health centre and hospital visits, periodic shortages of essential drugs are still reported, but the situation is improving due to the special pharmacies. However, there is no routine information system to monitor this indicator.
5		HMIS completeness and timeliness reporting rate	NA	80%		Currently it is difficult to estimate the performance of this indicator as not all health facilities are using a common HMIS reporting format due to implementation of the pilot HMIS.
6		Level of HSDP III harmonization with the "one plan, one report and one budget" principle	This policy was not yet defined in 1997	NA	Implementation initiated	FMOH and Development Partners have signed a Code of Conduct, and are working through joint steering committees. All partner plans are aligned with HSDP III and FMOH policy, however, there are still many reporting formats for the different sources of funding. Although figures are available for budgeting purposes, expenditure is not captured. Funding through channel 3 remains off-budget. There is little progress in alignment with government systems.
7		Primary health service coverage	72%	100%	109%	Although it appears that the target has been reached by over 9%, this figure is likely inflated, due likely errors in the nominators/denominators. However, as a result of the accelerated expansion of the primary health service coverage plan in Ethiopia, many regions will reach the 100 % target.
8		Health service utilization rate OPD / pp / yr	0.30	0.66	0.32	The HSDP III target is to increase per capita health service utilization rate from 0.30 to 0.66. Currently OPD utilization rate is used and is at 0.32. In most hospitals visited,

Serial No.	Category	Indicators	Baseline HSDP III EFY 1997	Target HSDP III EFY 2003	Current Status MTR EFY 1999	Comments
	Output	Admission / 100 persons / yr	1.6	NA	0.2	this rate has not increased in recent years. A underreporting is identified as one of the reasons, it seems necessary to explore further for possible reasons.
9		Contraceptive Acceptor Rate (CAR) / Contraceptive Prevalence Rate (CPR)	21%	45%	28%	The HSDPIII plans to expand family planning service coverage from 21% to 45%. There is a problem to use this coverage figure to monitor progress of CPR, the latter is only being collected through EDHS.
10		Proportion of births attended by skilled health personnel	12%	32%	16%	The HSDP III target is to increase deliveries attended by skilled birth attendants from 12% to 32%. Data from the regions suggest that the great majority of women do not deliver in a health facility in the presence of skilled health personnel.
11		Pentavalent coverage (DPT3)	70%	80%	73%	The original HSPD III target was to increase DPT3 coverage from 61% to 90%. Findings from the regions show that this is on target. Various problems were reported with staffing, supervision and maintenance of the cold chain but if these are addressed then coverage can be achieved.
12		ART coverage	NA	150,000	73,000	The HSDP III target was to provide ART to 150,000 people. Current estimates are that over 73,000 are on ART and numbers are increasing.
13		Performance and coverage of community conversations at different level	NA	NA	See comments	Though no target was set for this objective the review found plenty of evidence that community conversations are well established and that the health sector is increasing using this forum to mobilize communities.
14		PMTCT services	NA	Hosp 100% HC 70%	See comments	The HSDP III target is to have PMTCT services available in 100% of hospitals and 70% of health centres. Currently many regions have reached the target for hospitals and through the accelerated expansion plan will soon reach health centre target also.
15		ITNs coverage rate	NA	20 million	See comments	Over 20 million ITNs have been distributed throughout malaria endemic parts. A study is underway to assess ITN utilization but it was unavailable at the time of the MTR.
16		Inpatient case fatality rates	NA	NA	NA	Not available
17		TB: Case Detection Rate TB: Treatment success Rate	34% 81%	50% NA	32% 85%	Treatment success rates are improving in most regions but low detection rates are still a major concern and require follow-up.
18		Improvement of sanitation access rate	20%	80%	50% See comments	The HSDP III target is to increase latrine coverage from 20% to 80%. In many regions coverage had reached over 50% and plans for expansion are in place..
19		Institutions staffed as norms Dr / Pop Ratio Nurse / Pop Ratio Midwives / WRA Ratio HEW / Pop Ratio	 1: 67,821 1 : 6,082 1 : 13,682 1 : 26,687	 1 : 14,000 NA 1 : 6,759 1 : 2,500	See comments 1 : 79,267 1 : 5,928 1 : 19,734 1 : 8,608	There is a need to revise staffing standards as per designation of health facilities. HSDP III sets some norms, such as 1 HEW to 2,500 people, increase ratio of midwives to WRA from 1:13,682 to 1:6,759. Results in EFY 1999 show the Dr/Pop Ratio and the Midwives/WRA Ratio both decreasing, while Nurse/Pop Ratio and HEW/Pop Ratio are improving.



Administrative Map of Ethiopia: Regions and Zones, 2007

Executive Summary

1. OVERALL HSDP III PERFORMANCE

Introduction

Between the 5th May and 7th June 2008 (EFY 2000), the year of the Ethiopian Millennium, a multidisciplinary team of 38 national and nine international consultants studied the mid-term performance of the HSDP III (1998-2003). The team worked on the basis of a Terms of Reference (TOR), endorsed by the Joint Core Coordinating Committee (JCCC) and the Central Joint Steering Committee (CJSC). In the first week, the team reviewed a multitude of documents and prepared (with relevant inputs from JCCC) an exhaustive questionnaire (by level and by component).

In the second and third week, six teams with experts in service delivery, support systems and finance/governance visited and interviewed responsible staff in all the regions and in the two city administrations. They also visited training institutions, regional Bureaus of Finance and Economic Development (BOFED) and other relevant authorities. In all regions, care was taken to visit at least two Weredas (a strong versus a weak one). Interviews were conducted with health managers at all levels, Health Extension Workers (HEW), trainers of HEWs and midwives. Feedback was provided on findings, challenges, conclusions and recommendations to all Heads and their staff in the 11 regional health bureaus (RHB). During the visits, all teams drafted their regional reports, using a pre-established format. The same format was used during their debriefings with the RHB staff.

Back in Addis Ababa (week four), the teams debriefed each other in the presence of representatives of the Federal Ministry of Health (FMOH), Development Partners and Civil Society Organizations. The regional reports were circulated among all team members (Annex II). This formed the basis for the zero draft of the main report. The main report was internally discussed and validated by all team members in week five. Finally, the key findings of the main report's first draft were presented to the FMOH Management Team and the JCCC.

Limitations of the MTR

Reviewing a complete sector that provides health care and support to more than 80 million people in a period of five weeks is by definition limited in scope and depth. Other limitations relate to the lack of information on the functioning of the private and NGO sectors, the high turnover of health staff, and the inability to travel to the more remote and poorer areas of the country. Finally, in some instances, the reliability of national and regional data appeared questionable. Nevertheless these are the only sources available, along with the Ethiopian and Demographic Health Survey (EDHS). For these reasons, gaps or incomplete information may be found in various parts of the report.

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The MTR team would like to express its gratitude to the Minister of Health, His Excellency Dr Tedros Adhanom G/yesus for his dedicated leadership and stimulating support to the review process. Gratitude goes also to the two State Ministers, His Excellency Dr Kebede Worku and His Excellency Dr Shiferaw Teklemariam for their time and their vision on the performance and future of HSDP. Warm thanks goes to all staff of the Ministry, the RHBs, the zonal health departments (ZHD), the Wereda health offices (WORHO) and the HEWs working at kebele level for taking the time to respond to the multitude of questions. We have tried to bring their views and concerns as much as possible into this report.

Leadership and Vision

In reviewing the HSDP III performance over the last 2½ years, the MTR team found that health staff at all levels, demonstrated a strong commitment and vision to achieve its objectives. The FMOH, under the inspiring leadership of His Excellency, the Health Minister, his two State Ministers and his team of senior managers, has shown dedicated leadership and an impressive dynamism. With its concerted energy, the FMOH has set in motion a wide variety of innovations that are now in the process of being implemented. These innovations include: the Business Process Re-engineering (BPR) of some of the most important departments, the Civil Service Reform Programme (CSRP), the accelerated expansion of the health infrastructure (health posts and health centres), the massive training and deployment of HEWs, the start of an impressive bottom-up planning exercise by the WORHOs (the 'Core Plan') and the development of a community health insurance strategy for the country. In addition, important management initiatives have been put in place, such as the weekly, senior, management meetings, the bi-monthly meetings with all the heads of the RHBs and the improvements in hospital management. Together, these initiatives have led to the setting of very ambitious targets, summarized by His Excellency, the Health Minister as follows: "In this initial phase we aim for High Speed, Big Volume and Minimal Quality".

From a bird's eye view of the health sector, the MTR team concludes that the FMOH has initiated bold and courageous steps, aimed at achieving the HSDP III targets. FMOH has shown committed leadership and impressive management practice over the last three years.

Many examples of these initiatives will be discussed in the following sections of this report, but first the question, asked by His Excellency the Minister needs to be answered: Is the reform agenda headed in the right direction?

Is the Ministry Headed in the Right Direction with its Reform Agenda?

The MTR's answers to the Health Minister's questions: "Are we headed in the right direction with our reforms? Does our reform agenda address the right issues?" are based on the findings and analysis provided later in this report.

YES you are rightly emphasizing and investing in the expansion of health care provision at the kebele level;

YES you are rightly initiating a process of bottom-up and top-down planning;

YES you have rightly put in place the building blocks for adequate support systems.

BUT we found a disconnect between the implementation of service delivery objectives and the development of the required support systems, including the implementation capacity at the Wereda level;

BUT we found excessive emphasis on and high expectations of the health extension programme (HEP) and leading to insufficient attention for maternal health, human resource requirements and the risk of compromising the reliability of the Health Management Information System (HMIS);

BUT the time-frame to bring about the 'change in mindset', the required capacity building and leadership training needs to be revised and adjusted to realistic proportions.

Findings from FMOH and Regional Interviews

The FMOH is very much aware of the various challenges and constraints that lie ahead: (i) the acute lack of adequate resources to fund the many ambitious plans, (ii) the emphasis on quantitative targets with less attention for the more qualitative aspects of their implementation and (iii) the need for a more comprehensive approach to solve the outstanding issues in the various support systems. The FMOH rightly aims to change 'the mindset' of the workers in the sector and is doing so by 'shaking up' the sector, introducing important reforms in information systems, human resources, hospital reforms, pharmaceutical supplies/logistics, and rapid expansion of peripheral infrastructure (health posts and centres). All these reforms are commendable and very much needed.

While acknowledging the need for rapid and concerted action to achieve the HSDP III (and MDG) goals, the questions the MTR team asked were: "Have these innovations been sufficiently understood and taken on board by the managers at regional and wereda levels? Is there sufficient capacity at all levels to achieve these objectives within the time frame of HSDP III? Is the emphasis on quantitative numbers not to the detriment of quality, thus becoming self-defeating in the end? Is the time-frame to achieve the HSDP III objectives too tight or – in other words – are the objectives in themselves justified, but not possible to realize within the remaining two years of HSDP?"

These fundamental questions stem from our findings during the regional visits: In many places, regional and Wereda managers showed a preoccupation with numbers at the detriment of functionality and quality of services. The overall impression was that the HEP consumed most of everybody's time, while the necessary support systems and planning were not simultaneously addressed. While the HEP has advanced, insufficient support has been provided to make it fully effective and operational. The development of an 'all inclusive' plan to address the weaknesses in all the support systems is required.

Findings in Major HSDP III Objectives

It is likely that the first major objective of HSDP III to cover all kebeles with HEP to achieve universal primary health care (PHC) coverage will be reached (see table below). While most of the other major objectives of HSDP III[1] can be improved considerably, their targets are likely to remain out of reach during the lifespan of HSDP III. Nevertheless, the under five mortality rate (U5MR) and the infant mortality rate will improve considerably when the performance of the various programmes are further strengthened through interventions in the area of (i) nutrition interventions and Vitamin A distribution; (ii) treatment with oral rehydration salts (ORS) and Zinc; (iii) the widespread use of insecticide treated nets (TN) and treatment of malaria with coarthem; (iv) improvements in the TB programme; (v) integrated management of childhood illnesses (IMCI) expansion, including the treatment of pneumonia with antibiotics (co-trimoxazol); (vi) increased use of family planning commodities and (vii) strengthening of the immunization programme. Together these interventions undertaken by the HEW and with relevant support by the supervisors are likely to contribute substantially to the improvement of infant and child mortality.

Improvements in the area of maternal health will be more difficult to achieve, as they rely on a comprehensive improvement of the health system, rural infrastructure, supporting systems and require long-term actions in the area of (i) human resource development; (ii) planning and (iii) infrastructure, logistics and adequate referrals systems.

MTR Findings in Major HSDP III Objectives

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY HSDP III
1. To cover all rural kebeles with the HEP to achieve universal PHC coverage by 2008	Availability of HEW will be reached by the end of 2008, but their functionality is still limited due to delayed construction of health posts (72%) and distribution of health post kits (30%) and lack of supervision.
2. To reduce maternal mortality ratio from 871 to 600 / 100,000 live births	Since DHS 2005, no recent figures are available, but the attainment of this target is unlikely due to serious gaps in the implementation of the Reproductive Health Strategy, B/CEmONC in particular.
3. To reduce the under-five mortality rate from 123 to 85 per 1000 live births and infant mortality rate from 77 to 45 per 100 live births.	Since DHS 2005, no recent figures available, but further reduction is likely to happen, if the implementation of the vertical programmes and nutrition interventions will advance as planned. Furthermore, sustaining the trend of UFMR reduction is unlikely unless community-based pneumonia

[1] As stated on p. xiv of the HSDP III document

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY HSDP III
	management is introduced and newborn care is integrated in existing MNCH programmes
4. To reduce the total fertility rate from 5.4% to 4%	No recent figures available, but unlikely to have been reduced substantially, due to limited access to contraceptives. However, funding is increasing.
5. To reduce the adult incidence of HIV from 0.68% to 0.65% and maintain the prevalence of HIV at 3.5%	Adult incidence rate is 0.28%. The adult (15 till 49 years) prevalence rate is 2.1% (GOE, 2007).
6. To reduce morbidity and mortality attributed to Malaria from 22% to 10%.	The recent overview of HSDP III 9 months implementation (in 2000 EC) show morbidity at 90.000 cases and mortality at 35.000 cases, being a 48% and 55% reduction in morbidity and mortality respectively.
7. To reduce the case fatality rate of Malaria in age groups 5 years and above from 4.5% to 2% and case fatality rate in under 5 children from 5% to 2%.	In-patient case fatality for > 5 years old is 3.3% and for the < 5 years, the figure is 4.5% (FMOH 1999). The case fatality of the > 5 years old seems to have improved.
8. To reduce mortality attributed to Tuberculosis from 7% to 4% of all treated cases.	TB case fatality is reported at 5%, but this figure is against a very low CDR of only 32%

In this overview we have provided the FMOH with the requested strengths/weaknesses of its overall operations in the health sector. Below we suggest two concrete recommendations to address the most important current challenges:

Recommendation 1: Consolidate Achievements

Based on these observations, the overarching suggestion of the MTR 2008 is to finalize the training of the HEWs as planned and to shift to **a phase of consolidation** (through the end of HSDP III) in which the important numerical achievements of the first three years will be consolidated and deepened with the following activities:

- Harmonize construction of health posts and centres with the provision of the necessary equipment as a transitory system to ensure that HPs get the required supplies while the PFSA is building its capacity;
- Provide a one month course to all HEWs in clean delivery care (focus on timely referral of women with critical signs, and improved relations with traditional birth attendants (TBA) and Volunteer Community Health Workers (VCHW));
- Decide on the inclusion of additional curative care to be provided by HEWs, in particular for treatment of pneumonia and iron deficiency;
- Strengthen the relation between HEWs and their referral health centres. Make Wereda planning, supervision and support the responsibility of ALL staff at Wereda level, while each staff member could specialise in relevant areas, like planning, finance, logistics, supervision and quality of care;
- Prepare training of trainers (TOT) for the up scaling of midwifery training and define/prepare for the selection, staffing, transport and equipment of health centres with basic emergency obstetric and neonatal care (BEmONC) functions;
- Develop a comprehensive ('all inclusive') plan to address the shortcomings in the support functions (construction, human resource for health, capacity building and leadership training, logistics / pharmaceutical supplies and HMIS)
- Strengthen and expand the hospital reforms after evaluating the experiences currently going on (use lessons learned before going to scale);
- Finalize the Human Resources for Health (HRH) Strategy as a matter of urgency
- Bring the NGO/FBO/CSOs and private sector into the health sector, as allies with a common objective to provide care and support to the Ethiopian people.

Recommendation 2: Initiate Preparations for HSDP IV

In the same period, important preparations for the elaboration of HSDP IV should begin:

- Revise the overall governance/coordinating system of HSDP III, including the management of all funding sources under one decision-making body (provisionally called in this report "HSDP+/Coordinating Committee"); strive for the establishment of a 'unified coordinating system' at federal and regional levels with clear lines of communication;
- Continue negotiations with the Development Partners on the International Health Partnership (IHP) and their funding of the MDG Performance Package Fund (PPF); build confidence and credibility of the government budgeting, financial management and procurement systems; mobilize funding to pay for a waiver system for the poor; initiate a 'fiduciary risk assessment' of the performance of the financial and logistic support systems at short notice.
- Together with Ministry of Finance and Economic Development (MOFED), revise the component structure of HSDP IV in order to allow the allocation of funds (and priority setting) to the respective themes, by harmonizing it with the Government of Ethiopia (GOE) finance structure (chart of accounts);
- With health infrastructure and staff in place, decide on how to incorporate the new coordinating and implementing functions related to Nutrition, Population and Emergency Preparedness into the FMOH and RHB structures;
- Take gender, nutrition, population and pastoralists out of the cross-cutting issues and mainstream them into the new HSDP IV document. Bring Information Education and Communications (IEC) and Behavioural Change Communications (BCC) under HEP and other components.
- Add 'Planning' as one of the support functions in the new HSDP IV, as it has not been included as a system in its own right within HSDP III. It will benefit and strengthen from specific attention and funding.
- Consider developing the HSDP IV from a bottom-up approach (starting with Weredas).

More details on these overall findings and recommendations will be provided in the remaining part of this Executive Summary on the basis of the various HSDP components. For the relevant indicators, the reader is asked to consult the "National Level Indicators" (page xi-xiii and the overall performance indicators for HSDP III for the period 1997-2000 (EC) in Annex 1A and for the full period of HSDP (1990-2000 EC) in Annex 1B.

2. HSDP III PERFORMANCE BY COMPONENT

2.1. Health Service Delivery and Quality of Care

2.1.1. Health Extension Programme (HEP)

MTR Findings of HEP Performance

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY
Major objective: Cover all rural kebeles with HEP to achieve universal PNC coverage by the year 2000 (EC)	A number of regions have reached over 80% potential PHC coverage and the remainder is likely to reach their target to cover all kebeles with HEP before the end of this year, except for Oromiya, SNNPR (pastoralist areas), Somali, Benishangul Gumuz and Gambella.
SPECIFIC HEP TARGETS	
The construction of 13,625 health posts. The HSDP III target is a 15,000 health posts in place by the end of 2001.	There are 11,000 health posts in place at the end of EFY 2000. This is 73% coverage. Construction work is continuing. The 100% target is likely to be achievable by the end of HSDP III.
A total of 30,000 HEWs: This will ensure two HEWs per health post.	By May 2000, there were 24,500 HEWs trained and deployed (82% of the target). Target of HSDP III will be reached.
A ratio of 1 HEW per 2,500 people.	In May 2000 the ratio was 1: 3265 persons. Target is very likely to be achieved.
Supervisors were not envisaged	A total of 3000 supervisors have been trained (100% target)
A strong collaboration with a network of VCHWs at kebele level	Progress is being made: a guideline has been prepared to harmonize the collaboration with the VCHWs. A total of 900,000 Model Households have 'graduated'.

The MTR assessed the progress made with the HEP during the first phase of HSDP III. As most sections include observations related to the HEP, below only the ones directly related to its performance are mentioned. As there are high expectations about the contribution that the HEP will have towards the objective of universal primary health care in the country, it is important to take stock of the situation. What can be realistically expected at this stage? The MTR finds that the maximum output has been achieved given the resource constraints in the sector. The HEP clearly operates in line with the objectives of the Accelerated Expansions of Primary Health Care Coverage (AEPHCC) and the Essential Health Services Package (EHSP). The Government provides major support to the HEP (financial and policy wise). In addition to the achievements in the table above, all the HEWs are now on payroll from Wereda budgets. A total of 586 TOTs have been trained in Integrated Refresher Training (IRT) and 5,000 HEWs have received their first IRT trainings. From several studies it is evident that the community engagement of the HEWs in a number of regions is effective and highly appreciated. A major achievement is the "graduation" of 900,000 model households. The target for the year 2000 (EC) was 2,436,840 households, which equals 37% of the annual target. In maternal health, there is need to limit the scope of functions that is expected of the HEWs. The MTR stresses the importance of integrating the treatment of pneumonia at the health post level in order for it to be a life saving strategy. This will reduce the need for time consuming referrals to the health centres and will increase the utilization of the health posts. There is a clear need to address regional disparities especially in the area of capacity building in the emerging regions and in pastoralist areas.

Although it is too early to establish the impact of the promotive, preventive and curative services, there are strong indications that the HEP programme has contributed to positive changes in health seeking behaviour. Data to substantiate these findings are not evidenced enough yet, but there are good reasons to believe that the HEP is on its way to achieve its overall objective to a large extent.

Constraints

- Despite massive support at national level, insufficient allocation of resources by the Wereda councils to health related interventions leads to limited availability of resources for the HEP. The WORHO functionality may be affected due to their limited availability. The causes and remedies for this situation need to be further explored. There is still a need to construct a total of 4,200 health posts in a period of approximately one year. A number of regions will, most likely, have considerable difficulties to achieve full health post coverage by the end of EFY 2001.
- There is a considerable delay with the distribution of the health post kits. Currently only 30% of the health posts have received their kits with equipment, while it seems that consumables reach the HEW more easily.
- There is an indication that attrition and maternity leave among the HEWs contribute to long absences of HEWs in the health posts but to what extent is not fully known at this stage. HEWs recruited from outside of the kebele can be absent from the health posts over weekends, affecting continuation of services.
- The recent HEW career development plans might undermine the performance of HEP. This could mean a substantial loss of the investments made into the HEP since 1996/7.
- The quality of the HEW training facilities in the Technical and Vocational Education Training Centres (TVETs) is not up to standard. Little has changed over the past years. The quality of the pre-service training has not been given the attention it deserves.
- The progress with the IRT training seems to be affected by resource constraints in a number of regions. There is a concern that the IRTs will drain health staff from health centres.
- It is evident that the HEWs in the regions that receive extensive support from international programmes, gain advanced skills compared to the HEWs in other regions. This might lead to increased regional disparities in the HEWs qualifications.
- The pastoralist areas require a tailor made approach for the HEP in terms of health post construction, HEW selection, performance and mobility
- There is a concern that the HEWs may become overloaded with too many tasks, ranging from malaria treatment to model household training and will be considered as a *jack of all trades*! A number of HEWs are also politically engaged at community level as members in the kebele cabinet. This implies that they are not fully available for HEP activities as they are also called upon for other tasks/trainings.
- There is need to remain focussed on the priority, core areas of the HEWs; health promotion and prevention while limited expansion of basic curative services should be included.
- HEP interventions need a supportive environment, in which the HEWs are well linked to the health centres, the supervisors, the WORHOs and the NGOs. Currently this supportive environment is not yet sufficient.
- In maternal health, there is need to limit the scope of functions that is expected of the HEWs and improve their referral linkages with health centres.
- There is concern that the health posts cannot deliver the full Integrated Management of Newborn and Childhood Illnesses (IMNCI) package. It is a missed opportunity that pneumonia among children cannot be treated adequately at health post levels, because pneumonia represents 30% of child deaths and mothers are unlikely to go to the HC due to high opportunity costs.

Recommendations for the Health Extension Programme

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
	EFY 2001	Within EFY 2001-2003	After EFY 2003
Resource Allocation	Advocate for sufficient resource allocation by the Wereda councils to the health programmes.	Strengthen the planning process at WORHO and kebele levels to cater to health programmes priorities.	
Health Post Construction	Complete the health post construction in the remaining regions	Assess the options for matching funds for increased health post construction in pastoralist areas.	
Distribution of Health Post Kits (see also technical chapter on procurement and logistics)	Accelerate the distribution of the kits. Strengthen the RHB capacity in ordering drug kits.	Complete the distribution of the remaining kits. The provide health post consumables on an annual basis once a system restocking has been defined.	Distribute drugs and supplies in line with service package at health post level. Ensure adequate supply system.
Training and Career Development.	Assess HEW attrition rates to determine the need for additional HEWs. Improve on the quality of the pre-service training. Pursue the IRT courses and assess options for training options that match the health centre staff capacity. Provide more reference materials.	Develop a comprehensive and sustainable capacity-building plan for HEWs (including quality of pre-service training, IRT, upgrading courses, replacement strategies). Develop alternative incentives for HEWs. Address regional disparities in capacity- building.	Roll out a comprehensive capacity-building plan for HEWs. Include appropriate HEP principles in primary school curricula. Maintain and utilize the web-enabled HEP database for monitoring and planning of capacity-building activities.
Maternal Health	Revise the role of the HEWs in maternal health.		
Basic Curative Treatment	Agree on basic treatment for pneumonia in children	Roll out basic treatment strategies for the treatment of pneumonia.	Document lessons learned on the community based pneumonia treatment
Pastoralist Areas	Strengthen effective HEP approaches.	Strengthen effective HEP approaches.	Impact study of HEP.
Supervision and Monitoring	Provide capacity- building on the mandates of the HEP focal persons, health centres, supervisors, HEWs and VCHWs.	Assess the adequacy and effectiveness of the support supervision model between the WORHO, health centres, supervisors, HEWs and VCHWs. Conduct a study on the impact of HEP before the HSDPIII evaluation.	Impact study of HEP.

2.1.2. Family Health

MTR Findings in Family Health Performance

Specific Targets HSDP III	Progress Halfway HSDP III
To increase family planning service coverage from 23% to 45%.	'CAR increased to 30% in the first year of HSDP III.
To increase deliveries attended by skilled attendants from 9% to 32%.	Increased from 12% (EDHS 6%) to 16%.
To provide CEmONC2 in 87% of the hospitals and 20% of health centres	69% hospitals (FMOH data) – but probably less since HR data indicates less the 50% have the staff trained in BEmONC
To provide BEmONC in 100% of the health centres	25% health centres (FMOH data)
To reduce the prevalence of teenage pregnancy and unsafe abortion from respectively 20% and 50% to 5% and 10% respectively.	No data, but safe abortion services in the public sector are in a very early stage of implementation
To increase DPT3 coverage from 61% to 90% and increase the proportion of fully immunized children from 37 to 85%.	DPT pentavalent increased to 73% Fully immunized increased to 55%
To increase the proportion of neonates with access to proper neonatal resuscitation and ampiciline/gentamycine for neonatal sepsis from 6% to 32%.	No data but probably little improvement in resuscitation, sepsis, preterm and low-birth weight management.
To expand IMCI implementation from 36% to 90% of health facilities; C-IMCI implementation from 12% to 80% of the districts; and the pre-service IMCI training from 65% to 95% of health professionals teaching institutions;	Data is incomplete regarding IMCI in health facilities, but 45% health centres are reported to have1-2 staff trained in IMNCI. 172 Weredas and 8,000 HEWs trained in C-IMCI. All health professional training institutions are supposed to have integrated IMCI training except Medical Colleges

Progress in Family Health is varied, but generally below the targets set by HSDP III.

A. Maternal and Neonatal Health (MNH)

The GOE has formulated a number of policies and strategies that provide an excellent framework for improving MNH. Several steps towards implementing these strategies have been initiated through initiatives that are described in the main body of this report. Key examples are the HEP which extends outreach services and IEC/BCC activities into communities and households, the massive investment in expanding the number of health posts and health centres through the AEPHCC, and human resources strategies such as the 'flooding strategy' for the accelerated production of HEWs and health officers, and 'task shifting' to enable health officers to perform Basic Emergency Obstetric Neonatal Care (BEmONC) which are tasks usually done by obstetricians. Ethiopia has demonstrated impressive energy and commitment to increasing access for rural populations through the HEP, whereby communities and HEWs are expected to recognize and refer life-threatening childbirth complications to the facility where emergency obstetric and newborn care services are available. There is an urgent need to develop capacity in the health system to provide appropriate care for such referrals, so that lives will indeed be saved. Two critical bottlenecks need to be addressed:

- Poor quality and inadequate numbers of midwives to provide skilled birth attendance.
- Inadequacy of staff and poor quality services for B/CEmONC

[2] A health facility is considered as a functional BEmONC facility when it provides the seven basic signal functions and a CEmONC facility when it provided obstetric surgery (in particular Cesarean section) and blood transfusion in addition to the seven basic signal functions. These signal functions are parenteral antibiotics, oxytocines and anticonvulsants, manual removal of retained placenta, removal of retained products (Manual Vacuum Aspiration -MVA), assisted vaginal delivery (forceps or vacuum extraction) and newborn resuscitation *(recently added as the seventh signal function)*.

Unless these are addressed with the same dedication and vigour that has characterized the HEP, maternal and newborn health is unlikely to show much improvement.

The MTR recommends a two pronged strategy to address these bottlenecks during the remaining period of HSDP III:

Lay the Foundations for improving access to better trained skilled birth attendance and B/CEmONC services, particularly (but not restricted to) the rural poor by:

(i) Improving the *midwifery training quality* for midwives and clinical nurses to enable them to be skilled birth attendants (for example, through TOT), better practical training by improving service quality in training centres so as to attract more clients for childbirth); establishing nationwide standards for *midwifery certification*, addressing leakage of midwifery trained nurses to other nursing areas.

(ii) Improving *access, quality and use of B/CEmONC* services.

- Implement a stepwise increase in access to obstetric and newborn care, by designating selected health centres and hospitals as '**Strategic' B/CEmONC centres**' based on an emergency obstetric and new born care needs assessment;
- Consolidate available resources by deploying to the strategic centres, trained staff in sufficient numbers, with equipment and facilities to provide 24 hour services; link them with HEWs for referral and provision of clinical support;
- Progressively increase the number of these 'strategic facilities'.

(iii) Sustain CEmONC: Support trained CEmONC teams through twinning arrangements.

Implement Interim Period Strategies: While health system capacity is being built to utilize available resources, including the HEP, VCHW, and HIV/AIDS programme to prevent maternal and newborn death and disability:

- Improve MNH services through better coordination with HIV/AIDS
- Strengthen:
  - HEP focus on birth preparedness, recognition of danger signs and community mobilization for referrals,
  - Collaboration between HEWs and Traditional Birth Attendants (TBAs) to improve cleanliness, early recognition and referral of complications, and management of third stage labour;
  - HEP focus on improving tetanus toxoid (TT) coverage, providing iron supplementation and nutrition counselling, and
  - Post Natal Care (PNC) & newborn care with 24-48 hours so as to reach every woman who gives birth/newborn in the kebele covered by an HEW

B. Child Health and IMCI: The quality of IMCI implementation in health facilities, and the effectiveness of community IMCI in changing health seeking behaviour need to be assessed through studies, and appropriate remedial measures. Treatment of pneumonia should be extended to health posts level to increase access to life saving measures for rural children.

C. Immunization: Immunization scope and coverage have increased, although still below targets for herd immunity. Better coordination between health centres and the HEP would improve drop-out tracing. Locally appropriate measures are needed in pastoralist and insecure areas and to ensure the Expanded Programme of Immunization (EPI) reaches children living in those areas. The lack of maintenance of the cold chain, due to lack of qualified cold chain technicians, spare parts and more important, a comprehensive and robust maintenance system, requires urgent attention to preserve the potency of vaccines. Regional cold chain maintenance plans supported by appropriate resource mobilization are needed.

D. Adolescent and Youth Health: This is a new programme and implementation needs to be accelerated through integration with reproductive health, EmONC and PMTCT programmes and support to regions for planning and for capacity building.

E. Family Planning: This area has shown some progress, although much below the expected targets. Improving counselling aimed at fears of side effects and health problems, and tailoring contraceptive advice to the real needs of clients would improve acceptor and continuation rates. There is also a need to strengthen involvement of men in the use of family planning and empower women and their families to make informed decisions and have the means to attain optimum sexual reproductive health. Imaginative use of local leaders, including priests, and innovative approaches aimed at the 15-24 age groups are also needed.

Recommendations for Maternal and Neonatal Health

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
	EFY 2001	Within EFY 2001-2003	After EFY 2003
Laying the Foundations Improve Training	Improve the quality of midwifery training, by investing in midwifery and nursing schools, start TOT and improve quality of care in training sites, and establish nationwide standards for qualification and certification.	Systematically increase and monitor midwifery training for midwives and clinical nurses, and evaluate output competencies in BEmONC.	Mobilize resources for MNH.
Select Strategic Facilities	Based on a nationwide rapid assessment survey, select facilities to be strategic B/CEmONC centres, deploy existing staff, and establish referral and support mechanisms.	Evaluate the output competencies of CEmONC training. Establish twinning arrangements for CEmONC centres, improve collaboration with professional bodies, and establish legal cover for staff under the 'task shifting' strategy.	Coordinate Development Partners and government on implementation as well as policy issues.
Implement Fee Exemption	Implement fee exemption for pregnant women and young children.	Establish referral and clinical support procedures and mechanisms, and monitor performance outputs of B/CEmONC centres.	
Interim Period_Strategies	Strengthen coverage in coordination with HIV/AIDS activities and linkages with health centres	Develop plans and seek resources for regional emergency ambulance and transport.	
Promote Birth Preparedness	Focus HEWs on promoting birth preparedness, preventing harmful practices, TT, nutrition, PNC coverage, newborn care and improve coordination with TBAs.	Sustain and upgrade high level advocacy to place MNH on the agenda of communities, and political bodies.	
Community Mobilization	Improve the emphasis on community mobilization and IEC/BCC for birth preparedness and use of referral.		

2.1.3. Communicable Disease Prevention and Control

MTR Findings of Communicable Disease Prevention and Control Interventions

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY
1. To reduce the adult incidence of HIV from 0.68% to 0.65% and maintain the prevalence of HIV at 3.5%	Adult incidence of HIV is 0.28% and Adult HIV Prevalence 2.1% (Single Point Estimate 2007)[3]
2. To reduce morbidity attributed to Malaria from 22% to 10%.	It is not possible to collect this data. A recent malaria assessment shows that there was 54% and 55 % reduction in malaria admission and death respectively.
3. To reduce the case fatality rate of Malaria in age groups 5 years and above from 4.5% to 2% and case fatality rate in under 5 children from 5% to 2%.	In-patient case fatality rate of malaria in age group >5 years is 3.3%, while the case fatality rate of malaria in age group <5 is 4.5%. Case fatality rate for >5 years has reduced more than <5 years. (FMOH 1999 EC)
4. To reduce mortality attributed to tuberculosis from 7% to 4% of all treated cases.	Mortality attributed to tuberculosis is estimated to be 5%, but this is against a low CDR. (FMOH 1999EC)
SPECIFIC DISEASE CONTROL OBJECTIVES	
To achieve provision of VCT services in 100% of hospitals & health centres and PMTCT service in 100% of the hospitals and 70% of the health centres, respectively	1230 VCT sites country-wide and 5.8 million persons tested to date in all hospitals except two.
To increase the number of PLWHA on ART from 13,000 to 150,000 and provide prevention of opportunistic infections to 150,000 PLWHA.	329 sites providing ART and 131,360 clients served.
To increase the proportion of households with 2 bed nets, properly utilized from 2% to 49%.	With a total of 10 million households in malaria endemic areas and 20 million ITN distributed, the coverage is well over 100%; No study on utilization has yet been undertaken.
To increase tuberculosis treatment success rate for smear positives cases from 76% to 85%.	Current TB treatment success rate estimated at 85% in 1999.
Reduce the prevalence of leprosy grade-II disability from 12% to less than 10%.	The 10% objective has just been reached.
To reduce active trachoma in targeted 80 Weredas by 80% and increase the current Cataract Surgical Rate (CSR) from 350 to 600 per million people per year.	In 65 Weredas, mass treatment has suppressed transmission. Remaining Weredas will be covered within two years. CSR is incompletely reported and will be evaluated by MT assessment of the strategic plan.
To ensure the therapeutic coverage of onchocerciasis control above 65% in all CDTI areas and ensure its sustainability.	Therapeutic overage has exceeded targets. Sustained efforts are needed.
To interrupt indigenous transmission of dracunculosis in endemic areas of Ethiopia.	Documented transmission is interrupted. Imported reintroduction is still possible.
Achieve and maintain timeliness and completeness of the IDRS reports of 80%.	All regions doing IDRS, some doing monitoring full range of the 23 WHO advised diseases, others less depending on local conditions.
To establish permanent health emergency management team in the FMOH and ad hoc teams in 100% of RHBs and 80% of WORHOs	Emergency preparedness and response teams established at federal and regional level, working in close collaboration with DPPA, data on Weredas not available

[3] Original targets were based on antenatal sentinel surveillance data. Following the EDHS 2005 which showed different levels of prevalence, the FMOH commissioned a review to re-examine the data sets and to produce a single point estimate for incidence and prevalence. It is the findings of this Single Point Estimate in 2007 that are reported here.

A. Malaria

The malaria prevention and control programme in Ethiopia is guided by a five-year National Malaria Prevention and Control Strategic Plan developed in line with the goals of the HSDP. The goal of malaria prevention and control in Ethiopia is to reduce malaria morbidity and malaria-related mortality by 75% by the end of the year 2013 (GC) as compared to the annual averages seen in the period from 2001-2005 (GC). Major malaria targets include:

- 100% household coverage with two ITNs per household in all malarious areas.
- > 85% of the population living in epidemic prone areas covered with indoor residual spraying > 80% of the population have access to prompt and effective treatment with artemisin-based combination therapy (ACT).

Significant reductions in malaria related deaths have been reported by health facilities, as well as a reduction in the number of epidemic affected villages. In-patient case fatality rate of malaria has reduced in all age groups. With in-patient case fatality in age group >5 years falling from 4.5% to 3.3%, while the case fatality rate of malaria in age group <5 has fallen from 5% is 4.5% (1999 EC). Significant progress has been made in malaria control in the last three years, with a significant input of funds from a number of key donors especially the GFATM, but also including the World Bank, UNICEF, UNITAID[4] and others. This progress has included the distribution of approximately 20.5 million nets resulting in a household coverage of at least 70%

B. Tuberculosis and Leprosy

Both tuberculosis and leprosy have proven strategies and effective treatment schedules. They also benefit from sustainable global support. The main strategy for these two diseases is to enhance the detection rate and completion of regularly provided treatment. The findings of the MTR is that while improvement in the detection rate of these two diseases still require more efforts, the treatment success being achieved so far is encouraging. The number of new cases of leprosy was found to be still significant. Strategic plans for TB 1999 – 2002 (EC) and Multiple Drug Resistance (MDR) prevention and control have been developed and disseminated. Various manuals including TB Laboratory Manual and TB/leprosy manuals have been developed and distributed to all hospitals and health centres in accordance with international recommendations. Directly Observed Treatment Strategy (DOTS) is available in all hospitals and health centres equipped to conduct laboratory tests. The preparation and coordination of a simple, clinical definition of TB suspect case to facilitate referral by HEWs has been useful. Guidelines for Public Private Partnerships (PPP) were developed to promote the involvement of the private sector.

C. HIV/AIDS

The objectives for HIV/AIDS prevention and control are to reduce the adult incidence of HIV and maintain the prevalence rate through provision of VCT services and increase users of ART and provision of prevention and treatment of opportunistic infections. According to the multi-sectoral strategic plan developed for the programme, the focus is on capacity building; community mobilization and empowerment; integration with health programmes; mainstreaming; coordination and networking; and focus on special target groups.

The findings of the MTR are that achievements so far have been impressive as there has been a remarkable reduction in the prevalence of HIV. A five-year multi-sectoral strategic plan 1996-2000 (EC), the National Road Map and important guidelines were developed. The health sector response is much better harmonized with partners and other stakeholders' inputs. With better coordination and involvement of RHBs and partners, fund utilization has

[4] UNITAID is an international drug purchase facility established to provide long-term, sustainable and predictable funding to increase access and reduce prices of quality drugs and diagnostics for the treatment for the treatment of HIV/AIDS, malaria and tuberculosis in developing countries.

improved. The ART and VCT service sites (number of clients served) have shown an increase over the last three years. The achievement in the reduction of incidence and prevalence has exceeded the HSDP targets. Projected incidence for 2000 (EC) is 0.27 (HSDP III target, 0.65) and prevalence is 2.2% (HSDP III target, 3.5%).

D. Blindness Control

In blindness control, cataract, trachoma, glaucoma and childhood blindness are the major targets. A Global Initiative VISION 2020 was launched in Ethiopia and efforts have been made to expand services to tackle the problem. Cataracts account for 50% of blindness cases with about 600,000 backlog cases in the community. The main strategy in place for trachoma control is "SAFE", i.e. Surgery, Antibiotics, Facial cleanliness and Environmental Sanitation, including preventive measures. Accordingly there are trachoma control programmes run in highly affected districts, mainly through community distribution of antibiotics, but with limited attention given to static trachoma detection and care at OPDs, and health posts. A Strategic Plan for Blindness Prevention (1998-2002 EC) was developed. This is strengthening collaboration with partners and donors. Cataract surgeons' training is ongoing; the first batch of graduates has begun to work**.** A number of cataract surgery campaigns were carried out i, both through the public and private sectors and in collaboration with NGOs.

2.1.4. Medical Services

The aim of HSDP III is to improve the quality of medical services and their utilization by the population through re-organizing the health service delivery system into a four-tier system; to (i) implement decentralized management to ensure full community participation; (ii) develop and implement an essential health service package and referral system; (iii) develop health facility standards and staff, and (iv) equip the health facilities accordingly.

In the last two and half years national standards and building designs for health posts, health centres and district hospitals have been developed including standardized lists of equipment and furniture for these facilities. The scope of services to be provided has been determined through the development of an EHSP for Ethiopia, including information on the cadres of staff required, and drug lists for each level. Under the CSRP's business process re-engineering, the key support systems are being reviewed and revised, including the development of new standards on access to and quality of the essential health service package.

The main challenges to medical services continues to be: the provision of quality services and to increase utilization; the availability of appropriately trained human resources and maintaining strong professional ethics; the delay in the development and implementation of a functioning referral system; the need for coordination mechanisms for providers with common catchment populations; shortage of diagnosis and treatment protocols and need for more supportive supervision to ensure their utilization. All these inputs are still catching up with the enormous expansion in medical services.

Recommendations for Service Delivery

Actions to be Undertaken	Short-Term In Next EFY 2002	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Strengthen National TB & Leprosy Programme	Assign additional technical staff to the national *TB and leprosy* programme at all levels. Study health system constraints in improving TB	Strengthen centres of excellence for leprosy control and treatment of leprosy related disability. Carryout TB prevalence survey.	Review stewardship roles of stakeholders in relation to TB and leprosy control.

Actions to be Undertaken	Short-Term In Next EFY 2002	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
	case detection rates. Review regulations on supply of leprosy drugs.		
Accelerate Coverage of HIV Services and Build on Health Systems Strengthening Best Practices	Continue accelerating and strengthening access to HIV services, both preventive and care. Strengthen integration into routine health service delivery and linkages with community and private sector.	Transfer best practices on community involvement in defaulter tracing from HIV programme to other programmes.	
Expand Blindness Prevention	Appoint focal persons for blindness prevention programme at lower levels and incorporate key activities into core plan and monitor, strengthen links with HEP.	Expand role of community, private sector and NGOs in blindness prevention.	
Strengthen Role of IDSR and EPR at all Levels	Strengthen capacity for IDSR and emergency response at all levels, including linkages with HEP.	Include IDSR as part of core planning and provide budgetary support, link to emergency response and preparedness.	
Update EHSP	Revise EHSP to include emergency health facility units, i.e. nucleus health centres, primary hospitals.	Incorporate the EHSP into planning, budgeting and M&E guidelines. Use EHSP to guide planning for capital investment to establish functionality in health facilities.	
Accelerate Health Management Strengthening Initiatives	Accelerate health management strengthening initiatives, including role of experienced managers as mentors for newly appointed health managers.	Develop local level technical and administrative coordination mechanisms between referral hospitals and catchment Weredas.	Include hospital strengthening as component of HSDP IV.
Resources for Malaria	Mobilize funds to maintain the gains made in malaria control scale-up.	Maintain funding for malaria moving emphasis from treatment to prevention.	Advocate for continued investment in malaria prevention, until elimination can be achieved.
Increase Malaria Prevention	Increase emphasis on IEC/BCC to translate high levels of net ownership into utilization. Strengthen indoor residual spraying programme to ensure high coverage of epidemic areas.	Target high risk groups for future ITN distribution, i.e. pregnant women and children <5 years of age.	

2.1.5. Hygiene and Environmental Health

MTR Findings on Hygiene and Environmental Health Interventions

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY
Increase latrine coverage from 20% to 80% and ensure 100% of the facilities are properly handled, sustained and utilized.	Access to improved sanitation 50.8% but no national data on utilization of sanitation services
Promote communal solid waste disposal sites in 100% of villages and ensure 100% utilization rate.	No national data coverage yet, solid waste disposal sites promoted through model village initiative
Improve medical and other waste management system in 100% of public and private health institutions.	No national data coverage available, but waste management part of standard design for new facilities
Increase drinking water quality monitoring from 44% to 90%.	Access to safe water 51%
To achieve 100% monitoring of food safety in food processing industries.	No national data available, food safety inspection now part of routine work of environmental officers

The key objective of this subcomponent is to increase the coverage of hygiene and environmental health services throughout Ethiopia with the overarching goal of achieving the National Vision of universal access to hygiene sanitation by 2005 (EC). The main hygiene and environmental health strategies of HSDP III aim to promote national policies and sanitation practices at the community level, engage the private sector in the provision of sanitation services, and strengthen technical capacities to ensure the quality services. Currently, national figures indicate that access to safe water has risen to 51% (2007)[5] while latrine coverage has reportedly increased from 35% at the beginning of the HSDP III to 50.8% (2007) [6] at the time of the MTR.

Despite the significant rise in access to water and improved sanitation, there is no data on the rates of usage of these services. Ethiopia still suffers from a heavy disease burden that is directly related to poor hygiene practices and sanitation services. Each year, the average Ethiopian child has –five to 12 diarrhoea episodes and diarrhoeal illnesses kill between 50,000 to 112,000 children each year[7]. Women and girls are most affected by inadequate sanitation services, as they are forced to spend more time fetching water and caring for the sick than participating in income-generating activities or attending school.

Recommendations for Hygiene and Environmental Health

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Coordination and Cooperation		Harmonize the activities and financial disbursements of institutions and actors in hygiene and environmental health particularly at the RHB and WORHO levels.	
Accountability		Mobilize local political leaders and private sector professionals to improve accountability and quality of the provision of services.	
Monitoring and Evaluation		Strengthen the integrated Monitoring and Evaluation system that is currently being used at the community, wereda, regional and national levels. Adopt indicators related to hygiene practice and behavioural change.	

[5] UNICEF Approach Paper: Water Supply and Water Safety
[6] Ethiopian Country Sanitation Report Feb 2008, World Bank
[7] National Millennium Hygiene and Sanitation Movement (MHSM)

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Advocacy	Formulate a health extension package for urban communities. Provide public recognition to communities, individuals and institutions for their commitment to hygiene and environmental health using awards and incentives.	Promote national hygiene and sanitation policies at all levels. Engage local community and religious leaders and the private sector in promoting hygiene and sanitation practices Strengthen hygiene and sanitation awareness and services in schools.	Strengthen the HEP and the training of the HEWs to raise awareness, promote behavioural change and sanitation practices that improve community health and empower women.
Financial Resources	Allocate funds for hygiene and environmental health activities at the RHB and WORHO levels. Strengthen the capacity of regional public health laboratories to facilitate testing and ensure hygiene and sanitation standards.	Increase negotiation capacity of the FMOH to mobilize more resources for hygiene and sanitation.	Encourage the private sector to provide sanitation supplies, technical solutions and transportation options.

2.2. Information, Education and Communication and Behavioural Change Communication (IEC/BCC)

Promoting IEC/BCC is one of the primary goals of the National Health Policy and hence a key component of HSDP III. Although IEC/BCC is a standalone component, its integration into relevant health programmes, including the prevention of communicable diseases, HEP, family health, hygiene and environmental health and medical services, is critical to the overall success of these interventions.

A National Health Communication Strategy (NHCS), which now serves as the basis for guiding the health communication activities of the country, was developed in 1996 after the final recommendations of HSDP I. Its role is to provide direction in strengthening IEC/BCC interventions in the country; to outline requirements for coordination, to define roles and responsibilities of relevant stakeholders and to assist regional health bureaus to develop their own communication guidelines.

At the federal level, the Health Education Centre (HEC) was the original institution, as set out in the NHCS, with the mandate to coordinate all IEC/BCC related activities and to take the lead role in policy development, training, technical support, research and the production of communication materials. In 1998, the Centre was expanded to include the coordination and implementation of the HEP and is now aptly named the Health Extension and Education Centre (HEEC).

Recommendations for IEC/BCC

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Financial Resources	Allocate resources for audio-visual equipment, staff training and reproduction of audio-visual programmes for community education	Create a funding pool for donor contributions. Provide a radio for every HEW.	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Technical Support	Re-establish the federal level Technical Working Group on IEC/BCC to strengthen support for health education and communication.	Develop an IEC/BCC technical working group at the regional level to harness best practices, share experiences and resources among IEC staff, NGOs, UN agencies the private sector and media.	
Advocacy and awareness raising	Revise the NHCS to feature the HEP.	Prioritize IEC/BCC activities in all health programmes with particular emphasis at the regional level and on critical programmes such as maternal health and family planning.	Engage in pro-active dissemination and promotion of IEC/BCC frameworks and strategies among relevant RHBs and WORHOs to increase political commitment for IEC/BCC initiatives.
Training		Introduce IEC/BCC module in the IRT.	Introduce IEC/BCC as a sub-specialization in colleges and universities.
Monitoring and Evaluation		Map and review existing IEC materials to determine gaps, consolidation requirements and client needs.	Strengthen the M&E system to better assess the impact of health education and behaviour change interventions. Develop guidelines and adopt indications for the collection of data at the district and zonal levels.
Harmonization	Ensure inclusion of guidelines in HEP to harmonize the roles of and clarify incentives for VCHWs.	Ensure that HEP initiatives such as Community Conversation and the Model Household approach are harmonized as complimentary interventions.	Clearly articulate the supervision role of the new 1,300 Wereda coordinators for HEWs and ensure they are trained in IEC/BCC.

2.3. Cross-Cutting Issues

2.3.1. Gender

Progress has been made in the appointment of focal points and the availability of guidelines at regional level. Stronger leadership to promote attention to gender issues over the next few years is needed to capitalize on the fruits of a gender sensitive health service, leading to faster progress towards key HDSP III targets including lower maternal mortality rates, slower population growth, and a greater balance between the sexes in health services. Management needs to ensure that budgets are allocated at regional and wereda levels to fund activities addressing gender concerns. Management is advised to commission a more in-depth review aimed at developing a budgeted action plan to improve progress in mainstreaming gender.

2.3.2. Nutrition

Given the magnitude of the problem of malnutrition and its consequences in Ethiopia, urgent and far-reaching action must be taken to improve nutrition. Some of the hardware is already in place, with the increasing presence of HEWs, VCHWs, and Enhanced Outreach Strategy (EOS) campaigns. The policy is also in place: the National Nutrition Strategy (NNS), approved by the GOE in February 2000 and set to be implemented as the National Nutrition Programme (NNP) in July 2000, has the potential to significantly improve nutrition. The necessary structure must be put into place to implement NNP, in order to achieve HSDP III and MDG targets related to nutrition within the given timeframe. This can be facilitated by

establishing a Nutrition Department at the federal level, and increasing the presence of nutrition focal persons and monitoring of nutrition indicators at all levels.

2.3.3. Pastoralist Care

Progress has been made in implementing the strategy for pastoralists. Progress could accelerate, if more earmarked resources were ring fenced for pastoralist health care. The modification of the HEP is now at a final draft stage. It includes modifications to the national package, including permission for pastoralist HEWs to treat pneumonia. Inter-sectoral collaboration with other ministries on a coherent integrated accelerated support for services aimed at pastoralists are not (yet) taking off. Despite a few meetings at federal levels between ministries, coordination at regional levels is still minimal. There are some notable experiments such as equipping HEWs with camels to increase their mobility and training HEWs to treat pneumonia. Health education in vernacular via radio transmission has expanded, but other successful strategies, such as combining cold chains for livestock and humans, experimented in the past in Ethiopia are still unheard of. There is a lot of good-will from international partners to support expansion of these promising initiatives; the creation of a pastoralist health coordination group in the division of family health is an excellent development. It now needs to be pro-active and reach-out more aggressively to secure more funding to expand the special attention to pastoralists, if HSDP III is to stand a chance at reaching outcome targets for pastoralists

2.3.4. Emergency Preparedness and Response

Preparation of manuals for Health Emergency Preparedness and Response (HEPR) has started, for instance in the FMOH and in Tigray region. FMOH has recognized public health emergency management preparedness and response as a core process in BPR. In general, there is an urgent need to address emergency in the FMOH more purposefully, right from the federal level to the lowest levels by: (i) strengthening coordination at the RHB level; (ii) preparing annual budget allocations; (iii) drafting contingency plans; and (iv) building the capacity at the level of the RHBs as well as other levels in order to respond effectively and efficiently to any form of emergency outbreak that may occur.

2.3.5. Population Issues

Progress in population issues can be made through the deployment of HEWs. As HEWs are deployed, RHBs could study the impact they are having at expanding the use of family planning with a view to decide what extra actions are needed to provide further support to HEWs, especially in more remote areas where fertility is highest. HSDP III does not mention specific targets related to population issues, but the recent adoption of a National Population Action Plan yields great potential to bring population issues back into the spotlights. Given the high population growth, renewed attention and a comprehensive approach with full support from the FMOH are essential, if the targets of HSDP III and the MDGs are to be met.

3. Support Services

3.1. Health Facility Construction and Maintenance

MTR Findings of Major Facility Construction Objectives

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY
Increase the potential health posts coverage from 20% to 100%	Target number 15,000. There were 9,914 health posts reported by the end of EFY 1999. This is 66% coverage. Construction work is continuing. Estimate for the MTR is 11,000 (73%). The 100% target is achievable by the end of HSDP III.
Increase the potential health centre coverage from 18% to 100%	Target number is 3,200. There were 671 FMOH health centres reported by the end of EFY 1999.[1] This is 21% coverage. However, other data indicates 644 health centres. 180 to be completed by end of EFY 2000 giving a total of 824. A further 871 by the FMOH and 598 by the RHBs are expected to bring the total to 2,293 by the end of EFY 2001 (72%).
Increase the general potential health services coverage from 64% to 100%	With the current expansion of health posts and centres, no recent data could be found. A possible source for this information is the web-based data base initiated by UNICEF.
Equip and furnish 80% of the health facilities as per the standard	30% of health posts have been issued with equipment kits. Kits for 66% of health facilities are planned. Most facilities have basic equipment and furniture with an estimated 50% of health facilities sufficiently equipped to carry out essential services.
Upgrade 30% of the health centres to enable them provide BEmONC services	Infrastructure is in place to carry out BEmONC at 30% of the facilities if so required but poor support and human resource services mean that in practice BEmONC services rarely take place.
To establish at least one functional medical equipment workshop in each region.	No data is available which supports physical progress. A number of people are on training courses in some regions.

A considerable amount of capital investment is being made on new and upgraded health facilities. The results are impressive given the constraints and challenges. However, the number of facilities required to achieve 100% coverage based on the HSDP III criteria is unlikely to be achieved. Based on demographic data estimates alone, the population is expanding at a faster rate than the planned rate of construction progress at health posts level. If communities are motivated and recognize the benefits, 100% health posts coverage is achievable with the level of commitment shown by FMOH.

The upgrade of Nucleus Health Centres (NHC) to clinics and the construction of new primary hospitals (formally known as a Type A health centre) are receiving considerable investment. However, this building programme faces many logistical and technical challenges. It is unlikely that the work will be completed satisfactorily within the given time frame. Some regions will be more successful than others. The limited capacity of the construction industry and the expansion of rural electricity and water supplies, as well as other necessary health service components, are not capable of supporting the number of health facilities currently planned or under construction. The MTR observed that, unless there are sustainable solutions for appropriate water, power and maintenance, very few of the health facilities will function to the standards of HSDP III. The effort, though, to meet the targets is commendable.

Many other health related construction programmes are taking place, such as pharmaceutical stores, blood banks, zonal and district hospitals, all of which will contribute to the increase of health service coverage. No comprehensive HMIS or programming data was available during the MTR to give a national view.

Recommendations for Facility Construction and Maintenance

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Review Policy and Design	Learn from problems in existing buildings. Remove WC cisterns from all health facilities, with or without water connections. Provide a one-tap policy to sanitation blocks using pour flush techniques. Review material specifications. Install manually filled water containers above existing wash facilities. Reduce the number of light points. Provide small generators, in the short-term to power BEmONC services only.	Develop standard guidelines for all components: space standards, room data sheets, appropriate use of water, lighting and power. Apply to new designs. Research alternative power sources.	Monitor and evaluate effectiveness of the design modifications. Be prepared to adjust the standards again.
Capacity Build the PPD Engineering and Architecture Units	All parallel and vertically funded construction programmes should be required to contribute to the strengthening of the PPD: with vehicles, equipment, staff incentives, on the job training. Recruit an architect/designer/engineer who is a specialist in health facility design in emerging countries to guide policy and strategy in the FMOH.	Continue to strengthen the PPD.	The PPD should be in a position to develop strategic physical Master Plans looking forward 10 to 20 years.
Implement a backlog maintenance programme. Recommend minimum of 10 to 15 % of retained revenue used for routine cleaning and maintenance. Budget for RHBs to include significant funds for cyclic and preventative maintenance.	Either: Develop the capacity within the FMOH through direct labour. Or (both approaches can be followed – in different areas) Tender out to the private sector using Performance-based fixed price contracts for standard packages of maintenance work.	Establish Regional Workshops for maintenance and repair. M&E effectiveness M&E effectiveness	Provide more resources to which maintenance approach is the most effective.

3.2. Human Resource Development

MTR Findings of Major Human Resources for Health (HRH) Objectives

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY
Increase HEWs to population ratio to 1:2,500	24,500 of the projected 30,000 HEW have been trained. The target is likely to be reached. However, as the population increases, the number of health facilities has to be adjusted.
Increase the ratio of midwives to WRA group from 1:13,388 to 1:6,759	Not yet achieved. From 1995-1999, the output of midwives from institutions decreased, however, current intakes have increased.
Staff all health facilities according to the standard and RHBs and WORHOs as per their respective organizational structure	Not yet achieved.
Establish implementation of transparent and accountable human resource management at all levels	Not yet established. Most regions lack management policy and a trained HR manager. Data of HRH not yet updated

The Government's capacity-building programme has scaled up the intake and output of HEWs and health officers through the so-called 'flooding strategy' to increase the number of health workforce available at lower and middle levels of the sector. Specific targets include:

- Increase HEWs / population to 1:2,500;
- Increase the ratio of midwives to WRA from 1: 13,388 to 1: 6,759;
- Implement a transparent and accountable human resource management at all levels;
- Strengthen both the production and the retention of health personnel.

In the past two years, the FMOH with joint technical and financial assistance from different stakeholders initiated one of the seven BPR core processes that brought a thorough analysis of the HRH situation in the country. Improving HRH management at all levels has proved to be a complex and difficult undertaking. Very often in the regions there is no HRH focal person and HSDP III policy documents, including the HSDP Harmonization Manual (HHM) are either not known at all or little understood. The uncoordinated and donor-driven provision of continuing education programmes further complicates the situation, especially as curricula are not updated and facilities are often inadequate for the large numbers being trained.

Training institutions generally lack curricula updates, though numbers of trainees have greatly increased. There has been a conscious effort to increase numbers of female health professionals but the imbalance is still substantial; most employed at higher grades are males. There have been fluctuations in availability of different cadres, as outputs from training institutions for individual cadres have either increased or decreased in the past 10 years. On the whole availability of most cadres has increased but the shortage of midwives remains critical. The targeted numbers of HEWs have almost been achieved but there are problems with the quality of their skills and training.

Recommendations to Strengthen Human Resources for Health

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Policy and Planning	Finalize the HRD strategy. Bring quality issues into training targets. Improve coordination and effectiveness within HRH and the in-service training	Build the capacity of the RHB, wereda and zonal facilities in leadership and management (including financial) skills. Finalize the restructuring of the HRD within the FMOH.	Establish HRIS/HRH database for professional working in both the public and private sectors.

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term within HSDP III	Long-Term Design HSDP IV
	programmes		
Management and Deployment	Consolidate and institutionalize the existing retention scheme.	Develop an official dissemination process for all documentation and guidelines including availability on FMOH website	
Capacity Building	Map and monitor the overall in-service training programme especially for areas like IMCI and child health; maternal health, BEmONC, HIV/AIDS/TB.	Introduce twinning arrangements to support newly trained CEmONC teams.	Introduce HEP and PHC elements at primary and secondary school level.
Training Schools	Develop a comprehensive plan to improve the HEW training curriculum in the TVETs. Initiate improvement in midwifery training through (a) training of trainers (b) upgrading service quality in practical training sites	Improve HEW training with particular care to the practical sites for students, strengthening the cooperation with other stakeholders, including the traditional health resources at community level (e.g. TBAs, healers and herbalists).	Plan a mid-long term revision of curricula, especially those for generic diploma nurse and for HEWs. Improve quality of training and standardize qualifying exams for all health professionals to ensure same standards of practice, irrespective of training institution.
Pre-Service and In-Service Training	Accelerate training in rare skills through B/CEmONC, and MD training.	Request more inputs from the regional education bureaus on the selection of trainees, curriculum development and quality of training	Train health officers in MSc programmes for surgical and obstetric emergencies.
Continuing Education		Set up boards/councils to start re-registration assessments for all health professionals to ensure continuous education.	Begin re-registration of all health professionals based on recommended continuing education.

3.3. Pharmaceutical Supplies and Logistics

MTR Findings of Pharmaceutical Supplies and Logistics

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY
To increase availability of essential drugs from 75% to 100% in each public health facilities.	Indication of increased availability due to enhanced supply through PFSA and the establishment of special pharmacies. Further improvement to be expected as a result of the restructuring of the pharmaceutical and supply sector through the PLMP.
To ensure 80% availability of standard medical supplies and equipment in all public health facilities.	Funding and partner support available, but there is delay due to the multi complexity of supply chain and the sheer volume of goods to be provided.
To scale up the percentage of imported and locally produced drugs with safety, efficacy and quality investigated from 40 to 100%.	There is an increase in Good Manufacturing Practices inspection, document evaluation and lab investigation of drugs manufactured locally and internationally.
To reduce the percentage of expired drugs from 8% to 1% in public health facilities.	PFSA standard policy is to distribute drugs with at least 80% shelve life left, but effects in the field are yet to be seen.
To increase the proportion of health institutions that practice rational use of drugs from 25% to 100%.	Rational Drug Use (RDU) seems to be improving thanks to the 56 Drug Therapeutic Committees (DTC) in selected hospitals.
To increase the inspection coverage of drug trading facilities from 20% to 100%.	There is progress but less than hoped due to the need for Drug Administration and Control Authority (DACA) to expand its offices in the country. Where there are no DACA hubs, inspection is delegated to the RHB or agriculture bureau.

Three government institutions (DACA, PSLD and PFSA) are the major stakeholders of the pharmaceutical sector in Ethiopia. Under the umbrella of the FMOH, and supported by partner organizations and donors, they have been working towards achieving the objectives

of the sector outlined in the HSDP III. A well functioning pharmaceutical service is described in HSDP III as the corner stone for any worthwhile health service. The 5-year Pharmaceutical Logistics Master Plan (PLMP) is the all-encompassing tool to reach this goal. Comments on the implementation of the PLMP are provided in the main body of the report.

During the period of HSDP III, a lot of achievements have been registered, especially in institutional transformation and capacity-building areas. However delays in decision-making, shortage of funds and constraints to keep development partners involved are some of the major challenges. There is a general expectation in the regions that the PLMP will solve the chronic problems regarding the pharmaceutical supply and logistics management, but real ownership by the stakeholders will only be achieved if they are fully informed and involved.

3.4. Health Management Information System (HMIS), Monitoring and Evaluation (M&E) and Operational Research (OR)

MTR Findings of HMIS/M&E/ Operational Research Objectives

MAJOR OBJECTIVES HMIS	PROGRESS HALF-WAY HSDP III
Health Management Information System (HMIS)	
Develop and implement a comprehensive and standardized national HMIS and ensure the use of information for evidence-based planning and management of health services	Piloting of comprehensive and standardized national HMIS has been evaluated and a massive preparation is underway for nationwide roll out.
Review and strengthen the existing HMIS and at federal, regional, Wereda, health facility and community levels and ensure use of health information for decision-making at all levels	As there was more focus on designing a new system, nothing has been done to strengthen existing information systems. There is no improvement in use of information in decision-making.
Achieve 80% completed and timely submission of routine health and administrative reports.	Both the completed and timely submission of routine health and administrative reports are about 80%.
Achieve 75% of evidence-based planning.	There is no standard defined against which a plan could be assessed to derive percentage of evidence-based. Nevertheless, use of information as evidence in planning is far from satisfactory.
Monitoring and Evaluation (M&E)	
Develop and implement comprehensive and integrated Monitoring and Evaluation guideline at all levels of the health system.	Comprehensive and integrated M&E guidelines at all levels of the health system not yet developed.
Establish Wereda Joint Steering Committee (WJSC). Form linkages between Wereda, Regional and Central Joint Steering Committees.	No evidence of establishment of Wereda Joint Steering Committee and Regional Joint Steering Committee has been found, let alone the establishment of linkage between them.
Conduct regular supervision and review meetings at WORHO level.	Supervision and reviews are planned to be quarterly. However, due to lack of resources, not all facilities are supervised and performance reviews are not conducted in every quarter.
Conduct JRM, ARM, final evaluation of HSDPII and regular FMOH donor consultative meetings.	The final evaluation of HSDP II was conducted; findings and recommendations were reviewed during ARM and JRMs are regularly conducted at federal level.
Harmonize the donor-government reporting cycles and monitoring and evaluation system	There have been some efforts towards harmonization of donor-government reporting cycles and monitoring and evaluation system. In most cases, it is still parallel.

Development of a comprehensive and standardized **HMIS** has been a top priority on the agenda of FMOH. Identified as one of the seven core businesses, HMIS was the first to complete the BPR processes. Consensus was built on a comprehensive list of cascaded indicators. Based on these indicators the necessary tools and guidelines were developed. The new system was piloted in a selection of health facilities in 11 Weredas in seven regions. The final evaluation of the pilot implementation endorsed the new HMIS. It made the recommendation to roll out the system nationwide. Preparation is now underway to roll out the new system in all regions. It is in the interest of the health sector and its stakeholders that

the new system is in place nationwide as soon as possible. The reporting by the new integrated HMIS should start in all facilities nationwide in August 2008. However, there seems a gap between the available and required funds to roll-out the new HMIS.

The M&E system has improved generally at all levels. Routine reporting, periodic reviews, supervision, follow-up, and feedback are in practice at all levels. Though they are sometimes irregular and there is little focused on core issues and actions, it is a good start towards building a system.

The goal of **operational research** is to increase the efficiency, effectiveness, and quality of services delivered by providers, and the availability, accessibility, and acceptability of services desired by users. Currently, operational research is in disarray. There is no system that identifies priority areas or coordinates and regulates their implementation.

4. Financing and Governance[8]

4.1. Financing the Sector

MTR Findings in Health Financing

FINANCING OBJECTIVES HSDP III	PROGRESS HALF-WAY
To increase overall health expenditures per capita from 5.6 USD to 9.6 USD.	This can only be estimated during the next National Health Accounts (NHA). Based on incomplete data available, per capita public health expenditure is estimated at 3 USD.
To double the share of health as a proportion of total government budget (domestic spending and direct budget support).	It remained at about 7.5% of the overall government budget and 12.5% of poverty targeted expenditures.
To ensure retention and utilization of 100% of revenue generated at hospitals and health centres	SNNPR, Oromiya and Amhara regions have started retentions.
To expand special pharmacies to cover 100% of hospitals from the current level of 82% and 100% of health centres from the current level of 58%.	The Health Care Financing (HCF) reform implementing regions have established special pharmacies in all hospitals and health centres. Other regions are at various levels of achievement.
Design and pilot test community health insurance	CBHI is in the design stage and implementation has not begun.
To setup HIV/AIDS fund at all levels of the health sector and advocate its establishment in the other sectors	No information available

The overall channel 1 allocation to the health sector is far more than what was projected in the HSDP III financing plan, but, in spite of this increase, the share of health from the overall government health budget remains around 7% and 12% from overall poverty targeted budget, mainly due to a rapid increase in the total government budget. Available resources for financing HSDP III from channel 2 has steadily been increasing from ETB 360 million in 1997 to ETB 921 million 1999, of which 95% has been contributed by GHI. GHI funds, particularly of GAVI and GFATM, are also being used at a catalytic fund by FMOH to increase allocation of resources at regional and Wereda levels through agreement to accelerate expansion of health facilities.

The health pooled funds (HFP) have also been financing the sector, particularly the protection of basic services (PBS). Together, they have increased the per capita public health allocation from 23 (2.6 USD) in 1997 to 60 ETB or (6.3 USD) in 2000 and the actual spending from 23 in 1997 to 28 ETB per capita in 1999 (3 USD). It is therefore necessary to step up the resource mobilization to ensure that the sector meets its target of doubling the share of health from the total budget by the end of the HSDP III period. As a result, the

[8] Recommendations will be brought together at the end of this section

sector remains partially under-funded. While the outcomes that are being achieved for this amount of resources are encouraging, evidence from the field show that there is room to improve efficiency through more rational use of inputs and improving utilization of services by clients. The current health sector financing is dominated by vertical disease-based services that have achieved significant results in the last two years. However, there is now a need to give priority to strengthening comprehensive health systems, if the current expansion is to deliver acceptable and quality care. Financing by donors is still unpredictable; alignment with government systems remains very limited, as most donors feel that the fiduciary systems (budgeting, PFM and procurement) remain weak and are not able to attract more donors to join the MDG performance fund. The capacity of these systems need to be reviewed and strengthening plans be put in place to fast track alignment and harmonization agenda. The inconsistency between HSDP III components and budget codes continue to make expenditure tracking and priority setting difficult (read impossible).

4.2 Health Care Financing Reforms (HCF)

Regions are at different stages in implementing health financing reforms. The three implementing regions are doing well in retention, special pharmacies and to some degree with fee exemptions. The implementation of the waiver scheme is delayed, mainly because of its financial implications for the Wereda councils. The development of social and community insurance scheme has just begun with the development of a strategy and legislation. Increasing the pace of design and implementation arrangements through stakeholders' participation is highly recommended. Financing the cost of fee waivers by a pooled fund, or establishing an 'equity fund' and scaling up the best practices of the HCF reform to other regions, could consolidate the gains from the HCF reform further.

The development of the core and comprehensive plan is a break-through and an innovative approach that tries to harmonize the conflict between top-down, sector-wide approaches (HSDP) and devolution. It has the potential to bring in more resources to the sector, if planning capacity is improved and all stakeholders and particularly administration and finance offices at all levels are meaningfully involved. However, there is a need to balance between need-based and resource-constrained planning, as the credibility of the planning process rests heavily on the plan being funded. Increased participation of health facilities as the actual service providers in the planning process is highly recommended.

4.3. Financial Management

The flow of funds from Channel l (MOFED) to FMOH/ BOFED and then to RHB level has been substantially improved. By contrast, subsequent flows to lower levels particularly to ZOFED/WOFED and health facilities are often less smooth in terms of timeliness of disbursements. The same also holds true regarding the flow of Channel 2 funds to lower levels, but tracking the purposes of such funds appear to be problematic at both FMOH and RHBs. By and large, despite the progress, delays in disbursement, utilization and timely liquidation of funds are still common phenomena at lower levels, due to several factors such as the ineffectiveness of the pool system which is operationally deficient of business-process orientation, communication gaps, lack of institutional capacity, as well as weakness in timely management of available financial resources.

Notwithstanding the variations in underlying approaches and infrastructures, standard accounting and reporting systems have been fully institutionalized at all levels. The system at FMOH has considerably benefited from adoption of a process-oriented approach and IT support. Conversely, such essential institutional inputs are missing at RHBs and below. Irrespective of this, the system is generally capable of informing the GOE about the utilization of recurrent and capital budgets. Nevertheless, it is less robust to do HSDP accounting and, hence, generate financial reports by programme component. It has difficulty to meet the donors' multiple financial reporting requirements; hence it is urgent to accelerate

harmonization to reduce the pressure on the system. The latter constraint has forced entities to resort to setting up a parallel "*twin accounting system*".

The role of internal audit units in supporting HSDP III has been less significant as a result of over-emphasis on financial pre-audits, lack of adequate structure, and shortage of skilled manpower. The FMOH has recently moved forward in terms of placing BPR blue-prints and reorienting the internal audit function along *"consultancy and assurance*" lines. Yet, institutionalizing and subsequently replicating this is still quite challenging, due to scarcity of skilled manpower that fits process-oriented auditing, and widespread resistance of people trained in medical/health sciences to accept doing performance audit.

4.4. Governance and Sector Management

There exists committed leadership which has mobilized stakeholders around a common vision and has enabled stewardship structures for HSDP III. A Code of Conduct was developed in 2005 and signed by 14 Development Partners. Adherence to it has been evaluated. Subsequently, a HSDP Harmonization Manual (HHM) has been developed. Its use is in its early stages including in the Wereda-based bottom-up planning.

Although remarkable progress has been made to improve partner communication and establishment of acceptable structures, most coordination structures are still weak especially at the lower levels. There is need to strengthen national structures and to institute mechanisms for capacity building to improve functionality of these structures at all levels. At the same time there is a need to build leadership and management capacity at all levels with a special emphasis on change management.

Governance bodies like the CJSC, the MOH/HPN donor group and the JCCC could both benefit from regular sharing of information from both sides on recent developments and decisions that are being taken in important areas, such as expected levels of funding and disbursement, expected external missions, arrivals of new Technical Assistance, bottom-up Wereda planning, HRH, HMIS and the developments around the master-plan for pharmaceuticals and logistics. A restructuring of these bodies is suggested in the body of the report to harmonize and streamline decision-making and to bring all the players and funding agencies together around the same table. The reader is asked to look for details on these suggested changes in the relevant section of the report.

The Civil Service Reforms have begun to show results. Senior management coordination and leadership has significantly improved. The Finance Department has been re-organized along process lines and has become more effective and efficient. The HMIS system has been re-designed tested and is ready for scaling up. Other critical processes like, logistics' system design and access and quality of care BPRs are at advanced levels of completion. Hospital reforms have been initiated and improvements in all other health service delivery are expected to be initiated within the year. The reforms however, are only in their initial stages in the regions. There is need to accelerate the pace of implementation of these reforms to translate investment made into service outcome for the patients/clients.

4.5. Donor Alignment and Partnership with NGOs

Several pooling mechanisms have been established which have, in principle, performed well, substantially increasing the sectors resources especially at the lower levels. The FMOH, taking advantage of the renewed commitment to the Paris Declaration through the IHP, has developed a roadmap for attainment of MDGs and a draft Compact which is under review. The central feature of the Compact is the MDG Performance Package Fund (PPF) and coordination mechanisms. In this regard, it is necessary that a fiduciary management plan is developed and the coordination structures are strengthened to build sector partners' confidence as they advance to the next pooled funding level. The sector also needs to systematically monitor the Paris declaration alignment and harmonization indicators to facilitate the fast-track momentum the country has adopted as a result of the IHP commitment.

Whereas the HSDP III harmonization and the public-private partnership targets are on track a lot still needs to be done to institutionalize them. Although human rights were not incorporated in the HSDP III, it contains key principles that require being main-streamed in the planning process and extended in the design of HSDP IV.

Recommendations for Financing the Sector

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
Period	EFY 2001	Within EFY 2001-2003	After EFY 2003
Fee Waivers	Consider financing the cost of fee waivers as one of the elements in any dialogue for future pooled funding		Develop HSDP IV, using a bottom-up approach, to help align local and national priorities.
Social Health Insurance (SHI)and Community-Based Health Insurance (CBHI)	Continue the design of SHI and CBHI with adequate consultation of stakeholders at all times.	Expand SHI/CBHI to other regions with necessary technical support.	Align the HSDP IV components with overall government budgeting process.
Annual planning	Refine annual planning tools.		Improve the absorptive capacity of the sector. Align the HSDP IV components with overall government budgeting process.
Resource Mapping	Support resource mapping with annual public expenditure reviews and tracking studies.	Balance need based and resource constrained planning approaches.	

Recommendations for Governance and Sector Management

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III period	Long-Term Design of HSDP IV
Period	EFY 2001	Within EFY 2001-2003	After EFY 2003
CSRP Decentralization	Accelerate the pace of the BPR core process reforms especially for access and quality of care		
Capacity Building	Introduce change management to improve the staff confidence in the on-going reforms at all levels.	Institute a leadership and management capacity building programme for regional and wereda level managers.	
Coordination between	Define the core functions	Train and support all governance structures.	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III period	Long-Term Design of HSDP IV
FMOH/Development Partners	(TORs) and composition of the strengthened coordination structure.		
Strengthen PPD	Strengthen the capacity of PPD as a Secretariat to improve the coordination mechanism and all departments.		
Review Mechanisms	Introduce a bottom-up review mechanism to reflect the wereda planning process, and ensure inclusion of NGOs.		

Recommendations for Alignment, NGO Partnerships and Rights to Care

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
Period	EFY 2001	Within EFY 2001-2003	After EFY 2003
Alignment	Assessment of Ministry financial, procurement, audit and capacity and improvement plan.	Develop tools and mechanisms for annual systematic monitoring of the Paris Declaration on alignment and harmonization indicators as a package.	
NGO Partnership	Conduct NGO resource mapping to reduce duplication of services.	Involve NGOs/CSOs/FBOs in wereda- based planning process at all stages.	
		Promote an international NGOs network using an acceptable mechanism to enable harmonization and effective communications.	
		Strengthen CRDA's capacity to support sector NGOs/FBOs/CSOs.	
Rights to Health Care		Create awareness and access to information about the available services at the community, kebele and wereda levels including the urban population	Integrate a rights-based approach to health in the design of HSDP IV and human rights related targets in provision of care.
		Build capacity of all staff at all levels on human rights concepts and rights-based approach to provision of health care. Appoint focal persons on human rights.	
	Integrate rights-based approach into the HHM.		
	Liaise with National Human Rights Commission and Capacity-Building Bureau to integrate human rights framework in HEW modules.		

5. Overall HSDP III Performance

There is strong commitment to achieve the MDGs and HSDP III targets both in the areas of service delivery and systems strengthening by the FMOH and its partners. Stakeholders have been mobilized (regions and development partners, global funding initiatives) around the same vision. Alignment and harmonization of stakeholders is increasing, through strengthened annual budgeting and planning processes which are developed to deliver the national and regional five-year strategic plans for the sector. Massive expansion of primary health care has taken place and systems are now being strengthened to support this expansion. A transition from expansion to consolidation is envisaged. However, physical coverage of facilities alone is not sufficient to address issues of access, utilization and equity. A major issue for the sector is the inadequacy of resource availability. Growth in real terms is low and the NHA 2005 estimate of USD 7.50 per capita is a long way off the Macro-Economic Commission on Health's estimation of USD 34 per capita. The crisis in human resources as well as the need to build the capacity of health managers at all levels is restraining the potential effectiveness and efficiency of the sector.

6. Status of Previous Recommendations

During the past few years, there have been a number of recommendations that have prompted responsive actions by the health sector. Recommendations assessed for follow-up during the current review include HSDP II evaluation, 8th and 9th ARM in 2006 and 2007. The follow-up of recommendations are organized around the major components of HSDP and the health reform areas. The current review provides an in-depth analysis of follow-up recommendations related to HEP and MNH. The health sector has implemented the majority of the recommendations during the past two and half years. In some areas, the sector made substantial progress in implementation, while in a few areas recommendations have either been dropped or have not seen follow-up. In the body of the main report, the implementations that have not been followed up are presented, while the full overview of the most important recommendations and their follow-up are summarized in Annex 8.

Overall Conclusions

The findings of this MTR are clear. Thanks to the visionary and committed leadership of the GOE, FMOH and its RHBs, enormous progress has been made. Most indicators are moving in the right direction and a 'change in mindset' in the sector seems possible. If this pace of reforms can be maintained, at least some of the MDG targets will come in very close reach. The MTR team is unanimously impressed with everything that has been put in place in a very short time period.

In order to support the FMOH in pursuing its vision and drive, the MTR would like to make the following 10 key recommendations:

1. Consolidate achievements by giving more time to reach the objectives of the HEP;
2. Continue to focus on health promotion and prevention for the HEP, but expand some of the care packages provided by the HEP;
3. Strengthen the various support systems (planning, HRH, logistics, HMIS) that are needed to make the HEP operational (at federal and regional levels);
4. Invest in family health (expand training schools and TOT for midwives) in the immediate, as it will take time to see results. There is no quick fix to bring down the high maternal mortality rate;
5. Strengthen the planning capacity of the FMOH (the PPD), as all information (on infrastructure, HRH, logistics and procurement) should come together there;
6. Revise the governance structures, streamline them and bring all agencies regularly around the same table;

7. Improve coordination. In particular, invest time and staff in regular sharing of information with ALL the partners in order to build trust and effective collaboration;
8. Continue to insist on the alignment of the Development Partners and their adherence to the Compact, while at the same time strengthen planning, financial and procurement systems.
9. Develop a viable community health insurance system, as this might be the only way to expand services that are affordable for the poor. The experience in Rwanda seems worth studying in this regard;
10. Roll out the new HMIS as soon as possible to ensure a reliable information system for any future decision making on priorities and pro-poor resource allocations.

1. Introduction

1.1. Background to the Assignment

The Ethiopian Health Policy, HSDP I and HSDP II
In September 1993 (EFY 1986), the transitional government of Ethiopia published its "Health Policy of the Transitional Government", a visionary and lucid document, containing the general policy, the priorities and 17 general strategies. The document defines the overall principles to realize a fair and equitable health system, based on popular participation and social justice. A few years later, in 1997/98 (EFY 1990), the Ethiopian Government initiated its Health Sector Development Programme (HSDP), a 20-year sector programme, covering 1997/98 till 2017/18 (EFY 1990 – 2010).

The first and second phases of HSDP were completed in 2002 (EFY 1994) and in 2005 (EFY 1997) respectively. The third phase, HSDP III, covers the period July 2005 to June 2010 (EFY 1998 – 2003). According to the HSDP Harmonization Manual, the Mid-Term Review (MTR) will take place in 2008 (EFY 2000 or 2001) during the third year of the plan period. It will be conducted by teams of national and international experts working according to a TOR prepared at the level of the JCCC (see Annex 3) and approved by the CJSC. The MTR report will be submitted for endorsement to the JCCC, the CJSC and eventually to the HPN donor group and the Annual Review Meeting (ARM EFY 2001).

HSDP III
HSDP III comprises seven components that together define the health sector in a comprehensive way. For each component detailed objectives / indicators, strategies and support / key activities for the various intervention levels are given. Cross-cutting issues receive special attention (The health expenditure per capita under HSDP III is expected to rise from USD 5.6 to USD 9.6 over the five year period. While components specific costs were given, no component specific budget is available to assess the relative priorities of the various components

The overall objectives of HSDP III are described as follows:

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

Terms of Reference of the MTR
According to the TOR (Annex 3), the general objective of this MTR is:
"To measure and document the extent to which the targets set for the HSDP III are achieved, assess constraints and/or challenges encountered and solutions provided, draw best lessons learned and experiences gained, and forward recommendations to improve future management and implementation of activities to attain the HSDP III goals".

In addition to a set of 19 specific objectives and indicators, the expected outcome of the MTR has been defined as follows:

1. The strengths and weaknesses of the health system in the national policy context (democratization & decentralization, development of preventive & promotive health service, and other policy focuses) to proceed with the implementation of the HSDP III;
2. The level of progress made in achieving both impact and outcome indicators during HSDP III period;
3. The strengths, weaknesses and main challenges of the implementation process of HSDP III key activities in the context of its main goals and major objectives, the national development programme (PASDEP) and the MDGs;
4. Identification of best practices and lessons learnt and major implementation problems;
5. Conclusion on achievements to determine whether HSDP III is on track or needs any adjustments in implementation including recommendations on useful measures that will help to improve the implementation of HSDP III in the remaining period of time;
6. Provide recommendations for the formulation of the HSDP IV for issues that require long-term implementation

Special focus should be given in the main report to the achievements and constraints of the HEP and the maternal and neonatal morbidity and mortality situation in the country.

1.2. Methodology

HSDP III is a comprehensive and complex sector programme. It is meant to reach more than 80 million people through (i) the policies of the FMOH, (ii) the service delivery related activities of the nine National Regional States and two City Administrations (Hariri and Dire Dawa) and (iii) the actual service provision in the 819 weredas[9] and 15,000 kebeles. The capacity to provide services in these regions and city administrations varies, from limited in the four 'emerging regions' (Gambella, Benishangul Gumuz, Afar and Somali), to advanced in regions like Tigray, Amhara Oromiya and SNNPR. The Addis Ababa region, being predominantly urban poses special challenges in ensuring good quality care for all its citizins.

This MTR builds on the previous evaluations of HSDP I (March 2003) and HSDP II (March 2006) and two recent ARMs (2006 and 2007 GC). It incorporates important policies, like the CSRP and the BPR. These are currently operating in seven thematic areas of the FMOH. In addition, it takes into account the HSDP Harmonization Manual, the Code of Conduct (signed in October 2005), the IHP and the Roadmap for scaling up harmonization and alignment among FMOH and DP (IHP+, Nov 2007) and the draft Compact (April 2008).

A multidisciplinary team of 38 national and 9 international consultants conducted this MTR over a period of five weeks (05 May to 05 June 2008).

After extensive preparations (Annex 4/Programme) and a review of available / updated documentation (Annex 7/Documents), detailed questionnaires by level were developed with inputs from all team members and the JCCC. The qualitative and quantitative questions, served as a guide during the interviews with the various stakeholders (Annex 6/People met) at federal, regional, zonal, wereda, facility and community/household levels.

Six teams composed of experts in the various components of HSDP III (Annex 5/Matrix) visited all regions, city administrations and the FMOH (each region during one week). Back in Addis Ababa, the teams shared their findings with other team members, interested departments from the FMOH, technical staff from the development Partners and NGOs.

[9] Sources are from various regional reports.

The teams first finalized their regional reports (Volume II) with regional specific data over a ten year period. Team members then regrouped in 'content and thematic areas' and drafted 'component based' reports, taking the different experiences from all regions into account. All the inputs were then brought together in a zero draft and an executive summary was added. This zero draft report was discussed with the whole MTR team (page by page) in order to reach consensus about content and wording. This consensus version (the first draft) was submitted to the JCCC for a first round of comments. The next version was submitted to the Management Committee of the FMOH (including the Heads of the RHB) for approval. Thereafter the document was circulated for a final round of comments among the Development Partners.

An overview of performance indicators provided the basis for the analytical work. Much effort went into standardizing the database and making the figures as consistent over time as possible. Linking these data with the figures from the evaluations of HSDP I and II allows for an analysis over the full ten years period of HSDP I, II and III (EFY 1989 – 2000 /half) for all regions and for the national level (This information is provided separately in Annex 2 / Indicators by region and national). A one page summary of the overall performance indicators of HSDP III has been included in Annex 1A and 1B. These two summary tables allow for an overview of the overall performance of the sector over time. The picture that emerges of the performance of the sector is thus more than a 'snapshot' of the current situation. It will allow for the appearance of a 'slow motion film', providing trends towards the goals set by the overall HSDP programme.

1.3. Limitations

This MTR acknowledges various limitations, the most important ones being:

- The methodology used for these reviews/evaluations is extensive and demanding. In addition it is quite 'external' in nature, as little 'self-evaluation' from the regions and Weredas is requested. Some therefore indicated that this review process is not 'owned', particularly by those that have to implement its recommendations. This limitation was already highlighted during the evaluation of HSDP II. Unfortunately, it has not been addressed by the FMOH during this MTR.
- Another limitation is the relative short duration of the field visits. Only a limited number of HEWs could be interviewed in each region, making a detailed assessment of the HEP and other interventions difficult.
- The national and the regional figures as available from the statistical booklet of the FMOH were not always reliable, due to incomplete reporting at the lower levels and inaccuracies in the reporting on quantitative targets.
- There was only limited information available on the private and NGO sector. Representatives from MOFED, MOCB and RHBs did not participate in the team, nor did traditional health practitioners. These institutions and individuals are essential to the performance of the whole sector and their missing contributions are an indication of the limitations in our findings and suggestions. This evaluation therefore addresses mainly 'public service delivery' and to a limited extent, the health sector in its full scope.
- The team was not always able to visit the more remote and poorer areas, due to distance and security constraints (Somali). Such a limitation might have biased our findings.
- Many staff in the RHB / WORHO had only recently been appointed. The high staff turnover limited the gathering of information on the experiences, the constraints and best practices of HSDP III.

These limitations should be taken into account when reading the various chapters of the main report.

1.4. Acknowledgements

The MTR team would like to express its gratitude to the Minister of Health, His Excellency Dr Tedros Adhanom G/yesus for his dedicated leadership and stimulating support to the MTR. The special interview has been greatly appreciated. Gratitude goes also to the two State Ministers, His Excellency Dr Kebede Worku and His Excellency Dr Shiferaw Teklemariam for their time and their vision on the performance and future of HSDP. The MTR team was impressed with their detailed mastering of the issues, their commitment to the HSDP to bring about a 'change in the mindset' of the workforce in the health sector. Together, the senior management of the FMOH showed us leadership and a vision for the way forward, despite the many constraints and impediments ahead. They have also inspired us with hope that HSDP III will achieve most of its objectives in the coming years.

The MTR team would also like to express its sincere gratitude to all members of the JCCC, headed by Dr Nejmudin Kedir, Head of PPD, for their active support during the MTR preparations and during the interviews and visits. Through the elaboration of the TOR, the selection and provision of the team members, the individual interviews and the brainstorming session on the 22nd May, the JCCC members showed active interest and commitment to the work and challenges of this MTR. As management agency of the Technical Assistance pooled fund, the UNICEF Ethiopia office (and in particular Dr Viviane van Steirteghem and W/ro Temenit Seyoum) have been instrumental in providing financial and logistic support to the daily operations of the team. Similarly, the PPD office (in particular Dr Mekdim Enkossa and Dr Rahel Gizaw) provided timely support for the many interviews at the federal level and for inviting the participants at the debriefing session with the regional teams.

The Chair and Co-Chair of the HPN Donor Group (Dr Theo Pas and Dr Viviane Van Steirteghem respectively) and the technical staff of the various DPs have been instrumental in providing us with the required information and new developments in HSDP III.

Many thanks are due to the heads and staff working at the 11 RHBs, the various heads of departments with their collaborators at federal level, the staff in health, training and finance departments, working at zonal and wereda levels and all the other staff in the health and training facilities that the team has visited. We are very grateful for their time and effort in sharing ideas and suggestions with us. We hope that the draft regional reports we submitted to them for comments will be studied and used for their future planning exercises. Unfortunately, it turned out that no answers have been received from any of the RHB.

We are grateful to the staff working in CSOs, the NGOs and other non public sector organizations for their inputs and their patience to respond to our questions. The interview and coordination support provided to the MTR by CRDA is greatly appreciated.

We hope that this MTR report will contribute to the necessary improvements in the implementation of the HSDP III at regional and wereda levels and will allow for a further commitment of the FMOH to make HSDP III deliver on its stated outputs. There are still two years ahead and much can be achieved, if the potential of ALL Ethiopian stakeholders in the health sector is brought into the equation.

2. Service Delivery during HSDP III

2.1. Health Service Delivery and Quality of Care

This part of the HSDP III focuses on strengthening the preventive, curative and promotive aspects of health care through the implementation of the Essential Health Service Package (EHSP) and through maternal and child health services, HIV/AIDS, malaria, tuberculosis and personal and environmental hygiene. The FMOH has adopted a health systems strengthening approach to address the increase and quality of care in service delivery. Innovative approaches are being adopted to ensure that systems' strengthening is a core objective of all programmes regardless of the source of funding. This innovate approach has great potential, not only for the Ethiopian health sector but also as an example of best practice for other countries that are also undergoing reforms to improve their health services.

2.1.1. Health Extension Programme (HEP)

A central component in the HSDP III is the HEP. The HEP is a *flagship* programme and is considered as the most important institutional framework to achieve the major goals of the HSDP III at community level. The objective of the HEP component is: *To cover all rural kebeles with the HEP to achieve universal primary health coverage by the year 2008 (EC).* The overall aim is to improve access and equity by the provision of essential health interventions at kebele and household level with a focus on sustained preventive health actions and increased awareness.

The key HSDP III strategies to achieve the overall HEP objectives are:

- Vigorous implementation of the HEP for the effective prevention and control of communicable diseases and the promotion of a healthy environment and lifestyle.
- Enhancing the capacity of the HEWs for the detection, referral and follow-up of patients.
- Bridging the gap between the communities and the health facilities and increasing health awareness, knowledge and skills at community level.
- Ensuring full community participation in planning, implementation, monitoring and evaluation of health care.
- Mobilizing adequate, financial resources, ensuring efficient utilization and strengthening the sustainable financing mechanism for the health sector.

Box 2.1 HSDP III Targets for 2002 (EC)

The HEP targets are:

- The construction of 13,625 health posts. A total number of 15,000 health posts will have to be in place by the end of 2001.
- A total of 30,000 HEWs: This will ensure two HEWs per health post.
- A ratio of 1 HEW per 2,500 people.
- A strong collaboration with a network of VCHWs

Policy Drivers for the HEP

During HSDP II, the government introduced the HEP together with two other essential programmes, the AEPHCC and the EHSP

AEPHCC (1997-2001) outlines specific objectives that aim to contribute to the delivery of primary health care services to all the rural areas (it provides the *hardware* for the HEP) through:

- Construction and equipping an additional 12,249 health posts in order to provide preventive and promotive services to a target population of 5,000 people per health post. Training and deployment of 24,498 paid female HEWs to work in these health posts.
- Construction and equipping an additional 2,730 health centres (staffed with nurses) in order to provide curative and referral services to a population of around 25,000 people.
- Preparation of standard guidelines for planning, implementation, monitoring and evaluation (at different levels of the health sector).

The AEPHCC document estimated in 1997 that the *capital cost* for the health posts (construction, medical equipment, furniture and HEW training) for the five-year period would require a total budget of USD 332 million. The *recurrent* costs for the HPs (HEW salary, operational costs and preventive maintenance) would require a budget of USD 74 million.

The EHSP (1997) aims to (1) enhance the effectiveness of the health sector programme and (2) to standardize the essential health services (It provides the *software* for the HEP). EHSP provides an overall framework for the services that are provided at community, health centre and District hospital level. The following EHSP services need to be provided at community level (Table 2.1);

Table 2.1 Provision of EHSP Services at Community Level

Category of Services	Interventions
Family Health Services	Antenatal care, immunization of mothers and children, clean and safe home and institutional delivery, PNC, promotion of Essential Nutrition Actions (ENA), family planning information and services, reproductive health services, management of childhood illnesses and treatment of malaria and diarrhoea.
Communicable Disease Control and Services	Surveillance and epidemic control activities, malaria prevention and control, TB and leprosy treatment continuation, HIV/AIDS and STI related support and rabies control.
Hygiene and Environmental Health	School health services, water source protection, promotion of healthy housing, sanitation, personal and food hygiene.
Health Education and Communication Services	IEC/BCC on major health problems at home, community mobilization and sensitization, IEC/BCC on balanced diet, emergency conditions and demonstration of environmental health actions at community level.
Basic Curative Care and Treatment	Treatment of diarrhoea, malaria and intestinal parasites, treatment of eye and skin infections, emergency conditions, school health services.

Resources for the HEP

The main contributors providing direct and major support to the HEP during the HSDP III are; (1) the GOE (salaries HEWs, construction, supervision), (2) GAVI (health system strengthening and HEW capacity building), (3) Global Fund (equipment), (4) PBS (logistics master plan, equipment), (5) USAID (HEWs and VCHWs training) and (6) UNICEF (health post kits support, RT, HEP website development). In addition, a substantial number of Development Partners also provide indirect support to the HEP through the HSDP III programmatic areas[10]. Part of the allocated funding is channelled by the Development Partners through several NGOs and special programmes[11].

[10] The programmatic areas include: (1) child health (EPI and IMNCI), (2) malaria, (3) HIV/ AIDS and TB, (4) maternal health, (5) nutrition, (6) water, sanitation and hygiene and (7) health systems Strengthening (including HEP)

[11] DFID provides support to; (1) Merlin (malaria, nutrition, and EPI), (2) PSI (malaria), (3) DKT (HIV/AIDS and reproductive health) and Action Aid (HIV/AIDS). The European Commission channels part of its support through; (1) Save the Children Fund, AMREF and SOS (health financing) and German Red Cross, Care UK, Christian Aid, Interaide (HIV/AIDS). USAID supports the NGOs; (1) The Carter Centre (training of health officers) and (2) Pathfinder International (maternal and child health, reproductive health, post abortion care, adolescent sexual health, HIV/AIDS/STI). USAID supports the ACCESS programme (survival of mothers and newborn children) and the ESHE programme.

HEP Implementation Guidelines

The FMOH updated the implementation guidelines of the HEP in 1999 (EC)[12]. The implementation guidelines will form the base for a line management structure that stretches from federal to kebele level in order to organize, coordinate, implement and monitor the programme. This will enable offices at all levels to implement their duties and responsibilities as planned. The implementation guidelines have been distributed in Amharic to all the HEWs and key actors in the HEP. They provide detailed information regarding the duties and responsibilities for relevant offices at all levels: FMOH, RHBs, ZHBs, wereda administrations, WORHOs, health centres and NHCs, kebele administrations, HEWs, VCHWs, communities, schools, CSOs and partner organizations.

At the national level, the Health Education and Extension Centre (HEEC) is mandated to coordinate and monitor the health extension related activities. The HEEC is furthermore responsible for the preparation of national health education standards and materials, the development of HEP packages, IRT manuals, and training guidelines for VCHW. The institutional position and role of the HEEC is set to change during the BPR process. The FMOH is responsible for policy development, technical support, resource mobilization and the procurement of equipment and medical supplies. The RHBs all have a focal HEP experts (or units) and are overall responsible for the coordination and monitoring of the HEP programme at the regional level. The wereda administration is responsible for the allocation of the necessary resources to the HEP (finance, material and man power). All levels are responsible for strengthening the political will, determination and support.

The WORHOs play a central role in this process to:

- Implement, coordinate, monitor and evaluate the HEP at community and household level.
- Carry out supportive supervision, monitoring and evaluation of the activities and provide necessary feedback. Collect and analyze information and disseminate the reports to the RHBs, ZHDs and the wereda administration.
- Train and orient newly assigned health workers on pertinent health issues, expected activities, data collection and reporting, and collaboration with VCHWs.
- Strengthen the coordination between partner organizations and sector offices.
- Expand the establishment of health posts by helping the community and partner organizations coordinate their respective efforts.
- Support the HEWs in their collaboration with VCHWs in line with existing guidelines.
- Strengthen the referral system between the HEP and other health institutions in the wereda.

The Core of the HEP

At the core of the HEP is a sizeable cadre of HEWs who are trained to implement a health extension package of 16 health care activities at the kebele level. The majority of the HEWs are female with a minimum age of 18 years at the time of selection. The educational level is a minimum of 10th grade education and they are recruited from the communities in which they will work. The HEWs must complete a one-year course of instruction and field work. These courses are organized by 40 TVETs throughout the country (including four TVETs in the pastoralist areas). The TVETs are operated by the FMOE and receive support from the respective RHBs for the HEW training. In line with the EHSP, 16 training packages were developed for the training of HEWs (see Table 2.2).

[12] FMOH: Implementation guidelines of HEP; All Roads Lead to Health Extension, February 2007.

Table 2.2 Overview of the HEP Training Packages

HEP Focal Area	HEP Training Packages
Hygiene and Environmental Sanitation	Proper and safe excreta disposal system. Proper and safe solid and liquid waste management. Water supply safety measures. Food hygiene and safety measures. Health home environment. Arthropods and rodent control. Personal hygiene.
Disease Prevention and Control	HIV/AIDS prevention and control. TB prevention and control. Malaria prevention and control. First aid.
Family Health Services	Maternal and child health. Family health planning. Immunization. Adolescent and reproductive health. Nutrition.
Health Education	No sub packages.

Upon completion of the one-year training, two HEWs are assigned to a health post. The HEWs are to spend 75% of their time to conducting outreach services and strengthening the networks of VCHWs. The HEWs are to identify and train model households to become role models for desirable health practices at community level. These model households will be trained (100 hours) on a "family package" that includes topics related to basic hygiene and environmental health, family health care and prevention and control of disease (see implementation guidelines). A household will "graduate" (and will receive a certificate), if they meet specific criteria (e.g. presence and use of a latrine and solid waste pit, clean and shelved food utensils, practice of personal hygiene, vaccination of children, use of ITN). The VCHWS will ideally be selected from the model households.

The HEWs also play a role in the kebele planning process. One HEW per kebele is a member of the kebele cabinet. In collaboration with the members of the kebele council, a baseline survey is conducted. Based on the findings of the baseline survey, plans of action are prepared. The draft action plan is then submitted to the wereda council for integration into the wereda health plan.

Is the "Hardware" in place?

Monitoring Progress
Since the onset of the HEP, the progress of the programme has been closely monitored.
The HSDP III has effectively addressed most of the recommendations of the HSDP II and the 1998 / 1999 (EC) ARMs (see Annex 7). The recommendations that still require attention are:

- Strengthen the technical capacity of the HEW trainers and ensure adequate provision of training materials to the TVETs (HSDP II recommendation).
- Assess the attrition and career development of the HEWs (HSDP II and ARM 8 recommendations).
- Strengthen the referral system (ARM 8 recommendation).

Construction of Health Posts

A core strategy for bringing the primary health care services closer to the villages is the construction of health posts (one per 5,000 people)[13]. It was observed that there are some discrepancies between the statistics used in the HEEC Profile 1999 (EC) and the PPD presentation of May 2000 (EC)[14], as annual targets were adjusted. Furthermore, to determine the precise number of health posts that have been completed is not easy, as regions report on progress differently. Some regions report that a health post is already completed if the contract for the construction has been signed. Despite these discrepancies, RHB have accelerated the construction of HP since 1996/7 (EC). This progress is reflected in Table 2.3.

Table 2.3 Cumulative Progress in Health Post Construction since 1996/7 (EFY)

Year	1996/7 (EFY)	1997/8 (EFY)	1998/9 (EFY)	1999/0 (EFY)	Expected by End 2000/01
HEEC Annual targets	400	4,148	9,914	10,680	15,000
Cumulative number of health posts constructed	400	4,148	9,914	10,998 (by the end of EFY 2000)	

Source: HEEC profile 1999 (2007) and PPD presentation May 2000 (2008).

Although health post construction is well on track, it is unclear whether the HSDP III will achieve its target of 15,000 health posts by the end of 2001. There is still a need to construct a total of 4,200 health posts in over the next year. The findings from the MTR indicate that there are considerable regional differences. Table 2.4 demonstrates that a number of regions (Benishangul Gumuz, Gambella, Oromiya and the pastoralist areas in the SNNPR) will have considerable difficulties to achieve full health post coverage by the end of EFY 2001.

Table 2.4 Overview of Health Posts in Selected Regions

Region	Health Posts Construction Completed (versus Regional Target)	Health Posts not constructed (Gap versus Regional Target)
Afar	66% (265 health posts)	34% (139 health posts)
Amhara	73% (2,933 health posts)	27% (1,067 health posts)
Benishangul Gumuz	29% (136 health posts)	71% (337 health posts)
Gambella	25% (57 health posts)	75% (172 health posts)
Harari	52% (19 health posts)	47% (17 health posts). No construction has been done since 2006 (GC).
Oromiya	28% (1,814)	72% (4,664)
SNNPRS	80% (2,818 health posts)	20% (735 health posts). However, there is a major delay in the pastoralist areas. The pastoralist areas require 321 health posts but have only 135 health posts in place. There is a gap of 58% in this part of the region.
Tigray	67% (614 health posts)	

Source: MTR Regional reports May 2008.

The main causes of delayed construction are related to the limited allocation of resources (either from the wereda or communities). Insecurity and inaccessibility of the kebeles have affected the construction in some of the regions (e.g. Gambella). In the pastoralist areas access to construction materials is limited. In addition the population's mobility, the limited availability of building materials in the arid and semi-arid areas, further impacts the

[13] The health post target for the pastoralist areas is under discussion as it has been proposed that these areas would actually require 1 health post per 2,500-3,000 people. However, as this discussion has not been concluded, the MTR will follow the overall target.

[14] Presentation by PPD Head Dr. Nejmudin: Overview of implementation HSDPIII at 9 months of the year 2000 (8th May 2000).

communities' ability to construct health posts. The provision of local materials (e.g. cement, nails, and iron sheet) is a pre-condition to receive matching support from the WORHO, the GOE and NGOs in the pastoralist areas (either financial or material).

Another area that requires attention is the construction of the houses for the HEWs. Although it is assumed that the community will assist with the construction of residential homes (with matching support from the WORHO), a number of HEWs interviewed during the field visits live in the health posts due to lack of housing. This limits the optimal use of a health post.

Box 2.2 Visit to a Health Post

In the health post, two of the three rooms were occupied by the HEW and her sister. The left room was a sitting room with storage place for clothes. The right room was a bedroom. The bed was positioned next to a non-functional kerosene fridge. This room also contained a cupboard with drugs. Only the middle room was available for patient visits. It contained a table, a bench and shelves to store equipment. Privacy for the patients was limited, as other relatives of the HEP also lived in the health post.

Visit to Site Zone: Alicho Woriro Wereda May 2008

Equipping the Health Posts

The health posts are supposed to be provided with furniture and have to be equipped with health post kits. The findings from the regional MTR indicate that there is delay with the provision of furniture to the posts. Some of the regions (Amhara, Oromiya, Tigray, and SNNPRS) have received this kind of support through the international NGOs (e.g. Pathfinder International). Other regions do not have NGO support and depend on the RHBs, ZHBs and WORHOs. This area requires follow-up, as the HEWs are not able to carry out all their duties if the health posts are not (fully) furnished.

More important is the provision of essential equipment to the 11,000 health posts. The criteria for receiving a health post kit in the kebeles are; (1) the health post is constructed and (2) at least one HEW is deployed in the post. Although a substantial number of kebeles already meet these criteria, they have not received the HP kits, because of the complexities in the entire supply chain. During the first phase of HSDP III (1998-2000 EC):

- In 1997 standard health post kit containing essential equipment and consumables[15] was developed by the FMOH and UNICEF. At this stage UNICEF was only responsible for the procurement of the kit.
- After an assessment of kit delivery constraints (see remarks in Table 2.5), it was agreed with the FMOH that UNICEF would become responsible for the overall coordination of the health post kit supply process[16]. UNICEF has recruited technical assistance to assist with this process.
- Table 2.5 provides an overview of the health post kit distribution between1998-2000 (EC).

[15] There are two standard types of health post kits: Kit A and Kit B. Kit A includes a refrigerator (1 health post serves two other posts with vaccines), Kit B has a vaccine cold box. Both kits include non-consumables and consumables. The non consumables include (among other items): thermometer, sterilizing equipment, weighing scales, delivery bed, midwifery kit, first aid and EPI equipment. The consumable items include (among other items); paracetamol, ferro, folic acid, ORS, albendazole, tetracycline eye ointment, mucus extractor, gloves and bandage materials. The consumables last for one year. After their expiration, UNICEF provides a new one-year supply of consumables. The items and drugs from the vertical programmes are not included in the kits but are distributed through the RHBs: EPI vaccines and items, TB, leprosy and malaria drugs, and family planning commodities.

[16] This process includes: ordering, approving procedures for procurement, transport, custom clearance, warehousing, packing, distribution from Addis to the health posts, assembly of the equipment in the health posts, training on the use of the equipment and follow-up of the utilization of the health post kit.

Table 2.5 Distribution of Health Post Kits (1998-2000 EC)

Health Post Kits Purchased and Distributed	Remarks
End 1997: UNICEF procured 2,346 kits on behalf the FMOH. UNICEF assisted with the procurement and was not responsible for the entire supply process.	The 2,346 health post kits were procured at the request of four regions and were distributed in 1998 However, after 10 months only 50% of the kits had reached the health posts. Some kits had been dismantled and some parts were sent to health centres and hospitals. The problem was caused by lack of transportation and communication constraints between the different levels in the health system.
UNICEF Becomes Responsible for the Entire Supply Process of 10,500 Kits.	
1999: First batch: 455 kits	UNICEF ordered and distributed through a commercial contractor. This caused serious problems with the unpacking, assembly and utilization of the kits.
1999: Second batch: 650 kits	UNICEF ordered and distributed through a commercial contractor (see above).
1999: Third batch: 685 kits:	UNICEF ordered and distributed early 2000.
2000: Fourth batch: 3,670 kits	UNICEF ordered (GAVI support) and distribution has started.
2000: Fifth batch: 1,500 kits	UNICEF ordered at the request of SNNPRS. A number of kits have been distributed. Consumables have been taken out by the FMOH.
2000: Sixth batch: 3,670 kits	UNICEF not yet ordered (GAVI support). Order preparations ongoing.

Source: UNICEF overview of health post kit distribution; interview with UNICEF Logistics specialist (May 2000)

During the period 1998-1999 (EC), a total of 3,451 health post kits were distributed. However, from the very first distribution (1997) only an estimated number of 1,173 kits (50% of the supply) reached the health posts. From the first two batches of 1999, 1,105 kits were transported to the health posts. In 2000, an additional 1,000 kits have been distributed. Based on the available data, it is estimated that, up till May 2008 a total, of 3,278 kits have been distributed amounting to 30% of the 11,000 health posts equipped with kits. The distribution of the health post kits is evidently a cumbersome element in the HEP process.

UNICEF aims at ensuring quality at all stages of the entire supply process. However, several factors have hampered the procurement and distribution process:

1. It is difficult to receive the distribution plans from the RHBs about the health posts that meet the criteria. The information is often delayed. It is therefore difficult to synchronize the health post construction, staffing and equipping, as the first two components progress faster than the latter.
2. Considerable problems have been experienced with the international suppliers as large supplies of delivery beds, fridges and steam sterilizers are not readily available. Furthermore the volume of the orders (up to 800 containers with equipment) is time consuming to deliver.
3. Tax exemption procedures are complex and time consuming. This contributes to considerable delays with the custom clearance.
4. In the UNICEF warehouse (Addis), the kits have to be re-packaged and prepared for distribution. The consumables of the last batch were removed, as FMOH was concerned that they would expire before arrival at the health posts. It is not clear how the distribution of consumables will be done later on. UNICEF is procuring additional consumable kits but quantities might not meet the replenishment needs in the following years. This situation will be temporarily, until the logistic master plan can take over the routine supply.
5. UNICEF is able to outsource the kit distribution to commercial contractors who distribute the kits to the weredas. This was done with the first two batches. However, from the first batch, only 50% of the kits reached the HPs. The rest remained at the wereda office. The other two batches reached the health posts (with UNICEF transportation assistance), but

this approach could not secure adequate capacity building to the HEWs regarding the correct assembly and maintenance of equipment.

UNICEF uses in-house transport facilities for the distribution of the kits, but the current in-house transport capacity is too limited. UNICEF therefore, plans to contract Population Services International (PSI) to complement the existing capacity with: (1) the distribution of 8,000 kits; (2) deployment of trained staff to accompany the commercial contractor to ensure the kit is well received and properly assembled by the HEW; (3) capacity building to the HEWs on the utilization of the kit's items. PSI will tentatively begin distribution in May 2008 (GC); However, distribution of the remaining kits will still take a period of 15 months (from May 2008 till July 2009 GC). As a consequence, a number of HEWs will not be able to carry out their duties as planned.

It is important to assess whether the distribution of the kits can be scaled up in a shorter period. This is only feasible if the kits can be delivered on time by the international suppliers, which is another area of concern. Furthermore, it is important to assess how to provide health posts with a temporary supply of consumables (through the WORHOs and the health centres) in order to bridge the gap during the waiting period.

The World Bank apparently also planned to order 7,000 health posts kits. If this is the case, there will be more kits than health posts! It is yet unclear how this order will be incorporated into the UNICEF kit distribution system.

Training and deployment of HEWs

Despite the constraints experienced with the construction of the health posts and the distribution of the kits in some areas, the training and deployment of the HEWs have been progressing according to plan. At this moment, a total of 24,534 HEWs have been trained and deployed. This is 82% of the HSDP III target. Table 2.6 provides an overview of the cumulative trend.

Table 2.6 Cumulative Total of HEWs Trained (1996/7-1999/00 EC)

Year	1996/7 (EFY)	1997/8 (EFY)	1998/9 (EFY)	1999/0 (EFY)	Expected by end 2000/1
Cumulative target	2,800	9,900	17,653	24,810	30,000 (target)
Achieved	2,800	9,900	17,653	24,534	

Source: HEEC profile 1999, HEEC interview May 2000 and PPD presentation May 2000.

The table shows that a major leap forward has been made during the first phase of the HSDP III. A number of regions have already achieved their target (Amhara, Dire Dawa, Harari and SNNPRS). Other regions are still training HEWs and will achieve their target by the end of 2000 or early 2001 (Afar, Benishangul Gumuz, Gambella, Oromiya, Tigray).

All the HEWs have received a monthly government salary of about ETB 600-735 (the salary ranges show regional differences). If we assume that an average HEW salary is ETB 700 per month, than the total Government investment for the HEW salary component in EFY 1999/0 is approximately ETB 206,085,600 (USD 21,693,221[17]). This is clearly a major government support to the HEP.

A New Cadre: The Supervisors

The need for more support supervision to the HEWs and increased monitoring of the HEP programme at community level has been emphasized in the ARM 8 and 9. The FMOH has taken up these recommendations and started this year with an one-month training of HEP

[17] Exchange rate of USD 1 = Birr 9.5.

supervisors. The target is to have one supervisor for five health posts. The available data (May 2008 GC) indicate that a total of 3,000 supervisors have been trained. Hence, the target of supervisors has been fully reached.

The supervisors are qualified health professionals, who will become available full-time for HEP supervision. In addition, they will provide training to the HEWs on EHSP related topics and can assist with the provision of supplies to the HEP. The supervisors will be located in the health centres (at Wereda level), thereby strengthening the relations between the HEWs and the HCs. The supervisors have only just taken up their position in May 2008 (GC); therefore it is too early to comment on their functionality. From the MTR regional reports a number of potential constraints appeared:

- The supervisors have to rely on wereda transportation facilities. This will cause a potential bottleneck for the supervisors, as most weredas face considerable transport shortages. This will affect the support supervision modality.
- A budget to cover supervision, transportation costs, per diems and meetings is not available. This will need to be addressed.
- Confusion may arise regarding the different mandates of the HEP focal person in the WORHO and the HEP supervisors.

Motivation and Attrition

The Tigray study (1998 EC) indicated that motivation was reduced among 25% of HEW, as they were not posted in the kebele of their choice. This contributed to considerable periods of absence from the health posts. In some of the regions HEWs were absent during the MTR team visits. Reasons for their absence could not be established. The limited availability of resources and transport facilities has also affected the motivation of the HEWs.

Data of attrition rates are not readily available. The Dire Dawa regional report revealed that 14% (12 HEWs) of HEWs dropped out after their training. Reasons for their departure were: (1) unwillingness to stay in a rural area, (2) re-settlement to other areas and (3) search for better employment opportunities. The SNNPR reported an attrition rate of 1.3% (93 HEWS) but did not explain the reasons for their departure. Some RHBs indicated that they would carry out a survey to update attrition rates.

Other regions reported that a considerable number of HEWs were on maternity leave (28%), which impacted on the functionality of the health posts.

There is an indication that attrition and maternity leave amongst the HEWs contribute to long periods of HEWs absence in the health posts, but the extent is not fully known at this stage. It will therefore be relevant to assess the level of attrition in order to estimate how many new HEWs require training to replace the HEWs that have left their job. In addition, temporary replacements should be made available to cover HEWs on maternity leave. If the average attrition rate is 10% per year, training 3,000 new HEWs is required on an annual basis. This implies that a number of Technical and Vocational Educational Training Schools (TVETs) have to remain functional.

Technical and Vocational Educational Training Schools (TVETs)

The capacity of the TVETs for the provision of HEW training has been assessed over the past years (CNHD: 2005[18], Tigray study: 2006[19], HRH study: 2007[20]). The main findings from these assessments showed serious constraints within the HEW training facilities. The overall conclusion was that the quality of the HEWs training was likely to be compromised, because of the sub-standard training facilities. The overall findings of the MTR regional reports mirror

[18] Centre for National Health Development in Ethiopia: Training of Health Extension Workers: First Intake Assessment: 2005

[19] Assessment of the HEP in Tigray: 2006

[20] FMOH, Human Resources for Health Business Re-engineering, Volume I, July 2007

the same concerns as earlier studies[21], indicating that little has changed over the past years. The need to train large quantity of students in a relatively short period has clearly prevailed above the quality of the training.

The TVETs are part of the regional education bureau, while the HEWs training falls under the responsibility of the RHB. The MTR regional reports (Afar, Gambella) indicated that the TVETs receive limited material support from the RHBs. Supervision of the TVETs by the RHB is not frequently carried out.

Although the training target of 30,000 HEWs is nearly achieved, there is still a need for continued HEW training during the second phase of the HSDP III (and beyond). Therefore, it is relevant to assess the capacity of the TVETs. Key findings from the MTR regional reports include:

1. Language barriers are a constraint for the HEWs. A substantial number of HEWs did not meet the grade 10 admission criteria and have reportedly limited knowledge of English and Amharic. This has affected their ability to fully grasp the training content. Dire Dawa and Gambella regions reported drop-out rates of HEW trainees at 4.5% and 38% respectively.
2. There is a persistent shortage of training materials (HEP manuals, IEC/BCC materials, demonstration equipment, reference books).
3. There is a shortage of tutors in the areas of child health and maternal health. As a consequence, more emphasis is put on hygiene and environmental health during the HEW training.
4. The majority of the tutors did not receive any additional training. As a result, the HEWs were mostly taught from the original 16 HEP packages, which are now outdated.
5. Some TVETs (e.g. in Gambella) have reduced their practical skills training from two months to two or three weeks due to a shortage of funds Furthermore, the health centres cannot accommodate all the students.
6. In the pastoralist areas, the MTR found that the 6-months training for the pastoralist HEWs is too short. There is a need to extend the training of the pastoralist HEWs or to include a different training strategy after the graduation. In Afar this has been addressed by providing continued training to the HEWs at health centre level.

Although these observations are not new, it is a matter of concern that the various problems continue to persist during all these years. The quality of the pre-service training has not been given the attention it deserves, even though the HEP is a priority programme in the HSDP III. According to the HEEC, the revision of the HEW training package is in progress. As long as the one-year HEW training continues, serious efforts should be made to improve the quality of the training programmes in order to lay a firm foundation *during* training, rather than *patch up* the gaps *afterwards* through refresher courses. The latter is not a cost-effective and efficient approach.

Integrated Refresher Training (IRT)

The ARM 8 and ARM 9 recommended to prepare additional training guidelines and reference materials for the HEP. The FMOH, with UNICEF support, has taken this recommendation seriously and has initiated the IRTs in 2007 (GC). The training is based on newly developed IRT manuals (e.g. integrated management of newborn and child illness, safe and clean delivery, PHAST training notebook, HIV community planning, IEC/BCC, Monitoring and Evaluation). A total of 856 staff members from RHBs, ZHOs, WORHOs and health centres have been trained as TOTs through special 18-day IRT courses. They will form a TOT pool for future refresher training to HEWs. The RHB and the ZHOs will become responsible for the coordination of the IRTs at a later stage. At this stage (May 2008), a total number of

[21] Several international organizations provided material support to a number of the TVETs (e.g. Pathfinder International).

5,000 HEWs have received their first IRT training on different topics. This group represents 20% of the total group of 24,500 trained HEWs. This implies that 80% of the current group HEWs still has to receive their IRT courses.

The TOTs specialized in IRT will have a major task ahead during the last phase of HSDP III. In some regions, the IRT process has experienced delays due for resource constraints. The SNNPR reported that the IRT training could only be completed in six zones due to funding shortages. The SNNPR took this up with UNICEF and expects to receive financial support to complete the training in the remaining seven zones during the coming months. Other regions may face similar delays with the implementation of the IRT courses. They should be monitored closely, since there is an urgent need to strengthen and update the knowledge and skills of the HEWs.

Another concern is the removal of staff from the health centres. A number of nurses are now included in the health officer's upgrading courses, and as a result, the health centres experience staff shortages. Training other health centre staff in IRT courses, will further reduce the centres' capacity. There may be other ways to provide regular IRT training at health centre level, through continued education.

In addition to the IRT courses, a number of HEWs participate in training courses from other organizations[22], indicating that increased capacity building is a priority. However, HEWs who receive extensive support from international programmes gain advanced skills, which will cause regional disparities in the level of HEWs' skills and competences.

A complete overview of all the additional trainings currently provided to the HEWs by different actors could not be established. A new development is underway to provide this kind of information. UNICEF has entered into an arrangement with a UK-based university to develop an online database. This database will provide detailed profiles about the health posts and the HEWs (e.g. status of equipment, coverage of services, courses followed by the HEWs etc).

Career Development for the HEWs

Both the HSDP II and the ARM 8 recommended looking into the career development of the HEWs. This recommendation has been taken up and the process has started to develop a training curriculum for a one year refresher's course (either in environmental health or public health nursing). As this process is still on-going, it is not yet clear what plans are exactly in the pipeline. According to the available information, the HEWs will be entitled to a one-year upgrading course after completion of a three-year service in a health post. This is considered by the HEWs as a major incentive.

Box 2.3 Importance of Upgrading

"The HEWs will go for the "gold". They have been promised a one-year training"

Source: Interview with HEEC team, May 2000

At this stage, It is unclear what the career development strategy entails and what are its implications. The following suggestions could increase incentives for HEWs to upgrade their training:

- The current incentive for the career development of HEWs is the one-year upgrading course. Possible alternatives could include training HEWs to become supervisors or community midwives in their area. Other incentives such as high quality, short-term courses and loan schedules could also attract HEWs.

[22] ESHE, ACCESS and Pathfinder International

- A competence needs assessment study could provide direction to the upgrading requirements for HEWs (what kind of courses will be relevant and what outcome is expected by the FMOH?).
- If *all* the HEWs are entitled to a one-year upgrading course, the health posts will not be able to operate at its full capacity. The first two groups of HEWs (years 1996/97 and 1998/99) are already entitled to an upgrading course. They have served for three years. This is a group of 12,700 HEWs (52% of the current establishment). If all of them will be sent to a one year upgrading course, the HEP will only operate at 48% of its capacity. If just half of this group (6,350 HEWs) attend an upgrading course (26% HEWs), the HEP will function only at 74% of its capacity. Either way, the implementation of the ESHP at community level will be severely hampered and activities will slow down.
- It is not clear whether the upgraded HEWs will be posted back to the health posts or whether they will be posted at the health centre level. There is concern that the upgraded HEWs will not return to the health post level. There is a risk that the health posts will face a permanent loss of capacity. One way of preventing this potential loss of capacity would be to continue training of new HEWs in order to maintain the target of two HEWs at every health post. However, this requires substantial further investments in HEWs training.
- New HEWs will also require one-year upgrading courses and upgraded HEWs will require a higher salary. This implies the need for increased resources and touches on the sustainability margins of the HEP.

The HEW career development plans bear the risk of undermining the entire HEP. It could mean a substantial loss of the investments made into the HEP since 1996/97. Therefore, the MTR recommends to finalise the HEP programme, make all health posts functional (with two HEW) and continue to aim to achieve the original objectives of the HEP.

The HEWs at Work

Service Provision

The HEP is operational with a network of 24,500 HEWs. The overall impression is that the majority of the HEWs are committed and dedicated to their work. This is fundamental for the success of the programme. Substantial progress has been made with the HEP coverage and expansion. The health posts that have received the health post kits are well positioned to provide adequate services. The MTR regional reports point to important improvements: Increased EPI and TT immunization, increased contraceptive use, a high level of vitamin A distribution, increased distribution of ITNs, improved hygiene, sanitation, latrine coverage and management of malnutrition. Gender issues have been integrated in key messages on early marriage, female genital mutilation and violence against women during community conversation and school programmes. Although it is too early to establish the impact of these promotive, preventive and curative services, there is a strong indication that the HEP programme has already contributed to positive changes in health seeking behaviour. However, data to substantiate these findings is lacking. From the MTR regional reports numerous observations were made regarding the capacity and skills of the HEWs in specific areas. Detailed information and recommendations can be found in the specific technical chapters in this report. Table 2.7 provides a summary overview of future capacity needs.

Table 2.7 Summary of HEWs Capacity Needs

Programme Area	Capacity Needs
Communicable Disease Prevention and Control	HEWs have distributed ITNs for malaria prevention. Need for increased community follow-up on utilization. Results of malaria rapid diagnostic tests are not always adhered to. Sometimes, negative results are still treated with ACTs. Increase involvement of HEWs in identification and referral of TB suspect cases. In HIV/AIDS prevention, increase HEW involvement in the communication conversation and

	PMTCT approaches.
Family Health	Improve capacity of HEWs to recognize and refer life threatening childbirth complications and improve access to B/CEmONC. Stimulate partnerships between HEWs and TBAs, so that there is better access to modern technology during the actual delivery. Stimulate EPI dropout tracing by HEWs. Strengthen cold chain skills. HEWs should undertake family planning defaulter tracing and provide FP counselling.
Hygiene/Environmental Health	Strengthen the skills of HEWs on promotion of behavioural change and improved sanitation practices.
Nutrition	Teach HEWs to identify malnutrition before it reaches the acute stage. Improve HEWs nutrition counselling and promotion. There is often limited collaboration with agricultural extension workers to promote consumption of locally available food.
Pastoralist Areas	Ensure adequate selection of HEWs who can work in pastoralist areas. Provide alternative training strategies for the HEWs who have only received six-month training. Increase mobility of HEWs in pastoralist areas.
Female and Male HEWs	Female HEWs are considered too young to provide effective messages on reproductive health issues. Male HEWs are often not accepted in reproductive health interventions (ANC, delivery, PNC). Emphasise the correct use of the established selection criteria
VCHWs	Strengthen their IEC / BCC skills; Stimulate partnerships with HEW
Quality of Care	Assess and Strengthen overall quality of care provided by the HEWs. Concerns include diagnosis of major communicable diseases, rational drug use, service utilization and impact on health seeking behavioural changes (emphasise preventive messages). Include the treatment of Pneumonia in the package of curative care (next to ACT and ORS).
Health Post Hours of Operation	Address the hours of operation for the health posts in order to ensure availability of HEWs for basic curative treatment and timely referral. Reconsider the current practise of both HEWs leaving the health post at the same time to go on field visits, meetings or trainings.

Source: MTR Regional reports 2000.

Community Engagement

As stated earlier, a Mid Term Review is not the right approach to establish the effect of the HEP at community level. This will require an in-depth study. From several studies carried out so far[23], it has appeared that the community engagement of the HEWs in a number of regions is highly appreciated and seems effective. In those regions, HEWs work together with Community Health Promoters (CHPs), health workers, religious leaders and community leaders. The majority of the HEWs are well organized in their activities and divide their time between community and health post activities (ESHE: 2006). Female headed households reported monthly visits by the HEWs and had received health education on various topics (housing, food hygiene, waste disposal, immunization, family planning). The majority (58%) indicated that the knowledge of the HEWs was good and useful (Negusse: 2007). However, it is evident that other regions lag behind with the expansion of the HEP. In those areas the community engagement is still limited.

Different categories of volunteers or 'village community health workers' (VCHW) collaborate with the HEWs (e.g. Community Based Reproductive Agents, TBAs and CHPs). As stated in the implementation guidelines (2007) *all* these different volunteers will be called VCHWs. The HEWs will become responsible for the organization, training and supervision of the VCHWs in their kebele. It is important to coordinate these activities with the different NGOs operating in the regions as they provide essential support at community level.

The total number of VCHWs is not clear. The MTR regional reports indicate that there are considerable differences per region. In the regions where Pathfinder International and the ESHE programme operate, a large number of VCHWs has been trained (10,000 CBRHAs and 30,000 CHPs). Both organizations aim at increased collaboration between the HEWs and VCHWs. In three regions (Amhara, Oromiya and SNNPR), the ESHE programme has

[23] (1) Pubmedcentral: HRH: Augusts 2007: Negusse H. and others, (2) ESHE: Qualitative assessment of ESHE BCC community interventions, (3) Pathfinder International 2008.

provided extensive technical support to the RHBs, NGOs, HEWs and VCHWs on the community conversation approach and the harmonization of health preventive messages.

The selection and training of model households is a key intervention area of the HEWs. Much of their time is dedicated to this activity. A major achievement is the "graduation" of 900,000 model households (see earlier explanation). The target for the year 2000 was 2,436,840 households[24]. Hence 37% of the annual target has been achieved. At this stage it is too early to say whether the model household approach will contribute to a more healthy environment and lifestyle. This will also depend on whether the model families will be able to reach the weaker households (each model family is supposed to train 10-20 other families). The results of this approach should be assessed in the next phase of the HSDP III.

Critical Areas for Attention

Prevent Dilution of the HEP Core Focus
Over the past two years, IRTs and other trainings have taking place in order to upgrade the technical capacity of the HEWs. This is a positive development in itself. However, as we have seen from table 2.7, the HEWs have to deal with many different topics with the expectation that they will be able to deliver the full HEP package. There is general concern among those interviewed that the HEWs will become overloaded with too wide a variety of tasks (ranging from PMTCT to model households) and will be considered as a (non-effective) *jack of all trades*! There are also indications that a number of HEWs are politically engaged at community level, as members in the kebele cabinet, thus taking time away from their HEP activities.

In order to succeed with the HEP, it is of paramount importance to remain focussed on the core areas of the HEP while taking into account the different regional characteristics (e.g. pastoralist areas). There is the need to carry out the HEP interventions in a supportive environment, in which the HEWs are linked to the health centres, the supervisors and the WORHOs. Currently this supportive environment is not optimal due to resource constraints, staff shortages, high turnovers and insufficient supervision mechanisms. The resource constraints are related to limited planning capacity at WORHO level and limited priority given to the HEP. Almost all the MTR regional reports point out clearly that, even if the WORHOs submit all the required information (e.g. baseline data, activity plans, budgets), the requested budgets are being reduced by the wereda administration. This needs urgent follow-up.

The MTR highlights two critical areas for attention;
- The role of the HEWs in maternal health.
- The provision of treatment for pneumonia.

Maternal Health
The strengths and weaknesses of the family health programme are discussed later in this report. However, in terms of the HEWs role in maternal health, there is a need to limit the scope of functions expected from the HEWs:
- Focus on mobilizing families, communities and pregnant women to recognize the danger signs in pregnancy and childbirth and promote child spacing and family planning.
- Discourage harmful traditional practices.
- Establish good relations with TBAs and support the TBAs when they do deliveries.
- Aim for at least four ANC visits and include the provision of iron folic acid, preventive treatment of malaria, Vitamin A and nutrition counselling.
- Ensure basic principles of cleanliness and implement prompt referral to designated facilities known to provide BEmONC. Prepare for transport accordingly.

[24] Presentation of PPD May 2000.

- Manage third stage labour including administration of misoprostol.
- Take note of every childbirth in the kebele and make postnatal visits within 24 hours of childbirth to implement basic PNC and newborn care.
- Visit every woman who has had an abortion and implement post-abortion care.

Increased Demand for Curative Services

The MTR has been requested to look into the feasibility of pneumonia treatment at health post level. Pneumonia is the leading cause of death among children under five years of age (28%). Early diagnosis and treatment with antibiotics can prevent a large proportion of deaths. All MTR regional reports show that there is an increased demand for basic curative services at health post level. In pastoralist areas, pneumonia treatment has been included in the HEP package. However, in other regions the HEWs can only provide treatment for malaria (ACT), diarrhoeal diseases (ORS), parasites and simple eye infections. The HEW cannot provide the complete IMNCI package due to shortages of required drugs and limited training. At health post level, the HEW should be able to treat pneumonia in children. Several leading studies and Ethiopia-based pilot studies show that once a child develops pneumonia, prompt treatment with a full course of effective antibiotics is life saving[25]. Effective treatment at the community level, offered by a health worker who has basic training will therefore contribute to the achievement of the MDG 4. In Ethiopia, basic curative care has already been included in the HEWs package (malaria and diarrhoeal diseases), so there is no fundamental objection not to include a safe antibiotic in their package. A recent study[26] (Lancet, 2008) found good evidence that such curative care provided by lay health workers contributed to reduced child mortality and morbidity and also resulted in a greater uptake of immunization in children.

The MTR recommends to integrate the treatment of pneumonia in the HEW package of care at health post level, as this will be a life saving strategy. It will reduce the need for time consuming referrals to the health centres and will increase the utilization of the health posts. Furthermore, it will also increase the credibility of the HEWs.

Overall constraints

- Despite the provision of massive support at national level to the HEP and related programmatic areas, insufficient allocation of resources by the wereda councils to the WORHOs leads to limited availability of resources for transport, supervision, supplies, training of VCHWs, and matching funds for the construction of health posts and residential houses. The WORHO functionality is affected by the limited availability of resources. This requires follow-up in order to assess the precise causes.
- There is still a need to construct a total of 4,200 health posts in a period of approximately one year. A number of regions will have considerable difficulties to achieve full health post coverage by the end of EFY 2001 (Benishangul Gumuz, Gambella, Oromiya and the pastoralist areas in the SNNPR). Due to the mobility of the pastoralist population and the limited availability of building materials in the arid and semi-arid areas, the health post construction by communities seems not feasible in those areas.
- There is a considerable delay with the distribution of the health post kits. Currently only 30% of the health posts have received the kits. A shortage of consumables is foreseen during the period that the health post kits are not in place. The World Bank seems to plan for an order of 7,000 health post kits as well. It is not clear how this order will be harmonised with the UNICEF health post kit distribution system.

[25] (1) Lancet 2006, Volume 368, September, Article by Tessa Wardlaw, a.o.: Pneumonia: the leading killer of children, (2) USAID/ESHE: Community based pneumonia treatment, a pilot intervention in SNNPRS (2008), (3) SCF: Community based management improves use of life saving curative interventions among pastoralists in Oromiya (2008).

[26] Lancet 2008: 371:668-74 by Chopra M. And others, Effects of policy options for human resources for health: an analysis of systematic reviews.

- There are indications that attrition and maternity leave among the HEWs contribute to substantial periods of HEWs absence in the health posts but to what extent this affects their outputs is not fully known at this stage. It is evident that – in the coming years – there will still be a need for training of new HEWs. This implies that a number of TVETs have to remain functional.
- The quality of the HEW training facilities in the TVETs is not up to standard. Little has changed over the past years. The quality of the pre-service training has not been given the attention it deserves. The MTR concludes that – as long as the one year HEW trainings continue - concerted efforts should be made to improve the quality of the HEW training (at the level of tutors, curriculum, training approaches, educational tools, attachment periods).
- The progress with the IRT training seems to be affected by resource constraints in a number of regions. There is concern that the IRTs will take health staff away from the health centres. There may be other ways to provide IRT training (on a more regular basis at HC level through a continued education programme).
- It is evident that HEWs in the regions that receive support from international programmes, gain advanced skills compared to HEWs in other regions. This is a concern, as this might lead to regional disparities.
- Regional disparity is also visible in the pastoralist areas. The pastoralist area will require a specific approach (see pastoralist paragraph) with special support for health post construction, inclusion of male and female HEWs, need for alternative training and mobility of HEWs.
- The HEW career development plans seem to bear the risk of undermining the entire HEP. It could mean a substantial loss of the investments made into the HEP since 1996/97 and might jeopardise the original objectives of the HEP.
- There is concern that the HEWs may become overloaded with too wide a variety of tasks (ranging from PMTCT to Model Houses) and will be considered as a *jack of all trades*. There are indications that a number of HEWs are also politically engaged at community level (being a member in the Kebele cabinet). This implies that they are not fully available for the HEP activities, as they are also called for other meetings and trainings.
- The HEP should remain focussed on its core areas: promotion, prevention and basic curative services. Management should ensure that HEP interventions can be carried out in a supportive environment in which the HEWs are well linked to the health centres, the supervisors, the WORHOs and NGOs that support the HEP. Currently this supportive environment is not optimal, due to staff shortages, staff turnover and insufficient supervision mechanisms.
- In maternal health, there is need to limit the scope of functions that is expected of the HEWs. However, it is a missed opportunity that pneumonia among children cannot be treated adequately.
- There is a shortage of in-depth studies for the HEP regarding the working environment motivation, capacity and actual practices of the HEWs and the effect and impact of the interventions at community level

Conclusion

The MTR concludes that the maximum output has been achieved given the resource constraints in the health sector. The HEP operates in line with the objectives of the AEPHCC and the EHSP. It is too early to establish the impact of the promotive, preventive and curative services, but there are strong indications that the HEP programme has contributed to positive changes in health seeking behaviour and that the HEP is on its way to achieve its overall objective to a large extent.

Table 2.8 Recommendations for the Health Extension Programme

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
	EFY 2001	Within EFY 2001-2003	After EFY 2003
Resource Allocation	Advocate for sufficient resource allocation by the wereda councils to the health programmes.	Strengthen the planning process at WORHO and kebele levels to cater to health programmes priorities.	
Health Post Construction	Complete the health post construction in the remaining regions.	Assess the options for matching funds for increased health post construction in pastoralist areas.	
Distribution of Health Post Kits (see also technical chapter on procurement and logistics)	Accelerate the distribution of the kits. Strengthen the RHB capacity in ordering drug kits.	Complete the distribution of the remaining kits. The provide health post consumables on an annual basis.	Distribute drugs and supplies in line with service package at health post level. Ensure adequate supply system.
Training and Career Development.	Assess HEW attrition rates to determine the need for additional HEWs. Improve on the quality of the pre-service training. Pursue the IRT courses and assess options for training options that match the health centre staff capacity. Provide more reference materials.	Develop a comprehensive and sustainable capacity building plan for HEWs (including quality of pre-service training, IRT, upgrading courses, replacement strategies). Develop alternative incentives for HEWs. Address regional disparities in capacity- building.	Roll out a comprehensive capacity-building plan for HEWs. Include appropriate HEP principles in primary school curricula. Maintain and utilize the UNICEF HEP website for monitoring and planning of capacity-building activities.
Maternal Health	Revise the role of the HEWs in maternal health.		
Basic Curative Treatment	Agree on basic treatment for pneumonia in children	Roll out basic treatment strategies for the treatment of pneumonia.	Document lessons learned on the community based pneumonia treatment
Pastoralist Areas	Strengthen effective HEP approaches.	Strengthen effective HEP approaches.	Impact study of HEP.
Supervision and Monitoring	Provide capacity- building on the mandates of the HEP focal persons, health centres, supervisors, HEWs and VCHWs.	Assess the adequacy and effectiveness of the support supervision model between the WORHO, health centres, supervisors, HEWs and VCHWs. Conduct a study on the impact of HEP before the HSDPIII evaluation.	Impact study of HEP.

2.1.2. Family Health

A. Maternal and Neonatal Health (MNH)

Status of Maternal and Neonatal Health
Ethiopia has one of the highest maternal mortality ratios in the world. It is estimated that every year, about 25,000 mothers die and 400,000 more suffer long-term disabilities due to complications during pregnancy, delivery or postpartum period. The leading causes of death are abortion, sepsis, haemorrhage, and obstructed labour. The majority of these deaths are preventable with affordable interventions. Many more women die as they battle malaria, TB, HIV/AIDS and other preventable illnesses.

The health of newborns also is poor. With 39 newborn deaths per 1000 live births, Ethiopia is among the five countries that account for half of Africa's newborn deaths. Infections, including neonatal tetanus, account for 44% of neonatal deaths, while asphyxia and preterm birth contribute to 26% and 17% respectively. Most of these deaths are preventable with appropriate antenatal and neonatal care within the first week of life.

Factors that contribute to the poor health status of pregnant women and their newborns in Ethiopia include a high fertility rate, widespread poverty, low female literacy, low nutrition status, and poor access to health services. Additionally, early marriage, gender in equality, female genital cutting and closely spaced pregnancies aggravate the problem. About 85% of women deliver at home, and about one in three use traditional birth attendants while the others use relatives and family members. Midwifery skills in the country are very scarce, with a ratio of one midwife to almost 20,000 women in the reproductive age.

Policy and Strategy Responses
The GOE is committed to health sector reforms and recognizes that addressing MNH is central to the reform agenda. Several national policies aim to contribute significantly to the welfare of mothers and children. The 1993 National Health Policy provided the basis for the multi-year HSPD. Together with PASDEP, these initiatives give priority to reproductive health, and demonstrate commitment to the Millennium Development Goals (MDG), including the reduction of maternal (MDG 5) and child mortality (MDG 4). The 'Making Pregnancy Safer' (MPS) initiative was initiated in 1993 as a health sector strategy to reduce maternal and newborn mortality. Central to the MPS approach is the critical role of skilled birth attendance and the importance of ensuring a functional continuum of care from the community to the referral level for effectively reducing maternal and newborn deaths. Several subsequent strategies complemented and enhanced the focus on maternal and newborn health. Foremost are, the National Reproductive Health Strategy (RH Strategy) which provides the foundation for addressing MNH, the National Population Policy aimed at addressing unregulated fertility, the National Policy on Women aimed at empowering women, the National Strategy on Child Survival, and the Adolescent and Youth Reproductive Health Strategy (AYRHS).

At the heart of the RH Strategy are two key elements, namely (a) "empowering communities to recognize pregnancy related risks and take responsibility for developing and implementing appropriate responses to them", and (b) "ensuring access to a core package of MNCH services especially in rural areas where health facilities are limited." The GOE acknowledged that health system strengthening is essential for improved MNH, but also recognized that health system strengthening would take time. Therefore, the GOE decided to implement three interlinked initiatives through HSDP III to dramatically scale up key services particularly for rural populations, and poor women and children.

International evidence shows that:

- Providing BEmONC care at a health centre, with effective referral back up by a hospitals providing CEmONC remains one of the most cost-effective options for saving mother and newborn' lives.
- Increasing coverage of skilled care at delivery is a critical intervention to save mothers and newborn life, but not sufficient in itself, for achieving MDG 5.
- Ensuring access to antenatal care is a potential entry to increase access and utilization of skilled birth attendants at delivery and in the postpartum periods in the health facilities.

The RH Strategy uses these principles to specify actions needed at the community, systems and policy levels. The Minister of Health specifically requested[27] that the MTR should review whether HSDP III was 'taking the right road' towards the overall goals, identify risks and suggest risk mitigation strategies.

The policies and strategies outlined in the preceding paragraphs provide an admirable framework for improving MNH and moving towards the MDGs. Therefore the remaining focus of the MTR will be on reviewing progress, diversions and constraints in implementing the strategies.

Progress towards HSDP III Objectives and Specific Targets

The specific objectives and targets of HSDP III are framed in terms of births by skilled attendants, contraceptive use, and the provision of BEmONC. For these targets, HMIS data quality is limited, and while progress has been made, this is not likely to affect the maternal mortality substantially.

But important steps are being taken. The GOE has reaffirmed commitment to MNH through the declaration of an annual celebration of Safe Motherhood Day. Rapid progress is being made in expansion of physical facilities (health posts, health centres and hospitals) (see Section on Construction and HEP). Considerable investment has been made in the procurement of equipment for clean delivery, and B/CEmONC. Competency-based training manuals have been prepared, and several in-service training programmes supported by GOE and Development Partners focus on various aspects of MNH. An accelerated training of health officers has been initiated. The inadequacy of the pre-service training of HEWs in MNH has been recognized, and a one month in-service training has been designed. There are on-going negotiations to introduce a Masters level programme in Emergency Surgery and Obstetrics for health officers. Some research studies have been requested, such as a Situational Analysis of Midwifery, and a Safe Motherhood Community Based Survey, and these have contributed to a better understanding of critical gaps. Key pilot initiatives such as Making Pregnancy Safer have been evaluated. Follow-up action on these studies is being planned.

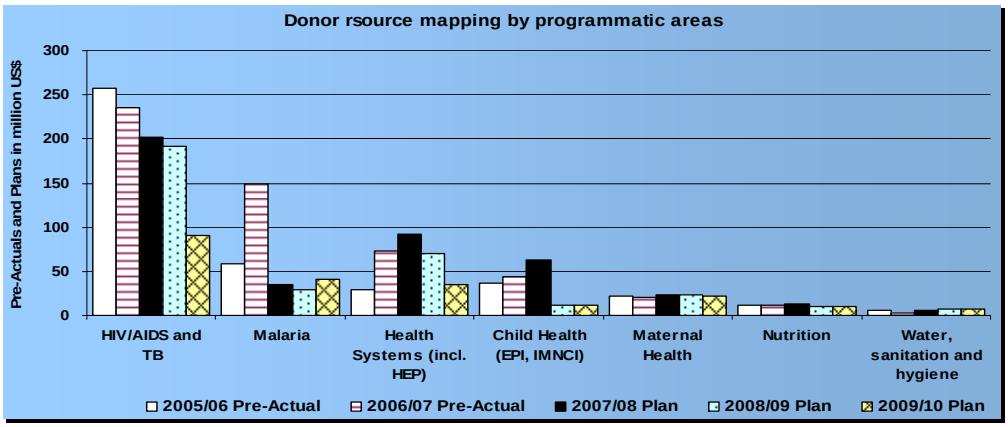
Constraints

Funding gaps: As indicated in the recent IHP report (2007), there is a funding gap for the MNH programmes compared to other national health programmes. This is a serious constraint to scaling up safe motherhood initiatives envisaged in the RH Strategy.

[27] Briefing to the MTR team by the Hon. Minister of Health

[28] Victoria Rumbold, Charlotte Warren and Yared Amare, Final Report on the Community-Based Safe Motherhood Survey, Ethiopia. Population Council and UNFPA

Figure 2.1 Funding for Family Health



Source IHP 2007

Implementation Gaps: At the *community level*, there has been limited progress in implementing the prescribed RH Strategy of informational campaigns and mobilization efforts to discourage early marriage and educate communities regarding danger signs during pregnancy and childbirth, and establishment of community referral mechanisms.

Health Extension Programme

Outreach services have increased dramatically through the HEP, yielding great potential for improved health through the preventive and promotive activities by the HEWs. However, the health system is unable to provide the clinical support and technical supervision needed for the outreach services and for the treatment of referred cased (details are given in later paragraphs). Additionally effectiveness of the HEP is limited because the routine ANC currently provided does not sufficiently emphasize some important elements, namely birth planning, information on danger signs, and provision of iron folic acid supplementation. Also, although about 50% women receive at least one antenatal contact, only 16% deliver with skilled attendants and only 19% receive PNC. This indicates that the ANC contact is not used sufficiently to facilitate entry into the health system. Also, since PNC is not specified to occur within 24-48 hours of childbirth, potential opportunities for HEWs to provide newborn and postnatal care are lost.

A recent community-based survey indicates several factors that inhibit facility-based delivery including (but not limited to) loss of control over the birthing process, ignorance of danger signs such as bleeding and prolonged labour, and cost associated with facility delivery[28]. TBAs were the most trusted sources for advice and help with pregnancy related problems. It appears that HEWs have yet to make an impact in terms of building rapport and confidence with pregnant women and their families.

The RH Strategy provides for HEWs to be trained to 'attend normal deliveries and detect and refer more severe complications', and also to provide 'essential care for the newborn including hypothermia, resuscitation or sepsis'. HEWs are not expected to manage obstetric complications. Their task is limited to proper identification and timely referral of obstetric complication. Pre-service training of HEWs in clean and safe delivery has been found to be inadequate to provide basic midwifery skills or the confidence to conduct deliveries, and a one month in-service training package on clean and safe delivery has been instituted. This

[28] Victoria Rumbold, Charlotte Warren and Yared Amare, Final Report on the Community-Based Safe Motherhood Survey, Ethiopia. Population Council and UNFPA

training curriculum has not been evaluated nor has the clinical competence on completion of training been assessed. Feedback suggests that most training sites (health centres) do not have sufficient case load or competent trainers for the trainees to acquire practical skills and competence required for the prescribed functions. Based on international experience it appears unlikely that non-technical workers would be able to acquire the skills to conduct a normal delivery and manage complications with a one month in-service training. Further, there is as yet no evidence whether such community levels workers with limited training and multiple other functions can reduce maternal deaths.

The limited training of HEW in midwifery carries several risks:

- Inadequately trained HEWs, placed in rural communities will be unable to manage childbirth. They could lose credibility with communities while mothers and newborns will continue to die;
- In communities where TBAs are currently functioning, tension between HEWs and TBAs is likely to hamper the effectiveness of HEWs in their other functions;
- The limited training creates false expectations that this strategy will reduce maternal deaths.

In order to mitigate these risks while recognizing that it will take some time before there will be sufficient access to have all births attended by skilled birth attendants an interim strategy would be desirable. The next few paragraphs suggest some policy and strategy options.

Collaborative Roles between HEWs and Trained TBAs

Almost one in three women uses TBAs during childbirth. There is lack of clarity and consensus among stakeholders regarding the desired respective roles of trained TBAs and HEWs in situations where both function within the same kebele. Consensus needs to be reached and policy guidelines formulated to avoid potential conflict and confusion.

The policy options are:

- Use HEWs to replace TBAs **or**
- Create partnerships between trained TBAs and HEWs so that HEWs provide access to modern technology while TBAs handle the actual childbirth in its social and cultural context (*WHO/FIGO/ICM statement in 2004 advocated working partnerships between health care providers and TBAs, and described partnership roles*.)

Some critical questions need to be considered when selecting between the desired options. Taking into consideration feasibility, cost, cultural acceptability, the questions are:

- Will a HEW (as currently trained) be better able to reduce deaths due to sepsis and bleeding than a trained TBA?
- What 'value-added' could an HEW (as currently trained) bring to situations where TBAs are doing deliveries? Will the HEW be better as a full-fledged birth attendant or as an agent to prevent harmful practices and a provider of equipment for clean delivery, misoprostol to reduce bleeding, better referral links to a higher level facility, and better newborn care?

Taking into consideration these issues, the MTR recommends that the role of the HEW be reviewed, taking a pragmatic approach to make optimal use of the resources such as the (health post and its equipment) made available through the AEPHCC. Box 2.4 illustrates how the HEW using her knowledge and the equipment and facilities in a health post, worked effectively in collaboration with a TBA. Detailed recommendations regarding the revised role of the HEW are given in the Section on HEP.

Box 2.4 Win-Win Situations: Collaboration between HEWs and TBAs

Win-Win Linkages

In a Wereda in Oromiya, a health post was reported to have provided safe and clean delivery services for about 100 women over a two year period. When a woman began childbirth, she and her TBA went to the health post, where the two young HEWs provided gloves, aprons, water and other essentials for clean childbirth, while the TBA conducted the delivery. When a woman had prolonged labour, the HEWs contacted a nearby hospital which had provided them a radio-telephone. An ambulance was sent and the patient was taken to the hospital and delivered safely. The HEWs appeared to have very good rapport with the community, and several clients visited the health officer during the visit of the MTR team.

Skilled Birth Attendants

The most critical implementation gap relates to *skilled birth attendants* and the related support and supervision chain. The RH Strategy envisages increasing births attended by skilled attendants to 60% by increasing the number of midwives trained per year, and amending the midwifery curriculum to satisfy the requirement of "skilled birth attendant". This would include the ability to provide BEmONC (WHO, 2004). International evidence confirms that access to life saving BEmONC is critical for reducing the MMR. Recognizing the severe shortage of midwives in the country, steps have been taken to increase production capacity (see Section on Human Resources).

However, a recent study that reviewed pre-service midwifery training found several serious deficiencies, like inadequacy in training infrastructure, few tutors, and insufficient skills training including lack of deliveries and case load at training sites. It is doubtful whether midwives trained in such circumstances would meet the clinical competence criteria established by WHO/AFRO[29]. The RH Strategy to amend the midwifery curriculum has not been implemented as yet. The FMOH and MOE have recently reviewed and developed a revised midwifery curriculum that has been circulated to the midwifery schools. However, the midwifery schools are still using the old curriculum. There is a need to strategically role out the new training curriculum.

The MTR understands that it is currently planned to reach consensus with stakeholders on how best to address the findings of the study. The MTR recommends that action be implemented urgently, because it will take some time for the effect of changes in training to reach the grassroots, impact on service performance and improve utilization of services. Detailed recommendations are given in a later section (see section "Laying the Foundations: Improving Training Quality and Output).

Midwifery Services

Currently, the midwife-population ratio in most regions is very low (ranging from about 0.3 in Tigray to 0.9 in Oromiya and up to 3 per 100,000 population in Addis Ababa). A recent facility survey (WHO, December/2007) found that almost 70% hospitals and 90% health centres are understaffed with regard to midwives[30]. The assessment also showed that the number of deliveries conducted at health centres increased with the number of midwives.

29 WHO, Africa. Consensus on Essential Competencies for a skilled attendant. Report of a Regional Consultation. Brazzaville. 2006

30 Ascheber. G. et al. Report on the National Situational Analysis of Pre-Service Midwifery Training In Ethiopia. Jan 2008. Sponsored by WHO.

The health system does have clinical nurses who can be given additional training to become nurse midwives, and this provides an opportunity for accelerating the production of midwifery skills in the country. The downside is that nurse midwives are not placed in a dedicated staff category. Hence there is leakage of nursing staff with midwifery skills to other nursing areas.

Anecdotal evidence suggests that the quality of maternity care is patchy. This includes not only the quality of clinical care but also gender sensitivity, preservation of dignity and cultural sensitivity. These factors together with the community level factors mentioned in earlier paragraphs explain the extremely low utilization (around 10-13%) of midwifery services for deliveries.

In order to address the critical skilled attendant gap, two key steps are needed:

- First, reach consensus on several key issues as listed in Box 2.5.
- Second, mobilize resources (funds, human resources) and plan for a systematic increase in the availability of competent skilled attendants

Box 2.5 Key Questions Regarding Skilled Birth Attendants

It is necessary to reach consensus with stakeholders regarding key issues, for example:

- The *type of worker* who would be the skilled birth attendant - midwife or nurse-midwife? Or both?
- *Clinical supervision and support* is essential for skilled birth attendants to be effective: what category of worker would provide this?
- How would *sufficient numbers* of skilled attendants and supervisors be produced?
- How would they be *retained* to provide care at the appropriate level?
- Deliveries and emergencies occur at all hours. How would round-the-clock services be made available?
- How would the skilled attendants *relate to others* in the health system (existing TBAs and community health workers, HEWs, nurses, HOs, GPs trained in CEmONC etc)

Comprehensive Emergency Obstetric and Newborn Care (CEmONC)

Production and retention of human resources for provide CEmONC at sites that are accessible to the majority of women is another major challenge. FMOH reports that CEmONC is available in 79 health facilities out of the 623 health centres and114 hospitals (1999). The WHO sponsored study found that half the hospitals did not have obstetricians and 73% of the district hospitals do not conduct caesarean sections. Earlier initiatives to provide in service training to medical doctors (GPs) in CEmONC were unsuccessful and most did not provide the service after training. The limited review done by the MTR was not able to determine all the factors contributed to this failure, but anecdotal evidence indicated that poor legal protection for doing tasks outside their normal purview, and poor support from qualified obstetricians might have been contributory. This is a known risk for the 'task shifting' strategy.

HSDP is attempting to address 'task shifting' by using health officers instead of GPs and obstetricians. Some approaches have been piloted. For example, in Tigray one pilot successfully trained CEmONC teams consisting of health officers (for surgical interventions)

and clinical nurses (for anaesthesia and scrub nurse)[31] Evaluation of the pilot stressed the need for continued supportive supervision after graduation. The on-going accelerated training of health officers is expected to produce officers competent in CEmONC. However, this training has not yet been evaluated, nor has the exit competence of graduates been assessed.

Legal Implications of Task Shifting
There is a risk that health officers will face problems of legal cover similar to those faced earlier by the GPs trained in CEmONC. The success of the "Task Shifting" policy will depend on (a) appropriate coordination between FMOH and legal authorities to ensure sufficient protection for workers who perform tasks not usually performed by that category, and (b) improved collaboration between FMOH and stakeholders such as professional bodies to ensure support for the strategy.

Continued Clinical Supervision and Support.
It is evident that CEmONC trainees will need continued clinical support and supervision from more experienced practitioners. One useful model would be the twinning approach, whereby a designated newly CEmONC facility is twinned with referral hospital that has experienced teams of qualified obstetricians and anaesthetists. Short-term staff exchanges and apprenticeship arrangements to enable CEmONC teams to perform interventions under the guidance of experienced visiting staff would build confidence and capacity.

Box 2.6 Twinning to Improve Clinical Competence

Twinning: An approach to Upgrade Clinical Competence.
Assela Hospital (government) in Oromiya has established twinning arrangements with St Luke Woliso hospital (NGO Catholic) for upgrading clinical skills for trauma and orthopaedic surgery. Visiting specialist and rotating foreign specialist arrangements are in place and boost on the job training and support.

Referral and Support
The continuum of care from the community to the referral level will be successful in saving lives only if there are mechanisms in place for prompt upward referral of complications as well as continued clinical support for each level of the system to the next lower level. Thus, HEWs need support from BEmONC trained skilled attendants, who in turn need support from referral centres that provide CEmONC. And all of these need to be linked by referral systems and ambulance or equivalent transport systems.

Coordinating the Health System Inputs
The AEPHCC initiative is actively expanding and equipping health posts, health centres and rural/district hospitals to provide essential obstetric and newborn care, BEmONC and CEmONC respectively, for defined population sizes. However, as evident from the preceding paragraphs, human resource production and deployment will take some time to reach the ground. There is a risk that expensive equipment provided to facilities such as health posts and health centres will not be used, because of scarcity of trained staff, and the equipment will quickly become non-functional. Unless these issues are addressed urgently there is a risk that MMR will hardly be reduced despite significant investment of resources (funds, health facility construction and upgrading, provision of equipment and investment of time).

[31] Waxman, R., Kwast, B., and Kodindo, G. Evaluation Report. Strengthening of Emergency Obstetrical and Surgical Care at Health Facility Level, Tigray Region, Ethiopia Sept 2004–June 2007, AMDD Programme, Columbia University (sponsored by UNFPA).

FMOH and the regions need to have master plans to coordinate systematically, the various inputs so as to ensure functional service delivery.

Fee Exemption
The policy of fee exemption for pregnant women and young children for both services and supplies has not been implemented. As a result, poor families still face serious cost barriers in accessing MNH service.

Conclusion

Ethiopia has demonstrated impressive energy and commitment to increasing access for rural populations through the HEP. The same type of dedication and effort would be needed to improve access to essential obstetric and newborn care including BEmONC and CEmONC.

It would take a few years for all the implementation results to reach the ground. Therefore, it is recommended that during the remaining period of HSDP III, the FMOH should adopt a two pronged approach, namely:

- Lay the foundations for better access to effective EmONC
- Implement interim period strategies (while capacity is being developed)

Box 2.7 Two-Pronged Approach to Improve EmONC

Laying the Foundations requires policies, strategies and implementation plans for:

- Increasing the numbers and clinical competence of the trainers of skilled attendants (TOT programme) and of trainees,
- Consolidating the available numbers of skilled human resources in strategically selected BEmONC and CEmONC centres, and
- Monitoring the provision and quality of services in the strategic centres,
- Incrementally increasing the numbers of strategic Centres, as more human resources become available.

Interim Period Strategies require the most optimal use and input of available technology and human and physical resources to prevent deaths and disability.

Laying the Foundations

Improving training output and quality for skilled attendants:
In order to provide adequate quality of skilled birth attendance, at health facility level, and in turn to provide support and supervision for the community level MNCH package it is necessary to revamp midwifery training and create a specific staff category for midwives. This would require a series of steps (see Box 2.8).

Box 2.8 Critical Steps to Improve Production and Quality of Skilled Birth Attendants

(a) Revise an agreed upon standardized, competency-oriented midwifery curricula for midwives and for clinical nurses.
(b) Upgrade and modernize nursing tutor skills through TOTs, using a core group of competent master trainers (with technical assistance);
(c) Upgrade the quality of midwifery service provided in selected training sites so as to provide sufficient case load for practical training for trainee midwives;
(d) In each region, develop and implement a Midwifery Training Master Plan to systematically increase the numbers of trainee midwives, while ensuring the clinical competence of graduates,
(e) Establish nationwide standards for all qualifying examinations for midwives and nurses
(f) Establish appropriate certification or accreditation and registration and provide recognisable status (such as special uniforms) for midwives
(g) Implement measures to prevent leakage of those with midwifery skills to other nursing disciplines.

Improving Provision of EmONC
Service delivery needs to be improved by consolidation of available resources and a step-wise approach to improving the quality and increasing access to such services. Critical steps are:

(a) Implement a rapid needs assessment survey to obtain base-line information on B/CEmONC needs and capacity, including mapping of facilities, their access to rural populations, and their physical and equipment needs.

(b) Step-wise incremental provision of B/CEmONC services. EmONC service needs to be provided on a 24 hour basis, throughout the year. In order to obtain optimum outputs from the available skilled staff, they need to be consolidated in selected facilities in sufficient numbers to provide reliable and good quality care. Families with an emergency on their hands would know where to go in order to obtain the care they need.

Based on the needs assessment survey, it would be possible to select health centres and hospitals located in strategic locations in each wereda or zone and having the required physical facilities, and designate them as strategic B/CEmONC centres respectively. Available skilled staff would be placed in the strategic centres. HEWs and communities in the designated catchments area would be informed about the services available in their referral centre. Output of strategic centres should be monitored using standard guidelines and indicators. It is foreseeable that utilization will increase rapidly in such strategic centres, which, in turn would be good training sites for skilled attendants.

(c) The number of strategic B/CEmONC sites would be increased incrementally when more staff becomes available.

Establishing Referral Mechanisms
HEWs should have orientation visits to the strategic EmONC centre serving their area. This would aim at (a) building inter-personal linkages between HEWs and EmONC staff, (b) making HEWs familiar with referral procedures. Regular meetings should be held at strategic BEmONC health centres with all HEWs in the catchments area to discuss clinical and referral problems. Strategic BEmONC health centres should be provided with vehicles to transport patients from health posts and other health centres to the BEmONC centre, and also to send patients from the BEmONC centre to CEmONC strategic centres. Similar referral linkages should be established between B/CEmONC strategic centres.

Ambulance and Transport Plan
In order to be effective, the referral system needs to have transportation systems than would ensure that any patient, who arrives at a lower level health facility but needs higher level care, can be transported promptly to the appropriate level. Therefore each region needs to develop an ambulance and transport plan to (a) meet the needs of transporting patients between health facilities, and (c) enable staff from higher level facilities to visit lower levels regularly to provide clinical support and mentoring. Using such plans, regions and FMOH should mobilize the resources to obtain and maintain suitable transport systems. In addition, the each wereda should monitor the proportion of kebeles who have developed an emergency obstetric transport plan to bring obstetric and childhood emergencies from communities to a health facility.

Monitoring Output Performance
Each region should monitor their strategic centres in terms of, for example, the supply of requisite equipment and essential emergency obstetric and newborn care drugs, and also the output performance of B/CEmONCs using agreed indicators.

Interim Period Strategies

While the foundations are being laid for better access to EmONC, actions to derive optimum benefit from the current investments and strategies would be:

- Refine the expected scope of HEW functions by define the "intra-partum care"[32] expected of an HEW, taking into consideration the constraints of her short training, her age and acceptability to the community, and the potential benefit of working with TBAs. (See Section on HEP for a detailed list of possible functions).
- Strengthen MNCH outreach coverage through better coordination with HIV/AIDS activities.
- Strengthen the focus of IEC/BCC and HEWs on promoting birth preparedness, preventing harmful practices, and TT, nutrition and PNC coverage and newborn care
- Improve the emphasis on community mobilization and IEC/BCC for birth preparedness and use of referral.
- Improve HEW effectiveness by strengthening collaboration with trained TBAs and linkages with selected health facilities.
- Accelerate the provision of safe abortion and post-abortion services.

Sustain and Upgrade:

- High level advocacy to place MNH on the agenda of communities, and political bodies and kebele, wereda, regional and national levels,
- Mobilization of resources for MNH
- Coordination between Development Partners and government on implementation as well as policy issues.

[32] FMOH Implementation Guidelines of the Health Extension Programme, Feb 2007, Addis Ababa

Review the Specific Objective and Targets of MNH in HSDP III

Considering the analysis of constraints and potentials for improvement during the remaining period of HSDP III, it appears that the specific objectives and targets established for HSDP III were unrealistic. The MTR is an opportunity to review and revise the specific objectives and targets to better reflect the reality on the ground and the feasibility of making achievements. For example, the proportion of facilities to provide B/CEmONC could be reviewed taking into consideration the recommended strategy of consolidating human resources in strategic EmONC centres. Also, targets could include output indicators for EmONC. Separate objectives could be established for laying the foundations and for the interim period measures.

Table 2.9 Recommendations for Maternal and Neonatal Health

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
	EFY 2001	Within EFY 2001-2003	After EFY 2003
Laying the Foundations Improve Training	Improve the quality of midwifery training, starting with TOT, improve quality of care in training sites, and establish nationwide standards for qualification and certification.	Systematically increase and monitor midwifery training for midwives and clinical nurses, and evaluate output competencies in BEmONC.	Mobilize resources for MNH.
Select Strategic Facilities	Based on a nationwide rapid assessment survey, select facilities to be strategic B/CEmONC centres, deploy existing staff, and establish referral and support mechanisms.	Evaluate the output competencies of CEmONC training. Establish twinning arrangements for CEmONC centres, improve collaboration with professional bodies, and establish legal cover for staff under the 'task shifting' strategy.	Coordinate Development Partners and government on implementation as well as policy issues.
Implement Fee Exemption	Implement fee exemption for pregnant women and young children.	Establish referral and clinical support procedures and mechanisms, and monitor performance outputs of B/CEmONC centres.	
Interim Period Strategies	Strengthen coverage in coordination with HIV/AIDS activities and linkages with health centres	Develop plans and seek resources for regional emergency ambulance and transport.	
Promote Birth Preparedness	Focus HEWs on promoting birth preparedness, preventing harmful practices, TT, nutrition, PNC coverage, newborn care and improve coordination with TBAs.	Sustain and upgrade high level advocacy to place MNH on the agenda of communities, and political bodies.	
Community Mobilization	Improve the emphasis on community mobilization and IEC/BCC for birth preparedness and use of referral.		

B. Child Health and Integrated Management of Newborn and Childhood Illnesses (IMNCI)

The major causes of childhood death are pneumonia malaria, diarrhoea and newborn deaths. The HSDP III and the National Strategy for Child Survival strategies stipulate to expand IMCI training and implementation and increase access to neonatal resuscitation and antibiotics for neonatal sepsis. Other strategies that impact on child health are immunization, HIV/PMTCT, family planning, nutrition, and safe water and sanitation which are all discussed in the appropriate sections of this report.

Progress and Achievements

45% of health centres report having one or two staff trained in IMCI, and some hospitals have implemented IMCI algorithms. IMCI training is reported to have been integrated into the curricula of all universities training health officers and nurses, but has not been integrated into undergraduate medical courses except for a couple of pilots. Comprehensive data on the implementation of C-IMCI is not available, but partial information indicates that at least in 172 weredas, VCHWs have been trained in community IMCI (C-IMCI). Newborn care is part of the BEmONC and CEmONC training for which data on implementation was not available.

Constraints

While there is evidence that IMCI algorithms are being implemented in some facilities, some constraints were noted, namely (a) some trained staff are unable to implement the algorithm correctly, (b) decline in the implementation of IMCI arising from transfer of experienced staff to health officer training and other duties, (c) CEmONC training does not equip nurses and midwives with sufficient skills for newborn resuscitation, (d) concern that HEWs are not acquiring sufficient competence in IMCI.

In addition, there is a tendency to treat every fever as malaria as was evidenced by the very high proportion of negative slides examined in one Region. The introduction of zinc, in addition to ORS, for the treatment of diarrhoea has been delayed due to complications arising from drug registration. This is expected to be resolved in the near future.

The quality of care provided to sick children in first referral hospitals should be improved through the introduction of the referral care package which is complementary to the outpatient IMNCI guideline.

IMNCI Policies and Implementation

Prevention of Pneumonia Deaths in Rural Children

Access to antibiotics for rural children suffering pneumonia is limited because HEWs at health posts are not allowed to treat pneumonia. HEWs are using very powerful drug combinations in the management of malaria. There is strong evidence on the effectiveness and feasibility of reducing childhood pneumonia deaths through the use of antibiotics by community level workers. The rationale for the policy restricting HEWs from managing pneumonia is unclear.

Improved Implementation of IMCI in Health Facilities

It is necessary to review the extent to which IMCI algorithms are being implemented in health facilities and the quality of implementation. Based on such a review, strategies are needed to (a) strengthen the quality of IMCI implementation, and (b) expand the number of facilities especially health centres and district hospitals that implement IMCI.

It is also necessary to assess the clinical competence in newborn resuscitation of nursing and midwifery staff that have undergone CEmONC training, and implement appropriate measures.

Expansion and Strengthening of C-IMCI
Information is required on whether C-IMCI has been able to change community behaviour. Quick surveys in a sample of weredas would provide guidance for future expansion of C-IMCI to other weredas.

C. Immunization

Achievements
The number of children under one year of age who were immunized increased during the first two years of HSDP III, and declined during the current year. (See Table 2.10)

Table 2.10 Results EPI Programme 1997–2000 (EC)

Less than One Year	1997 EFY (HSDP II)	1998 EFY	1999 EFY	HSDP III Target
DPT3	70% (EDHS 32%)	76%	77%	80%
Measles	61%	66%	67%	80%
Fully Immunized	44% (EDHS 20%)	54%	55%	54%

The pentavalent vaccine has been introduced into EPI. The initial increased coverage is widely attributed to better access provided by the HEP, although data discrepancies due to changes in estimates of births make the data impossible to verify. The decline in the current year is reported to be due to divergence of staff and attention to control the epidemic of 'acute watery diarrhoea (AWD)'. However, coverage even in the best performing year (EFY 1999) falls short of the HSDP III target.
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Constraints
The major constraints in achieving HSDP III targets are:
- Insufficient follow-up and tracing of drop outs (DPT1 to DPT3 gap);
- Need for tailored measures to reach pastoralist and poor security areas (for example, in Somali Region 16 weredas do not have EPI and a further 15 have weak EPI);
- The cold chain is a serious risk with widespread breakdown due to lack of maintenance and spare parts throughout the country. It is very likely that vaccine effectiveness has already been compromised and is likely to deteriorate further.
- (Refer to chapter on Logistics on why the cold chain is not working).

Additionally, the EPI performance demonstrates clearly that routine programme activities are badly affected whenever a campaign is implemented.

D. Adolescent and Youth Reproductive Health (AYRH)

Achievements
Over the last two and half years the FMOH, in collaboration with Development Partners has made an encouraging effort in the development of policies, strategies, standards and guidelines. The National Adolescent and Youth Reproductive Health Strategy (2007 - 2015) advocates for a redistribution of resources and renewed efforts to reach all segments of adolescents and youth, including the marginalized and most vulnerable groups. Service Delivery guidelines and Minimum Service Delivery package for Youth Friendly Reproductive services have been drafted. Training of health care providers in the area of youth friendly service has begun. In addition, AYRH issues are adequately addressed in National Population Policy plan of action (2008 to 2015)

In general AYRH services are largely offered by the private/NGOs facilities across the country. The effort at the regional level in the implementation of youth friendly services in the public health service is minimal and varies between regions.

E. Family Planning

Progress toward HSDP Objectives and Specific Targets
HMIS uses Contraceptive Acceptor Rate (CAR) as equivalent to "Family Planning Service Utilisation" .The CAR increased from 18% at the end of HSDP II to 21% in the second year of HSDP III. The federal and regional governments have committed funds for the procurement of contraceptive commodities. This is an encouraging achievement and sign of GOE commitment for family planning.

Constraints

Careful use of Information for Decision-Making
CAR is calculated by aggregating the new and continuing users who are reported each month at facility level. In this way, CAR is a measure of utilisation, not of protection (like CPR). Counting all the new users who may discontinue their use probably after one contact or without finishing the 12 months, will increase the numerator and give higher rates of use. Although the CAR is used according to international standards, using CAR to track progress towards the HSDP objective of reducing TFR from 5.4 to 4.0 might mislead decision makers regarding the rate of progress in fertility reduction (as this requires information on protection rather than use of FP). Further, it might contribute to incorrect assessment of contraceptive needs which in turn affects resource availability. It is timely to use the MTR to realign family health objectives towards the HSDP objectives of reducing TFR. (see section on Recommendations).

A further misconception arises from data on contraceptive use as given in FMOH publications. This is based on a mixture of HMIS data on 'contraceptive acceptors' and contraceptive distribution data provided by suppliers. This data is used to calculate CYP. Therefore a portion of the CYP is based on the assumption that all contraceptives distributed, are in fact used by clients, although this might not be true.

Unmet need: EDHS 2005 indicated significant unmet need for contraception, and indicated three main contributing factors, 'religious objections', fear of side effects and fear of health problems. Evidence from Pathfinder studies and project experiences[33] suggest that inadequate time and expertise among health workers at facility level results in poor counselling on side effects and health problems. Also, little information is given regarding follow up that would be needed to resolve problems arising from side effects. Innovative approaches appear to have been successful in dealing with perceptions regarding religious objections. For example, working in low key mode with local religious leaders, when recruited as community based distributors have been effective in providing counselling to men as well as women and in serving as contraceptive suppliers.

Highest fertility group: Despite the adoption of the AYRHS, the programme has yet to make any special effort to reach out and meet the needs of the 15-24 age groups. This is a serious missed opportunity for reducing fertility and well as maternal mortality and disability (see AYRHS).

Method Mix and Choice
The large majority of contraceptive users in Ethiopia use hormonal contraceptives, and very few use longer acting or permanent methods. However, EDHS data suggests that 14% of

[33] www.pathfind.org

respondents did not wish to have any more children and a further 10% did not want another child within the next 3 years, indicating that almost 4 million couples have an unmet need to longer acting or permanent methods. A recent study[34] illustrated how improving the availability and counselling for a wider range of contraceptives, changed the preferred method mix with a high proportion of couples adopting permanent and long acting methods. Although theoretically choice is available in the form of available commodities, it appears that health workers strongly influence potential users towards hormonal methods, particularly injectables that are relatively easy to provide rather than methods such as IUD, implants and permanent methods. There is a danger that the system might not be responding to user needs, and additionally missing good opportunities to reduce fertility. However, many health facilities do not have the staff and equipment to provide the longer acting contraceptives and permanent methods (vasectomy and tubal ligation).

In the past few years no condoms were imported to the country through family planning programmes, on the assumption that HIV/AIDS and social marketing programmes would manage the need for condoms. EDHS data indicates that condom use is declining. There is concern whether condoms supplied through social marketing are reaching the rural population, and also whether such condoms are affordable for the rural poor. Further, it is unclear whether women and youth have adequate access to condoms supplied through social marketing and HIV/AIDS programmes.

Box 2.9 Contraceptive Choices

Illustrative Anecdotes

- A client who was on hormonal contraceptives, developed goitre and approached the HEW for advice. She was told she should stop her taking her contraceptive – but was not offered any alternative!
- Some hospitals that provide CEmONC do not provide long term or permanent contraceptive methods such as vasectomy or tubal ligation.

Discontinuation

The health system does not track discontinuation rates nor trace users who have discontinued. Thus, at the local level, it is not possible to determine whether a user has stopped because of side-effects, or due to an unintended pregnancy. Each of these eventualities requires appropriate measures from the health system.

Contraceptive Supplies

Currently the FMOH and regions are putting little amounts of budget for the procurement of contraceptives. As these budgets are not allocated regularly, there is uncertainty about future budgets, and a resulting risk of lack in continuity of programmes. In addition in the area of supplies there is an issue of availability of choices of different contraceptives. The increased percentage towards some of the contraceptives is related to the provision of the different methods that are preferred by clients.

Procurement and Logistics

Service delivery sites experiences interruption of supplies during the first two years of HSDP III, and a UNFPA review commented that “it appears that coordination between all actors in this field of contraceptive logistics is particularly needed”. “Despite the regular coordination

[34] Mengistu Asnake, Lakachew Walie, Yilma Melkamu, Improving the Range of Contraceptive Choices in Rural Ethiopia. Ethiop. J.Health Development, 2006; 20, (2).

efforts to assists FHD through the family planning Technical Working Group, there exists considerable confusion over the methodology and data sets (FMOH targets or EDHS) for forecasting contraceptive requirements. In addition, it emerged that World Bank and UNFPA procurement regulations for (contraceptive) procurement differed to such an extent that the PBS financed contraceptive arrived in Ethiopia with a half year delay".
Currently the issues have been resolved and it is estimated that sufficient commodities are available. However, there is continued concern whether the resources as well as commodities will be sufficient, if demand increases significantly. Agreement has been reached to integrate contraceptives into the new PLMS. Extra effort will be needed to ensure a smooth transition phase that does not interrupt supplies at the front line.

Table 2.11 Recommendations for Family Health

Actions to be Undertaken	Short-Term In the Next EFY 2001	Medium-Term HSDP III Period	Long-Term Design of HSDP IV
	EFY 2001	EFY 2001-2003	After EFY 2003
Child Health	Review policies regarding prevention of pneumonia deaths so as to introduce treatment at health post level.		
	Based on a sample facility assessment, conduct a survey of actual coverage and quality of IMCI that is reported to be implemented. Develop strategies to expand coverage and quality.		
	Based on a household sample survey of behaviour change, assess the quality of C-IMCI, and develop strategies to expand coverage and quality.		
Immunization	Strengthen drop-out tracing, using HEWs to trace health centre drop-outs.	Reach consensus with stakeholders, adopt a National Plan for Cold Chain maintenance, repair and mobilize resources.	
	Identify weredas needing special EPI strategies, and provide additional technical assistance to design specific measures to overcome local constraints.		
Family Planning	Strengthen counselling approaches, messages and follow-up of users by: (a) strengthening defaulter tracing and counselling by HEWs and VCHWs; (b) recruiting local religious leaders to motivate their communities, and where feasible distribute commodities, (c) integrating family planning information, counselling and services in VCT initiatives to reach the young and male clients, with a focus on delaying age at marriage and age at first child bearing.		Improve estimates of contraceptive users and realign family health services objectives and targets accordingly; (a) Replace the CAR indicator with Point Prevalence estimates of current users.
Adolescent and Youth Reproductive Health Strategy	Provide support to assist the RHBs in the development of Regional Master Plans for AYRH service, capacity building, and dissemination of best practices.	Strengthen coordination of relevant sectors, partners and NGOs.	
IEC / BCC		Strengthen documentation and dissemination of public and private initiatives.	
M&E		Strengthen monitoring and evaluation mechanism.	

2.1.3. Communicable Disease Prevention and Control

The major programmes included in the HSDP III strategic plan are malaria, tuberculosis & leprosy, HIV/AIDS and blindness control. The commitment of the GOE and Development Partners to combat the threats of malaria, HIV/AIDS and TB has always been significant. In 2000 (EC), these programmes took advantage of the Ethiopian Millennium celebration to undertake sensitization and advocacy campaigns and foster greater collaboration between partners and all stakeholders.

A. Malaria

The malaria prevention and control programme in Ethiopia is guided by a five-year National Malaria Prevention and Control Strategic Plan developed in line with the goals of the HSDP. The goal of malaria prevention and control in Ethiopia is to reduce malaria morbidity and malaria-related mortality by 75% by the end of the year 2013 (GC) as compared to the annual averages seen in the period from 2001-2005 (GC). Major malaria targets include:

- 100% household coverage with two ITNs per household in all malarious areas.
- > 85% of the population living in epidemic prone areas covered with indoor residual spraying > 80% of the population have access to prompt and effective treatment with artemisin-based combination therapy (ACT).

Malaria is one of the major public health problems in Ethiopia. Approximately 68% (52 million) of the population lives in malarious areas, covering almost 75% of the country's landmass. Annually, approximately 5 million clinical malaria cases are reported from health facilities and the actual total number of cases is expected to be more than double this figure. Due to the diverse eco-climatic conditions in the country, transmission is unstable and often characterized by epidemics. Whilst pregnant women and children less than five years of age remain most at risk from malaria, all age groups are affected due to relatively low levels of immunity.

Achievements

Significant reductions in malaria related deaths have been reported by health facilities, as well as a reduction in the number of epidemic affected villages. In-patient case fatality rate of malaria has reduced in all age groups. With in-patient case fatality in age group >5 years falling from 4.5% to 3.3%, while the case fatality rate of malaria in age group <5 has fallen from 5% is 4.5% (1999 EC). Significant progress has been made in malaria control in the last three years, with a significant input of funds from a number of key donors especially the GFATM, but also including the World Bank, UNICEF, UNITAID and others. This progress has included the distribution of approximately 20.5 million bed nets resulting in a household coverage of at least 70%. The majority of mosquito nets distributed have been long lasting insecticide treated nets (LLITN) distributed through health facilities, the enhanced outreach strategy, and campaign approaches. The highly effective anti-malarial medicine, artemether-lumefantrine has been introduced nationwide for the treatment of *Plasmodium falciparum* malaria, including at health post level. Access to parasitological diagnosis of malaria has been extended to the periphery through the introduction of rapid diagnostic tests. Indoor residual spraying for the prevention of malaria epidemics continues to be implemented but coverage remains below target due to inadequate financing. Much of the malaria scale-up, particularly treatment and diagnosis has been integrated with the HEP.

Constraints

- High household ownership of mosquito nets does not always result in high utilization of nets by priority groups. Although a large number of ITNs have been distributed there were reports from the regional reviews that ITN distribution has not reached the household level in some regions and were still stored in health facilities.

- Results of rapid diagnostic tests are not always adhered to, and so negative tests are still treated with ACTs. This may be partly due to the lack of alternatives for treatment of fever once malaria has been ruled out (e.g. treatment of pneumonia at health post level has not yet been introduced)
- Vertical financing can lead to vertical programming, especially for training, and so further integration of malaria within the HEP is required.
- It is essential that malaria control efforts are maintained in order to sustain the gains already made. This will require continued advocacy for funding, and also increased surveillance.
- It is not possible to verify the positive effective the malaria campaign is having on reducing mortality and morbidity in the community as such vital statistics or surveys are not carried out, so reports of reductions in the community are anecdotal at this stage.

Table 2.12 Recommendations for Malaria Interventions

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III Period	Long-Term Design of HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Resources	Mobilize funds to maintain the gains made in malaria control scale-up.	Maintain funding for malaria moving emphasis from treatment to prevention.	Advocate for continued investment in malaria prevention, until elimination can be achieved.
Increase Prevention	Increase emphasis on IEC/BCC to translate high levels of net ownership into utilization. Strengthen indoor residual spraying programme to ensure high coverage of epidemic areas.	Target high risk groups for future ITN distribution, i.e. pregnant women and children <5 years of age.	
Strengthen Diagnosis	Introduce of pan-specific rapid diagnostic tests and enhance HEW compliance with these tests.		
Monitoring and Evaluation		Study other causes of fever and study consequences of inappropriate use of ACT.	

B. Tuberculosis and Leprosy

Achievements

The TB and leprosy programme is maintaining high levels of treatment success and cure rates. There is a high level of concern and dedication at FMOH regarding the outputs of the TB control programme. Enhanced by the TB Millennium Campaign (EC 2000), all RHB are committed on a contractual basis to reach the national target of 60% case detection rate.

Once put on TB treatment, adherence of patients is satisfactory and has reached the 85% target for treatment success rate. This is a remarkable achievement in terms of quality of the programme, and contributes to reducing the risks of emerging resistance (MDR TB).

In accordance with HSDP III strategic framework, the noticeably prioritized strategy aims at increasing the demand for TB care (see current CDR by region below) by rising community awareness through advocacy communication and social mobilization and more integration into the HEP. A simple, clinical definition of a suspect case to be referred has been set up

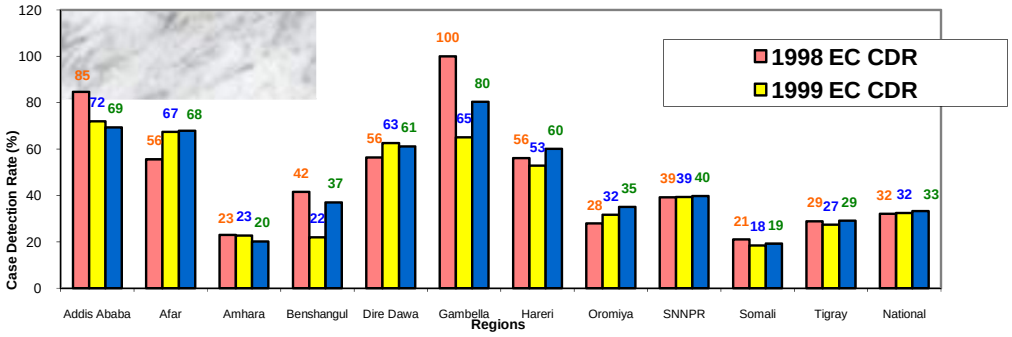
and disseminated through massive sensitization efforts undertaken to get all HEW onboard for identification and referral of suspect cases (Millennium TB Campaign).

The normative standardized tools for the TB control programme are updated and in place (Strategic Plan 2007-2010, TB Laboratory Manual 2007, TB-HIV operational guidelines, TBL Manual 2008, Public Private Mix guidelines, MDR prevention and control plan). Provision of TB services, in accordance with international recommendations (DOTS), is available in all hospitals and all health centres equipped with a laboratory.

Procurement and supplies of drugs and reagents is overall acceptable. Except for some reported local mismanagement of stocks and deliveries, no shortage of drug has been experienced nationally. The free dispensation of TB drugs is ensured countrywide according to the national standardized regimens.

The specific TB (leprosy + TB-HIV) recording and reporting system is well functioning and will be maintained until the new HMIS is fully operational; it provides a sound basis for programme monitoring and management. An improved TB-HIV reporting format, addressing the shortfall previously mentioned has been consensually revised and should soon become operational. Many, specific, in-service trainings for clinicians, laboratory technicians and public health managers have been carried out during the last two years to keep up with staff attrition.

Figure 2.2 Ethiopia New Sputum Smear + PTB Case Detection Trend 1998-2000 (EC)



Thanks to the Millennium campaign, a new commitment is observed in the area of laboratory quality (a comprehensive assessment and supervision campaign has been carried out for the first time in some regions, with a standard methodology) and a comprehensive external quality assurance scheme should be in operation, with the guidance of EHNRI and taking advantage of the Global Fund support. Ethiopia is in the process of strengthening the capacity of the TB national reference Laboratory (EHNRI) and the regional reference laboratory that should soon have the capacity to perform TB culture and potentially diagnose MDR TB (Drug Sensitivity testing).

In accordance with the international recommendations, new components have being added into the DOTS control activities to improve efficiency: 1) involvement of the private for-profit sector has started in three regions (the probable potential contribution of the network of private practitioners remains considerable), 2). TB-HIV collaborative actions are implemented nationwide, supported by active coordinating bodies at central level and increasingly reported with quarterly TB and leprosy data, 3) a comprehensive package of measure has recently been taken to tackle the threat of MDR (as planned in the HSDP III) and obtain second line TB drugs to start a pilot MDR care programme at Kidus Petros hospital.

Regarding leprosy, reported activities are stable and the HSDP III target of reducing the prevalence of leprosy grade-II disability to 10% has been reached nationally, showing an acceptable level of early detection. There is continued support from an international NGO (German Leprosy Relief Association) as expertise and interest in the areas of leprosy is declining. However, it is important to continue attention and financial resources for leprosy and build further on the gains of the last 30 years. The new strategy is to focus treatment of disabilities on only three or four hospitals so as to concentrate expertise.

Constraints

The main challenge for the national TB programme continues to be the low CDR which remains stagnant overtime. Attempts to increase CDR through in-service training of HEW and other health staff to identify and refer suspect cases is not yet demonstrating an increase. This suggests that there may be problems within the health system itself, making it unlikely that CDR goals within the next two years will be reached (especially in view of latest TB burden estimates and population growth). As it is planned before the end of HSDP III, a TB prevalence survey might be carried out to re-assess with more accuracy the actual TB burden in the country to readjust objectives accordingly.

The management of the national control programme is entering a new era where much focus has to be put on coordination of implementing bodies (EHNRI, PFSA, HEEC, HMIS, Kidus Petros MDR hospital, RHB, HAPCO's partners) that are gradually taking over many activities pertaining to the control of TB.

As an integrated programme at all levels, TB shares the main limitations of the overall systemic delivery of service, in terms of access, coverage, and utilization. The chronic nature of the disease doesn't leave much room for campaign accomplishments and relies mostly on routine sustained activities. Human resources allocated to the TB programme management are strikingly low (in term of full-time staff, of commitment, of effective support to the provision of health services) and are probably insufficient to impulse the needed boost of performance to reach HSDP targets. The comparison with malaria or HIV is significant in that regard.

The output of review meetings appears relatively weak in terms of effectively addressing main constraints. The quality of DOTS services (verification of patient's adherence, excessive proportion of extra-pulmonary and smear-negative TB) is not properly addressed. The actual support provided to the periphery by combined integrated supervisions seems only minimal and not able to help identifying or solving problems at facility or wereda level; this point could be assessed and addressed through field operational researches.

Monitoring of activities is appropriate, but specific (re)action on data is limited. The degree of completeness of reporting is not known and TB-HIV routine reporting is incomplete, due to insufficient collaboration. As attention is put on DOTS clinics (for continuation of care) the role of OPD (identification of suspects) is somewhat overlooked. OPD clinicians (and Health Officers) have not consistently benefited from in in-training courses and physicians are not always aware of– nor compliant with- guidelines; those guidelines and standard are insufficiently disseminated.

The functional/operational coverage of DOTS (i.e. proportion of population with operational access to TB clinics for DOTS = 3-4 km, being a major obstacle for patients), needs consideration.

Leprosy is not eliminated yet, but rates of infection are lower. This is both a positive and a negative aspect for the programme. The reduction of leprosy is very positive and commendable, but there is a concern that the programme will no longer have the resources and attention required to maintain decreasing infection rates. Some training has been

organized for health managers to re-boost the programme and training has also taken place for clinicians: this is helping to maintain, but not increase, the level of expertise. Currently pre-service training completely ignores leprosy and trainers who have the skills to teach about leprosy are also reducing. Leprosy drugs are provided by WHO in response to reported cases. This supply of drugs against reports may be reducing the timeliness of treatment. One suggestion would be to allow for a minimum stock of leprosy drugs (WHO is reluctant) to allow some flexibility in distribution, as reports are not always timely. Integration of leprosy should come together with maintenance of expertise and commitment of staff, this requires repeated trainings as diagnosis is difficult and, most of all, management of disabilities is extremely neglected with very little expertise.

There is a need to conduct a TB prevalence survey so that the real burden of TB is known in the country. TB detection and management depends probably more on the functioning of the health system as a whole as it does on creating awareness and increasing demand (in other word, IEC may have little potential to increase CDR). Before the health system is strengthened as a whole there is need to do something in the interim during the rest of HSDP III. Lessons should be taken from the successes in malaria and HIV.

Table 2.13 Recommendations for Tuberculosis and Leprosy Control

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
Period	EFY 2001	Within EFY 2001-2003	After EFY 2003
Capacity Building	Assign additional expert staff to support the integrated management of TB & leprosy control at all levels.	Study other programmes for best practices in the areas of detection, prevention, diagnosis and quality care, including EQC strategies for laboratory support for the TB programme.	
Monitoring and Evaluation	Study effect of recent TB campaigns and identify aspects that can strengthen the routine TB control programme.	Strengthen dedicated supportive supervision and programme reviews rather than integrated until all targets are being met.	
Increase Strategies to Improve TB CDR	Introduce active case finding through the HEP. Need to design innovative schemes to increase access and compliance for patients in hard to reach areas.	Assess effectiveness of HEWs in TB control interventions.	
Strengthen TB Case Management	Start MDR TB care as planned with balanced focus on diagnostic and care capacity. Organize nutritional support for TB patients.		
Strengthen Leprosy Programme	Greater involvement needed from public health managers to address leprosy, including improving health workers skills and IEC/BCC campaign. Review current policy on supply of leprosy drugs and pre-position stocks at regional levels.	Include leprosy in pre-service training of health workers. Create centres of excellence in the management of disability due to leprosy.	

C. HIV/AIDS

Achievements

There have been remarkable achievements in several major HIV intervention areas. The leadership and coordination at central level has been strengthened and significant improvement has been noticed at district and lower levels. The health sector response has been effectively harmonized within federal and district health sector plans within the context of HSDP III framework. Furthermore, significant progress has been made in harmonizing partners with federal and regional HIV/AIDS response plans. Also, encouraging result has been achieved in the area of fund utilization because of strengthened coordination and involvement with RHBs and partners. Ethiopia is showing innovative approaches in the use of funding for HIV/AIDS to support health systems strengthening, providing valuable lessons in good practice not only for the Ethiopian health sector as a whole but best practices that can be replicated in other countries.

In the area of HIV service delivery, remarkable outputs have been registered as summarized in the following Table 2.14, the data shown is up till the end of December 2007 (GC) as this is the data from the last official country report. However data from Federal HAPCO show that further acceleration of HIV services in the beginning of 2008 (GC) yielded over 5.8 million clients, having received HIV testing and counselling in over 1,200 sites, with a further 57 sites providing ART (total sites now at 329 and reports from regions of other assessed and will soon start ART). The total number of clients now served is 131,360.

Table 2.14 HIV Outputs 2005 to December 2007 (GC)

Type of service	GC 2005		End December 2007	
	# of sites	Clients Served	# of sites	Clients Served
ART	3	900	272	122,243
HCT	658	448,241	1005	2.3 million
PMTCT	12	2208	428	12,000

Source: UNGASS Ethiopia Progress Report 2008

According to the HSDP III objectives, 81% and 79% of the ART and HCT targets respectively were achieved by the end of 2007. However, the performance of the PMTCT falls far short of the target of 100% of hospital and 70% of health centres. At outcome level, a remarkable reduction both in the incidence and prevalence of HIV has been registered. The projected incidence for 2008 is 0.27 (HSDP III target, 0.65) and prevalence is estimated at 2.1%[35] (HSDP III target, 3.5%). However, caution must be exercised in the interpretation of the incidence and prevalence because two different data sources were used for setting the HSDP target (ANC data) and for this report (the Single Point Estimate). Community conversation has been scaled-up to 12,875 kebeles (HAPCO 9 month report, 2000 E.C).

The successes of the HIV programme in major component areas can be attributed to the strong leadership and coordination, availability of funds, innovative initiatives such as the Millennium anti-AIDS campaign (MAC-E), and strong technical support received from partner organizations. Also, the synchronized effort between the health sector and the non-health sector responses (such as targeted social mobilization) has had significant positive impact.

[35] FMOH/HAPCO Single Point HIV Prevalence Estimate, 2007

Constraints

Although the overall performance is positive, quite a number of weaknesses have been noted. There are still inter-regional and intra-regional variations in terms of successes.

The key constraints include:

- Low performance of the PMTCT programme as a result of weak integration and linkages;
- Weak HIV related service linkage;
- Limited success in mainstreaming in major sectors;
- Inadequate and erratic care and support system;
- Weak non-health management information system;
- High turn-over and staff attrition rate at public sectors;
- Stock-outs of HIV test kits and drugs for opportunistic infections;
- Default rate of ART patients;
- Limited number of children on ART;
- TB screening for PLWHA poorly implemented;
- Less attention to prevention;
- Inadequate involvement of managers in the public system in the planning and implementation of activities carried out by development partners;
- The drawing effect of the HIV/AIDS sector is fuelling mobility and attrition of staff from other services.

Table 2.15 Recommendations for HIV/AIDS Interventions

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design of HSDP IV
Period	EFY 2001	Within EFY 2001-2003	After EFY 2003
Accelerate Access to PMTCT and Paediatric ART	Strengthen programme integration, ownership and leadership. Decentralize Paediatric ART to health centres and to mid-level health workers.		
Strengthen Service Linkage and Improve Adherence	Develop standard operating procedures for the implementation of the health network model (HNM). Avail TB screening tools in all HIV units including VCT units	Monitor the implementation of the HNM. Address stigma and discrimination. Strengthen the care and support system.	
Strengthen Multi-Sectoral Response to HIV	Strengthen mainstreaming efforts. Design non-health related HIV data management system.	Continue mainstreaming and strengthening.	Continue mainstreaming and strengthening.
Focus on Prevention	Develop specific prevention package for the most-at-risk population. Consolidate the scale-up effort of community conversation, involve HEWs.	Continue	Continue
Sustainability of Care	Convert campaigns into routine activities. Involve local institutions more in the training and mentoring activities. Incorporate topics covered by in-service trainings into pre-service curricula.	Continue Continue	Continue Continue

D. Blindness Prevention and Control

Achievements and Constraints

Based on a recent comprehensive needs assessment and within the framework of a Strategic Plan for Blindness Prevention (GC 2006-2010) regional and zonal plans are available and focal points (part-time) have been designated to support implementation in some regions. Regular review meetings contribute to enhanced coordination of focal points. Awareness of present strategies and targets is increasing, though incomplete, at the periphery. However achievement of these HSDP goals is uncertain especially regarding cataract surgery targets.

Human resource development is also progressing with growing generations of specialized nurses (whose curriculum has been standardized) trained to be operational at primary level of eye care. Cataract surgeons' training is on-going; the first batch of graduates has started to work. Retention of skilled staff, nurses and surgeons, is still challenging.

The control of trachoma has recently made noticeable progress (2000 EC) in the highly affected districts, with successful execution of massive campaigns for community distribution of antibiotic for more than 6 million persons. Effective collaboration with partners and donors is ensured through a coordination body at central level and by support of field campaigns. A comprehensive strategy for trachoma is in place ("SAFE" for Surgery Antibiotics, Facial cleanliness Environmental sanitation) including preventive measures. However, limited attention is given to static trachoma detection and care at OPD in the non-highly affected weredas that were visited.

Cataract surgery is carried out in various settings, both in public and private sectors, with continuous collaboration with NGOs, but reporting to public health institution is incomplete and not organized, making observed progress difficult to assess. Cataracts account for 50% of blindness cases with about 600 000 backlog cases in the community. In general, insufficient level of priority is given to this programme, by clinicians and public health managers.

The vector borne causes of blindness (Oncho) are reported to be decreasing due to the free distribution of ivermectin in affected villages. With the limited sample surveyed by the MTR teams, much of the information collected is based on national data. Sustained efforts are however definitively needed for consolidation and extended control. This programme is mixed (diluted) with the malaria programme, and this is probably suboptimal in terms of efficiency/dedication. The weakest point, from the public system point of view, seems to be surgical treatment of cataract. With the current efforts, newly logged cases (incident, 120,000/year) are not being cured. There is also a huge backlog of cataract patients who require surgery (1/2 million) and this area is more or less neglected.

Table 2.16 Recommendations for Blindness Prevention and Control Interventions

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III period	Long-Term Design HSDP IV
Period	EFY 2001	Within EFY 2001-2003	After EFY 2003
Strengthen Programme Management	Appoint regional Focal Persons for blindness prevention programme.	Increase expertise in cataract surgery.	
Strengthen Programme Planning		Incorporate activities in all core plans in line with implementation of the National Plan to reach the 2020 targets, beyond the	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III period	Long-Term Design HSDP IV
		present HSDPIII.	
Strengthen Recording and Reporting	Records of essential eye surgery should be readily captured and analysed, both from public and private facilities to monitor progress and gaps.		
Improve Promotion and Demand		HEW involved in promotion activities and in trachoma early detection and referral.	
Improve Resources	Additional resources to address logistic constraints for campaigns for trachoma control.		

Integrated Disease Surveillance and Reporting (IDSR)

IDSR is a global commitment to international health regulation for ensuring global health security. All members of the United Nations are therefore required to establish a functional and effective system of surveillance and response to public health emergencies of national and international concern.

Ethiopia has developed IDSR strategy in 1999 based on the 1998 recommendation of the WHO Regional Committee for Africa. Following this there has also been an effort to establish a structure at regional and zonal level and focal persons at wereda level. It is a responsibility of public health practitioners to report accurate data and ensure timely response to communicable diseases and emergency conditions. For this reason IDSR technical guidelines and training manuals for the in-service training of health workers was developed. Two additional initiatives have been the establishment of a taskforce to advise the FMOH on IDSR and a quarterly publication of an IDSR Bulletin.

Strengthening capacities for improved management of IDSR is part of the HSDP III strategic plan. The objective is to generate community based data through the involvement HEWs.

The recent outbreak of AWD created a good opportunity for reviewing the working of the IDSR and informed the redesigning the emergency preparedness and response mechanism. Better coordination among partners and high political commitment was noticed over the last couple of years, evidenced in how the sector responded to the AWD outbreak. Public health management preparedness and response is recognized as a core process in FMOH's BPR. According to the re-designed process, disease surveillance will be placed at EHNRI as a division with its full team of professionals. A Field Epidemiology and Laboratory Training Programme was designed and the Addis Ababa University/Medical Faculty will train Epidemiologic Intelligence officers who will take the lead in emergency preparedness and response. Linkages with the HEP and role of HEW provides potential for the strengthening of the IDSR.

Achievements

- A pilot site was established in SNNPR to study the feasibility of involving HEP in generating data from community level.
- Timeliness and accuracy of reporting has improved and remains at between 80-85% compared to prior to 2005 (GC).
- As soon as the training manual on IDSR was developed more than a thousand health workers were initially trained and mop-up training continues.
- Draft BPR work is completed and awaits final approval.

Constraints

- The federal level IDSR team is often involved in regional-based emergency responses. Recently the national team was occupied in the control of AWD that involved many regions. These kinds of activities have distracted the attention of the national team from undertaking the oversight and capacity-building activities to strengthen the functions of the regional task forces and follow-up of the data collection and regular analysis to provide timely feedback. As a result, the publication of the bulletin has been interrupted and the timeliness and completeness of reporting is showing some decline.
- Findings at regional level showed lack of capacity to do regular analysis of collected data and to organize fast response to emerging problems.
- Shortage of human resource at all levels, but especially at facility level. Inadequate infrastructure (building, laboratory, communication means, weak partnership), coordination and weak monitoring systems impacts on the ability to respond to outbreaks without affecting the delivery of routine services, (see also section 2.3.4 on emergency preparedness and response).

Table 2.17 Recommendations for Integrated Disease Surveillance and Response

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Strengthen National Capacity	Strengthen the IDRS team at the federal level to assume the function of preparing standards/guidelines and building capacities of the regions.		
Strengthen Regional Capacity	Strengthen regional level capacity for fast and early response to emergencies and epidemics.		
IDSR Integration to HEP	Develop user-friendly tools for use by HEWs to strengthen IDSR in the HEP.	Strengthen HEW supervisors to support and mentor HEWs in IDSR.	

2.1.4. Medical Services

The aim is to improve the quality of the health service and utilization by the population through re-organizing the health service delivery system into a four-tier system; to implement decentralized management to ensure full community participation; to develop and implement an essential health service package and referral system; to develop health facility standards and staff and equip the health facilities accordingly.

Coverage, Utilization and Access

The main coverage objective to be achieved under HSDPIII is to increase the general potential health services coverage from 64% to 100 %. By the end of 1999(EFY), according to FMOH data, this had reached 86.7% and from MTR reports many regions are already over 90% and some expect to achieve the 100% target within this EFY or next. This is a major achievement in terms of physical expansion of coverage implemented through the AEPHC service strategy. A number of other strategies are also being implemented to ensure that all this high level of coverage translates into functional health facilities which will be utilized and will increase access, especially for the most vulnerable in the community. Evidence from the MTR shows more emphasis is needed for these strategies to address utilization and access Ethiopia is reaching its targets on expanding health coverage. However, it must be noted that expanding coverage in some areas continues to be difficult due to security reasons, Somali

region has not been able to implement construction, upgrading, expansion, refurbishment and maintenance work for this reason, so it continues to fall short of the national target. The most populous region Oromiya is also lagging behind other major regions. This will have a big implication in terms of the absolute number of people reached with key interventions such as immunization.

Utilization of services varies across the country ranging from 0.1 in Somali to 0.72 (per capita) in Tigray, see Table 2.18 below. Overall national utilization has fallen slightly from 0.36 in EFY 1996 to 0.32 in EFY 1999. This reduction in utilization may be due to a number of reasons, but until proper household assessments on health seeking behaviour and household utilization studies are done, the reasons can only be taken as 'indicative'. Reasons put forward include: increase in private sector health providers, introduction of user fees are a deterrent to poor people, lack of understanding/implementation of fee waiver schemes, poor communication of and adherence to exemptions, poor staff attitude in public health services and poorly functioning referral systems. Increase of outreach services through the HEWs has meant that some basic curative services are now available in the community.

Table 2.18 Estimated Health Service Coverage/Utilization by Region, 1996-1999 EFY

Region	Potential Service Coverage (%) 2003/2004 (GC)*	Potential Service Coverage (%) (2006/2007-GC) 1999 (EC)**	Outpatient Visits Per Capita[36] 2003/2004*	Outpatient Visits Per Capita (2006/2007-GC) 1999(EC)**
Tigray	83.39	105.6	0.77	0.72
Afar	72.93	110.7	0.75	0.12
Amhara	46.93	88.8	0.37	0.21
Oromiya	60.98	73.1	0.38	0.44
Somali	43.56	48.8	0.09	0.10
B/Gum	198.65	207.8	0.69	0.60
SNNPR	75.61	40.0***	0.15	0.16
Gambella	226.50	268.8	0.10	0.04
Harari	148.65	105.9	0.84	0.31
Addis Ababa	86.45	31.2	0.47	0.44
Dire Dawa	100.00	59.5	0.34	0.23
National	64.02	86.7	0.36	0.32

* Source of data HSDPIII programme document

** Source of data: Health and Health Indicator 1999, PPD, FMOH

*** If private-not-for-private health providers are included in the calculation of potential coverage in SNNPR the rate is 114.4%.

Although the RHBs invested in training staff and introducing incentives to attract and retain staff, there is still a problem with appropriate supply of staff to support the provision of services at the different levels which is having a direct impact on the quality of care. In a number of regions, health centres and hospitals are not functioning and this is in part due to staffing shortage, and in some cases to staffing mix (e.g. lack of complete surgical teams). In other facilities staff is available and trained but have not received the necessary equipment to perform their duties in their newly trained skills. This appears to happen often in relation in abortion care, so non-availability of appropriate services may also be impacting quality of care and resulting in under-utilization of services.

Due to inappropriate staff mix and staff shortages, hospitals are not providing their full range of services. Lack of surgical services and care of acute cases are reported to be the most

deficient. This is reflected in the in-patient bed occupancy rate for patients in public health facilities reported as 44.9% nationally (ranging from 20.3 in Amhara to 97 in Oromiya), FMOH 1999 (EC). This also means that patients who have been referred from lower levels are often referred to another hospital. Hospitals do not provide return data on bed occupancy or average length of stay. It would be useful if this was reported as standard in all regional reports so that the situation could be better monitored.

Physical access has improved throughout the country with the construction and upgrading of many facilities but comprehensive access has been hampered by the shortage of professional staff or appropriately trained staff, equipment and supplies at all levels. Equity has been addressed with the policy of first building health posts in the rural and underserved areas and providing them with HEWs. This is a major step in that the HEP through the HEWs is directly linking the formal health system with the household. Access to an increased range of drugs and their availability is happening through the special pharmacies, though some expressed concerns about access for the poor to these drugs and supplies. Access to more higher trained staff, especially doctors is happening through the incentive schemes that are being used to attract and retain staff in the regions, including support from some partners. Innovative approaches to improve access for the poorest in the community are being taken through the registration of households to benefit from the waiver of fees, with the cost of this being included in the annual budget from EFY 2001 onwards.

The access to health services is limited in many parts of the country due to the inaccessibility of areas during the rainy season. Access to health services is also limited in the locations where the health centres do not provide the full EHSP package (due to shortages in supplies and equipment, staff). From the regional reviews it was reported that women's services are often not available. This is also observed in the lower utilization of services by women than men. In Amhara, women represent only 44% of OPD users while typically women are the main users of these services.

Standardization and Norms

Standardization and norms have received more attention through the CSRP. The ARM for 2000 (2007) reflects important developments: (1) the minimum service standards for the delivery of services, (2) t performance standards, (3) the preparation of a professional ethical code, and (4) improved financial control system. Furthermore, the regions are following the national policies for communicable diseases, family health services, hygiene and environmental health, nutrition services and other relevant areas. Although standard guidelines and norms have been put in place, it remains a major challenge to implement them due to the human resource gaps at all levels.

Fulfilling the required adherence to standards and norms is threatened by the shortage of qualified human resources that in turn, is exacerbated by the high turnover of staff particularly at service delivery outlets. Moreover, due to the workload of health managers supportive supervision is not able to take place according to schedule. Many aspects of adherence to norms and standards can be detected and addressed during such supportive supervision visits. However, the MTR team observed that treatment standards are displayed on the walls of health facilities in the regions but that staff usually complained of shortages of manuals and reference materials.

Quality of Care

The FMOH and RHBs through the BPR process are addressing issues of quality and access in a systematic way. All national health programmes address quality through their treatment guidelines and protocols. Health workers and health facility managers implement standards and protocols in many areas of service delivery. Upgrading courses for health workers are promoted with the purpose to strengthen the overall quality of services. Substantial progress has been made with the HEP coverage expansion, but the overall quality of care provided

through the HEWs needs to be further assessed and strengthened. There are a range of concerns regarding the quality of care, the diagnosis of major communicable diseases, rational use of drug, actual service utilization (and its effectiveness) and the impact on behavioural changes in health-seeking behaviour. The functionality of health centres and hospitals needs to be monitored to ensure that they are functioning to the set norms and standards. Basic hygiene and sanitation, equipment repair and plant maintenance needs require attention (see also section 3.1 on facility construction and rehabilitation). The use of integrated supportive supervision check-lists in the three largest regions will contribute to the improvement of quality. These check-lists need to be scaled up to cover other regions.

Overall quality of services, evidence-based research and diagnostic support to improve the quality of care is being coordinated by the FMOH in collaboration with the EHNRI, especially the strengthening of laboratory support services. Recent reforms have resulted in the restructuring of the EHNRI to be delegated with major sectoral activities and strengthened management. The major activities of the institute are; research on priority national health problems, nutritional problems (particularly on micronutrient deficiency, traditional medicine; and produce animal vaccine; and national laboratory support services). A five-year master plan and the strong FMOH leadership support are as key factors for enabling the institution to discharge its delegated responsibilities to support the current on-going reforms in the health sector.

Major achievements in strengthening laboratory services include:

- Shift from client/patient based service provision to a national supportive;
- The initial CDC supported ART laboratory service has expanded into integrated laboratory services;
- The ART laboratory logistic management which has been given to the private sector has been effectively delegated to the institute;
- Intensified capacity-building activities including the strengthened capacity of HIV and quality of care department, site level support, equipped health facilities with essential laboratory equipment and supplies, improved effort in maintenance of medical equipment;
- Provide local and international syllabus-based training on ART laboratory;
- Develop relevant national HIV laboratory algorithms and guidelines
- Initiate robust epidemic response unit;
- Strengthen referral linkage of health facility with regional laboratory through training, development and avail relevant SOPs;
- Initiate a software-based system to forecast HIV laboratory supply logistic quantification;
- Takeover the national ANC based HIV surveillance;
- Strengthened national capacity through expansion of the polymerized chain reaction laboratory technology infant HIV diagnosis in three new sites;
- Finalize activities to expand TB laboratory culture in three new sites. Piloting is underway in two sites.

Other quality improvements observed during the MTR review were:

- Some regions are addressing the quality of care by increasing their allocation of funding to pre- and in-service training, through allocations to training institutions.
- The HIV/AIDS, malaria programmes and IMNCI have relatively strong quality control measures with well disseminated manuals, guidelines and checking procedures. Programmes such as MNCH, TB & leprosy, general curative care and nutrition are behind in this respect.
- Facilities for the safe disposal of medical waste were evident in all facilities that were visited, but their effectiveness due to design is questioned.
- Quality improvement initiatives started in selected hospitals in 2000 EFY. It is too early to appreciate impact of the initiative on client satisfaction. No such quality initiative has started at health centre level yet.

- Availability of essential drugs has improved, though with some stocks-outs, but the situation is monitored through functioning Drug and Therapeutic Committee (DTC). However, rational drug use is not fully operational. There is room for improvement

Constraints

As there is no substantive data to measure quality of care, all the following constraints were reported by health managers and workers as contributing to a reduction in the quality of care:

- Lack of uniformity of specification of buildings and how they are finished, serviced and equipped. In existing facilities, basic hygiene and sanitation, equipment repair and plant maintenance needs addressing (see section 3.1 on facility construction and rehabilitation).
- Health workers lack of practical skills and competence to provide services was reported widely, especially in newly trained staff such as midwives and HEWs.
- Weak technical supervision and poor technical support from higher levels.
- No gender sensitivity training for service delivery staff—a serious shortfall in a system—where the large majority of service providers, even for maternity and family planning, are male.
- Poor physical facilities and weak quality control processes compromise the quality of laboratory services.
- Communication and linkages with the private health facilities is on an ad hoc basis. Inspection and licensing varies across types of health facilities.
- Referral mechanisms and hospital designated catchments areas are not properly functioning or defined.
- Support supervision, needs to be done more regularly to ensure adherence to norms and standards and to improve quality of services.
- Health staff morale and motivation is reported as low and high-turnover of staff.

Essential Health Services Package (EHSP)

The EHSP defines the core health and health related interventions to address major health problems and disease conditions of the country. These core services are determined to be the minimum services that people can expect to receive through the various levels of the health delivery mechanisms and facilities within their reach. The delivery of the EHSP is also a core strategy of the health sectors' contribution to the Plan for Accelerated and Sustained Development to End Poverty (PASDEP).

Much of the core services of the EHSP were already defined, especially though national programmes, such as EPI, HIV/AIDS & STIs, TB & Leprosy, and MNCH. The EHSP builds on these services and includes curative, preventive and health promotion services to address most serious health problems of the country. The challenge has been to ensure that the EHSP is used as standard to guide the planning for infrastructure, staffing needs, training needs, equipment, drug and medical supplies needs and other recurring costs.

The review observed that the main components of the EHSP are being implemented at each level, but the concept of using the EHSP to guide the planning, budgeting, coordination of the implementation of essential health services is not generally understood, nor is it disseminated to health managers in the service, many of whom have recently taken up their new posts. Insufficient and in appropriate staff mix, lack of infrastructure, equipment, drugs and supplies are also factors contributing to non-delivery of the EHSP. Initial orientation was done when the strategy was launched but partly due to high turnover of staff and inadequate follow-up the strategy is not been fully used anymore throughout the system.

Secondary and Tertiary Care

The strengthening of secondary and tertiary care is coordinated through the FMOH Health Services Department. A number of activities have been implemented or are underway to strengthen these levels, ranging from changes in the legal framework of the management and financing of these institutions to initiatives to strengthen their effectiveness and efficiency. The failure to strengthen referral systems has put much pressure on hospitals due to patients bypassing health canters and clinics for minor illnesses.

Institutional Changes

Most regions have now passed health proclamations and have issued directives and guidelines, providing a degree of autonomy and self-management to secondary and tertiary hospitals. The impact of increased hospital autonomy was observed to be having varying degrees of success. The change in regulations to allow for the creation of hospital boards and the appointment of new management cadres (Chief Executive Officers and Medical Directors), as well as changes in revenue generation and utilization, is seen as a positive move. The directives issued need to be followed up with more prescriptive guidelines on what this autonomy entails. In some regions this has happened. However, some hospitals were observed to have the capacity to make greater utilization of this autonomy than others, suggesting that there is a need for continued support to the poorer performing hospitals and a need for the good practices from the better performing hospitals to be shared.

Management Changes

The FMOH are using the BPR process to address hospital management, linking the management strengthening to the implementation of the health care finance strategy (see section 4.2 on health care financing reforms). Currently 10 hospitals in Addis Ababa and 20 throughout the country are involved in implementing new hospital standards and guidelines. The FMOH is committed to the process and monitors the Addis Ababa-based hospitals through two-weekly reporting and coordination meetings. The FMOH is supported by the Clinton Foundation through its “Hospital Management Initiative” which develops ‘blueprints’ on standard operational procedures for improved hospital management. These new standards and guidelines will be implemented throughout seven regions, during a one-year pilot project in 40 hospitals. Collaboration between Jimma University and Yale University has also been established and is providing support for both short and long-term training of hospital managers.

The BPR for hospitals identified eight priority thematic areas to strengthen secondary and tertiary care through a rigorous participatory site assessment. These are: human resource management, governing boards, global budgeting and financial management, patient flow, medical records management, pharmaceutical inventory and warehouse management, nursing standards and practice and hospital acquired infection prevention. The move to build health management capacity is commendable both in terms of the quality of the initiatives themselves, but also the FMOH’s recognition of the need to develop a cadre of health managers within the sector to provide effective management support for the delivery of services to the people of Ethiopia.

Functionality

Secondary and tertiary hospitals have a major role in the delivery of the EHSP through; referral, technical supportive role, training role, mentoring and quality assurance and control of the health sector providers in their catchment or referral area. Due to shortage of resources, both past and present, the functionality of some hospitals is reported to have decreased, e.g. district hospitals functioning as a health centre, essential services such as emergency surgery not available in hospitals, X-ray and ultrasound services are not functional, range of laboratory services limited due to shortages of equipment and reagents. There has been no study of hospitals to assess their level of functionality against their designation, but RHBs reported that they are rebuilding the functionality of hospitals in their

regions. In many cases restoring of this functionality needs large capital investment and needs to be planned over a longer time period than the current annual plans. RHBs reported how they negotiate with their regional councils for increased capital budget. Tigray negotiated funding for Axum hospital in this year's budget through their regional council. Regions also apply for funds to partners and overseas charities and these are sources of additional funds in some areas. In some cases the use of health care financing (HCF) is allowing hospital boards to use their retained revenue to restore the functioning of their hospital and to improve the quality of patient care (see section 4.2 on health care financing). Many good examples were observed during the regional visits of the MTR (e.g. expansion of water systems, purchasing of equipment and supplementary drugs, maintenance and repairs). The review found the work in Amhara regional referral hospital was especially encouraging and felt that the board and its management should be commended for their work to date in the use of their revenues to improve the quality of patient care in the facility.

Once functionally has been restored to secondary and tertiary hospitals then the work through the BPR process on standards can be universally applied. Again this is a long-term process as hospitals may be upgraded or rehabilitated over time. In the meantime the review found that some RHBs do set performance targets for their hospitals. Benishangul Gumuz set performance targets to be delivered in their secondary and tertiary hospitals: 92.9% of the targeted 1,400 patients received major surgical care and 105% of the targeted 4,428 patients received minor surgeries.

Conclusion

- The scaling up of the provision of appropriately trained health professionals, strengthening of health systems and health managers capacity is still catching up with the enormous expansion of health services
- Overall availability of funding is restricting the pace of strengthening the support systems needed to back-up the expansion of health services. There is need for increased capital and recurrent funding.
- The efforts to expand the supply side of the health services must be balanced with efforts to mobilize the demand side for health.
- At national level norms and standards are available and training has been cascaded down the health delivery system. However, inadequate availability of manuals and reference materials and follow-up through supportive supervision is having a negative effect on adherence to these norms and standards and impacting on quality of care.
- The EHSP as a strategy of the FMOH to guide the delivery of services is still very valid but its use to guide the planning and provision of core services is limited.
- Initiatives to strengthen the management and functioning of secondary and tertiary hospitals is starting to show a positive effective and needs to be continues and rolled-out to all such facilities, but hospitals in Addis Ababa are not yet implementing their regions proclamation. Such strengthening will help to restore the functionally to these institutions and strengthen secondary and tertiary hospitals' role in delivering the accelerated expansion of PHC coverage in Ethiopia.

Table 2.19 Recommendations for Medical Services

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Restore Functionality of Health Facilities	Plan for the increase of comprehensive coverage of hospitals, i.e. restoring functionality, developing a referral system, and establishing coordination	Survey the functionally of hospitals against their designation over time to monitor progress.	.

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
	mechanisms for facilities in referral catchment areas (see section 3.1 on facility construction and rehabilitation and section 4.2 on health care financing).		
Adherence to Norms and Standards	Continue training on norms and standards and provide guidelines and manuals to staff. Strengthened supportive supervision, including greater role of national programmes in the monitoring of and adherence to protocols and quality standards.	Implement BPR strategy on quality of care and access.	
Essential Health Services Package	Reorient management and coordination structures to ensure the delivery of the different components of the EHSP at each level of care (see also section 4.4 on governance and sector management).	Incorporate use of the EHSP into annual and long-term planning.	Ensure that delivery of the EHSP is a core component of the next HSDP.
Private Sector	Develop means to capture health service data from the private sector.		
Strengthening of Secondary and Tertiary Hospitals	Scale up hospital management initiative, review possibility of exchange visits amongst hospital managers to review other management practices.	Strengthen role of hospitals in supporting the delivery of PHC.	Include hospital strengthening as a component under HSDP IV.

2.1.5. Hygiene and Environmental Health

Achievements

During the last few years, there has been an increased level of political commitment for hygiene and environmental health services in Ethiopia. Key policies such as the National Sanitation Strategy, Protocol and the Millennium Sanitation Movement approach are enabling frameworks that serve to motivate and align relevant actors to speed up sanitation coverage and hygiene behavioural change. In addition, three key ministries of Health, Water Resources and Education joined up to launch the National WASH programme which provides a strategic framework to achieve the National Vision of universal access to hygiene sanitation by EFY 2004.

Of the 16 packages that the HEWs deliver in four main areas of healthcare, seven of them focus on helping households improve their sanitation and hygienic practices. In addition, the "model household" approach supports the HEWs role of promoting behavioural change in health and hygiene practices.

Although hygiene and environmental health activities remain seriously underfunded at the RHB and WORHO levels, donors (World Bank and DFID) provided 65 million USD at the end of 1999 EFY (representing 10% of the required funding to achieve full sanitation coverage) that will be used to improve the hygiene and sanitation services in institutional facilities and to support promotion and social marketing activities.

The regional visits of the MTR indicate that many areas have made significant strides in increasing sanitation coverage. In Oromiya, access to safe water improved from 46.7% in 1998 EFY to 50.9% in 2000 EFY; while access to sanitation increased from 20% to 46%. SNNPR, a hygiene and sanitation success story, reported a rise in latrine coverage from 75% to 90% in the last two years. 'Open field defecation free villages are being promoted to improve the utilization of latrines.

Constraints

Despite positive trends and increased political commitment, Ethiopia still faces large gaps in funding, capacity building and communication to ensure that the activities of relevant actors and stakeholders are aligned under the National WASH Programme and the HEP and those appropriately trained personnel are available to implement programmes and promote behavioural change at the rural, district and community levels.

The following major constraints were identified during the regional visits of the MTR:

- Poor cooperation and coordination is pervasive, especially at the RHB and WORHO levels as well as among different actors in hygiene and environmental health.
- Budget allocations for hygiene and environmental health at the RHB and WORHO levels are often insufficient or nonexistent. Some regions are entirely dependent on donor funding. RHBs also report budget delays and slow transfers.
- Supervisory field visits are inadequate. Supplies, construction materials, testing and transport facilities and support supervision are insufficient due to budgetary and human resource limitations.
- Data collection and trend analysis is poor at the national and regional levels making it very difficult to assess coverage versus usage especially on issues such as the use of latrines, hand-washing and safe water management in the homes. As an example, national data reports latrine coverage at 50.8%, but usage of latrines was demonstrably low in many of the regions.
- Communication and advocacy interventions for hygiene and environmental health are not integrated in prevention and control of diseases such as malaria, TB, diarrhoeal diseases in children. In addition, potentially influential actors in the private and education sectors and level are not engaged in promoting sanitation practices.
- Shortage of clean water in communities, schools and health facilities are key impediments to scaling up hygiene and sanitation.
- The model household approach has limitations due to the non-subsidy approach adopted by the FMOH. Households are often committed to adopting the recommendations in the 16 HEP manuals, but do not have the financial means, especially for the more costly practice of building latrines.

Table 2.20 Recommendations for Hygiene and Environmental Health

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Coordination and Cooperation		Harmonize the activities and financial disbursements of institutions and actors in hygiene and environmental health particularly at the RHB and WORHO levels.	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Accountability		Mobilize local political leaders and private sector professionals to improve accountability and quality of the provision of services.	
Monitoring and Evaluation		Strengthen the integrated Monitoring and Evaluation system that is currently being used at the community, wereda, regional and national levels. Adopt indicators related to hygiene practice and behavioural change.	
Advocacy	Formulate a health extension package for urban communities. Provide public recognition to communities, individuals and institutions for their commitment to hygiene and environmental health using awards and incentives.	Promote national hygiene and sanitation policies at all levels. Engage local community and religious leaders and the private sector in promoting hygiene and sanitation practices Strengthen hygiene and sanitation awareness and services in schools.	Strengthen the HEP and the training of the HEWs to raise awareness, promote behavioural change and sanitation practices that improve community health and empower women.
Financial Resources	Allocate funds for hygiene and environmental health activities at the RHB and WORHO levels. Strengthen the capacity of regional public health laboratories to facilitate testing and ensure hygiene and sanitation standards.	Increase negotiation capacity of the FMOH to mobilize more resources for hygiene and sanitation.	Encourage the private sector to provide sanitation supplies, technical solutions and transportation options.

2.2. Information, Education and Communication/Behavioural Change Communication

Achievements
In the past two years, IEC/BCC activities at the federal level have accelerated considerably particularly in the area of print and audio-visual media. The HEEC has produced over 1000 radio and 140 television health programmes for broadcast across the country in five different languages. In addition, over one million IEC/BCC printed materials for the promotion of health programmes have been distributed throughout the regions in the appropriate local language and the HEEC has recently procured audio-visual equipment to be placed in every health post across the country.

As part of its efforts to increase the number of health officials trained in IEC/BCC, the HEEC developed a BSc and MSc programme at Jimma University. The first three graduates of these programmes have been deployed to work at the FMOH.

Last but not least, the HEEC has been instrumental in developing training programmes and manuals for HEWs. The most recent development in this area is the implementation guidelines for HEWs on Community Conversation, a social mobilization tool with proven success to engage community members in becoming frontline agents for behavioural change. At its nascent stage, Community Conversation was particularly successful in minimizing discrimination and stigma of HIV/AIDS and with the support of the FMOH, it is now being integrated as a key activity with which to guide and facilitate the achievements HEP and its partners.

Constraints
At the policy level, a central consideration for the IEC/BCC component is that the national health communication strategy was developed before the full conceptualization of the HEP and therefore this flagship programme, with its primary role of communication for health prevention and promotion, has not been fully articulated in the IEC/BCC strategy.

As a result, there is a lack of support and guidance for the structure and activities for both IEC/BCC and the HEP. This has an impact at all government levels for budget allocation, alignment of activities, linkages with other partners, ability of HEWs to carry out their responsibilities successfully and most importantly, for communities to receive health education that can catalyse behavioural change.

The disconnect between the two partnering components is very visible at the regional level where linkages with other community-based strategies are not defined and where IEC/BCC programmes and staff are linked with the HEP in some regions and with the family health department in others. Specifically, there is a lack of linkage and harmonization between the Community Conversation component of HEP and other community health interventions such as the Model Household Approach, Community IMCI, Community-Based Nutrition, Community-Led Total Sanitation, Community Conversations on Harmful Traditional Practice and Youth Dialogues on HIV & AIDS.

The FMOH recognizes the importance of harmonizing and aligning IEC/BCC and HEP activities and has made this a component of the BPR exercise. This exercise is scheduled for completion in July 2000 (EC) and one of its outputs is to restructure the HEP to better coordinate the functions of IEC/BCC.

Access to mass media in Ethiopia is low, especially for women, who are the primary targets of health programmes. Only 20% of women of child bearing age (15-24 years) listen to radio once per week. Approximately 75% in the same age range have no exposure to mass media of any kind (newspapers, radio, TV). This underlies the importance of community-based IEC/BCC and the HEP programme.

Additional constraints during the regional visits were identified as:

- Inadequate financial resources, shortages of IEC/BCC-skilled staff, poor coordination and lack of inter-sectoral integration at the RHB and WORHO levels have adversely affected the implementation, quality and diversity of IEC/BCC activities in a number of regions.
- Awareness of the NCHS as the guiding framework for IEC/BCC and health education is lacking at the regional level and to a certain extent, the federal level.
- The provision of IEC/BCC materials is supply-driven from the federal level and does not take into consideration local beneficiaries' needs for health education. Additionally, IEC materials are produced and distributed by vertical health programmes (EPI, malaria, and TB) but lack central coordination and follow-up from the regional bureaus.
- Many RHBs have not developed a regional IEC/BCC strategy tailored to the specific needs of the local communities and designed to manage the coordination of multiple actors.
- Printed materials available in local languages and audio-visual materials and equipment are insufficient.
- Limited resources make it very difficult to monitor and evaluate the actual impact of IEC/BCC activities on local communities.
- Linkages between federal, regional and wereda offices on technical assistance and training in IEC/BCC interventions are virtually non-existent.
- VCHWs who provide a supporting role to HEWs do not receive training in IEC/BCC. In addition, VCHWs' supporting role has not been formalized.
- The incorporation of Community Conversation as a key activity of the HEP has not been fully mapped out and important linkages at the wereda and kebele levels, which are critical to the success of Community Conversation, remain undefined.

Recommendations

IEC/BCC is a cost-effective approach to mobilize communities into making the life-saving changes in their daily health and sanitation practices. As such, IEC/BCC must become a key priority in both cross-cutting and vertical health programmes. The regional and wereda health offices must take the lead role in ensuring that resources, staffing, technical expertise are in place to support IEC/BCC activities at the community levels while the HEEC needs to accelerate the dissemination of the recommendations of the BPR and assist in providing coordination and technical supports to the regions.

Table 2.21 Recommendations for IEC/BCC

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Financial Resources	Allocate resources for audio-visual equipment, staff training and reproduction of audio-visual programmes for community education	Create a funding pool for donor contributions.	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Technical Support	Re-establish the federal level Technical Working Group on IEC/BCC to strengthen support for health education and communication.	Develop an IEC/BCC technical working group at the regional level to harness best practices, share experiences and resources among IEC staff, NGOs, UN agencies the private sector and media.	
Advocacy and awareness raising	Revise the NHCS to feature the HEP.	Prioritize IEC/BCC activities in all health programmes with particular emphasis at the regional level and on critical programmes such as maternal health and family planning.	Engage in pro-active dissemination and promotion of IEC/BCC frameworks and strategies among relevant RHBs and WORHOs to increase political commitment for IEC/BCC initiatives.
Training		Introduce IEC/BCC module in the IRT.	Introduce IEC/BCC as a sub-specialization in colleges and universities.
Monitoring and Evaluation		Map and review existing IEC materials to determine gaps, consolidation requirements and client needs.	Strengthen the M&E system to better assess the impact of health education and behaviour change interventions. Develop guidelines and adopt indications for the collection of data at the district and zonal levels.
Harmonization	Ensure inclusion of guidelines in HEP to harmonize the roles of and clarify incentives for VCHWs.	Ensure that HEP initiatives such as Community Conversation and Model Household approach are harmonized as complimentary interventions.	Clearly articulate the supervision role of the new 1,300 Wereda coordinators for HEWs and ensure they are trained in IEC/BCC.

2.3. Cross-Cutting Issues

2.3.1. Gender

Summary

Progress has been made in the appointment of focal points and the availability of guidelines at regional level. Stronger leadership to promote attention to gender issues over the next few years is needed to capitalize on the fruits of a gender sensitive health service, leading to faster progress towards key HDSP III targets including lower maternal mortality rates, slower population growth, and a greater balance of the sexes in the health service. Management needs to ensure that budgets are allocated at regional and Wereda levels to fund activities addressing gender concerns. Management is advised to commission a more in-depth review aimed at developing a budgeted action plan to improve progress in mainstreaming gender.

Specific targets HSDP III

The HSDP III strategic focus is to mainstream gender at all levels of the health system through institutionalization of gender, promotion of gender mainstreaming guidelines, capacity building of gender units/focal points and promotion of use of desegregated data.

Achievements and Constraints

Institutionalization of Gender

RHBs are making efforts to address gender related issues by assigning experts as a focal person or establishment of gender units. These cadres are absent at wereda levels. In Somali region, the zonal health worker showed keen awareness of gender issues and was actively supporting implementation of some measures. In that zone, there is a gender focal person in the zonal administration and she has initiated efforts to mobilize and empower HEWs, who are exclusively female. HEWs are permanent members of the kebele health committee and thereby enjoy some decision-making power at community level; they can use their proximity to the community to address gender concerns with a bias to women empowerment. For institutional collaboration at all levels, the health sector works with women's affairs in planning, and evaluation of gender related activities and provision of trainings and guidelines. Some NGOs are also involved in the RHB in meetings and trainings where gender concerns are addressed. Some gender focal persons in the RHB exhibited determination to ensure that gender issues had an impact in the sector and at community level. Gender focal points need space and management support for more proactive programming of gender mainstreaming and gender specific activities as was planned for in the HSDP III.

Gender Mainstreaming Guidelines

The National Women's Policy and Gender Mainstreaming Guidelines were found at several regional and wereda offices. In some regions the policy and the guidelines were being used to address gender related problems and disparities prevailing in the region. Moreover some regional adaptations are being drafted. The existing policy remains helpful; however, the patriarchal culture affects health outcomes and can only be resolved through a multi-sectoral concerted effort. The policy and guidelines are not yet being used as a reference point for budgeting.

Capacity Building for Gender Focal Points and Units

Capacity building interventions are implemented alongside activities addressing reproductive health and family health services. In regions where there is a gender unit head, she is a member of the RHB's management committee. She (and it is always a she) also takes part in

the employment and promotion of gender issues on the committee and advocates for women's rights. Most units do not have their own specific activities, as no budgets are allocated. Some regions' activities are funded from their departmental budgets.

Training at the RHB level has focused on gender related concerns within the HIV/AIDS programme. RHB female staff are trained on gender issues. However, these trainings did not incorporate women's rights concerns. It is important for training interventions to address the actual needs of women and men at RHB and other levels. Capacity needs assessment will be undertaken to identify and provide tailored and practical training to fill the gender gaps. In one zone visited, some HEWs and health staff are actively promoting key messages on early marriage, female genital mutilation, and violence against women during Community Conversations and school IEC/BCC programmes.

While a number of seminars and workshops have been conducted, no gender audits have taken place in any of the RHB or weredas. Certain Development Partners have helped to mainstream gender concerns and provide training and guidance.

Data reports are not sex disaggregated, training quotas are not divided by sex and there are no reports and studies on gender interventions with a bias to women empowerment. There are no recorded sex-specific numbers in plans and budgets. However, the new HMIS will collect fully gender disaggregated data sets.

Additionally, there are no reports which show the breakdown of gender of the RHB staff by number, position and education level. There is no indication of the number (if any) of women at a senior management positions. In one RHB, the gender unit head was found to be the only female member of the management committee. Her influence appeared minimal. Most of the women staff members are not technical staff and they hold the lowest positions. Information from one health facility showed that men are involved in HIV/AIDS, family health and nutrition services, but there were no data to substantiate this information.

Conclusion

While gender issues are starting to be addressed at regional levels and in a few zones on a modest scale, there is a need to further strengthen the understanding of gender issues, especially on how to programme for effective inclusion of budgeted gender activities in annual work plans. The low level of understanding and communication of gender awareness partially explains the lack of improvement of maternal health services despite the high maternal mortality.

Recommendations

Table 2.22 Recommendations for Gender Mainstreaming

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Leadership on Gender Mainstreaming	Empower JCCC to mainstream gender into HHM.	Monitor that specific budget allocations are made for gender mainstreaming activities at federal, regional and wereda levels, especially in emerging regions where women suffer the consequence of gender related injustices on a greater scale.	Adapt HMIS to capture data to measure trends in gender issues (see section 3.4 for more information).
Training	Train and build capacities of selected individuals from relevant departments of the	Include gender mainstreaming and gender analysis training in planning and programming.	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
	FMOH to work as trainers, advocates and focal points and form a gender task force.		
Communication Strategy to support HEWs		Provide in-service support to bolster both male and female HEWs' role as models to promote gender issues such as avoidance of harmful practices (notably early marriage and female genital mutilation) and to encourage family planning.	Conduct an assessment on gender-based knowledge, attitude and practices and explorative research on how gender affects health and the use of health services.
Affirmative Action (see section 3.2 for more information)	Apply a gender quota system at every level of human resources and not exclusively for HEWs.	Assign a task force to develop a long-term strategy to examine innovations e.g. identification of bright girls from pastoralist / other remote communities for sponsoring through completion of primary and secondary school with a view to advancement in nursing, midwifery and medical training as a key element in a long-term strategy for reducing maternal and child health disparities and encouraging the use of health facilities.	

2.3.2. Nutrition

Introduction

For much of the outside world, malnutrition is a defining characteristic of Ethiopia. Just under half (47%) of Ethiopia children experience chronic malnutrition resulting in stunting; 35% of Ethiopian children under 5 are underweight (DHS 2005). Ethiopia has one of the highest rates of malnutrition in sub-Saharan Africa. The consequences of this problem are enormous. Malnutrition kills more children than any other single disease: it is the underlying cause of over 50% of child deaths in Ethiopia. The acute cases of malnutrition account for only a small portion of these deaths whereas over 80% of deaths are due to mild and moderate malnutrition, which increase the risk of dying from diarrhoea, malaria, tuberculosis, pneumonia and other communicable diseases. The effect is that Ethiopia has one of the highest rates of child mortality, such that 12.3% of Ethiopian children die before reaching their fifth birthday.

Frequent droughts and unproductive soils in some parts of the country certainly increase malnutrition in Ethiopia. Yet most malnutrition is due to factors other than food unavailability. These include: lack of education on life-saving infant and young child feeding and caring practices, lack of gender equality which prevents adequate nutrition in pregnant women and impacts their power to make decisions about their children's welfare. Data demonstrates that even for those in the wealthiest quintile, who have access to sufficient food, malnutrition rates are still over 40% (EDHS 2005).

At the time of the writing of this report, an estimated 126,000 children in 325 EOS supported drought prone weredas are suffering from severe acute malnutrition precipitated by the recent drought and the global rise in food prices. Emergency response to treat malnutrition has become more successful in recent years, but more attention must be paid to its prevention in the future.

Achievements

The greatest recent achievement toward reducing malnutrition is the approval of the National Nutrition Strategy (NNS), implemented as the National Nutrition Programme (NNP). Set to begin in July, 2008 (GC), the NNP is a policy development demonstrating strong commitment of the GOE to tackle nutrition problems. Another major achievement during HSDP III is the

implementation of EOS. Over 90% of children nationwide have received twice-yearly vitamin A supplementation and de-worming as compared to less than 60% in 1998,

Management of acute malnutrition has improved in the past three years due to: (i) the identification of acute malnutrition during EOS campaigns, and treatment through supplementary and therapeutic feeding programmes (TFP); (ii) the presence of HEWs who identify severe malnutrition and facilitate referral; (iii) well-functioning emergency mechanisms and (iv) rapid mobilization of resources for therapeutic feeding during outbreaks of severe acute malnutrition.

Constraints

There are several areas where implementation falls below what is needed to achieve the HSDP III targets and the MDGs.

- Inadequate attention to mild and moderate malnutrition: HEWs use clinical signs to determine malnutrition and often cannot identify malnutrition before it reaches the acute stage, one reason being that they are not equipped with necessary tools/skills to monitor child's growth, detect invisible forms of malnutrition and prevent further deterioration. Therefore the community-based preventive nutrition will be a strong focus of the NNP.
- Nutrition training of HEW and clinical staff does not appear adequate; the nutrition training package for HEWs is not well attuned to the needs of the community, confidence of HEWs and clinical staff to give nutrition counselling is low, and accuracy of nutrition information is inconsistent.
- Nutrition advice is not universally aligned with Essential Nutrition Actions (ENA) nor is nutritional content of locally available and accessible foods.
- In a few weredas, HEWs collaborate with agricultural extension agents to jointly promote locally available foods to meet nutrition needs.
- Additionally, reference materials on nutritional messages, specifically ENAs, are not adequately supplied to clinical staff and HEWs.

In general more promotion and negotiation skills, rather than one-way education, are needed for effective behaviour change.

Quality of care in the TFP needs improvement: this has an immediate effect on child survival. Continuing challenges include lack of adequate staff and skills, inconsistent reporting, and sparse supportive supervision.

Lack of attention to maternal nutrition in general: inadequate routine monitoring of pregnant and lactating women's nutritional status due to few ANC visits and low community outreach (although HEP is still increasing), and supplementary food is only available to mothers screened during the bi-annual EOS campaigns. This contributes to Ethiopia's high rate of low birth weight (LBW), being around14%.

Inconsistent provision of Iron/Folic Acid (IFA) tablets: health workers have neither the supply of tablets nor knowledge of the policy mandating their provision to all pregnant women. At present only women visually identified as severely anaemic are given a prescription for IFA tablets, which they must then purchase from a pharmacy, drastically limiting the access of the poor to the life-saving service that is supposed to be provided free.

Slow progress on universal salt iodization: Process towards universal salt iodization is progressing in Afar Region, which provides 95% of the nation's salt, but the goal is not yet achieved. As an interim emergency arrangement, the government is providing (through the EOS) iodized oil capsules in highly iodine deficient endemic weredas in five regions to the most vulnerable population groups (e.g. under-five children and pregnant and lactating women).

The main institutional constraint behind these problems is low structural capacity: Inadequate indicators reported and lack of a mechanism for systematic monitoring and timely response. The only indicators reported out of all the HSDP III targets are coverage of vitamin A supplementation and number of children whose weight was measured. Prevalence of underweight, breastfeeding, utilization of iron/folic acid supplements by pregnant women, and use of iodized salt, are not monitored at any level. This lack of feedback mechanism makes appropriate analysis and action to correct these nutritional problems impossible.

Staffing inadequacy: Currently there are no nutrition focal persons at zonal and wereda levels, and few at the regional level (except for Tigray RHB having the Nutrition Division with three professionals). Existing family health staff are not focused on nutrition, and report that adding additional responsibilities for nutrition would be difficult because of the amount of travelling and reporting responsibilities they already have. There is currently very limited awareness of NNS below the regional level.

While there are major gaps in the current provision of nutrition support, the NNP is a strong action plan for resolving them. The NNP details an implementation plan of concrete and evidence-based strategies for impacting nutrition, such as community based nutrition including training on ENA, monthly growth promotion, improved inter-sectoral linkages, and improved monitoring of nutrition indicators with an NIS (Nutrition Information System). Carrying out these activities successfully is likely to yield large reductions in malnutrition.

Conclusion

The GOE has shown strong commitment to nutrition in approving the NNS. This commitment needs to be carried through by an equally strong human resource structure. Under the NNP, USD 350 million is to be allocated to nutrition activities over 5 years, 70% to service delivery and 30% to institutional capacity building. The GOE is currently undergoing a BPR and human resources review to decide on the best structure for administering the NNP.

Analysis and action of nutrition problems is complex, requiring inter-sectoral solutions with collaboration between health, agriculture, education, and gender sectors; this calls for a dedicated nutrition coordinator at each administrative level. Furthermore the NNP will bring a large influx of funding for nutrition service delivery (USD 70 million/year nationally), which needs to be managed effectively. Given the magnitude of the problem of malnutrition in Ethiopia, the severity of its consequences, the complexity of its causes and solutions, and the strong commitment of the GOE to address it, special nutrition staff and budgeting are needed to ensure adequate attention to this vital issue for Ethiopia.

Ethiopia cannot afford to have nutrition side-lined; neither for the survival of its children, neither nor the wealth of its economy. The job of HSDP III and HSDP IV is to provide structure / support to enable the planned activities to achieve the maximum benefit possible for Ethiopia.

Recommendations

Table 2.23 Recommendations for Nutrition Interventions

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Implementation of National Nutrition Programme	Form a Nutrition Department with adequate human resource capacity to implement the NNP through inter-sectoral coordination. Ensure accountability to the HSDP III targets and MDGs.	Create the NIS, establishing a coordination body, and conducting skill based training of HEWs and VCHWs in community-based nutrition (CBN). Place a nutrition focal person at zonal and wereda levels to respond to nutrition indicators and work with other sectors on the ground to achieve nutrition goals.	Review of NNP implementation.
Training	Increase availability of ENA reference materials for clinical and HEP staff in order to increase confidence and competence in nutrition counselling.	Integrate ENA into the health professional and HEP training curricula, and update the HEP nutrition package to encourage interactive counselling and inter-sectoral nutrition promotion activities; support the distribution of the updated nutrition package by refresher trainings.	Human resource development plan implemented under NNP.
Micronutrients	Enact legislation for iodization of all salt produced/procured in the country.	Supply adequate IFA tablets and training for health staff so that all pregnant women receive IFA tablets free of charge. Carry out iodine supplementation in worst-affected areas until iodized salt supply is realized.	Ensure USI for the entire country.
Collaboration with Ministry of Agriculture and Rural Development	Establish an inter-sectoral Nutrition Committee to oversee the implementation of the NNP. Provide a qualified and professional secretariat and an active chairperson.	Increase collaboration between agricultural and HEWs to better promote available, accessible, micronutrient-rich foods, linking HEWs with the agricultural departments and utilizing the nutrition information of Ethiopian foods that is available from EHNRI.	

2.3.3. Pastoralist Health Care

Introduction

Pastoralism is sometimes defined as a way of life, where more than half of the household income is generated from livestock. Pastoralism is extensively practiced in several regions in Ethiopia (Somali, Afar, Borana area of Oromiya and SNNPR). Pastoralist groups in Ethiopia have poor access to social services. Levels of malnutrition are often very high, as is mortality due to malaria. They suffer very high maternal mortality ratios, but no specific information is available.

Achievements

RHBs address the health needs of the pastoralists as an integrated part of the HEP and at times have focal persons assigned to coordinate implementation of special measures aimed at pastoralist health needs. Almost all these officers have other duties and more often than not, have little time to deal with pastoralists needs, even in regions with large numbers of pastoralists.

The scale-up of the HEP has potential to expand services to pastoralists. Federal level policies for the HEP are being modified after a period of experimentation and consultation a draft national policy for health services in pastoralist areas was produced by the Division of Health Services in January 2008. This policy will apparently include a few adaptations such as providing male HEWs with camel transportation, and training some HEWs in the use of co-trimoxazol.

In the Somali region, the RHB in collaboration with UNICEF deployed 15 mobile health teams and in the 15 most drought-affected weredas primary health care service and nutritional screening were provided.

The deployment of graduates has become a major hindrance to the HEP, due high levels of dropouts. Despite this, steady progress is being made to improve services from fixed facilities and through mobile outreach services as a way of taking basic health care services to the pastoralist communities.

Constraints

The incentives for professional staff to serve in fixed-point facilities close to pastoralists are reportedly not enough to encourage more professionals to serve. For example, only 35 doctors are serving in the four regions where most pastoralists live and these, on the whole, are not serving pastoralists. Similarly, incentives are inadequate for HEWs who are deployed in these regions to provide a service to pastoralists. Many HEWS are from urban areas and are related to wereda officials. It is not clear to what extent they are prepared to reach out to pastoralist communities. There have been high drop-out rates due to irreconcilable cultural differences between the HEWs and the pastoralists.

There is also a lack of uniformity in the training of the HEWs even within the same region. In certain regions some of the HEWs were trained for six months while other groups were trained for eleven months. There is a high turnover of health staff working in the regions, particularly those from other ethnic groups.

Pastoralist communities tend to have a more conservative outlook than much of the rest of Ethiopia. It will certainly be very challenging for young female HEWs to persuade older couples to adopt family planning without using a more culturally appropriate approach involving older members of society and religious leaders. Similarly the innovative approach of improving mobility for male HEWs by providing them with camels may be something female HEWS will find culturally difficult to adopt.

Conclusion

The pastoralist areas receive attention through the HEP. The coordination team in FMOH is an important addition to federal structures which requires nurturing from senior management. Little progress has been made in the implementation of the HEW programme although it is only now starting to take off in these areas. Some policy issues still need resolution and experimentation to find out what strategies will genuinely deliver quality services to pastoralists. More resources than are currently allocated will have to be provided to pastoralist health, if HDSP III targets are to be met.

Figure 2.3 Afar: A HEW helps increase EPI coverage rates and encourages uptake in family planning

Recommendations

Table 2.24 Recommendations for Pastoralist Care

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Inter-Ministerial Coordination	Strengthen inter-ministerial coordination to harness joint programmes such as cold chain resources for human and livestock.		
Special Attention to HEWS in Pastoralist Areas	Review options for increasing mobility of HEWs in pastoralist areas by providing appropriate transport such as camels.	Speed up implementation of localized curriculum, recruitment and deployment of HEW in pastoralists and emerging regions. Recruit and train a group of mobile frontline VCHWs from pastoralist areas to help expand HEP. Support the establishment of resourceful and stable senior management team at the regional level that will help to roll out the HEP in pastoral and emerging regions.	Put in a long-term recruitment process starting by identifying candidates even in the latter stages of primary school or focusing on adult education to bring older HEWs into the system.
Wereda Planning, Budgeting and Review	Continue deployment of UNVs to remote weredas.		

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Incentives for Professional Staff Working in Pastoralist Weredas		Provide incentives such as improved salary package, better housing conditions and quality static health facilities to health professionals working in pastoral and emerging regions.	

2.3.4. Emergency Preparedness and Response (EPR)

Introduction

Communicable diseases are major causes of morbidity and mortality in emergencies mostly where poor disease control programmes, limited access to health care services and malnutrition already exist. The availability and utilization of national policies and guidelines is of great significance and support in the timely control of any emergency.

Achievements

1. Several regions have developed an early warning system by using 22 epidemic prone diseases as indicators through the IDSR. They work with the Regional Disaster Preparedness and Relief Agency to coordinate the planning and response for major natural disasters. The IDSR experts are used as focal persons for emergency health. However the viability of the IDSR reports is a major concern since their timeliness and completeness of reporting are far below the expected rates in many regions.
2. Successful control of emergencies such as epidemics outbreaks (AWD, meningitis, and measles) was achieved in most regions. Other natural disasters such floods and droughts were also experienced and responded to, but with less timely results.

The AWD outbreak created a good opportunity for redesigning the emergency preparedness and response mechanism in many regions. Better coordination among partners and high political commitment was observed in most regions where the offices of the regional presidents are responsible for the coordination of emergency/relief interventions. Regular multi-sectoral coordination meetings strengthened epidemic preparedness and response committees that were established up to kebele level. They managed to enhance resource mobilization.

3. Few RHBs have stockpiles of basic emergency equipment and supplies, and even these are not at the desired amount for any possible outbreak.
4. Preparation of manuals for Health Emergency Preparedness and Response (HEPR) has commenced in several regions such as at the FMOH and Tigray. According to the BPR, disease surveillance will be placed at EHNRI as a division with its full team of professionals. A Field Epidemiology and Laboratory Training Programme has been designed and will take the lead in training epidemiology intelligence officers who will be leaders for the health sector in emergency preparedness and response.

Constraints

1. Shortage of human resource at all levels (distraction of staff from other services) but worst at facility level, are major constraints for effective and immediate control of emergencies.
2. Recurrent (for AWD) and protracted epidemic periods (droughts in certain regions) have adverse impact on the provision of other health care services. Although better coordination among partners and high political commitment was observed in most regions, such coordination is only visible during an emergency.

3. Information exchange due to undeveloped communication infrastructures is a bottleneck for coordination of emergency relief coordination. Lack of consistent reporting (IDSR) further aggravates the problems;
4. Poor organizational structure and weak coordination among partners and lack of monitoring and evaluation to document lessons learnt from previous emergencies is another constraint.
5. There is a tendency to relax when there are no obvious emergencies and there is an acute lack of basic supplies of emergency drugs and supplies. Many of the regions do not have contingency funds or plans for emergency response. They have limited funds to respond to emergencies effectively and immediately.
6. Poor referral and linkage among health facilities, between facilities and community services, and between RHB and lower levels.

Conclusion

In general, the emergency preparedness and response system is weak and IDSR strategy is the only early warning strategy (EWS) in place. This trend needs to change by broadening the EWS to include other areas of public health surveillance. There exist structural organizational problems right from the FMOH to the lower levels. Where committees exist, they work on an ad-hoc basis with limited capacity for emergency preparedness and response.

Recommendations

Table 2.25 Recommendations for Emergency Preparedness and Response

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Emergency Preparedness and Response Capacity	Institute a task team to review in more depth, emergency preparedness and response at federal, regional and wereda level and develop a budgeted action plan. Encourage sharing of EWS with other ministries for instance data coming from DPPA's livelihoods monitoring service, and the Agriculture Ministry and Rural Development's productive safety nets programme.	Create a semi-autonomous body at the FMOH level (with multidisciplinary approach) to improve EPRP based on an action plan that undertakes broader public health surveillance and preparation of annual budgets and specific targets to be achieved for emergency preparedness and response. Include HEPR in all curricula for all the regions and provide guidelines and protocols.	Review performance of enhanced EPRP capabilities. Work towards the positioning of experts in emergency preparedness and response at various levels of the system down to wereda level.
Disease Surveillance Departments		Build the capacity of the disease surveillance units at all levels by training more experts in emergency preparedness and response and by requesting for technical assistance from partners (CDC, WHO) to strengthen capacity at federal and regional levels.	Improve the capacity of the Regional Laboratories by providing the necessary resources (both human and materials) with more efficient communication systems.
Emergency Preparedness in Non-Disaster Prone Areas	Ensure and encourage that each level from FMOH to the Kebele (including those considered none prone to emergency) has developed emergency preparedness contingency plans and earmarked funds for immediate response in case of any emergency outbreak.		Emergency stockpiles of essential supplies should be in place to respond to any possible emergency outbreaks at all levels.

2.3.5. Population Issues

Introduction

Ethiopia's population growth rate estimated at 2.62 percent per year (1997 EC), is high compared to Sub Saharan and world averages. Such a rapid rate of growth results in an increased youth population with dependency burden. Children aged 0-14 years made up 45.4 percent of the total population of Ethiopia in 1994 (GC), compared to an average of 45.9 percent for Eastern Africa (1995). The increased percentage of youth in Ethiopia implies that a smaller population of working age has to care for a larger young population. This poses a great challenge to Ethiopia.

One significant demographic consequence of this youth dominated population is its fecundity potentials. The level of fertility, which is already very high, is further prompted by annual increases in the number of women entering the reproductive age group (15-49 years). For example, women aged 15-49 years of age in Ethiopia numbered about 15 million in 2000 (GC); and their number was projected to reach 17.5 million in 2005 (GC), about 20 million in 2010 and 24.4 million by the year 2015 (Central Statistical Authority, 1998). The high percentage of women entering reproductive age puts a continued pressure on demand for support services and facilities, such as health centres/hospitals, schools, food, housing. The problems affecting the youth such as poverty, unemployment, school drop-out, and drug related issues will be compounded by their increasing numbers.

Rapid population growth is a major barrier to poverty reduction. The addition of almost two million persons per year strains Ethiopia's resource base, the economy, and the ability to deliver services. It is a challenge to create sufficient employment, or in raise agricultural productivity, when approximately 38,000 people are added to the country each week.

There is also the direct cost of providing additional services. For example over a third of the cost of reaching the MDG for universal primary education is accounted for by the expected population growth. Finally, the high number of pregnancies (average six per woman) has a debilitating impact on women and children's health[37]. It is clear from this information that ´the population issue´ is one of the major constraints in achieving the HSDP III targets. If not addressed with all possible means (and by all sectors together), it might defeat the very purpose of the health development efforts in the country.

Achievements

During the first few years of HSDP III, the following achievements were made in support of population related activities:

- Development of strategies emphasizing the population related activities:
    - National Reproductive Health Strategy
    - National Adolescent and Youth Reproductive Health Strategy
    - National IEC/BCC Strategy
- The decision by the MOFED on wavering all tax payments on contraceptives;
- The allocation of funds by regional governments (Amhara, Oromiya, SNNPR and Tigray) for procuring contraceptives.
- Revitalization of the national reproductive health task force/core group and the various technical working groups under it.

[37] MOFED (2006), Ethiopia: Building on Progress: A Plan for Accelerated and Sustained Development to End Poverty (PASDEP) (2005/06-2009/10), Addis Ababa, Ethiopia: Federal Democratic Republic of Ethiopia, Vol. 2

- Drafting of the Population Policy Action Plan (2008-2015 GC) in which the main themes are population and development, reproductive health, gender and IEC/BCC.
- Establishment of the Population Council.

Constraints

Although there are several activities related to population activities, most of them were concentrated on service delivery and little emphasis was given to the advocacy and coordination components which play a major role in improving the service delivery part.

Despite the relative high level of awareness of family planning, the level of modern contraceptive use among married women is still very low (14 percent, 1997 EC) with 34 percent unmet need for family planning. This might be due to lack of appropriate knowledge, limited access to services, social, cultural and religious barriers and low economic and decision-making power of women.

In the formal school system, efforts had been made to integrate population/family life education contents into the curricula of primary and secondary schools in biology, geography and other subjects. However, attempts so far made to integrate POP/FLE in technical and vocational training programmes such as agricultural colleges, teacher training and health training institutions were not successful. In addition, efforts made by the Agriculture Ministry integrate POP/FLE in the agricultural extension programme did not last long after the completion of the UNFPA assisted 4th Country programme.

In the area of population and development the major challenges facing Ethiopia are:

1. Rapid population growth propelled by the young age population structure;
2. Limited capacity for integrating population factors into development plans;
3. Poor understanding among the populace about the linkage between population, development and the environment;
4. Weak coordination mechanisms including M&E;
5. Inadequate resources
6. Lack of culturally sensitive, appropriate and acceptable media communication strategies;
7. Poor logistics management systems to enable continuous flow of services and commodities.

Recommendations

Table 2.26 Recommendations for Population Issues

Actions to be Undertaken	Short-Term In next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Ensure Family Planning Services Benefit from HIV-Related Service Improvement Funds	Set up a task team to review use of HIV earmarked funds focussing on the extent to which they are being used to improve family planning services.	Implement agreed task team recommendations.	Review progress by ensuring all health staff are aware of the results of the 2010 DHS by ensuring budget is available to communicate the results across the system.
Contraceptives	Review reasons for stock-outs focussing on budget allocations and logistical constraints.	Implement results review setting management targets and reviewing progress by wereda.	
Review Performance of HEW in Encouraging Uptake of Family Planning.	Commission a study of HEW performance, once deployed in reaching their family planning uptake targets.	Use the results of the study to design and implement strategies to enhance system support for HEWs.	
Closer Collaboration	Implement the plan of action as	Use the lessons learned	

Actions to be Undertaken	Short-Term In next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
with MOFED Population Department	mentioned in the NPP. Learn from the successes of other countries in reducing fertility similar to Ethiopia through a combination of study tours and in service training of regional bureau staff.	through study tours and in service training to update and refine at regional level current strategies for fertility reduction.	

3. Support Services in HSDP III

3.1. Facility Construction and Rehabilitation

Strategy and Targets

The AEPHCC has an objective to construct, expand and renovate health facilities at all levels of the health sector, but in particular at kebele (health post) and wereda (health centre) levels. There is an ambitious goal to increase service coverage from 72%[38] to 100% before the end of EFY 2000. The FMOH has adopted a number of different construction methodologies with each of the RHBs fully committed.

Most regions have increased the numbers of health posts steadily in the last three years and the speed of development appears to be increasing. Between EFY 1998 1999, 3,000 health posts were constructed bringing the total number to 9,914[39] (66%). A further 5,000 are required to meet the target of 15,000 health posts.

The target is 3,200 NHCs by the end of HSDP III. The FMOH is currently supporting the construction of 500. Site operations started in early EFY 1999.

Health Post Strategy

The FMOH/PPD has developed a standard health post layout to accommodate the intended HEP. It is the RHBs and WORHOS that are responsible for their own programme of implementation to ensure one health post for 5,000 people, or one health post per kebele. Regions vary in how much support – none to 50% - is given in terms of "industrial materials" such as cement and iron roof sheeting, and the extent of communities' involvement in construction of these buildings.

Issue

An over reliance on community constructed health posts has provided disappointing results. Whilst the simplest of structures can be used as a health point, the poor condition and quality of many of the rural health posts should be improved rapidly to enhance the delivery of the HEP.

Health Centre Construction Strategy

In terms of investment in infrastructure, the plan to construct over 500 new or upgraded health posts and clinics to NHCs, offering OPD, BEmONC and 10 bed in-patient facilities, puts a high demand on limited administrative and technical resources. This programme has many challenges: difficult access to remote areas; limited pool of competent building contractors; rapidly increasing cost of commodities – particularly cement and steel; and the under resourced engineering departments within the FMOH and the Ministry of Works and Urban Development, to adequately supervise the work and ensure quality control.

The number of health centres to be constructed has been split into two groups: 1) FMOH funded by Global Fund and GAVI and 2) a matched number of sites with RHBs funds with some additional support from the African Development Bank.

[38] Annex 3, HSDP III – Health Sector Strategic Plan
[39] Health and Health Related Indicators EC 1999

Progress is being made in all regions but only a relatively small number have been completed and handed over so far. Most sites are at less than 50% completion. Oromiya is the most advanced where 266 health centres are being constructed. In March EFY 2000, construction was reported at 75% complete.

Issues
Two different construction methodologies have been adopted. The FMOH/PPD has contracted GTZ to implement 500 health centres. Contractors have been pre-qualified allowing contracts to then be directly awarded fixed price contracts where rates are determined at central level. With some cost saving technology this is known as a Low Cost Contract Approach. The base Addis Ababa price has recently been increased from 923,000 ETB to 1,063,236 ETB. Regional variations and transport indexes are applied.

The RHBs have followed traditional construction techniques and standard selective tendering. Contracts are reported to be 40% higher than the FMOH/GTZ contracts, mainly because local markets are used to source materials. GTZ projects benefit from cement at factory prices.

The consequences of the different approaches have significant implications for the way the next phase of work, for 891[40] sites, is managed and implemented. The FMOH is discussing alternative management modalities with a key objective to strengthen the national construction sector.

Construction Progress

There are continual references to the slow progress of the construction programme particularly for upgrading health centres[41]. Given the many constraints and universal problems of a large building programme, considerable achievements are being made.

Issues
The high numbers of facilities under construction are being achieved at the expense of quality and functionality. The current NHC designs do not appear to have drawn on the lessons that should be learnt from existing facilities where poor space standards, insensitive patient flows and the inappropriate technologies used for water and power supplies are serious problems.

Other Construction Strategies and Programmes
There is a USAID funded programme to assess the condition of 100 health centres and provide basic renovation for 50. The assessment and mapping methodologies adopted have the potential to influence infrastructure strategy but the implementation work appears to have had a limited impact on improving the selected health facilities.

U.S. Government (USG) funding has enabled the construction of new pharmacies and stores in many regions. There are a number of specialist programmes for new hospitals, teaching centres, medical and equipment stores and blood banks.

[40] Workshop planned with RHBs for 30-31 May 2008 expects plans and maps to be submitted to the FMOH/PPD for approval.
[41] Annual Performance Report EC 1999 Item 40.3.

Figure 3.1 New Pharmacies and Drugstores[42]

(Figure 3.1 not included so as not to increase the size of the file even more)

The new drug store and pharmacy look nice. However, the building's orientation is wrong, as the drugstore gets too hot from the direct sunlight on its walls. Standing in the queue at the hatch is very hot. The steps are difficult to manoeuvre for disabled patients.

Each RHB, through the decentralization process, is responsible for its own planning and building programme, whilst there are national programmes for specialist services such as the blood banks. It appears that most of the programmes will not be completed within the HSDP III period limiting the potential to contribute towards achieving health service targets.

Issues

Mapping tools are not used to assist site selection and to cluster contracts efficiently. There is no overall reporting mechanism, so RHBs are unable to keep a good record of all the programmes under their jurisdiction. Many projects are managed by independent organizations running in parallel. Linkages with the RHBs are weak, with activities not recorded by HMIS. It was not possible within the MTR period to collect accurate data regarding all the health related infrastructure plans.

The FMOH is only responsible for issuing standard drawings, through consultants, and for facilities in Addis Ababa. An HMIS mapping system has recorded existing facilities. Locations for the current construction phases are not yet documented to assess the impact on proposed coverage and access.

Infrastructure Management Resources

The FMOH, RHB, ZHD and WORHOs are traditionally responsible for health facilities. This is not the case in all regions. These offices receive very little funding and lack transportation to carry out field work. Staff are poorly paid relative to the private sector. However, the value of contracts awarded to parallel programmes and projects outsourced to local consultants and contractors enables vehicles, equipment and human resources to be procured to enable the work to be done.

Figure 3.2 Infrastructure Management Resources

(Figure 3.1 not included so as not to increase the size of the file even more)

A typical RHB engineering and architecture unit:
Most have two engineers, no dedicated vehicles and limited equipment.

Issue

Parallel programmes often allow new initiatives to be introduced but are usually short-term. The GTZ programme is currently two years which is too short for any substantial construction programme of any quality. The FMOH engineering units are long-term and have a better understanding of the issues involved, but have poor capacity. The RHB engineering units are currently very weak and they will get weaker without FMOH or donor input and support. The PPD has already identified these issues and changes were being discussed during the MTR.

[42] The figures 3.1, 3.2 and 3.3. have not been included in the text of the MTR report in order not to increase the size of the file even more. However, they have been presented during the various debriefing sessions in Addis Ababa.

Maintenance

The lack of preventive and cyclic maintenance is repeated in every report about the condition of health facilities: infrastructure, furniture and medical equipment. No national institutionalized scheme has been successfully implemented to solve this issue from the beginning of the HSDP programmes. Most regions report no progress.

An encouragement in this area is that many health facilities that now have a functioning Management Board in place have direct access to retained revenue. This has increased the sense of ownership and control over their facilities. Many have chosen to use this money to stop-gap two key areas: additional drugs and building maintenance. The percentage allocation for revenue for maintenance should be formalized in the guidelines for the use of this money. Management Boards would benefit by having in-house training and instruction about how to look after their buildings.

Design

Standard layouts have been produced for the three main health service levels: health post, NHC and primary hospital. The plans have generally been adopted by each of the regions. Designs have been carried out by a number of different agencies. The assessment and approval process for projects appears haphazard. There is no formal system of technical appraisal or approval.[43]

The layouts appear to have evolved over a number of years and have been prepared by local consulting engineers and architects showing good technical knowledge of construction methods and procedures. Some of the regions have further contracted out for engineering and architectural services, adopting the basic models to suit local requirements and alternative building techniques.[4] The FMOH/GTZ has a "one size fits all" approach with the only available variants being foundation designs to suit different soil conditions.

Figure 3.3 Typical Layout for Safe Delivery and CEmONC

(Figure 3.1 not included so as not to increase the size of the file even more)

Standard relationship of rooms in a maternity unit. The design does not reflect the needs of service providers or patients but has been designed by remote technician who are usually male.

Issues

There are a wide range of regional climatic conditions and a distinctive range of building techniques and materials which are difficult to accommodate in the target driven approach, but could be considered to provide more distinctive and locally appropriate facilities in the future. Better techniques to improved ventilation in hot areas could be explored for example.

Layout and Functionality

Health post and centre designs have been carried out mainly by architects and engineers trained for urban locations and environments. The designs do not reflect any engagement with health professionals and end users. Only in a few cases are health workers consulted about designs and their needs. Neither is there evidence that lessons learned and problems arising from previous phases of similar buildings have been applied to this current phase of construction.

[43] Different designs have been collected by the MTR team. Work has been done by SB – Consult, MH Engineering, Yosef Taye Consulting Architects and Engineers, some authorized by the MWUD, others by the FMOH/PPD and others by the various RHBs – Engineering and Architecture Units.

Basic principles needed for health facility design are clearly absent from the architectural vocabularies of many of the consultants and engineers responsible for site supervision: wrong orientation of buildings, ramps too steep; poor access for patients due to bad circulation, too many steps.

Issues
The architects and engineers who have prepared the designs appear to be unaware of the realities of the conditions and challenges in remote areas where the buildings are constructed. For example: The layout and patient flow for the maternity blocks, in particular, are not women friendly. Shaded waiting spaces are not available and training rooms are too small.

Water, Sanitation and the Environment

Given that an important component of the HSDP III strategic plan is to promote improved sanitation and hygiene practices in the communities, the misuse of water and flush toilets in the face of water shortage at all levels within the Health Sector (from health posts to FMOH offices) is a critical issue. NHCs reported only having access to 20 litres a day, brought by donkeys or carriers, to do their work.

Water closets or squatting pans with attached water cistern technology along with ceramic wash hand basins with stainless steel pillar taps will be difficult to maintain except in the most sophisticated and highly maintained buildings in major urban areas and alternatives should be sought as soon as possible, especially as most of the facilities visited during the MTR did not work properly. Working, clean and accessible latrines for patients are given low priority and only rarely was there provision for hand washing. The poor environmental conditions at the health facility compounds do not provide a good role model for the communities to follow.

Electricity

Where there are unreliable power supplies, most facilities would value the option of an alternative light and power source for BEmONC and EPI services. The standard design has been reviewed for a NHC which shows 10 light fittings just for the outside veranda to the maternity and in-patient area. This is unnecessary and expensive, but also creates a burden for maintenance in the future. Considerable savings and quality improvement could be made to the standard designs by alternative approaches to power and lighting. It is understood that two institutions have been approached to look at solar lighting alternatives.

Construction Programme – Quality Control

It is difficult to change the standard designs and the achievement of the building targets should not be slowed down. However, an “applied technology check” should be carried out as soon as possible on completed facilities. The use of inappropriate technology and fittings will only increase the maintenance burden in the future.

Conclusion

There seems to be a perception within the FMOH that construction is a category of its own. Decisions are left to “specialists”. However, this MTR would like to encourage all departments within the FMOH to challenge the engineers and architects to develop solutions which do not repeat the mistakes of the past but develop long-lasting and appropriate solutions that health service providers can be proud to work with.

Table 3.1 Recommendations for Facility Construction and Maintenance

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Review Policy and Design	Learn from problems in existing buildings. Remove WC cisterns from all health facilities, with or without water connections. Provide a one-tap policy to sanitation blocks using pour flush techniques. Review material specifications. Install manually filled water containers above existing wash facilities. Reduce the number of light points. Provide small generators, in the short-term to power BEmONC services only.	Develop standard guidelines for all components: space standards, room data sheets, appropriate use of water, lighting and power. Apply to new designs. Research alternative power sources.	Monitor and evaluate effectiveness of the design modifications. Be prepared to adjust the standards again.
Capacity Build the PPD Engineering and Architecture Units	All parallel and vertically funded construction programmes should be required to contribute to the strengthening of the PPD: with vehicles, equipment, staff incentives, on the job training. Recruit an architect/designer/engineer who is a specialist in health facility design in emerging countries to guide policy and strategy in the FMOH.	Continue to strengthen the PPD.	The PPD should be in a position to develop strategic physical Master Plans looking forward 10 to 20 years.
Implement a backlog maintenance programme. Recommend minimum of 10 to 15 % of retained revenue used for routine cleaning and maintenance. Budget for RHBs to include significant funds for cyclic and preventative maintenance.	Either: Develop the capacity within the FMOH through direct labour. Or (both approaches can be followed – in different areas) Tender out to the private sector using Performance-based fixed price contracts for standard packages of maintenance work.	Establish Regional Workshops for maintenance and repair. M&E effectiveness M&E effectiveness	Provide more resources to which maintenance approach is the most effective.

3.2. Human Resource Development

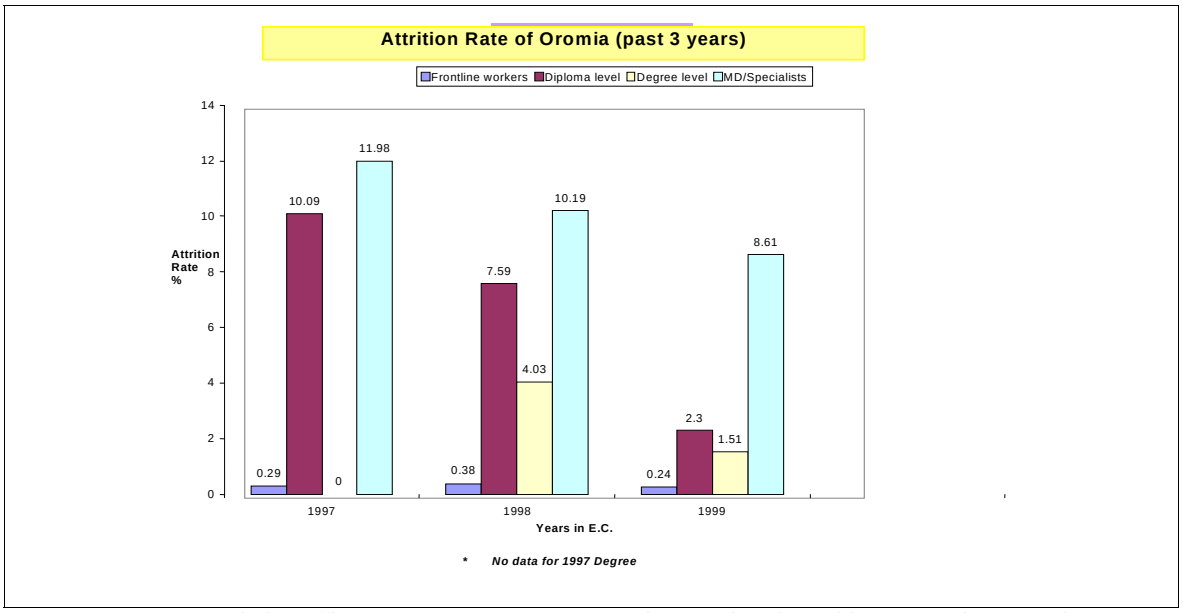
Policy & Planning

There is a strong political commitment and a vision to consider HRD a strategic issue in the HSDP III and conviction that without addressing the major bottlenecks, it will not be possible to ensure a smooth implementation of HSDP III. In the past two years, the FMOH initiated the BPR core processes that thoroughly analyzed the human resources for health (HRH) situation in the country, the preparation of a framework, drafts and background documents and international benchmarking. An implementation programme was then issued with areas of intervention in HRH management, staffing patterns and organization, education, training and skill development, retention of health personnel, policy, legal and financial framework.

In the framework of the CSRP, all civil servants' (including health sector) salaries have been updated since July 1999. However, higher categories of health professionals, like doctors and specialists received a much higher increment of up to 73% of their basic salary compared to diploma level professionals (around 20% increment). Most of the regional councils and RHBs independently started to implement their own retention policies to counteract staff migration to the private sector and abroad. There were achievements and constraints in designing and implementing retention packages, particularly to retain higher level professionals in the system. As an example, Amhara, Oromiya and SNNPR were able to show a positive trend in attracting and retaining health staff with incentive mechanisms, whereas it is still difficult to attract and retain health professionals in the emerging regions (see case study below).

Box 3.1 HRH Retention Strategy in Oromiya

The strategy was developed at the beginning of HSDP III, following a situational analysis of the Oromiya's health system organization and health service utilization and coverage. The region was thus divided into urban, semi-urban and rural zones (A, B and C) based on well defined criteria. This is a two-pronged strategy with both financial and non-financial incentive packages to motivate and retain health workforce with clear implementation guidelines. Under the financial incentive packages there are: top-ups, duty allowance, and positional allowance. Under the non-financial packages there are: improved RHB directives for deployment, transfer and release processes jointly with the classification of the weredas and improved RHB directives for on-the-job and off-the-job training with opportunities to get chance of training, being strictly linked to the classification level of the areas in which health professionals work. It is a policy that seems to fit quite well with the decentralization process and it is expected, if proved to be sustainable, to retain health workers in the public health system. Attrition rates seem to have decreased in the region in the past three years according to a recent survey on the effects of the HRD strategy. A positive trend of health personnel returning to public health system from private jobs has been observed, due in part to better training opportunities in the public system which are part of the non financial incentive scheme.



Source: Statistics office, HRD Department, Oromiya Regional Health Bureau (2000 EC)

Management

Improving HRH management at all levels has proved to be a complex and difficult undertaking. The MTR found more constraints than achievements at all levels. Except for a promising initiative on strengthening the hospital management in 30 hospitals throughout the country, there are serious problems in managing the health workforce at all levels of care. The RHBs are responsible for recruiting and the ZHBs deploy health cadres to the wereda level. Very often at RHB and decentralized levels there is absence of any HRH focal persons and the general HSDP III policy documents, including the HHM are little understood. In particular, at zonal and WORHO levels it is difficult to build capacity in terms of health management, recruitment/staff posting and updated HRH database. Identifying local staff needs at the facility level, tracking absenteeism and monitoring staff performance is limited. However, there are positive examples such as the use of performance based contracts (e.g. Tigray RHB).

Poor logistics and transportation seriously hinder proper management. High staff turnover, particularly in the four emerging regions, and an inequitable distribution of health workforce (rather than absolute shortage) are still affecting the system. Internal migration towards urban settings, private health service providers and the external flow of medical doctors to greener pastures are complicating the situation. Staff records are not updated on a regular basis and it is difficult to trace effective presence at work especially at lower levels of the health system. Health workers are often in training, in the absence of an appropriate in-service plan from the region. The uncoordinated and donor-driven provision of continuing education programmes further complicates the situation.

Staffing Levels and Deployment

Between 1994 and 1997-99 (EC), the ratio of public sector physicians (including health officers) to the population increased slightly in most of the regions except Benishangul, SNNPR, Addis Ababa and Dire Dawa. But this increase is due to the increased deployment of health officers, especially in Tigray, Amhara and Oromiya (Table 3.2).

Table 3.2 Public Sector Physicians (Including HO) per 100,000 pop. by Region

	Tigray	Afar	Amhara	Oromiya	Somali	Benishangul	SNNPR	Gambella	Hariri	Addis Ababa	Dire Dawa
1999	5.0	1.8	2.1	2.5	1.7	3.7	2.0	5.5	25.6	4.3	9.5
1998	2.8	1.4	1.3	1.2	1.5	5.1	2.2	4.4	19.4	8.1	10.8
1997	4.4	2.0	1.3	1.3	1.6	4.2	1.5	8.7	23.7	5.9	9.4
1994	3.3	1.7	1.6	1.7	1.5	5.5	1.8	10.8	22.1	9.2	12.9

Source: HHRI-FMOH

Between 1989 and 1999, targets were set for the different phases of HSDP for desired increase in human resources for health (HSDP III target is shadowed as a reference). Status of available professionals in 1999 (compared with 1989 levels) showed that none of the targets were attained despite a recorded increase in available numbers of different health professionals (except for radiographers-see Table 3.3 below).

Table 3.3 Available Human Resources 1989-1999 (EC)

Human Resources Category	Status 1989	Status HSDP I 1994	Status HSDP II 1997	Target HSDP III	Status HSDP III MTR 1999
Doctors (not including HOs	1,470	1,888	2,543	3,250	1,806
Nurses (not including midwives)	2,864	11,976	17,300	18,310	17,134
Midwives	250	862	1,509	3,570	1,012
Health Officers	30	484	776	5,000	792
Pharmacy Professionals	473	911	1,619	6,600	1,201
Laboratory Technician	621	1,695	2,837	4,200	1,816
Radiographer	139	247	491	620	87
Health Assistant	10,626	8,149	6363	n/a	3,184
Environmental Health Worker	657	971	1,312	1,650	1,109
Front Line Health Worker	12,198	10,050	11,200	n/a	1,738
Health Extension Worker	-	-	2,737	30,000	17,653

The situation with midwives is especially serious. As of 1999 there were only 1,012 midwives in the country which is inadequate considering the population size and the high maternal mortality rate. Most of the RHBs have recognized this as an issue and have began efforts to address this imbalance. For example three midwifery schools--Bahr Dar Health Science College, Gondar University and Dessie Health Science College--have been strengthened to produce midwives. In addition, 200 midwifes are being trained in Mekele.

The present staffing standards are not workload based and therefore it was not uncommon to find overstaffed (Addis Ababa) as well understaffed (Oromiya) facilities. Due to budget constraints the region cannot attain the required staff according to the agreed staffing norms. There are still too many vacant posts (usually only between 30 to 50% of the organigramme at every zonal and wereda level is filled). The ZDH are hesitant to deploy degree holders because of budget constraints in hiring qualified personnel. As a consequence, the sector is mainly deploying middle level health workers rather than degree level health professionals. This makes it difficult to raise the quality of services. In addition, motivation and morale of staff is rapidly declining because practice is done in poor conditions with facilities that have low volumes of activity. This is fuelling internal migration from the rural areas to the main

towns and to more affluent regions. External migration in Ethiopia applies mostly to highly skilled health workers.

With the serious lack of midwives in the country, some of the HEWs themselves as well as other more senior health workers are beginning to feel the need to make the HEWs perform some deliveries. Since maternal mortality is mainly due to complications of pregnancy and delivery, it is unlikely that the HEWs in their short training have any positive impact in reducing maternal deaths.

Capacity Building

Building the capacity of the sector to deal with the health needs of the population is a multi-faceted endeavour, which requires an inter-sectoral approach and a substantial financial support. Given the difficulties in keeping pace with population growth and the requirements to attain MDGs, an emerging issue is also the need of implementing appropriate levels of task shifting, among health cadres.

The RHBs do set an annual capacity-building budget, but most, if not all the funds are allocated for training and in-service training programmes of physicians. Most of the regions revised the structures of health facilities and nursing schools, which have been upgraded to Colleges. Upgrading training courses are almost complete in different regions and will bring junior and senior health assistants (certificate level) up to nursing diploma level. There are constraints in the capacity-building approach. In conflict prone zones, some forms of on-the-job training are led by NGOs. As it has been verified especially in term of HRD and financial resources, the impact of vertical programmes and targeted campaigns on staff utilization and remuneration is likely to produce distraction of HRH and disruption of basic health care deliveries at community level. There are growing concerns for greater programme integration between priority diseases initiatives and underlying health care delivery.

Training Schools

When the outputs of health worker institutions between 1996 and 1999 (EC) are compared with the period 1991 to 1994 (EC) the numbers of health workers produced by the various training institutions showed an increase in numbers of medical doctors, health officers, pharmacists, BSc nurses, senior and junior clinical nurses, junior radiographers, junior environmental health technicians and senior midwife nurses. In all these professional groups there were a higher proportion of female professionals produced (except for junior clinical nurses). On the other hand, there was a decrease in outputs of junior midwife nurses, junior pharmacy technicians, senior and junior lab technicians, senior environmental health technicians and senior radiographers. In this group, there was decrease in the percentage of female graduates except for senior environmental health technicians and senior radiographers where there was an increase (Table 3.4).

Table 3.4 Output of Graduates from Various Training Institutions

Categories of Graduates	1991-1994		1996-1999		Difference between 1991 and 1999	
	BS	F	BS	F	BS	F
Medical Doctors	517	51	939	108	81% increase	110% increase
Health officer	511	89	1584	279	200% increase	210% increase
Pharmacist	118	18	226	63	91% increase	250% increase
Nurse BSc	79	32	435	196	450% increase	510% increase
Senior Clinical Nurse	1355	741	5450	2689	300% increase	260% increase
Junior Clinical Nurse	1414	997	2978	556	110% increase	44% decrease
Senior Midwife Nurse	120	112	237	140	98% increase	25% increase

Categories of Graduates	1991-1994		1996-1999		Difference between 1991 and 1999	
	BS	F	BS	F	BS	F
Junior Midwife Nurse	695	350	97	66	86% decrease	81% decrease
Senior Pharmacy Technician	335	54	n/a	n/a	n/a	n/a
Junior Pharmacy Technician	263	60	39	12	85% decrease	80 % decrease
Senior Lab Technician	982	89	241	23	75% decrease	74 % decrease
Junior Lab Technician	448	134	422	105	5% decrease	20% decrease
Senior Environmental Health Technician	729	82	515	97	29% decrease	18% increase
Junior Environmental Health Technician	51	11	514	64	900% increase	480% increase
Senior Radiographer	52	2	25	3	52% decrease	50% increase
Junior Radiographer	21	0	46	4	110% increase	400% increase

The midwifery training schools have a number of problems which have a negative effect on the quality of training. The training institutions are not involved in the selection of students for training, the staff-to-student ratios for practical training of midwives is poor and the caseload for maternity practice is low as many health institutions reported a very small assisted delivery rate. Tutors for health workers lack updated courses to improve their skills and teaching methodologies, while the new curriculum for midwifery training does not include neonatology.

Quality control of training seems to be outside the jurisdiction of the RHBs and rather under the control of the regional education bureaus.

The curriculum for generic clinical nurses and for the other 10th grade +3 health professionals is said to have problems in the implementation and there is a general lack of capacity for adequate skills practice for the different categories of trainees. The previous year's shortage of mid-level and upper level health cadres has been diminishing due to the increase in overall production of health professionals, but the operational budget at training institution level is considered inadequate. The teaching/learning process at all level of training is seriously affected by the tremendous rise in student in almost all the training Colleges. Insufficient and inadequate resources and shortage of practical demonstration facilities hamper on the job skills training. The apprenticeship programme is incomplete and unsatisfactory, especially for HEWs at the TVET level. Health staff are given incentives to enrol in private schools. These private colleges are often not accredited in terms of standard quality assurance. Also the medical education curriculum has shortcomings and gaps especially in surgical and obstetric emergency skills, community-based health care and health management.

Common constraints at mid-level training level are:

- Recruitment at lower educational level faces language barrier issues;
- Inadequate budget allocation space and infrastructure lack of reference materials and textbooks and demonstration equipment.
- Overcrowding of students from public and private institutions competing for resources;
- Poor logistics and transportation at College level.

In-Service Training

A standard, coordinated in-service plan at regional level has not yet been developed and the different opportunities for training and updated coursework are mostly donor-driven. Relevant and badly needed in-service training programmes such as B/CEmONC courses need more stakeholder coordination and a better reporting system.

Major problems were found in uncoordinated efforts for delivering training and evaluating the impact on the role, position and performance of the trained personnel. The lack of planning for the replacement of staff away during long periods was a frequent observation. This affects the overall health service delivery at all levels of the system and causes a loss of institutional memory. On the other hand, as part of some regional retention packages, training opportunities and access to higher levels degrees (e.g. BSc, MSc) has proved to be effective in attracting and bringing the health workforce back to the public system. The programme for continuing education should be reinforced at the national level and owned and implemented at RHBs level.

The quality of various in-service and pre-service trainings is affected by lack of updated curricula and training methodologies and by the huge number of the staff to be trained. There is a need to establish a balance between the need of flooding the system with new HRH and the need for competent health care delivery for the people at all level of the referral system.

Gender and Training

Although the attention that has been paid to increase the proportion of female students in the country during HSDP III is commendable, especially thanks to the HEP and to some adopted new recruitment criteria (e.g. new midwifery training exclusively given to female students in SNNPR and Tigray), the general situation has to be further improved to reduce the existing gender imbalance.

As an example, of the graduates from the six public universities and the Defence College in 2006/07 (GC), only 18% were female. Looking at the regional, zonal and wereda health workforce, it is evident that the gender imbalance has not yet changed with the HSDP III and will have to be addressed with more focus in HSDP IV.

Conclusion

It is quite clear that there is no "blueprint" or magic recipe for HRD. Other country experiences may be useful for benchmarking, but have to be adapted to the local specific context. The HSDP III seems on track in accelerating the production of relevant health staff, but it is far from fulfilling the needs of a growing population that has diverse customs and traditions and is at different stages of human resource development. Moreover, the quality of training suffers because of minimal attention and capacity given to the time and modality of apprenticeship, internship and practical training at all levels of care.

Since the HRD solutions depend on a robust financial support by the GOE and Development Partners, it is mandatory to explore, the recurrent and capital sector investment scenarios and the aid effectiveness to target HRD. It is time to gather evidence and examples to assess aid effectiveness constraints in scaling up HRH within the country context and to identify how best it can be improved to address HRH issues.

Table 3.5 Recommendations to Strengthen Human Resources for Health

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Policy and Planning	Finalize the HRD strategy. Bring quality issues into training targets. Improve coordination and effectiveness within HRH and the in-service training programmes	Build the capacity of the RHB, wereda and zonal facilities in leadership and management (including financial) skills. Finalize the restructuring of the HRD within the FMOH.	Establish HRIS/HRH database for professional working in both the public and private sectors.
Management and Deployment	Consolidate and institutionalize the existing	Develop an official dissemination process for all	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term within HSDP III	Long-Term Design HSDP IV
	retention scheme.	documentation and guidelines including availability on FMOH website	
Capacity Building	Map and monitor the overall in-service training programme especially for areas like IMCI and child health; maternal health, BEmONC, HIV/AIDS/TB.	Introduce twinning arrangements to support newly trained CEmONC teams.	Introduce HEP and PHC elements at primary and secondary school level.
Training Schools	Develop a comprehensive plan to improve the HEW training curriculum in the TVETs. Initiate improvement in midwifery training through (a) training of trainers (b) upgrading service quality in practical training sites	Improve HEW training with particular care to the practical sites for students, strengthening the cooperation with other stakeholders, including the traditional health resources at community level (e.g. TBAs, healers and herbalists). Request more inputs from the regional education bureaus on the selection of trainees, curriculum development and quality of training	Plan a mid-long term revision of curricula, especially those for generic diploma nurse and for HEWs. Improve quality of training and standardize qualifying exams for all health professionals to ensure same standards of practice, irrespective of training institution.
Pre-Service and In-Service Training	Accelerate training in rare skills through B/CEmONC and MD training.		Train health officers in MSc programmes for surgical and obstetric emergencies.
Continuing Education		Set up boards/councils to start re-registration assessments for all health professionals to ensure continuous education.	Begin re-registration of all health professionals based on recommended continuing education.

3.3. Pharmaceutical Supplies and Logistics

Policy and Legislation

Legal basis for the pharmaceutical sector in Ethiopia is the National Drug Policy (1993), which is currently being revised by DACA. The draft Ethiopian National Drug Policy (ENDP) is awaiting government approval. One of the omissions in the 1993 document for instance is the lack of guidance on the disposal of expired drugs, leaving it to lower administrative levels to come up with their own policies and practices.

To resolve the deficiencies of the pharmaceutical logistics system observed in the previous years (indicated as a strategic issue in HSDP III), the FMOH initiated a comprehensive reform initiative. Accordingly, a national pharmaceutical sector master plan (PSMP) and a pharmaceutical logistics master plan (PLMP) were developed by DACA and PSLD, respectively. These two documents were later merged and submitted to FMOH management though response is yet to be received. However the PLMP, aimed at establishing a harmonized and efficient system for procurement and distribution of essential health commodities to the public health facilities, was officially approved and launched in October 2006 (GC). While some important milestones were achieved (proclamation of the Pharmaceutical Fund and Supply Agency being the most important one), delay in equally important areas such as the recruitment of staff and team leader for the Implementation Support Team, preparation of essential health commodities list, quantification and costing of health commodity requirements, and assignment of a Board for PFSA, will make it difficult to reach the objectives set out in the Plan of Action for Year 1 (ending June 2008). Delays also occurred regarding the institutional transformation processes. PFSA, PSLD and DACA went through a BPR exercise, revealing overlapping activities, which need to be resolved in such a way that the mandate of each party is clearly defined.

In line with the on-going process of decentralization, regions and health facilities will need to get more involved and informed of the PLMP to create a sense of ownership and to avoid duplication of efforts in implementation. Knowledge at the RHBs of the changes that the PLMP will bring about is limited and sometimes purely anecdotal (“PHARMID came to look for a plot of land to build a warehouse”), but there is a general expectation that the PLMP will solve the chronic problems, from the kebele to the region, of drugs stock-outs, inadequate storage conditions and insufficient distribution capacity.

Procurement, Tendering Process and Resource Mobilization

Supplies get to the final user through four main channels:

1. Regular programme supplies for EPI, treatment of TB/leprosy, malaria control, family planning, EPR, and HIV/AIDS commodities are received by the RHB and forwarded down the system; or directly supplied to the health facilities.
2. RHB secures or obtains additional supplies for specific emergencies;
3. Other partners (NGOs, FBOs) supply directly to the health facilities or programmes they support;
4. Health facilities buy supplies for other regular programmes.

RE (1): Procurement situation for vertical programmes is very complex with a number of USG-sponsored projects, UN agencies and government departments (PFSA and PSLD) involved as procurement agents. The procurement processes have to be streamlined and capacity of PFSA to take over the bulk of the procurement must be strengthened. In this context, PFSA is finalizing the BPR exercise that includes the study on the procurement sub-process under the supply core process. After considerable delays, a procurement agent (Crown Agents) has been contracted to PFSA and will be handling procurement activities

initiated by PSLD. Procurement through UNICEF is based on a general MOU with the GOE and specific MOUs for World Bank-funded procurement (PBS/C1).

A key challenge is the long and complicated international competitive tendering procedures of the World Bank procurement guidelines and the lack of training in World Bank procedures. Federal level procurement is also hampered by tax issues, shortage of qualified staff and a communication gap between various departments in the FMOH. PFSA has a plan to develop its own procurement guideline, under the framework of the national procurement guideline of MOFED, as it is mandated to do so by law. With exception of possible special conditions for some donor funds, there should be no obstacles to develop and implement a standard PFSA procurement guideline.

For the initial capitalization of the revolving drug fund (RDF), PFSA has secured 14 million USD from GAVI and PBS. PFSA has also placed an additional request for 100 million ETB (10 million USD) to the federal government. This is far short from the 81 million USD needed for the first two years (based on 2 USD per capita for drug expenditure). Most vertical programmes also take care of distribution, either directly or through PFSA. UNICEF is delivering an estimated 10,500 health post kits, including full service delivery (assembling, training in use of equipment). The purchase of 800 health centre kits through UNICEF is underway. An additional 7,000 health post kits and 705 health centre kits are being procured through PFSA (World Bank funding). The sheer volume of the orders and issues with tax settlement are putting a burden on the supply chain. HIV/AIDS commodities are being distributed to health facilities by USG partners.

Re (3): Procurement by NGOs and FBOs is very diverse and is based on their own guidelines and systems.

Re (2 & 4): As a result of the GOE decentralization process, procurement has devolved to WORHOs and health facilities, assisted by DTCs. Supplies are still mainly procured from PFSA. When supplies are not available at PFSA, procurement is done through private suppliers based on a comparison of at least three quotes and (physical) inspection of the goods. Purchase from the private sector is a complex issue as health facilities need to have an 'out of stock' confirmation from PFSA, which is usually difficult to get. For some drugs PFSA is the sole distributor, resulting in stock-outs when the supplies are not available at PFSA. The same procedure applies to the procurement done by the regions either for emergencies or on behalf of the facilities in their area (Re (2) above). Of concern is the late release of (insufficient) budgets for procurement, the lengthy procedure, and the absence of proper quantification, all contributing to stock-outs or expiring of drugs.

Availability of Essential Drugs and Rational Use

Many guidelines have been developed, revised and distributed to users by DACA, including the National List of Drugs for Ethiopia, Ethiopian National Formulary, Good Dispensing Manual and Good Prescribing Practice Manual. The national Standard Treatment Guideline is also under revision. Drug evaluation and registration guidelines and Adverse Drug Reaction reporting guidelines for traditional medicines have also been developed and disseminated. To institutionalize promotion of rational drug use, DACA has been trying to organize DTCs and drug information centres at public hospitals. So far, 56 hospitals established DTCs and all the necessary materials that are required for DICs have been purchased and imported. Observations from the field show that the available guidelines are not widely used; more training and dissemination is needed. Antibiotics tend to be over-prescribed in some of the sites visited. Although DACA is expanding its coverage, counterfeit and illegal drugs remain a major challenge. Inspection coverage of drug trading facilities is difficult to estimate. However, scaling up the effort from 20 to 100% within the 5 years of HSDP III seems unlikely to be achieved.

Stock-outs of some essential drugs, laboratory consumables and other supplies were observed at many public health facilities by the regional teams, but the general impression is that shortages are not as severe as in previous years. Stocks outs at health facilities are due to: long lead times for procurement, not available at PHARMID, receiving drugs on the verge of expiration from higher levels (for vertical programmes), weak information and storage systems, budget limitations, and shortage of transportation to fetch new consignments. Over-supply of some drugs (e.g. coartem) was observed in some sites, resulting in wastage. Availability of drugs at facilities managed by NGOs or CBOs tends to be less problematic.

Given the rapid expansion of health facilities in the country, reaching the target of 80% availability of standard medical supplies and equipment in all public health facilities will be a challenge, despite the considerable efforts of the FMOH supported by GHIs and Development Partners to fill the gap.

The introduction and rapid expansion of special pharmacies has significantly contributed to the availability of essential drugs, to stabilizing prices, to improved quality of care, and has served as pilot projects for implementing some components of the HCF reforms such as health facility autonomy and facility level retention and use. In Addis Ababa, special pharmacies have been replaced by Kenema pharmacies, but the revenue generated is not used to improve the health facilities. In SNNPR, budget pharmacies have been merged with special pharmacies. Further expansion of special pharmacies is one of the strategies to reach the HSDP III target of 100% availability of essential drugs, but it is not clear how this will impact access to drugs and supplies, if other mechanisms such as fee waivers are not implemented at the same time. It was observed that in some facilities, basic medical services were provided for free (under the waiver system), but patients were still charged for extras (drugs, lab tests, deliveries).

Logistics Management

PFSA is planning to expand its network by renovating five existing hubs, by constructing an additional six regional hubs and seven secondary hubs. Out of the 16.5 million USD required, only 8.9 million USD (Global Fund and GAVI) has been secured so far and PFSA is exploring other possible sources of funding. One option is to rent warehouses with the help of Development Partners. A technical task force has already been organized to help identify appropriate locations and warehouses. Vehicles are being procured with the help of Partners.

It is not clear whether even the existing regional hubs will be ready by the end of 2008 (GC) to take up their new duties. The institutional transformation process conducted at central level has not (yet) been replicated at regional level. Staffing levels and composition at the PFSA hub in Awassa for instance has not changed in the last years; warehousing, dispatch and transport capacity are still the same, despite an already increased workload. The Awassa hub is planning an expansion of the warehouse and cold room on the compound and to enlarge the EPI cold store at the RHB.

The quality of logistics management at all levels ranges from excellent to very poor. Many new regional and zonal warehouses have been built in recent years. Weredas also try to catch up with the requirements for storage space at health centres to receive supplies directly from PFSA, in some cases by adding a common store to the WORHO until each centre can be equipped with its own store. Availability of adequate storage space is not that acute anymore, but there is still a problem with the (physical) organization and management of the space. Very few of the stores (visited) have pallets, shelves or racks and none had handling equipment. Expired items or broken equipment take up valuable storage space. The design of some of the recent constructions is not appropriate for warehouse use (steps, split levels, small rooms, inappropriate ventilation, and reliance on A/C where electric power is not available).

Almost all warehouses had an inventory control system ranging from simple bin cards to a complex computerized system, but very few were operational and reliable. Some of the problems observed include: outdated information, no indication of min/max (and thus of no use for forecasting and ordering), no regular physical inventory, no indication of expiry dates or batch numbers, and no application of FEFO (first expired first out). On many occasions, keeping carbon copies of models 19 and 22 is confused with running a proper stock management control system. There was also a lack of direct supervision of the store keepers. Overall, strengthening of the inventory control systems is needed to help to prevent theft and pilferage.

Cold chain maintenance comes out as the number one problem in every region. Kerosene fridges require constant attention and maintenance, and staff members do not possess the necessary skills or show any committed to maintenance. Spare parts and kerosene seem to be in short supply or do not get distributed to the health facilities. Recent power rationing has caught facilities by surprise; some types of refrigerators are for domestic use and shouldn't be used where no sufficient backup power is available. In some regions and hospitals, new cold rooms are being installed for storage of ARTs, but it's not clear if they could also be used for EPI. Daily monitoring (followed by corrective action) of temperatures should be applied as a standard practice at all levels.

Maintenance of medical equipment in general is not handled in a standardized way. None of the RHBs visited had set up a regional medical equipment workshop (target of HSDP III), but one region (SNNPR) opted for an alternative strategy by deploying trained technicians to zones and health facilities.

Transport is another common constraint for health managers. Motorcycles, cars and trucks are too few and transportation budgets to pay for fuel (and maintenance) are not sufficient or are released late. Shortfalls are sometimes compensated with cash or in-kind contributions from donors or NGOs (e.g. fuel during campaigns or trucks for distribution of donated items).

Capacity Building

The support of partner organizations and donors to the pharmaceutical sector is shifting from specific programme support to supporting the PLMP and institutional capacity. FMOH, with the help of partners, developed an accountability matrix that maps stakeholder involvement towards building the system and institutional capacities of DACA, PSLD and PFSA. In this regard, partners have been providing significant technical and financial support to the government organizations. For instance, PFSA is getting a lot of support in areas like warehousing, distribution, short-term technical assistance, training, system design and transportation/fleet. DACA is also getting support in areas of expanding its regional coverage (opened five regional offices), strengthening the drug quality control laboratory, short-term technical assistance, trainings, promotion of RDU, containment of adverse medical reaction and establishment of mini-labs in the regions. Health facilities are also getting assistance for improving store management (organizing and inventory control systems).

It is estimated that the full implementation of the PLMP would require the mobilization of around USD 200 million. The main challenge will be to secure sufficient funding from Development Partners and GHIs for the coming years of implementation and for capitalization of the RDF. If Development Partners are not kept informed or involved, there is a real risk that they will lose interest. Some recent developments/changes in roles and responsibilities of government institutions demand revision of the accountability matrix developed in April 2007.

In preparation of the full implementation of the PLMP, training activities in drugs supply management are needed at all levels, with an extra focus on the integration of training on

LMIS with training on store management at facility level. In many occasions there is a lack of qualified staff or pharmaceutical staff in carrying out logistics duties for which they have not been trained. There is also a need for support personnel to input/manage logistics data at health facilities. Due to attrition and high staff turnover, training will need to be continuous. While training and capacity building is essential, it will only be effective with proper supporting mechanisms, refreshment courses, consistent monitoring and follow up in place.

Recommendations

Table 3.6 Recommendations for Pharmaceutical Supplies and Logistics

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
PLMP	Get regions and health facilities involved in the PLMP to stimulate ownership and commitment. Finalize institutional transformation process (as per the BPR outcome). Revise accountability matrix.	Maintain good cooperation with partners to keep implementation of PLMP on track and to secure sufficient funding for year 2 to 5.	Use (well-documented) lessons learnt from PLMP design and implementation.
Policy and Legislation (other)	Endorse and launch the PSMP. Develop a national obsolete pharmaceutical disposal policy/ guideline.	Implement PSMP.	
Procurement	Finalize PFSA procurement guideline.	Harmonize procurement processes with all actors. Build capacity of PFSA to carry out bulk of procurement.	
Availability of Essential Drug and RDU	Accelerate establishment of DTCs and DICs in support of weredas and health facilities. Disseminate printed materials and guidelines to all levels.		
Logistics Management	Give high priority to maintenance of cold chain and medical equipment in general through rapid deployment of technicians. Finalize design of LMIS and implement nation-wide.	Try out more innovative ways for maintaining the cold chain at lower levels (e.g. put guards or caretakers in charge).	Revise target for medical equipment maintenance workshops, in line with more practical solutions tested out in some regions.
Capacity Building	Prioritize training and capacity building in supply chain and logistics management at all levels. At facility level, combine training in LMIS with store management training.	Continuous training in supply chain and logistics management.	Continuous training in supply chain and logistics management.

3.4. HMIS, M&E and Operational Research

Health Management Information Systems (HMIS)

Achievements

The record keeping of service delivery and display of data in form of graphs and charts are excellent in almost all health facilities, Weredas, and ZHDs. Most facilities that were visited during the review did not have all the data collection tools. Yet, the established record keeping systems were fully maintained by making necessary rows and columns on plain registers. Ideally, the HMIS reform process should have been simultaneously started with helping them to analyze available data and demonstrating their use in improving quality of management decisions.

It is commendable that the PPD at FMOH has been publishing since 1992 (EC) the Health and Health Related Indicator (HHRI) annual booklet showing comparative data by region on a number of indicators. It provides information to compare the performance status of different regions over time - even though the data quality in the current system varies from region to region.

The GOE has adopted the BPR to improve the design, implementation, and management of services. The objective of BPR for HMIS was to design a system that will improve informed health decision-making at different levels of the health system through the utilization of complete, timely and accurate heath information. HMIS reform started with the assessment of the existing situation. The findings were shared with all stakeholders in the health sector. Subsequently, indicators were selected that adequately address the monitoring requirement of various key health programmes. This was followed by the designing of data recording and reporting tools that helps to generate the required indicators. In order to facilitate the proper utilization of the HMIS tools, training materials and guidelines were developed. All these processes have been accomplished through a wide-ranging consultative process, including all stakeholders from the government, health development partners, NGOs and private sector. Subsequently, the tools were pilot tested and finalized. Finally an evaluation was carried out in December 1999 (EC) which found the system appropriate for scaling up and therefore recommended for nationwide roll out with a few minor adjustments.

Tulane University has been tasked with the training of all 45,000 health and support personnel nationwide. It has a plan to hire around 200 master mentors, train, and deploy them to different health facilities for a period of 1-1½ year. The master mentor will undergo 3-4 weeks training before they are deployed to different facilities. The first batch of 24 mentors is already in training. They will be deployed among five regions from where roll out of new HMIS will be initiated. The current plan is to start implementation of new HMIS in all regions by August 2000 (EC). A residential mentor from Tulane will remain at the facility for a year providing practice-based training on analysis, dissemination and use of information in rationalizing management decisions.

Substantial resources will be needed for implementation of new HMIS. These resources include huge capital investment in training and infrastructure. The FMOH has already allocated 6 million dollars for starting of HMIS from five smaller regions. It is anticipated that development partners will help meet these resource needs. For a sustainable HMIS reform, a reliable method for meeting recurrent expenses must also be found.

Constraints

Though during the last 2½ years, improvements have been made on the quality of data collected, their analysis, interpretation and use in planning and management of health services are not yet satisfactory in comparison to their potential for improvements.

The nationwide rolling out of the system is a massive undertaking. The requirements of human resource, finance, materials and infrastructures are enormous. The new HMIS envisages incorporating a single reporting form, maintenance of an integrated card folder, and computerization up to the lowest possible level. All these characteristics have serious resource implications. There seems to be a gap between the available and required financial resources to implement the new HMIS nationwide. Implementation of the new HMIS will require a range of changes in legislation, organization, management and culture. This will present significant challenges throughout the sector; effective change management processes will be of particular importance. Therefore, it is essential that a clear and supportive legislative and information governance framework be established, not only for appropriate management and use of health information, but also for bringing the private sector into a mandatory reporting system.

Management information subsystems like logistics management information system (LMIS), human resource management information system (HRMIS), financial management information system (FMIS), and physical assets management information system (PAMIS) are expected to feed information to HMIS. However, the development of these sub-systems is not included in the current HMIS strengthening plan. Without strengthening these sub-systems, the new HMIS will no become comprehensive and effective.

It is in the interest of the health sector and its stakeholders that the new system be in place nationwide in shortest possible time. Reporting in the new integrated form should start in all facilities nationwide at the same date. There seems a gap between the available and required funds to roll out the new HMIS nationwide.

Table 3.7 Recommendations for HMIS Implementation

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Funding	Ensure adequate funding for implementation of new HMIS nationwide before going ahead with its roll-out.		
Implementation	Implement the new HMIS in entire country as soon as possible and start reporting on new indicators using new reporting form at the same date nationwide.		
Computerization		Introduce computerized systems in the FMOH, RHB, ZHD and big hospitals. HMIS data processing at HC and WORHO should be computerized only after demonstration of best practices on information use.	
Legislation	Finalize the draft health information bill and present to the legislative body for approval. The health information legislation should encompass, among other		

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
	things, reporting requirements of government and private facilities, notification of disease, data release protocol, and information authority.		
Target Population	Engage Central Statistical Authority to derive population for different target groups by kebeles for each wereda and make it available to them through their RHBs.		
Strengthening Sub-Systems		Develop and implement LMIS, HRMIS, FMIS, and PAMIS at all levels.	

Monitoring and Evaluation (M&E)

Achievements

The M&E system has improved generally at all levels. Major improvements include (i) the development of annual core plan (at all levels) with comprehensive set of indicators and annual targets on major priority areas, (ii) the development of standard reporting format based on the common set of core indicator; (iii) the monitoring and consultation forum created by the regular meeting conducted bimonthly between the management of FMOH and heads of RHBs; and (iv) the introduction of recognizing the best practice among regions.

Constraints

The guidelines on how to conduct periodic reviews at different levels, who to involve and which contents are to be considered in the review are not always followed.

Supervision visits are not always carried out on a quarterly basis as planned, mainly due to human resources, financial, and logistic constraints. Quality of integrated team supervision is also poor. So-called integrated supervision checklist are not complete, biased towards some well established programmes, focused on data collection rather than exploring the problems and their causes, more on fault-finding rather than helping to identifying the options to resolve them.

There is limited familiarity with the HSDP III and indicators at regional, Wereda, and health facility levels. As a result there is a gap in collecting the necessary information for comprehensive monitoring of the HSDP indicators. This issue was raised in the final evaluation of HSDP II, but no response has yet been given on this issue.

In the context of decentralization and health sector reform, new demands for monitoring the performance of the health sector have emerged, with clear statements on planned targets and measurement of actual achievements. This requires explicit standards for measuring performance, clear specifications of the relationship between inputs and outputs, and use of valid indicators to compare the actual achievements with the planned targets. In this perspective, performance monitoring should rely on a minimum set of key sector-wide indicators, as suggested in HSDP III and focus on the implementation of the activities and the intermediate steps that determine how inputs are transformed into outputs.

The information collected regularly from the health facilities through HMIS focuses only on the physical performance and there is limited information on the financing part. The budget structure, in which funds are allocated to expenditure categories (e.g., salaries, electricity,

fuel, medicines, rent), does not allow for detailed budget and expenditure analysis to evaluate efficiency and effectiveness of specific health programme. Hence, the evaluation practice so far is limited to sector/programme external reviews, like this MTR. The sector has not yet an inbuilt periodic evaluation mechanism.

Box 3.2 Reliability of HMIS Routine Data

For a number of reasons explained below, the data presented in this report may not necessarily represent the reality. Wereda health offices do not always include reports from all health centres and posts in their monthly report, due to late submission or non-submission. Due to the fragmentation of vertical reporting systems and non-existence of recording of reporting coverage, it is difficult to adjust the value of under-reporting into aggregated performance data. Most performance data presented in this report are derived from official publications of FMOH, mainly from the HHRI booklet. While the booklet is an indispensable resource, the data in the booklet contain a few inconsistencies.

- The sum of the regional aggregates is not always the same number as the national total, because of rounding of numbers. It is expected that the introduction of a common definition of the indicators and population estimates in 2006, will ensure standardization of procedures and comparability of results.
- The population for different service target groups has been derived from the 1994 census with subsequent likely discrepancies between the 1994 census projections and the 2005 census figures. An example can be cited from the 1999 HHRI booklet which presents less numbers of under-one children than surviving infants.

Table 3.8 Recommendations for Monitoring and Evaluation

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Supervision	Use integrated supervision guidelines and checklist for each level for supportive supervision and make them available at all levels.		
Budget		Allocate adequate budget for supervision, quarterly and annual reviews, and feedback.	
Performance-Based Recognition		Introduce performance based recognition and reward (institutional) for best performers, who have implemented the core and comprehensive plan. Define clear criteria that take into account both outputs and inputs.	

Operational Research

Achievements

The Medical Faculty of the Addis Ababa University is currently undertaking a study on the prevalence of cervical cancer and the causes of maternal mortality. Similarly, findings of a study on coverage and impact of the EPI should be available soon. Another study on the effect of misoprostol towards reducing maternal mortality associated with postpartum haemorrhage was underway in some health facilities.

There is anecdotal evidence of numerous operation researches recently completed or currently underway in different hospitals under direct donor funding. However, there is no mechanism/authority that can tell the exact amount of completed, on-going and planned operation research.

Constraints

- No mechanism yet established at FMOH and RHB to coordinate operation research.
- There is a lack of operation research strategy and plan.
- FMOH and RHB do not have adequate capacity to facilitate operation research.

Table 3.9 Recommendations for Operational Research

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Develop Strategy and Plan	Develop a national operations research plan for the remaining period of HSDP III.		
Capacity Building	Strengthen capacity in the FMOH and RHBs to facilitate planning, designing, implementing, publishing and dissemination of findings.		
Coordination	Develop appropriate mechanism at federal and regional levels to coordinate operations research.		
Stocktaking of Completed Operations Research		Compile an annotated bibliography of all operation researches carried out in Ethiopia in last five years. Disseminate to relevant stakeholders.	

4. Finance and Governance in HSDP III

4.1. Financing the Sector

This section heavily relies on the costing and financing estimates made during HSDP III and relate it to the best available evidence on allocated budgets and expenditure available to the MTR team. It is important to note that it proved difficult to present a comprehensive picture of financing in the health sector, as budget and expenditure figures cannot be fully captured in the existing system. Currently what can be analyzed, with some degree of confidence, are resources flowing through channel 1, channel 2 to FMOH and to a limited extent channel 3. Most of the resources coming through channel 3, like PEPFAR, NGOs and out-of-pocket expenditures are not captured. Hence the following description shows only half the picture of health financing. With these caveats, the analysis made was based on data from MOFED and FMOH.

HSDP III has two major components regarding health care financing: implementing health care financing reforms and costing and financing of the sector development programme. The programme was budgeted using the Marginal Budgeting for Bottlenecks approach under three scenarios.[44] It has projected the total cost of the programme to range from 17,129.8 ETB (or 1792 million USD) to 45,889.4 million ETB (or USD 4800 million). In other words, the estimated average per capita cost of the programme ranges from 44 ETB (or USD 4.6) per year under scenario one, to 117.4 ETB (12.2 USD) under scenario 3. Similarly, the estimated resources that will be available to finance the program have also been estimated.

Table 4.1 Estimated Cost and Financing Plan of HSDP III (in ETB million)

	EFY 1998	EFY 1999	EFY 2000
Estimated Costs			
HSDP III Costing: Scenario 1	2,818	3,247	3,800
HSDP III Costing: Scenario 2	4,071	4,639	5,433
HSDP III Costing: Scenario 3	5,078	6,102	7,385
Projected Financing Plan			
Government	945.4	1023.3	1152.4
Global Fund & GAVI	701.5	851.8	1040.3
Sector Specific Donors	660.2	699.2	767.4
Projected funding*	2307.1	2574.3	2960.1
Projected Gap (scenario one)*	380	446	512

* The projected contribution of NGOs/private sector and out-of-pocket expenditure is not reflected in the table above. Source: HSDP III.

[44] Scenario one involves roll-out of the HEP, with the establishment of two HEWs and a low-level health post for each kebele over the next five years, as well as upgrading of health centers and limited upgrading of hospital and curative services; Scenario two involves full implementation of the AEPHCC, and gradually increasing access to health centres to 94% of the population in five years, and significant expansion of hospital coverage. Scenario three is based on the MDG Needs Assessment *and* involves full attainment of all targets, without resource constraint.

In the area of health care financing reform, the programme has set a number of objectives to be achieved in the coming five years. They are summarized in the table below together with their mid-term HSDP III achievements.

Government Allocations to Health

The government both in the HSDP III document and PASDEP committed itself to gradually increase health spending to facilitate greater access to better quality health care. It was estimated that a total of 945.4 million ETB, 1023.3 million ETB, and 1152.4 million ETB will be allocated to health for 1998, 1999 and 2000 (EC) respectively. The total budgeted amount in the same period was 1.8 million ETB, 1.5 million ETB and 3.9 million ETB. It was also estimated that the share of health budget from total government budget will double during HSDP III. While there is an increase in allocation of budget to the sector, the share of health from overall government budget, for 2000 for instance, is at 7.5% and 12% of poverty reduction targets. But if only one only looks at the proportion of health budget at regional levels, where service delivery budgets are decided up on (excluding federal allocations), this has reached 9 percent.

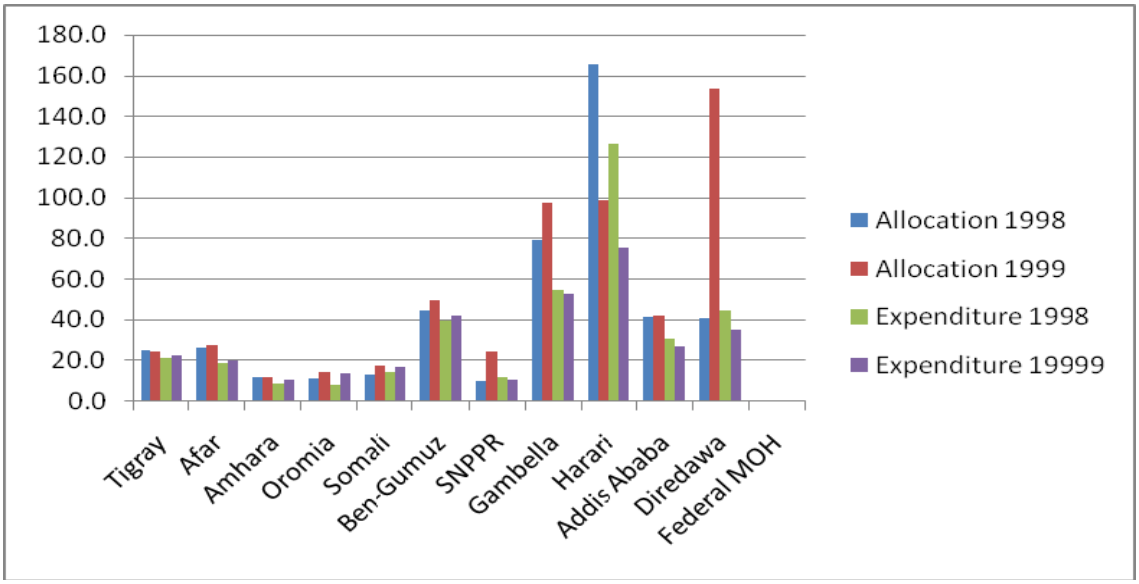
Table 4.2 Budget Allocation and Expenditure (ETB) by Region, 1997-2000 (EC)

	EFY 1997		EFY 1998		EFY 1999		EFY 2000
Region	**Budget**	**Expenditure**	**Budget**	**Expenditure**	**Budget**	**Expenditure**	**Budget**
Tigray	107,940,000	76,853,000	126,831,630	107,060,550	108,290,000	102,050,000	149,478,677
Afar	36,340,000	30,405,608	46,578,553	40,439,300	39,700,000	28,270,000	48,810,905
Amhara*	228,870,000	165,166,739	211,773,914	179,796,057	235,700,000	214,110,000	352,434,000
Oromiya*	300,320,000	210,505,205	290,289,568	253,932,299	399,140,000	379,860,000	643,138,208
Somali	56,770,000	33,787,715	56,014,876	46,878,407	78,340,000	76,760,000	127,210,258
Benishangul Gumuz	28,050,000	20,777,041	14,133,439	13,972,334	31,690,000	27,000,000	30,856,884
SNNP*	149,210,000	146,299,714	259,557,543	202,453,164	375,540,000	163,260,000	449,907,112
Gambella	19,590,000	11,710,250	16,810,627	17,836,260	24,710,000	13,310,000	14,712,721
Harari	32,500,000	15,866,466	21,091,962	18,767,201	20,110,000	15,270,000	19,902,800
Addis Ababa	124,240,000	65,846,236	112,787,994	77,702,371	129,070,000	82,040,000	212,317,378
Dire Dawa	16,210,000	12,323,484	14,625,295	12,752,728	63,380,000	14,450,000	37,552,987
Federal	158,100,000	510,910,000	599,835,374	530,362,518	44,622,900	31,402,798	1,805,456,720
National	1,258,140,000	1,300,451,458	1,770,330,775	1,501,953,189	1,550,292,900	1,147,782,798	3,891,778,650
Remarks	Budget	Not audited actual	Not audit Revised	Not audited actual			
Source	Health Indicator	MOFED accounts	MOFED accounts	MOFED accounts	Health Indicator	Health Indicator	Consolidate MOFED accounts

* The budget and expenditures figures shown for 1999 collected by the MTR team in Amhara, Oromiya and SNNPR are different from the figures provided in the health indicator bulletin. As the sources of these data is the same, reasons for these discrepancies should be found.

There is significant variation among regions both in terms of per capita allocation and expenditure. It ranges from the lowest of 10 ETB in SNNPR in 1998 to the highest in Harari at 127 ETB In all the regions, except Harari, which was already high compared to others, per capita budget allocation increased between 1998 and 1999 (see Figure 4.1).

Figure 4.1 Per Capita Allocation and Expenditure by Regions, 1998-1999



Donor Financing

To strengthen the resource base for HSDP III, a strong strategy is in place to mobilize resources from partner organizations and donors. Several multi-lateral and bilateral donors have shown commitment to support the activities and priorities of HSDP III. An analysis conducted in late 1999 (EC) as part of the IHP roadmap to document current year and future financial commitments by some of the key bilateral and multi-lateral partners (without PEPFAR and SIDA) in the health sector, revealed that ETB 539.1 million for 1998, ETB 684.3 million for 1999 and ETB 637.3 million for 2000 on- and off-budget support would be available to the health sector[45].

Most development partners were able to provide their contribution both during the resource mapping exercise and during the MTR of HSDP III, with the exception of PEPFAR, the World Bank and a few others. This stems from improved openness and dialogue, and the effort exerted to implement the Paris Declaration on Aid Effectiveness through the IHP roadmap. Nevertheless, with the existence of a large amount of resources off-budget, it remains a challenge to monitor the utilization of these resources.

Channel 2 and 3, off-budget support: The total resources coming through channel 2 through the FMOH is also increasing. Please note that significant off-budget support, particularly from PEPFAR, which is estimated to be around 230 million USD per annum, has not been captured in this record.

GHIs are becoming the major financiers of HSDP III. They are the first in terms of size and some like GAVI and Global fund are also relatively better in terms of the 'quality of aid provided'. These funds are being managed by the FMOH and are financing, in addition to their targeted programmes, some of health systems that are identified as bottlenecks for improving access and quality of care. According to the information generated from the FMOH finance department, available resources for financing HSDP III (previous years unspent balance at FMOH account plus disbursement in the financial year) has steadily been increasing from ETB 360 million in 1997 to ETB 921 million

[45] FMOH, Resource mapping Exercise 2007.

1999, of which 95% has been contributed by GHI (see Table 4.3 and Figure 4.2). The funds from the GHIs are being used as catalytic funds by FMOH as it has given it a power to negotiate for additional resources allocation at regional and wereda levels. The agreement between the FMOH and RHB on the construction of an additional 'matching health centre' by regions for each facility financed through GHIs, is an innovative approach that will increase resource allocation from domestic sources by lower levels in the coming years.

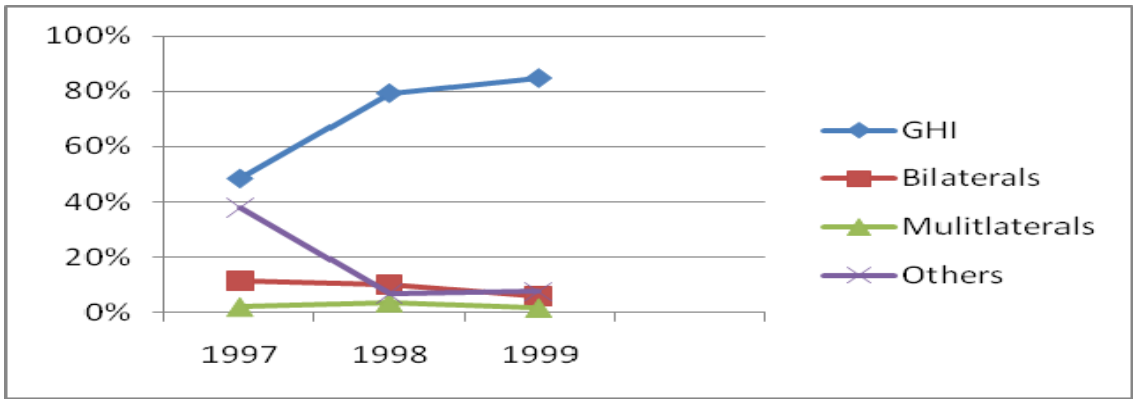
On the other hand the share of bilateral funding that went to channel 2 declined perhaps because some development partners have started channelling their resources to the two pooled funds: PBS and HPF.

Table 4.3 Resources Available for Use and Expenditure under Channel 2

	1997			1998			1999			2000		
	Available for use*	Expenditure	%	Available for use	Expenditure	%	Available for use	Expenditure	%	Available for use	Expenditure	%
GHI	368,079	331,088	90 %	472,323	211,810	45 %	921,590	752,597	82 %	837,395	308,457	37
Bilateral	85,455	36,952	43 %	60,069	35,227	59 %	63,468	55,658	88 %	9,864	1,850	19
Multilaterals	15,403	11,665	76 %	22,016	18,887	86 %	18,064	15,293	85 %	10,895	4,314	40
Others	287,553	211,270	73 %	40,779	25,956	64 %	83,568	71,156	85 %	30,904	14,501	47
Total	756,491	590,976	78 %	595,187	291,880	49 %	1,086,689	894,704	82 %	889,059	329,123	37

* Available for use: it is sum of utilized fund in the previous year and disbursement in the financial year. Source: FMOH, Finance department.

Figure 4.2 Financial Contributions by DP to channel 2, 1997-2000 (EC)

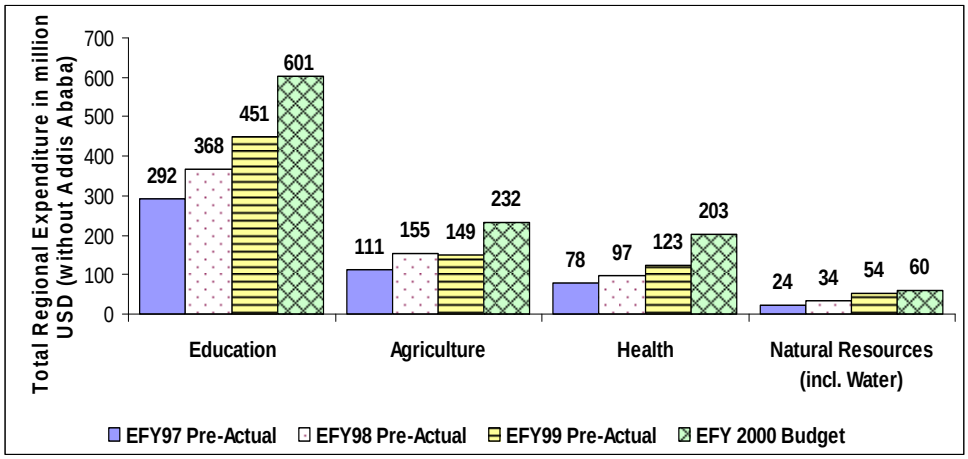


Pooled Funds

During HSDP III, donors have started to harmonize their funding through the establishment of pooled funds. In this regard, the HPF and the PBS are operational. Negotiation and dialogue are on-going between government and partners to establish the MDG Performance Fund. In the last two years the HPF has managed to finance

close to USD 729,603[46]. In addition, PBS has financed the procurement of significant amounts of commodities, worth USD 41,071,443.[47] The introduction of PBS component 1 has contributed significantly to the increased wereda allocation. The PBS block grants (component one) resources finance salaries to ensure retention of the available human resources.

Table 4.4 Total Regional Expenditure by Sector (in million USD)



Source: PBS Aid Memoire, 2007

The total estimated public health expenditures is presented in the table below:

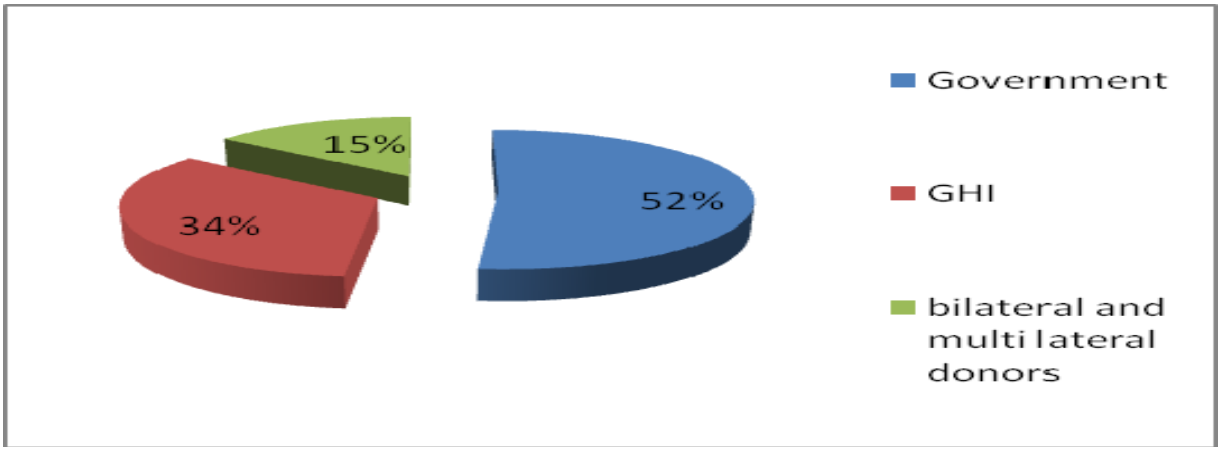
Table 4.5 Total Health Budget and Expenditure from Known Sources

	1997		1998		1999		2000	
	Budget	Expenditure	Budget	Expenditure	Budget	Expenditure	Budget	Expend. (six ms)
On-Budget	1,258,140,000	1,300,451,458	1,770,330,775	1,501,953,189	1,550,292,900	1,147,782,798	3,891,778,650	
Known Channel 2: Off-Budget	756,490,672	590,976,158	595,186,741	291,880,249	1,086,689,018	894,704,402	889,058,952	329,123,114
: HPF*			3,166,833	3,166,833	3,208,192	3,208,192		
PBS*			333,207,984	178,270,085	337,559,736	180,598,322		
Total	2,014,630,672	1,891,427,616	2,701,892,333	1,975,270,356	2,977,749,846	2,226,293,714	4,780,837,602	329,123,114

*The budget and expenditures of HPF and PBS is assumed here to be utilized equally in 1998 and 1999. The MTR team did not receive actual budget and utilization figures for the pooled funds from UNICEF and the World Bank.

[46] FMOH, Evaluation of HPF, 2007
[47] Aid Memoire, PBS, 2007.

Figure 4.3 GOE, GHI and DP Share of Public Health Expenditure (1998-1999 EFY)

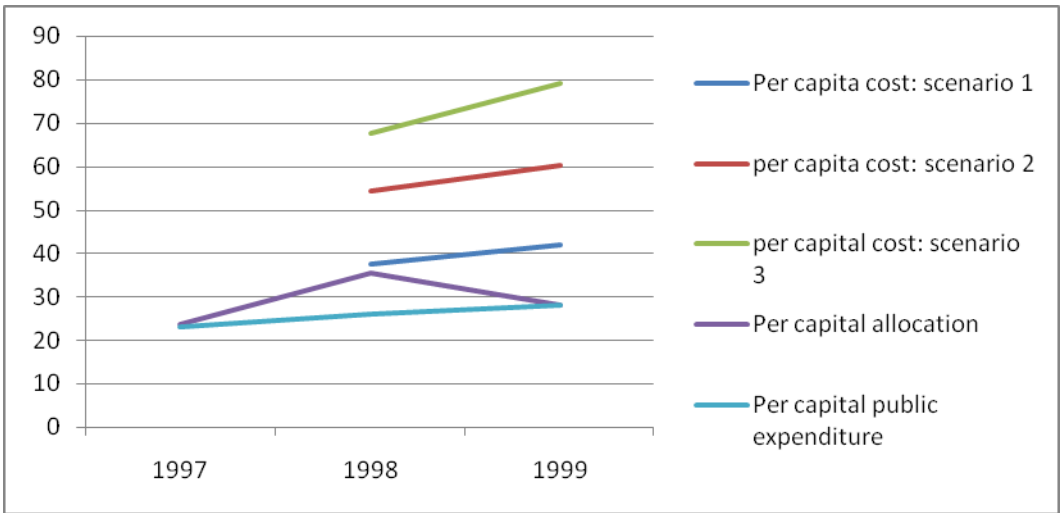


The increase in financing is reflected in the rise of per capita allocations and actual spending. The level of per capita public budget allocation on health increased from 24 ETB in 1997 EFY to ETB 38 in 1999 EFY and then to 60 in 2000 EFY, an increase of 160% in three years. Actual expenditure on the other hand increased from ETB 23 to only 28 ETB during the same period. Comparison of per capita estimated cost under scenario one with known resources only shows that allocated budget and actual expenditure fall short by 11% and 34 % respectively. If all the off-budget expenditures, contribution by NGOs and/or private sector and out-of-pocket expenditures are included, the level of per capita expenditure will be closer to or even more than what is estimated under scenario one.

Table 4.6 Per Capita Public Health Allocation and Spending in ETB

	EFY1997	EFY 1998	EFY 1999	EFY 2000
Per capita cost: scenario 1		38	42	48
Per capita cost: scenario 2		54	60	68
Per capital cost: scenario 3		68	79	92
Per capital public allocation	24	35	38	60
Per capital public expenditure	23	26	28	0

Figure 4.4 Per Capita Cost, Budget and Expenditure in ETB



Issues in Public Financing

Under-Financing

Despite the increasing expenditure in the last two years, the health sector remains under-resourced. The per capita health budget allocation in 2000 is only 60 ETB and actual expenditure in 1999 was 28 ETB. The scale of under-financing should be viewed against the background of the current unprecedented facility expansion of health posts and centres, and the staggering numbers of HEWs that are being trained and deployed in the sector. Most of the increased budget at lower levels is used for salary payment and at higher levels for expansion of infrastructure, leaving very little resources for operational cost at facility level. For example, the 1999 operation cost budgeted for weredas in Tigray is only 22% of the total budget. There is need to review the potential future burden (fiscal space) of channel 2 and 3 funding through a proper analysis of the nature of these expenditures (capital and or recurrent, aligned to the core sector priorities of the sector or not).The implications of these additional facilities in terms of recurrent cost (salaries and supplies) will be significant in the remaining period of HSDP III. Hence significant resources may NOT be available for improving quality of care. Thus, it is prudent to finalize the expansion during this HSDP III and focus on consolidating gains and improving quality of care in the upcoming HSDP IV. However, the current mobilization effort needs to be continued and strengthened.

Targets

One of the targets of the HSDP III is to double the percentage allocation of GOE budget to health within HSDP III. This target does not seem to be achieved. Significant efforts are required to influence all tiers of government to allocate more resources. The overall allocation of resources for the health sector in Ethiopia is largely dependent on the quality of health plans and budgets prepared at federal, regional and wereda levels and the ability of the health managers to successfully negotiate with their respective finance bureaus and councils. This is also influenced by the available resources at the different tiers of government to allocate these resources. The wereda-based planning process initiated in the last two years offers the best opportunity to identify areas to negotiate enhanced allocations, especially if it is able to identify priority areas for spending in the

sector. This process has the potential to bring together the three social sectors (health, finance and counsel/administration) to negotiate on the resource allocation. The development of sector-specific public expenditure reviews (PER), as part of the resource mapping exercise during the planning process, could strengthen dialogue and coordination with MOFED/BOFED and partners, by providing an opportunity to negotiate on sector ceilings at all levels and suggest areas that require additional or new funding. More effort is necessary to bring the administration, particularly at regional and wereda levels, into the planning process and into the negotiation process. The implementation of the 'matching health centre' is an innovative approach that will increase resource allocation by lower levels in the coming years. Finally there is also an emerging initiative to introduce performance based contracting among the FMOH, RHBs and WORHOs on the one hand and among the different tiers of the health facilities and the respective administrative organs. This - among other things - will help to concretize the wereda-based planning commitments. Such innovations need to be strengthened further.

Improve Efficiency

Given the current status of under-funding, the Ethiopian health sector might be considered as one that gets 'value for its money'. However, that does not mean that there is no room for improvement in terms of resource use. In fact, the MTR have anecdotal evidence that suggests that efficiency can be improved. This is related to two factors: rational use of inputs and low utilization of service. There is over-staffing of health professionals in some facilities, while others were not able to provide quality service due to lack of the same. Procurement of drugs with short shelf life and hence expiry of drugs is common. Furniture and equipment are stocked in some health facilities without being used. On the other hand, there is poor utilization of services particularly at lower levels, which is compounded by low motivation of health workers. The BPR has started to address some of these issues. As mentioned in previous sections of this report, these challenges must be overcome to gain efficiency.

Health Systems Strengthening

The scale of expansion of health services alone will not be able to deliver the outcomes that HSDP III aspires to achieve. The support systems need to be strengthened as well. Currently, there is a tendency to make service delivery a vertical programme. Indeed, the vertical programmes (HIV/AIDS, Malaria, and TB) have achieved significant results because of this. However, anecdotal evidence from the MTR shows that there is diversion of human resources away from other services particularly to HIV/AIDS. One medical director even stated that there is 'discrimination against non-HIV/AIDS patients'. There is a general shortage of human resources at all levels of the health system. The maintenance system is, be it for buildings or medical equipment, almost non-existent. The tested HMIS systems need resourcing to be scaled up. There are some efforts to strengthen the logistics management system, but these efforts have not yet been put into operation and rolled out to lower levels. The referral system at all levels requires revisiting and strengthening. Planning and monitoring systems are far from perfect. Supervision practices are more 'control oriented' than supportive. In addition, they are not integrated. Above all, leadership and management capacity particularly at lower levels require concerted effort to allow for well designed change. There are best practices that are on-going through the support of GAVI and the Global Fund to strengthen health systems particularly expansion), but these efforts needs to be strengthened further. Priority therefore needs to be given to elaborate a proper road map for comprehensive system strengthening and for financing its implementation.

Functioning of Pooled of Funds

The HPF aims at providing technical assistance and other support to the FMOH. Four Development partners (DFID, RNE, Irish Aid, and UNICEF) established the HPF in 2005 (GC). They were able to make an expenditure of USD 729,603, in addition to the amount available for the programme.[48] The JCCC takes decision on what should be done with these funds and UNICEF is responsible for financial management and control. The functioning of the system was reviewed a year ago and the second phase of the HPF has attracted two additional development partners (SIDA and Italian cooperation). In the same period, another pooled fund managed by the World Bank has been established which contributed to the resourcing of the sector through two channels; (i) increased block grants to regions and weredas that have positively affected financial allocation to the sector at both levels; and (ii) the establishment of PBS component 2 that is earmarked to finance commodity procurement. Procurement of these commodities used 54% of the resources allocated to this component, from which some 47% has been disbursed.[49]. Out of USD 76,767,410 (net) that has been made available for PBS/C2 by the development partners, commodities worth USD 41,071,442.58 have been procured (equivalent to 54% of the total available), out of which USD 36,669,215 has been disbursed.[50]

The procurement procedure used in PBS/C2 has not been satisfactory both to FMOH and some of the pooling donors. Its major challenges include (i) the limited capacity of FMOH to prepare bid documents in line with the World Bank procedure; (ii) poor communication within FMOH, particularly between PPD and PLSD; (iii) lack of training by FMOH on the World Bank procurement procedure; (iv) the long and complicated World Bank procurement procedure and (v) the long delay in recruiting the procurement agent. Furthermore, the World Bank provides quality in addition to the financial controls which has contributed to the delays in the procurement process. The capacity of the World Bank country office to provide support to the FMOH on the procurement procedures to correct mistakes before being sent to headquarters is reportedly weak.

In the meantime, dialogue has begun on the design of the PBS/C2 phase 2. There is a proposal by the FMOH to bring the fund under channel 2 through the establishment of the MDG Performance Package Fund (PPF). The argument for such a fund stems from the fact that the PBS/C1 is using GOE procedures with annual tests for compliance and so far has delivered. There is a lack of convergence among the donor community on the establishment of the MDG performance fund. GAVI has already put its resources into the account. There are also some donors willing to be part of this pooled fund. On the other hand, other donors would like to see PBS/C2 be continued and with more resources allocated to facilities and kebeles (communities directly). They question the capacity of FMOH to manage and report on the utilization of the fund, as MOFED currently manages the PBS/C1. There is indeed a gap in the absorptive capacity for money that comes through channel 2. In other words, there is lack of confidence in the procurement, PFM and monitoring systems to manage big pooled funds. Due to this, there is no real progress in the area of alignment to GOE systems and procedures.

The review on the adherence of the code of conduct clearly showed that many development partners were unable to adhere to what they signed for. The draft IHP

[48] FMOH, Evaluation Report, HPF, 2007
[49] GOE, Aid Memoire, 2007
[50] PBS, AID Memoire, 2007

compact sets the establishment of the MDG PPF as one of the main harmonization mechanisms. Responses to our alignment and harmonization questionnaire show that Development Partners continue using their own systems (see governance section for details), particularly budgeting, financial management and procurement. This is partly due to lack of confidence on these systems on the one hand and partly to the rigidity of processes and procedures at Development Partners' headquarters to allow county offices to align to in-country processes. We need to note that donors also operate within an organization with its own systems and procedures, with which country offices often have to comply.

The choice between the PBS/C2 MDG PPF should be made with due consideration of the potential benefits and constraints. While there is experience regarding PBS/C2, there is a need to explore the government system's capacity (fund management, procurement, financial management, reporting, audit), referred to as a 'fiduciary analysis or assessment'. This allows the information to decide whether the system's shortfalls, if any, could be improved through capacity building or other measures. It may also be prudent to put some government resources into this pooled fund to encourage more Development Partners to join. Concrete action in strengthening the sector coordination structures, may unlock the signing of the IHP compact and fast track the establishment of this pooled fund. The potential benefit of the MDG PPF is its ability to support the strengthening of the GOE systems at all levels. Its risk is that reporting and liquidation problems may affect resource utilization.

4.2. Health Care Financing Reforms

Introduction

The Health Care Financing Strategy[51], (HCF) which was approved by the Council of Ministers in 1998 (EC), laid out the Government's approach to health sector financing and set out a number of policy changes aimed at increasing the resources available for the health sector, improving the efficiency of resource use, and promoting quality, equity and sustainability in service delivery. Setting up a legal framework (proclamation, regulation and directive) is a prerequisite for the implementation of the HCF reform component. In this regard, Amhara, Oromiya, SNNPR, Tigray, and Addis Ababa have endorsed the Health Service Delivery and Management proclamation, while Dire Dawa and Harari are working towards this goal. Oromiya, Amhara, SNNPR have started the implementation process after developing additional regulations and directives. There is a significant delay in the federal proclamation (first draft in 2003. It is now expected to be included in the forthcoming regulation/directive on the Health Code.

Revenue Retention and Utilization

Proclamation and regulations issued by regions allow hospitals and health centres to collect, retain and use revenues they obtain from different sources as additional to government budget. Currently almost all hospitals and health centres in Amhara, Oromiya and SNNPR have started retaining their revenue. The amount of the revenue collected per facility is increasing over time. Facilities have opened bank accounts and staff are now available for operations. However, use of retained revenue is yet to be fully effected (with the exception of SNNPR, whose facilities have started this process far ahead of the others and recently Amhara), as facilities need to proclaim their retained fee as part of their budget.

The main challenge in using retained revenue is related to the lack of capacity for planning, budgeting, financial management, and procurement and monitoring at the health centre as building such capacity at lower levels takes time. This is compounded by vacant critical positions (accountant, finance and admin head), high staff turnover, and staff having below the minimum skills and experience required. The increasing trends of revenue collected at the health facilities and the slow pace of utilization may generate interest to offset the budget on the part of wereda officials, who are facing severe resource constraints. Hence, health facilities have to speed up the process of appropriation and start utilizing their retained revenue.

User Fees

The HCF strategy stated that user fee charges need to be revised and labelled according to the ability of the people to pay for the service they received and adjusted with the cost of delivery of services. Accordingly, some facilities have already started revising their fees. The recent HCF assessment revealed that out of the 88 health centres visited, 15 centres (two from Oromiya and 13 from SNNPR, equalling 17%) have revised their user fees. This is due to the fact that revising user fee is the mandate of the

[51] Three regions are front runners in the implementation of HCF reforms, SNNPR, Amhara and Oromiya. Tigray and Addis Ababa, and Harari have initiated the reform and are following while all the rest are yet to start.

health centre governing body in the case of SNNPR while in the case of Oromiya and Amhara this mandate is reserved for the regional government (ESHE 2007). As mechanisms for protecting the poor (the fee waiver and exemption) are not yet fully functional, the rush in revising the user fee may have undesired effects such as reduction in facility revenue and/or decline in utilization, and exclusion of the poor. Hence, it has to be halted, until such preconditions are fulfilled.

Enhanced Equity

The implementation of a health care financing reform that aims at increasing the available resources at the facility level through the user fees will have an adverse effect on the equity of health services. In this regard, the health financing strategy spells out the implementation of the targeting mechanism through exemptions and fee waiver, as well as setting up social and community-based risk sharing schemes/community Insurances over the long-term.

Exemption

Exempted health services refer to those health services that are rendered free of charge to all citizens irrespective of their level of income. Exemptions are mainly given to encourage consumption of particular kinds of preventive, curative, or public health services. The list of exempted services is identified by Health Service Delivery and Administration proclamation/regulations issued by each regional government. In the last two and half years, the implementation of exemption seems quite on track. Most of the facilities do display exempted services (EPI, delivery at PHCU level, TB, leprosy, PMTCT, post and antenatal care, VCT and fistula). During implementation, it was found that delivery at PHCU level is not free. Clients are charged in some health centres for the supplies used during deliveries and only obtain consultation free of charge. This will certainly push a pregnant woman without the financial means to opt out from delivering at facility level. Most of the exempted services are financed by donors' vertical programmes as government budget is rarely allocated for exempted services. To ensure sustainability and improve quality of these services the government should consider allocating resources as part of the annual budget.

Fee Waivers

The fee waiver system was introduced to alleviate the negative impact of cost-sharing (user fee charges) on access to medical care by the poor. The waiver scheme is designed based on the 'third party payment principles where health facilities will provide services free at the point of use for pre-identified beneficiaries and be reimbursed by the third party. However, the implementation of the waiver scheme is not progressing as it was planned. The first positive development that is occurring in the HCF reform implementing regions is the use of community targeting mechanism to identify the poor. Amhara has selected over one million beneficiaries; Oromiya and SNNPR are currently working on the targeting process. Secondly, almost all the weredas in HCF implementing regions have allocated budget, an average of 25,000 ETB, for covering the cost of fee waiver beneficiaries. This is a clear signal for their strong commitment to the scheme. However, reimbursing the cost of fee waivers to health facilities has not been started[52].

The implementation of the waiver scheme has faced two major challenges: the correct identification of fee waiver beneficiaries and the shortage of budget to finance such waivers, this in turn further limiting the number of beneficiaries. There is no established

[52] ESHE, Assessment report, 2007

mechanism or criteria to rank and select the poorest households among the potential beneficiaries submitted from the kebeles or across geographic or economic conditions. In this regard, Save the Children UK (SC-UK) for example used a transparent and participatory approach to identifying beneficiaries of waiver in its implementation area which can be reviewed and scaled up (see Box 4.1).

The new waiver system obliges waiver granting authorities to reimburse the health facilities for the service provided. Since most of the weredas will not have the capacity to finance all eligible beneficiaries, the number of fee waiver beneficiaries covered in each wereda is determined by the amount of budget available rather than the number of needy households. During the HCF assessment survey 13 weredas (18%) reported that they have imposed a limit on the number of fee waiver beneficiaries to be submitted from each kebele for approval. The difference that SC-UK made was to reimburse the wereda finance office the cost of consultation and drugs for waiver beneficiaries, as recorded by the health facility. This resulted in an average reimbursement of 8.8 ETB per capita per visit. The region-wide initiative exercised by the three regions will have limited coverage as it is constrained by financing limitations. In addition, lack of experience and information to properly estimate the cost of fee waivers has pushed the weredas to reduce the number of beneficiaries further. In this regard, it is worthwhile considering *the financing cost of fee waivers as a component of any future pool fund in the sector as until such time that* social or community health insurance covers the poorest of the poor. Other countries have started to establish 'equity funds' to address these challenges**.** This will have the potential for increasing resources at the facility level, and hence improved quality for care, and protecting the very poor from financial barriers**.**

Box 4.1 Piloting Fee Waivers: A SC-UK Best Practice

From 2004 to 2007, Save the Children UK designed and implemented a revised waiver pilot project in Debre Sina wereda in the Amhara Region. The overall aim of the pilot was to improve the access of the poorest of the poor to health services. The main findings of the pilot programme were the following:

- Team members from the wereda steering committee helped the community develop revised waiver criteria. The project demonstrated a participatory and transparent targeting system that resulted in 25% of the population in 10 kebeles (12,526 individuals) being selected as waiver beneficiaries.
- A high percentage of beneficiary respondents (75-92%) were aware of the criteria that had been used to select them. Of those who were aware of the criteria, the vast majority thought the criteria were fair. Both survey results and discussion with key informants indicated that targeting errors were minimal; and errors of exclusion prevailed largely due to an inadequate quota.
- Nearly 100% of the target population used the waiver service, increasing the OPD per capital per year from 0.18 in the general population to 0.87 amongst waiver beneficiaries.
- SC-UK reimbursed the wereda finance office an average payment of 8.8 ETB per visit by waiver beneficiary for the cost of the consultation and drugs.
- The approach fell short of empowering communities due to an absence of community targeting and appeal committees. It is recommended that future waiver schemes put in place community level structures that would handle appeals, regularly review of the master list, and continue to provide sensitization to community members.

Source: Save the Children, UK

Social Health and the Community-Based Health Insurance (SHI and CBHI)

These schemes are considered as important vehicles for achieving universal coverage of health service in Ethiopia. A background paper that documented the experiences of other countries and spelt out different options for Ethiopia has been developed and discussed with relevant stakeholders such as RHBs and the Social Security Agency. The plan is to implement social health insurance soon and pilot test the community health insurance before it can be scaled up to the national level. A Health Insurance draft strategy and legal framework for health insurance has been developed in 2000 (EC). The draft strategy states that "the scheme will be designed cognizant of the socio-economic condition of the country, i.e. 'mandatory social health insurance will be established for the citizens in the formal sector; whereas community-based health insurance is considered to be more feasible and appropriate for the large majority of Ethiopians in the rural farming and livestock rearing economy, as well as for the majority of urban people in the informal sectors".

A unit cost study has been completed and a study on the willingness and ability to pay has been initiated. These two studies are expected to provide the basis for setting an affordable premium for SHI. The draft has been discussed by the RHBs. However other sector stakeholders have not yet been involved in its development. While government ownership and leadership is very critical in this area, it will be essential to bring on board other stakeholders (donors), who in the end might be asked to finance some of the necessary technical assistance and capacity-building activities. The draft strategy and proclamation will soon be submitted to the Council of Ministers. The MTR has not accessed these draft proclamation and hence could not comment on its contents. However:

- There is a need to develop the financial projection of the SHI scheme (feasibility) under moderate expansion and rapid implementation scenarios to ensure that the benefit package can be provided by the premium collected with due consideration of the mark-up for the overhead cost.
- Legislation of SHI is just one step in the long process of establishing SHI. There are intricate design issues that needs to be sorted out and agreed upon before the scheme is up and running, including, but not limited to, defining the benefit package at all levels of health care, setting affordable premium levels to be paid by members, setting comprehensive service standards for providers of service, defining contracting arrangements, setting up cost containment mechanisms and most importantly, setting up the managing agency with adequate capacity for registration, settling claims, contracting, quality assurance and cost containment. Preparing all these will certainly take time. It is therefore necessary to speed up the design process. The sector may benefit more from adequate consultation and involvement of stakeholders in the designing process.

Improving Quality of Care through Special Pharmacy

HSDP III targeted to establish special pharmacies in all hospitals and health centres throughout the country. The experience of special pharmacies has been reviewed and the results have been very encouraging (see section on pharmaceuticals). The review concluded that "special pharmacies have significantly contributed in making drugs more readily available and, and in doing so, have played a significant role in stabilizing the prices of drugs in the marketplace as a whole. Special pharmacies have also contributed to quality-improving activities by investing their surpluses in ways that enhance service delivery'.

The review findings documented that:

- The availability of a selected list of drugs in special pharmacies is better than budget pharmacies and patient satisfaction on the availability is better in special as compared to budget pharmacies.
- There is capital growth in all hospitals and most health centres with average nominal growth of 163 and 137% respectively.
- The average price of drugs was found to be 60% higher and 28% lower than the average selling prices of budget pharmacies and private drug retail outlets respectively. Patients felt that the prices of special pharmacies are generally fair as compared to budget counterparts. Though the guidelines stated that the mark up for special pharmacies should be 30%, it was found that this had increased to 36%.
- Special pharmacies contributed to quality improvement through the investment of their profits in the facilities. On average, hospital and health centres spent ETB 37,992 and about ETB 8000 per year during 2004-2006 (GC) in quality improving activities.[53]

The implementations of HCF reform components, particularly revenue retention and the fee waiver and exemption system, could soon make the special pharmacies redundant and no longer relevant. In this regard, the SNNPR has already instructed health facilities to merge special and budget pharmacies. While it in indeed true that if these reforms are in place, the two can be merged, an immediate move in this direction could risk the sustainability of drug supply in the facilities.

Hospital Boards and Health Centre Governing Body

All the hospital boards and health centre governing bodies have been established in the three health financing reform focus regions. Facilities, through their health facility committees, are allowed to make their own decision based on their local needs. A survey of 82 health centres (91%) reported that they have established the health centre governing body as per their respective directives. While all health centres visited in Amhara and Oromiya have established their governing body, 8 health centres visited in SNNPR have not established the governing body. The majority of the established health centre governing bodies have not started their activities. Delay in establishment, lack of experience, capacity limitations among some members to comprehend the provisions of the directives, absentees and delegation to subordinates are major challenges. These structures within the governing bodies need capacities, if they are going to play a role in the usage of retained fees as additional to the government budget in planning.

Sector Planning and Budgeting

With the development of the HHM and the initiation of wereda -based planning process, the sector has, for the first time, been able to establish a mechanism that links HSDP III with the decentralized bottom-up wereda plans. The main achievements in planning and budgeting during HSDP III are:

- The development of a harmonization manual for instituting the concept of one plan, one budget and one report
- The initiation of wereda-based planning and core plan development
- The initiation of resource mapping exercise to inform planning at all levels
- Improved level of consultation on the planning process and the participation of other stakeholders

[53] ESHE project, 2008, Special Pharmacy Impact Assessment Survey Report

- Improved top management commitment and support to one plan concept
- Improved synergy among the administration, finance and health sectors in regions where administration has been involved in the planning process, and
- Improved motivation and enthusiasm for the planning process by the wereda levels with some degree of improved capacity.

A concerted effort has been made to link the targets of HSDP III to the annual planning process through the development of core and comprehensive plans at all levels. Apparently, sector plans reinforce top-down planning processes, and create conflict with devolution. The wereda-based planning process seems an innovative approach to resolve such apparent conflicts, as it allows indicative plans to be communicated to lower tiers of government while local priorities are identified and included at the local level. They form the basis for bottom-up consolidation of the revised core and comprehensive plans. This has enabled the sector to produce a vertically and horizontally aligned plan that is signed between the FMOH and the regions. It also allowed performance based contracting during the ARM 2000, which is being monitored on bi-monthly basis by the FMOH and RHBs joint meeting. Planning tools (profile and planning formats) have also been developed. 136 TOTs (50% from both government and partners) were trained and these in turn have trained five representatives of each wereda from both health and finance offices for 801 weredas. The plan is compiled and developed by wereda representatives at a central training point after they collected the required information from their stakeholders. Facilities are not yet required to develop their own plan in most of the regions.

This process is just two years old and has its weaknesses: (i) the methodology used is need-based trying to reach overly ambitious targets and (ii) not all stakeholders provide full and reliable resource projection on time with geographic desegregation. With the exception of Dire Dawa, Harari and to some degree SNPPR, all other regions reported that the resources mapping exercise carried out for EFY 2001 leaves much to be desired. The mapping that was made at all levels is far from reliable, as donors commitment is compiled using three scenarios: commitment, pledges and historical data, which may not always be realized. While stakeholders are requested to provide their resource envelope for the planning process, their participation in the appraisal and review of plans (priority setting and budget allocation) seems quite limited.

Secondly, the resource gap at the wereda level is expected to be mobilized either from the wereda council or FMOH resource mobilization efforts from partners. The credibility of the planning process heavily rests on the extent to which the plans are funded. If huge financing gap remains, it will affect the quality of the planning process and the motivation of the wereda staff in the future.

Thirdly, the planning capacity still needs strengthening. Though the principles of one plan have been agreed by all stakeholders, there are indications that some stakeholders are developing their own planning formats[54] and initiating another parallel process. The capacity of health managers at all levels to come up with an evidence-based plan remains a challenge. Though the capacity of PPD at FMHO, is being strengthened (16 new officers are employed and the department is being supported by technical assistance in the areas of HCF reforms, wereda -based planning, infrastructure development, health insurance and HMIS), given its complex duties and workload, it

[54] Letter from Harari Bureau to PPD

needs further strengthening, if it is to remain the dynamic engine of the health reforms. The need to look into the PPD's internal working arrangement has been pointed out by partners (see also section 3.1 facility construction/rehabilitation)**.** The utilization of technical assistants would be more effective, if they provide not only critical analysis and support in their core area of expertise but also transfer skills to strengthen internal capacity. There is a need to train the new staff to ensure that they have adequate knowledge and skills in their core areas of engagement. The PPDs at the other levels also require capacity building.

Recommendations

Table 4.7 Recommendations for Financing the Sector and Health Care Financing Reforms

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Financing the Sector	Continue advocating for increased resource allocation from government budget and mobilize additional funding from the international partners.	Strengthen the financial management, procurement and budgeting systems for better alignment to government system.	Improve the absorptive capacity of the sector.
		Negotiate with MOFED to align the HSDP IV components with overall government budgeting process.	
HCF Reforms	Speed up the design of SHI and CBHI with adequate consultation of stakeholders at all times.	Scaled up to other regions with necessary technical support.	
		Consider the establishment of an 'equity fund" to finance the cost of fee waivers as one of the elements of any future pooled funding.	
Planning and Budgeting	Refine annual planning tools.	Balance need-based and resource constrained planning approaches.	Develop HSDP IV from using bottom-up approach, to help align local and national priorities.
	Support resource mapping with annual public expenditure reviews and tracking studies.	Strengthen planning capacity at all levels.	

4.3. Financial Management

Ethiopia's Health Sector Strategic Plan conceptualizes financial management as "the procedures and processes governing the *flow funds*, *accounting and reporting*, and *auditing"* (FMOH, 2005 page 111). This section, therefore, draws on these themes in evaluating the financial management system of HSDP III, emphasizing, throughout, if and how the emerging financial practices are consistent with the espoused values documented in both the Plan and the HHM.

Flow of Funds

The HHM identifies three major ways through which funds flow to finance HSDP III viz., Channel 1, Channel 2, and Channel 3; the first two having variants within (FMOH, 2005, pp.80-81). With the exception of Channel 1A, the rest are generally at work at all levels in the sector, albeit Channel 3 appears less frequently used.

There is, however, marked variation in the authorization, disbursement and utilization of funds at all levels in the structure, i.e. from facilities to FMOH. On the one hand, considerable improvements have been noted in the flow from Channel 1 (MOFED) to FMOH/ BOFED and then to RHB levels. On the other hand, subsequent flows to lower levels particularly to ZOFED/WOFED and health facilities are less smooth in terms of timeliness, where in some cases funds are transferred after activities are completed or the annual budget is disbursed at third quarter. Equally, funds are neither retired on time nor their liquidation is reported as originally scheduled. A number of factors are identified as causes for disbursement and liquidation delays at the lower levels, such as, the ineffectiveness of the pool system. Even if it is cost effective in centrally serving several sectors, the system is operationally organized across functional structures rather being process-oriented, often lacking transparency and causing additional transaction costs. Other factors include lack of local banks and hence reliance on rather risky mobile cashiers, communication gaps, and lack of capacity as well as sensitivity in timely managing available financial resources.

Funds have also continued to flow through Channel 2 disbursements to the sector. However, evidence supporting its effectiveness for timely utilization are inconsistent at all levels. Whilst the purposes of funds channelled using FMOH as central point of disbursement to RHBs is fairly known for timely utilization, it has not been the case with most of the disbursements directed by donors to FMOH and RHBs. Delays in utilization and liquidation reports are common, as the finance department spends extra time to match resources with programmes before user departments are notified. This is largely attributed to communication gap between the concerned parties. Internally, the requesting units do not notify finance of the purposes of disbursement. Equally, most donors decline to provide extra details to their bank credit advices, trusting the internal coordination as effective. But again, considerable delays have been noted in the downward flows of funds from this channel to ZOFED/WOFED and health facilities, and hence liquidation of funds for similar reasons identified above.

Accounting and Reporting

The new government accounting system has permeated much of the health sector in terms of institutionalization of a double entry system of accounting and modified cash

basis method of recording. Central to both the system and the method are the chart of accounts, and the voucher-ledger driven transaction processing, all of which are directed towards generating sets of standardized financial reports informing the Government of the utilization of recurrent and capital expenditure budgets.

The basics are in place at all levels and have been supporting the financial management of the sector. However, considerable variations have been noted among the entities in both approach and infrastructure critical for strengthening the system of accounting and reporting of the receipt and utilization of financial resources. The contrast between federal level and the rest is particularly markedly evident in at least two ways. Firstly, subsequent to implementation of the BPR, the FMOH has recently transformed its approach from a predominately functional structure grounded in person-job specifications into a more systematic process-based structure, which recognizes accounting and reporting tasks as interrelated processes. Secondly, the GOE system is locally supported by ICT infrastructure including PCs, LAN, and accounting software application, developed by MOFED. Consequently, government financial reports can now be generated timely, accurately, and reliably at FMOH. By contrast, as these essential institutional inputs are glaringly and abundantly missing, financial management in RHBs and others down the echelon have continued to rely on the less efficient and mostly ineffective functional structures, and the manual skills of their personnel staff. These combined with high staff turnover and lack of qualified personnel at lower levels have persistently constrained their financial management systems, notably causing delays in reporting liquidation of funds in Channel 2.

Irrespective of whether it is automated or otherwise, the accounting system is undoubtedly capable of generating financial reports to the GOE, particularly on the utilization of recurrent and capital expenditure budgets. It is, however, less robust to meet the financial information needs specific to other stakeholders and of common interest to both the GOE and the partners. In this respect, two voids are most discernibly visible:

First, the code of conduct documented in the HHM underscores “the use of the Government chart of accounts for financial reporting of HSDP III (FOMH, 2005, p. 71). However, the structure of the chart, particularly in its present form, is inherently incapable of supporting the accounting system to generate financial reports for HSDP III. Because, it was primarily designed by MOFED to trace utilization of recurrent and capital expenditure budgets using multi-level budget codes for cost centres, itemized codes of expenditures, and sources of finance (Government, grants, and loans). As the emphasis is evidently skewed in favour of the budget system rather than sector programmes, simultaneously generating financial information by HSPD components continues to be a major challenge to realize one of the values espoused in the Plan, i.e. “placing harmonized procedures to satisfy the accounting and reporting requirements of the various bilateral donors” (FOMH, 2005, 111). Furthermore, the challenges are compounded by the multiplicity of Channels and the attendant variants. In this regard, the system lacks explicit coding structures concerning how funds in Channel 2, and Channel 3 can be accounted for to provide a holistic picture.

Secondly, as an outgrowth of this, finance departments across the board in the sector have resorted into setting up “*a twin accounting system*” in order to meet the specific needs of donors and partners, the style and content of which differ. These ‘sub-systems’ function independently to provide additional information which the GOE accounting

system barely captures, although the latter is considered "in theory, as enabling the collation of financial data in sufficient details" (FMOH, 2005, p.112). Beyond the rhetoric, the emphasis placed on "*one financial report*" in HSDP III is still – unfortunately - far from the reality on the ground.

Auditing

The strength of the internal audit function varies enormously in the sector. At one end of the spectrum, a relatively strong role is noted. On the other, several RHBs and lower levels suffer from both lack of adequate structure (i.e. understaffing) and shortage of skilled manpower. In some cases, even if thinly structured, internal audit functions still continue to be vacant. Most strikingly, however, is the absence of internal audit structures at lower levels, where not only considerable transaction take place but the corresponding audit functions at RHBs are organizationally feeble to reach the numerous geographically dispersed entities. This is indeed a major challenge for one of the key values emphasized in the plan, i.e., ensuring that "internal audit mechanisms continuously monitor financial management and proper adherence to financial and procedural regulations" (FMOH, 2005, p.113).

Furthermore, fragmentation of efforts is noted in external auditing involving both the government wing and donors. Cognizant of this, the audit department at FMOH has recently embraced internationally accepted standards to re-orient the role of internal auditing around "*assurance and consultancy"*. In light of this, the department has placed a blue-print BPR in which the scope of internal audit is broadened to encompass both financial and performance audit roles. Although, the ultimate objective of this approach is to stretch the internal auditing function to all levels, the challenges of institutionalizing this are enormous, the most of notable of which include: shortage of skilled manpower to conduct both financial and performance audits, and possible resistance to accept the new roles of internal auditing, which apart from covering performance audit, calls for people trained in medical/health sciences to do that audit.

Recommendations

Table 4.8 Recommendations for Financial Management

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
BPR	Replicate the BPR initiative, and extend IT support to finance as well as audit functions at RHBs and all levels.	Consider the development of programme budgeting for SDPs and accordingly modify the current accounting system to enable it do an overall HSDP accounting and auditing	
Capacity Building	Provide training and skill upgrading for finance and audit personnel.		

4.4. Governance and Sector Management

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

- Expanding and strengthening the scope of governance of HSDP at district level;
- Strengthening collaboration among FMOH, RHBs and WORHOs
- Widening the role of community and NGOs in planning, implementation and governance of health care delivery activities, particular at district level;
- Strengthening government, donor, NGOs and private sector collaboration;
- Harmonizing the planning, implementation, monitoring and evaluation system among the different stakeholders;
- Enhancing the effectiveness and linkage of implementation, monitoring and evaluation of HSDP at all levels of the health system.

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

Coordination Structures within the FMOH

The State Ministers for Health and Heads of Departments meet weekly under the leadership of the Minister to review the state of FMOH service delivery responsiveness (based on clients comments received in the 'suggestion box'). Departmental performance is based on their weekly plans that uses the total quality management principles of the balanced scorecard, BPR progress report, budget utilization status and planned activities. The head of department work plans form the basis for section heads' work plans which are generated and monitored weekly by all staff. Though the weekly plan process is appreciated by many, some staff have expressed apprehension about its objective with regard to their job security. Senior managers get an opportunity to familiarize themselves with the ministry's policy direction, input into its design and monitor the pace and quality of its implementation collectively.

The FMOH-RHBs Joint Steering Committee that is chaired by the Minister meets regularly (every two months) to promote and monitor the implementation of HHM and Civil Service Reform agendas amongst other strategic objectives of the HSDP III. It therefore, has served as a vital organ for the advancement of the overall reform agenda.

All RHBs (with the exception of two) reported having regular internal weekly or fortnightly management meetings to discuss progress, challenges and make recommendations for the next steps. All of the regions with the exception of the emerging regions reported having bi-annual review meetings with weredas and the health facility administration to review HSDP III implementation progress. The vast majority of the regions indicated that they participated in FMOH initiated meetings and that this information was passed on to their staff during their regular meetings.

With the exception of two regions, it was noted that the weredas had management committees in place but the regularity of meetings varied. It was also observed by the RHBs and in the weredas visited that leadership and management capacity building was needed at this level.

Coordination Structures between FMOH and Development Partners

HSDP III through the HHM defines the following sector coordination structures with their general duties and responsibilities as:

- Federal: CJSC, the FMOH Donor Joint Consultative meeting, JCCC, the FMOH/RHBs Joint Steering Committee and the ARM;
- Regional: The Regional Joint Steering Committee (RJSC) and the Regional Review meetings;
- District: Wereda Joint Steering Committee (WJSC) and the Kebele HIV and Health Committee.

The CJSC, which is the top policy-making body in health meets irregularly and far apart because of varied reasons cited by the members such as competing interests, multiple bilateral meetings, junior representation and several missions. Most of the members of this Committee are also members of other sector coordinating mechanisms such as those for global initiatives.

The FMOH-Donor Joint Consultative and JCCC meetings on the contrary have been regular with tremendous improvement of inter-communication. The Joint Consultative Meeting however, remains an advisory forum. Whereas the JCCC is functional and holds weekly plans, the thrust of its routine business is administrative and operational rather than strategic, as envisaged by HHM.

The global initiatives have in-country, functional coordinating structures. The Ethiopia Country Coordinating Mechanism for the GFATM and the Inter-Agency Coordinating Committee for GAVI/HSS have operated satisfactorily albeit as stand-alone mechanisms, whilst most of the service delivery stakeholder structures are through a number of task forces and working groups. Most of these structures do not functionally communicate with each other.

The three sector partners (FMOH, HPN and NGOs) appreciate the efforts made to create several platforms for dialogue from the strategic to the operational levels. This has enabled the joint development of the HSDP III, the signing of the 2005 Code of Conduct, establishment of pooled funding mechanisms, formulation and support for the implementation of the service delivery flagship programmes including (i) HEP, (ii) maternal, newborn and child health, (iii) joint development and implementation of the HSDP Harmonization Manual, (iv) the wereda level bottom-up planning, (v) design and implementation of BPR. The ARMs have been held with progressive improvement of the deliberations. The regional review meetings however, require strengthening.

Only three regions reported having a functional RJSC in place whilst the remainder are non-functional or there is no RJSC structure at all. Despite this, all regions responded affirmatively to having some form of coordination structures and mechanisms in place to monitor HSDP III implementation progress. These included: internal coordination mechanisms, such as regular RHB management meetings, which include monitoring HSDP III progress; external meetings between the RHBs and the Regional Councils, FMOH-RHB, and Regional Review meetings; participation in emergency response teams, as well as integrated supervision as a mechanism for coordination. RHBs indicated that they found it challenging to organize inter-sectoral meetings in their respective regions largely due to workload and scheduling conflicts: this was one of the

key reasons cited for non-functional RJSCs. A number of regions also noted that it was much easier to ensure participation for inter-sectoral meetings during an emergency. It was consistently reported that coordination had improved in the last two years. However, further improvements are still necessary.

None of the weredas visited reported having a WJSCs in place although, they indicated that they worked in close collaboration with their respective RHBs, the WORHOs, the hospitals and hospital boards (where in place), and health centres. At community level, HEWs are coordinating basic health service delivery with kebele councils through weekly activity review meetings.

Improved functionality of the coordination structures is deemed to be a central determinant of the pace and quality of service delivery towards the attainment of the MDGs and hence there is an overall goodwill and eagerness to make the structures more dynamic. In order to enhance efficiency of the federal level coordination structures and for them to provide the necessary coherent sector guidance, there is need to restructure and revitalize the key structures to make them more responsive to the: (i) attainment of ESHP objectives (ii) fulfilment of HSDP III objectives and (iii) HSDP Harmonization Manual principles in order to attain the “one-plan, one-report and one-budget” overall sector goal.

To provide integrated health service delivery and the quality of care as envisioned in HSDP III, four thematic areas are proposed to operate under a Service Delivery Steering Committee (SDSC) under the leadership of one of the State Ministers. These thematic areas are: (i) family health services; (ii) communicable disease prevention & control; (iii) curative services; (iv) HEP (including hygiene and environmental health services). This Committee can, on ad hoc basis constitute time-bound working groups for specific topical assignments.

The HSDP III recognizes the need to improve the support systems in order to improve efficiency and effectiveness of health care delivery. Four support thematic areas are proposed to operate under a Support Systems Steering Committee (SSSC) under the leadership of one of the State Ministers. These thematic areas are: (i) pharmaceutical services; (ii) human resource for health development and management; (iii) financial management; (iv) health management; (v) diagnostics and other support services. This Committee can on ad-hoc basis constitute time-bound working groups for specific topical assignments.

In view of the existence of other committees for global health initiatives and the functional but only advisory FMOH/HPN Joint Consultative Meeting, which have all been stand-alone arrangements, a high level coordination decision-making forum is proposed. This structure should be inclusive of HSDP III, global health initiatives and HIV/AIDS interests. The MTR proposes to ‘merge’ the HSDP and the HIV/AIDS Coordinating Committee to form a HSDP-HIV/AIDS committee that convenes monthly under the leadership of the Minister of Health or one of the State Ministers.

The CJSC as per the HHM TOR will endorse annual and medium-term sector policy, key strategic or funding documents and meetings under the leadership of the Minister of Health two to four times a year.

The JCCC as provided in the HHM will serve as the Secretariat to the CJSC and the re-structured HSDP-HIV/AIDS Coordinating Committee with members drawn from the SSSC and SDSC. JCCC will propose agendas to CJSC and the HSDP-HIV/AIDS Committees and review documents submitted by PPD in preparation for the Coordinating and Steering Committee's deliberation.

The capacity of PPD and other FMOH departments to take up this enhanced role requires assessment and strengthening. Guidelines need to be developed and disseminated in order to make the strengthened coordination structures operational.

Decentralization

Ethiopia is structured into nine semi-autonomous administrative regions and two urban city administrations which is a constitutional federal system since August 1995. The regions are mandated to generate their local revenue in addition to the federal subsidies allocated to them. Decentralization from regional to Wereda level was initiated in 2002 except in the emerging regions which started in 2004. This was a huge and major undertaking devolving decision-making process closer to the community. Weredas formulate their own priorities which form the basis for allocating available funds to all sectors. In this regard, the amounts allocated to the health sector fluctuates and is generally inadequate, especially the allocation for drugs and recurrent costs. The regional capacity to plan and implement programmes has improved over time but with a slower pace in the emerging regions.

While all regions during the review noted improvements in areas such as planning and coordination, it was consistently highlighted that management and leadership capacity needed to be strengthened at the regional and particularly at the Wereda level, including hospitals and health centres. The ability to plan, manage, coordinate, lead, motivate and coach was identified as critical areas at all levels. Staff also noted that this was a key component of the CSRP and yet very little had been done in terms of the development of top management. It was also noted that hospital CEO's and Medical Directors only received two to three days of orientation, which is not sufficient for leading and managing a health facility.

With support of the Clinton Foundation, hospital reforms have been implemented as part of the BPR process over the last nine months which has resulted in establishment of hospital management boards and retention of user fees in a limited number of hospitals. The direct support of the federal hospitals by the FMOH seems to have resulted into initial service delivery improvements as per their quarterly reviews, but it is too early to assess the actual outcome of these reforms. Similarly health centre governing bodies have been established in most regions, but are not yet functional.

Civil Service Reform Programme (CSRP)

The FMOH like all other sectors is implementing civil service reforms. These reforms are based on the fact that the Ethiopian civil service has for the last half century progressively reduced its ability to satisfy its clients. The civil service reforms therefore, are designed to improve the quality of service delivery to the beneficiary.

In tandem with other government sectors, FMOH is implementing the various sub-components of the civil service reform:

- Top management leadership performance improvement that includes weekly plans for all departments which are reviewed and discussed in senior management meetings;
- Service provision performance improvement that reviews client satisfaction and appropriate interventions;
- Ethical performance improvement where the main focus is corruption prevention and codes of conduct.

The FMOH having assessed the areas that required improvement in order to provide better health care defined the following as the core processes that require re-designing (BPR) to enhance efficiency and effectiveness:

- Human resource development where the focus is the HR training, "flooding" strategy and retention of HRH;
- Financial and expenditure management performance improvement that has achieved salaries reforms (payments through commercial banks), elimination of the fuel coupon system that was prone to misuse and vehicle maintenance system by privatization of repairs;
- HMIS has been redesigned successfully, pilot tests done and is ready for scale up;
- Improving access and quality of health services re-design has produced the blueprint standards for hospital reforms which is in use whilst those for health posts, health centres and primary hospitals are due to be completed soon.
- HSDP III Harmonization Manual as part of harmonization and alignment was developed and is in use;
- The re-design of the HCSS has been completed. Logistics management and pharmaceutical master plans have been developed and are in initial stages of implementation.

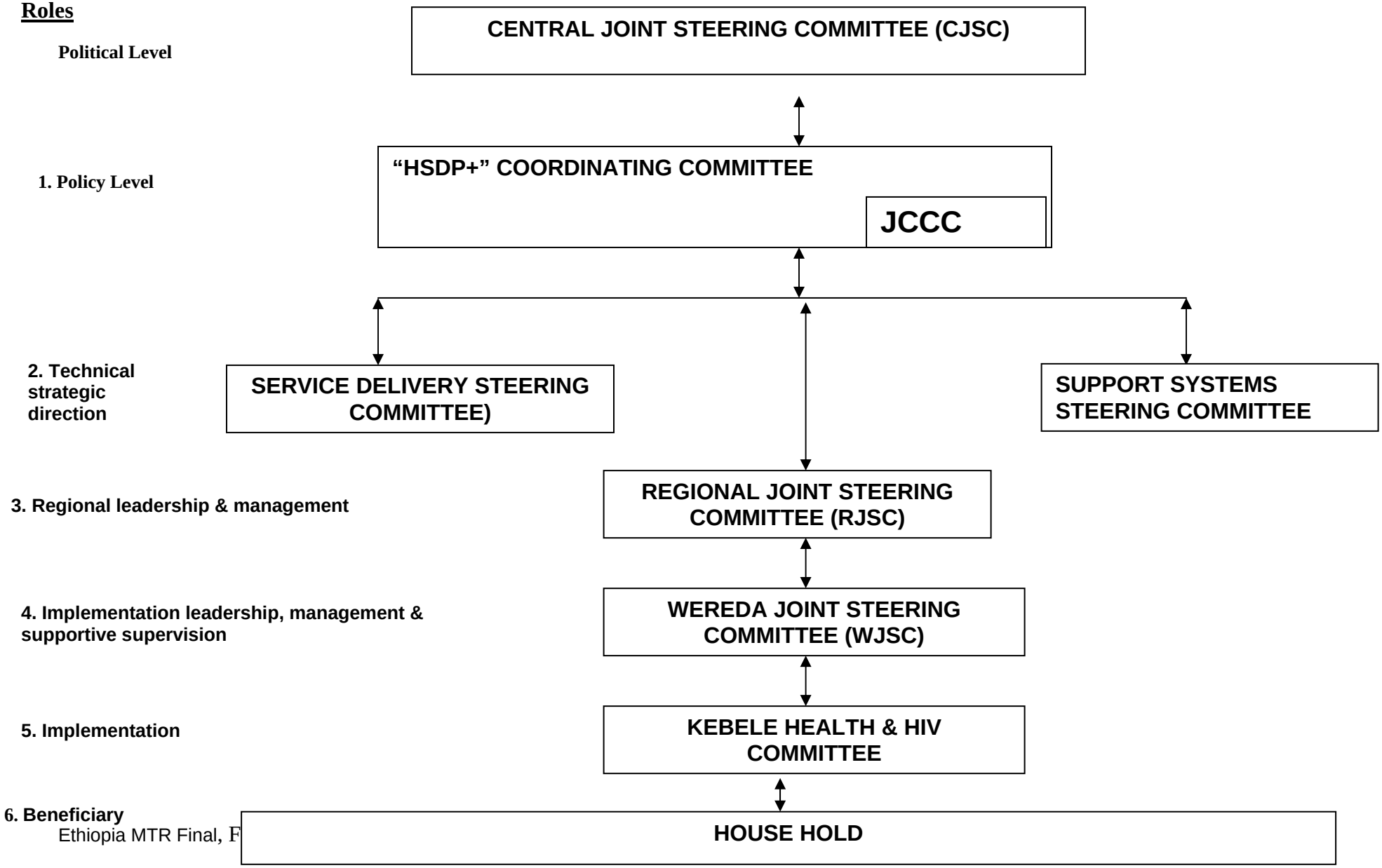
Three regions have CSRP plans which are being implementing, whilst six regions have a plan whose implementation status is at varied stages. Only two regions visited have a plan which is not being implemented. The CSRP has been embraced by the regions but actual systematic implementation is weak especially with respect to the BPR. The pace of the BPR core reforms needs to be accelerated to replicate the good results of HMIS core process and finance management support process. Consistent capacity building at the regional and wereda levels is required to replicate the vigour with which some of the FMOH reforms have been conducted.

Table 4.9 Recommendations for Governance and Sector Management

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
CSRP Decentralization	Accelerate the pace of the BPR core process reforms especially for access and quality of care		
Capacity Building	Introduce change management to improve the staff confidence in the on-going reforms at all levels.	Institute a leadership and management capacity building programme for regional and wereda level managers.	
Coordination between FMOH/Development	Define the core functions (TORs) and composition of	Train and support all governance structures.	

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term within HSDP III	Long-Term Design HSDP IV
Partners	the strengthened coordination structure.		
Strengthen PPD	Strengthen the capacity of PPD as a Secretariat to improve the coordination mechanism and all departments.		
Review Mechanisms	Introduce a bottom-up review mechanism to reflect the wereda planning process, and ensure inclusion of NGOs.		

Figure 4.5 Proposed Sector Coordination Structure



4.5. Alignment and Harmonization

Alignment of Development Partners with Government Structures

The GOE is supported through a variety of funds:

- A multi-sectoral budget support, called 'Protection of Basic Services' (PBS component 1 = PBS/C1) from which funds are disbursed directly to districts and regions for operations and maintenance.
- A similar fund for commodity procurement (PBS component 2 = PBS/C2) has progressed slowly due to lengthy fiduciary processes that are required for International Competitive Bidding which has been a source of sector frustration due to "unprecedented" delays.
- A Health Pool Fund which is a technical assistance common fund was jointly established and is managed by UNICEF. It has been instrumental for supporting coordination, joint monitoring and planning by the sector.
- The FMOH has also established the MDG Performance fund as part implementation of the HSDP III in which, GAVI/HSS remains the only functional partner.

The Code of Conduct 2007 evaluation report records that five development partners that have started using the Ethiopian fiscal year for some or all of their financial reports since 2005 and 11 are willing to align with the HMIS – i.e. use the information it produces and not request other health management information data. The evaluation, however, shows that aid predictability is still a major challenge and that many development partners were unable to adhere to what they signed for.

From the responses to the MTR questionnaire on alignment and harmonization, the RNE and DFID have aligned their procedures and processes either to GOE or to the pooled funds. They no longer use their own systems. Most Development Partners, on the other hand, use a combination of their own and government systems or their own system alone (see Table 4.10). The systems that most Development Partners have aligned to are provision of budget information and to the planning calendar. The most critical systems (budgeting, financial management and procurement), which have significant impact on reducing transaction costs for the government, record the least progress. This may be interpreted as a lack of confidence in the sector's common management arrangements mechanism, on the one hand, and a rigidity of Development Partners processes and procedures on the other.

Table 4.10 Development Partners Responses to Alignment and Harmonization Questionnaire

Alignment Issues	Own DP System	GOE System	Pooled System
Planning calendar	3	5	1
Planning process	3	4	2
Budget information	2	7	1
Budgeting process	4	2	1
PFM	4	1	3
Procurement	4	1	3
Audit	4	4	3
Reporting and review	5	5	3

Ethiopia being signatory to the IHP has reaffirmed its commitment to the Paris Declaration of March 2004 with national and international partners. In this regard, as part fulfilment of this responsibility and to further guide the on-going dialogue on the IHP and the MDG PPF, it is important that the sector considers monitoring the alignment and harmonization indicators as

a package rather than separate components, while it advances to the next level of its relationship.

Box 4.2 Paris Declaration Indicators

Alignment

- Reliable country systems;
- Aid flows are aligned on national priorities;
- Aid predictability
- Strengthened capacity by coordinated support;
- Use of country systems;
- Strengthened capacity by avoiding parallel implementation structures;
- Aid is untied

Harmonization

- Use of common arrangements or procedures
- Encourage shared analysis.

The Paris Declaration alignment indicators spreads responsibilities between all sector partners (highlighted in the box), requiring deliberate re-structuring of the budget(s), and strengthening of the planning and monitoring systems/capacities (HHM already lays a good foundation for the required consistent capacity building) to enable systematic tracking.

The choice between the PBS/C2 and the MDG PPF should be made with due consideration of the potential benefits and constraints. Making use of the experience of PBS/C2 and examination of the sector's systems' capacity (fund management, procurement, financial management, reporting and audit) including agreement on a process for improving them would facilitate an expedited and informed decision-making by all partners.

Harmonization

The GOE's commitment to harmonization and alignment has been elaborated in the Ethiopian Plan for Sustainable Development to End Poverty 2005 (and later the PASDEP) which formed the basis for subsequent health development strategies.

A Code of Conduct was jointly developed and signed by 14 partners to provide the organizational framework for supporting HSDP III. The establishment of PBS/C1 has succeeded in significantly increasing wereda budgets whilst PBS/C2 and the HPF have separately contributed towards increased commodities for sector priority interventions and enhanced system's development which have all been accomplished as a result of the code of conduct. Adherence to the code of conduct has been evaluated and its results presented to the ARM in October 1999 (EC). The review report shows that a number of development partners were non-compliant for varied reasons that require consistent dialogue and negotiations as well as understanding the views and policies of different donors.

Notwithstanding the gains achieved in the last two years,, a comprehensive sector resource mapping to guide overall equitable allocation of resources is yet to be concluded and numerous financing channels still exist with earmarked funds that require multiple accounting, reporting systems and monitoring requirements. The increased fragmentation of

funding channels decimates the sectors and especially the Ministry's efforts to provide the required stewardship for effective implementation of the core plan.

Dialogue has begun on the design of the next phase of PBS/C2. The FMOH in compliance with the HSDP III, proposes to move towards a broader harmonization and alignment through establishment of a MDG PPF and bringing the funds from channel 2 into it. This fund includes support to (i) the HEP (ii) maternal health and (iii) technical assistance. The responses to this proposal are mixed, ranging from its current utilization by the GAVI/HSS to those partners that are cautiously supportive and a few who are strongly in favour of continuing with PBS/C2.

International Health Partnership (IHP) in Ethiopia

Ethiopia, which is a first wave signatory to the IHP, has jointly developed the roadmap for harmonization and alignment of government and partner programmes and financing towards attaining the health related MDGs (November 1999). Subsequently, the draft compact between the GOE and Development Partners to scale up efforts to reach the health MDGs was formulated and is under review. This instrument builds on the existing Code of Conduct of 2005. The IHP has also revitalized and refocused dialogue amongst key stakeholders towards Ethiopia's desire to attain the MDG goals. Early adopters are supportively engaged but also taking into consideration their headquarters' guidance.

Considering the fact that the conditions set in the draft IHP compact for the establishment of the MDG fund are much tighter than those set in the Code of Conduct, Development Partners indicate that they require confirmation of functionality of key sector systems' performance. In view of the fact that the MDG PPF is central to the compact's design and commitment, it is expected that the like-minded partners that are willing to progressively shift to the MDG PPF would negotiate with the above mentioned concerns in mind. A fresh concern that may affect negotiations on the compact is the proposed NGO/CSO legal framework that is underway. The views of key stakeholders are assumed to affect the response to the compact even by those who have been keen to use the Fund.

Table 4.11 Recommendations for Alignment and Harmonization

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Capacity	Assessment of ministry financial, procurement, audit and capacity and improvement plan.	Develop tools and mechanisms for annual systematic monitoring of the Paris Declaration on alignment and harmonization indicators as a package.	

4.6. Partnership with the NGOs/FBOs/CSOs

A number of NGOs are using HSDP III targets to guide their strategic planning and project development. In 2001 (EFY) wereda-based planning included partners (NGOs/CSOs) in a number of regions. This represents a good initial step in alignment with regard to planning processes. Since financial contributions by the NGO/CSOs are formally declared to the government, their support can be known during the planning process and should not be an obstacle to their participation in the planning process.

The level of support from the private sector varies significantly between regions. Whilst there is a clear process for appraising and approving NGO projects at the regional level, there is limited possibility for the RHB to track NGO achievements and expenditure. Activity reports are submitted quarterly by NGOs to the Disaster Prevention and Preparedness Commission (PPC), but this information is not easily accessible by the RHB. However, depending on existing relations, such information should be provided directly to the RHB to allow for a full picture of the financial resources in the regions.

A task force was established to strengthen PPP, develop a series of guidelines to improve the working relationships and to update the standards of practice for the private sector as part of the government's commitment to PPP. To date, there has been no visible progress.

International NGOs participate in regional working groups, and sometimes in the RJSC, but membership tends to be based on the level of resources provided, rather than representation of civil society. NGO networks have established HIV and AIDS forums at the regional level to coordinate NGOs' in the area of service delivery, standardize approaches and reduce competition between agencies. There is an opportunity for the RHB to utilize such forums to facilitate joint-planning and resource mapping. Due to the number of high level of international and national NGO/CSO/FBO, representation needs to be strengthened at in order maximize utilization of resources and enhance NGO contribution as well as to reduce duplication of efforts.

Table 4.12 Recommendations for Partnerships with NGOs/FBOs/CSOs

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Mapping, Planning and Networking	Conduct NGO resource mapping to reduce duplication of services.	Involve NGOs/CSOs/FBOs in wereda- based planning process at all stages.	
		Promote an international NGOs network using an acceptable mechanism to enable harmonization and effective communication.	
		Strengthen CRDA's capacity to support sector NGOs/FBOs/CSOs.	

4.7. The Right to Health Care

Though the GOE is a member of the United Nations and has ratified major international conventions such as Convention of Civil and Political Rights, Convention on Economic and Social and Cultural Rights, the Universal Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women, a rights-based approach and principles have not been incorporated into the HSDP III. This, notwithstanding, provisions are made that show the commitment of the government to cardinal principles of Human Rights.

Representation, participation and capacity building were critical in the development of plans and most regions reported capacity support and inclusiveness in preparation of the plans. Participation is encouraged from the wereda level upwards and this provided the much needed accountability framework where inadequacies in relation to services and equipment were identified for action. Physical access to health facilities has improved since the health posts were constructed in the communities to minimize travel distance.

A fee waiver system is operational at the grassroots level which enables support for the poorest of the poor to access services for free, provided they receive a letter of exemption from their local kebele. There is, however, a lot more work to be done in reaching the poorest of the poor in geographically compromised areas. At the same time no standard criteria for exemption exists. The fee waiver legal and policy framework needs to be strengthened and uniformly applied so as not to compromise the quality of service. In addition, access to information needs to be ensured.

It was widely reported that information on human rights is lacking amongst staff, which explains why a rights based approach to programming is not addressed as a planning responsibility for health.

The weak health service delivery system will create problems for vulnerable groups like mothers and children. In reality, there are multiple social, logistical and financial barriers to girls, women and men accessing health care services in all regions. Despite the effort being made by the Ministry through the HEWs, the distances they have to cover are enormous. The following parameters that affect accessibility require further attention: (i) gender-based judgmental attitudes of families; (ii) general lack of information about available services; (iii) lack of privacy and confidentiality in some of the facilities which is a significant barrier to access; (iv) traditional norms of gender inequality, perpetuation of harmful practices such as female genital mutilation.

In some regions acceptability is hampered by language barrier between the health providers including the health providers and the consumers because the people trained cannot speak the local language. The other barrier on acceptance is the recruitment of mainly male staff; therefore women are not able to benefit from their service especially on maternal health and family planning.

Table 4.13 Recommendations for Right to Health Care

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
Period	EFY 2001	EFY 2001-2003	After EFY 2003
Awareness and Access to Information		Create awareness and access to information about the available services at the community, kebele and wereda levels including the urban population.	Integrate a rights-based approach to health in the design of HSDP IV and human rights related targets in provision of care.

Actions to be Undertaken	Short-Term In Next EFY 2001	Medium-Term Within HSDP III	Long-Term Design HSDP IV
		Build capacity of all staff at all levels on human rights concepts and rights-based approach to provision of health care and appoint focal persons on human rights.	
	Integrate rights based approach into the HHM.		
	Liaise with National Human Rights Commission and Capacity Building Bureau to integrate human rights framework in HEW modules.		

5. Overall HSDP III Performance

Introduction

There is strong commitment to achieving the MDGs and HSDP III targets both in the areas of service delivery and systems strengthening by both FMOH and Partners. Stakeholders have been mobilized around the same vision. Alignment and harmonization of stakeholders is increasing through strengthened annual budgeting and planning processes which are developed to deliver the national and regional five-year strategic plans for the sector. Massive expansion of primary health care has taken place and systems are now been strengthened to support this expansion, a transition from expansion to consolidation is being observed. However, physical coverage of facilities alone is not sufficient to address issues of access, utilization and equity. A major issue for the sector is the inadequacy of the resources available to the sector, growth in real terms is low and the National Health Account's 2005 estimate of USD 7.50 per capita is a long way short of the Macro-Economic Commission on Health's estimation of USD 34 per capita. The crisis in human resources as well as the need to build the capacity of health managers at all levels is restraining the potential effectiveness and efficiency of the sector.

5.1. Policy Changes

A number of policy changes have taken place at the national level but have not been fully implemented at the regional and wereda levels. In many instances, documents regarding new policies are absent in the regions and weredas and staff are unable to implement them and are still following previously available guidelines. For example, human resource policy documents are absent at all levels in the region. During the review it was evident that some health programme managers at RHB and wereda level were versed with the health policy framework while others were not. In many instances policy documents were not available for managers to refer to. Local offices of major NGOs were not well-informed of the national level policy developments in the health sector.

There is a need for a policy and guidelines to guide *public private partnership* in terms of delivery of services and establishing roles and responsibilities for regulations and reporting responsibilities. This is especially urgent as the private sector is growing in Ethiopia.

A policy on *monitoring and evaluation* of the sector as a whole needs to be developed, outlining the role of different methods and tools to monitor and evaluate the sector, linking M&E to tracking the sectors progress towards MDGs and HSDPIII targets. There is also a need for a policy decision on the adoption of a uniform HMIS system for the country, and allocate appropriate funding to implement it.

A policy on the adoption of *new technologies*, including ICT and the use of alternative power sources and the adoption of technologies which are more appropriate to the environment in which services are to be delivered, needs to be developed to guide the sector. In addition the sector requires a policy on *plant and equipment maintenance*. There are already initiatives in this area under the 'blueprints' for hospital management developed through the Clinton Foundation initiative (see sections 2.1.5 on medical services and section 3.1. on facility construction and rehabilitation).

A *health sector financing policy* will provide an overview of how all sources of health sector financing can be used to the best benefit for the sector as a whole. This includes the role of social health insurance, protection of basic services, and prioritized public health sector financing towards the delivery of core basic services to the most poor and vulnerable in the country. Policy decisions need to be taken to extend the funding of waivers and exemptions

to include other out-of pocket expenditure to promote access to essential services for the most vulnerable, Alternative types of financing such as demand side financing need to be considered under broader health sector financing strategies.

The existing *population policy* needs to receive increased attention in the health sector. Although the sector is expanding coverage of services to the population at an accelerated rate this is against an ever increasing population which means that comprehensive coverage of essential services constantly needs to expand. This has serious implications for planning and budgeting of services, including what targets and indicators are set to monitor progress of the sector. Population issues, including family planning, and early-marriage, need greater inclusion in curriculum in training institutions and schools.

The adoption of a *rights-based approach* to health needs policy guidance. This is where patients become claimants on the health sector and the sector is held accountable to provide services on an equitable basis. Such an approach will need to address issues of gender, poverty and discrimination in a more holistic and coordinated way.

As national policies are developed, there is need to follow-up not just with strategies for implementation, but also means of monitoring and evaluating their implementation. There is need to move from using health information systems towards broader sector monitoring and evaluation, which needs to develop capacities to carryout non-routine surveys and assessments, such as national health accounts, public expenditure reviews, and public expenditure tracking surveys.

5.2. Equity

Equity is being addressed with the policy of first building health posts in the under-served areas and providing them with HEWs who target households. But equitable access to key, curative services needs to be strengthened by ensuring consistent strengthening of health centres and hospital services and provision of referral systems and mechanisms. Increased supply of essential drugs, equipment and building adequate capacity of health staff especially at the lower level, where the majority of poorer people access health care, can address equity. The current exemption of essential services and the fee waiver system is also addressing equity of access, however both need strengthening in terms of range of services fully exempted and availability of funding to cover the cost of waivers. The pastoralist strategy is in place and focal persons are assigned. The implementation of the pastoralist strategy needs further acceleration both in terms of quality and coverage/accessibility so that those more underserved populations can be reached.

Very low utilization of services by the poor in urban areas suggests that supply-side interventions are inadequate to address equity of access if implemented in isolation. There are indications that investing in demand side interventions may prove more effective to increase access than expanding coverage and quality of care only. The GOE plans to address these issues through the expansion of a combination of community-based approaches (the health promoters' package) and enhanced use of the media. Health promoters are trained to support activities that promote behaviour and value change by utilizing resources from both the public and the private sectors. These demand side promotion initiatives may need to be complemented with further financial incentives to poorer non-users to help them use services.

5.3. Efficiency and Effectiveness

In health care, efficiency can pragmatically be looked at as either producing a desired output at a minimum cost or else combining available inputs efficiently so as to achieve the maximum benefit. Adoption of the essential health services package, which is based on cost effective interventions, to address the highest disease burdened is an efficient use of limited

resources. By defining the levels of care and packages to be delivered at those levels the sector is attempting to improve the efficiency of its investment in terms of what output can be expected.

It is important for the sector to consider changes in delivery mechanisms even though they may have the desired output but they may not be an efficient way of achieving that output. What is important is that in a resource constrained environment due consideration is given to the efficiency and effectiveness of how limited resources are used.

How inputs are combined or coordinated can also lead to inefficient and ineffective use of resources. There are many examples of inefficient use of resources: physical infrastructure available before equipment or appropriate staff is in place, trained staff deployed but insufficient equipment and supply of drugs and medical supplies for them to use their skills. The current expansion of physical infrastructure and certain cadres of staffing without the balance of health systems strengthening to support them in their work may also have an inherent level of inefficiency and in the short-term are ineffective at reaching the targets that this investment in the sector is expected to achieve.

Improving routine support services can have a positive impact on efficiency and effectiveness. For example addressing delays in funds release through more efficient financial management can mean that other investments in staffing and infrastructure can be more productive and potentially more efficient. Other essential systems such as procurement and logistical supply management can have a major impact on the efficiency of other inputs.

While much work is being done at the national level to address the overall efficiency of the sector, especially within the context of the civil service, there is also need for the sector to address efficiency and effectiveness at the programme and implementation level. There is a need to set and monitor programme targets to define effectiveness of implementation. The M&E system needs to be appropriate to monitor such effectiveness. Adoption of new technologies and new procedures can increase efficiency; this means that continuing medical education in new technology and treatment practices can increase both the efficiency and effectiveness of health workers and needs continuing support. Task transfer from one cadre to another can also be more efficient use of available resources.

5.4. Health Status Changes and the MDGs

The main health status indicators being monitored by the health sector relate to infant and child mortality rates, maternal mortality ratio and total fertility rates, all of which are collected through surveys such as the DHS.

Overall programming to achieve the MDGs in Ethiopia is through national development and poverty reduction strategies (PASDEP). HSDP III is aligned to the PASDEP and is the sectors' contribution towards national development and poverty reduction. Regions are also monitoring their progress through their annual progress reports, and have aligned their current five-year strategic plans with the MDGs and the HSDP III.

The sector monitors the percentage of children under-five years that are underweight or stunted. It is hoped that this figure will be collected through routine data sources but the last national figure was through the DHS. Regions do report screening for underweight children both routinely and through campaigns. Achieving MDG 1, eradicate extreme hunger, requires a multi-sectoral approach. The health sector is working very vigorously on both addressing the impact of extreme hunger through treatment of malnutrition but also through moving to address the causes of malnutrition and implementing more preventive strategies.

The fate of newborns, mothers, and children is closely linked, support must be focused to promote integrated maternal and child health package to reduce service-level, missed opportunities in the context of continuum of care approach and to provide services both at home and health facility, at every stage of life.
The risk approach has not worked and every pregnancy faces risk and thus pregnant women and their newborns should have access to proper care during pregnancy and delivery. To achieve the MDG 4 and 5 by 2015, experts have also recently recommended universal access to skilled care As the government HRH assessment report (FMOH, 2007) indicates, achieving health related MDG targets, especially reduction of maternal and associated newborn mortality reduction seems to be a daunting task, considering the huge gap in the supply and demand for human resource to meet the minimum staffing pattern for scaling up basic and emergency obstetrics and newborn care services in health centres and hospitals.

The national response to HIV/AIDS has been re-oriented in the context of the MDG 6 towards achieving a universal access focusing on three instrumental strategic approaches – the HEP, health facility expansion and capacity development (human resources). Progress on HIV/AIDS and malaria is commendable; however TB control needs attention if MDG targets for case detection are to be met.

The health sector is making impressive achievements towards targets of MDG 7 (environmental sustainability), especially in the areas of increasing access to safe water and the proportion of people with access to improved sanitation.

Table 5.1 Health Related MDGs and Progress towards PASDEP 2009/2010 Targets

Goals	International Targets	PASDEP Targets 2009/2010	Current Status
Goal 1: Eradicate extreme poverty / hunger	Target 2: Reduce by half the proportion of people who suffer from hunger		38%*
Goal 4: Reduce child mortality	Target 5: Reduce by two thirds the mortality rate among children under five		
	Under-Five Mortality Rate	85	123*
	Infant Mortality Rate	45	77*
	Proportion of 1 year-old Children Immunized Against Measles	DPT3 coverage 80%	68%**
Goal 5: Improve Maternal Health	Target 6: Reduce by three quarters the maternal mortality ratio		
	Maternal Mortality Ratio	600	673*
	Proportion of Births Attended by Skilled Health Personnel	32%	16% **
Goal 6. Combat HIV/AIDS, Malaria and other diseases	Target 7: Halt and begin to reverse the spread of HIV/AIDS		Adult HIV Prevalence 2.1% (Single Point Estimate 2007)***
	HIV Prevalence Among 15-24 year-old Pregnant Women	HIV prevalence among 15-24 year old pregnant women 8.4%	Only 6.48% of HIV-positive pregnant women received antiretroviral drugs to reduce the risk of mother-to-child transmission***.
	Condom use rate of the contraceptive prevalence rate and Population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	60% of people aged 15-24 years reporting the use of a condom during last sexual intercourse with a non-regular sexual partner	Data on condom use by 15-24 years age group needs to be done through secondary analysis of DHS data or collected through Behavioural surveillance survey, the last BSS was conducted in Ethiopia in 2002 15.8% of women and 28.7% of men aged 15-49 years have comprehensive

Goals	International Targets	PASDEP Targets 2009/2010	Current Status
			knowledge of HIV and AIDS ***
	Target 8: Halt and begin to reverse the incidence of malaria and other major diseases		
	Proportion of Population in Malaria Risk Areas Using Effective Malaria Prevention and Treatment Measures	100% of households in malaria areas with two ITNs	Over 20.5million ITN distributed Universal access to ACT through HEP/Malaria Campaigns
	Prevalence and Death Rates Associated with Tuberculosis		Death Rate 5%**
	Proportion of Tuberculosis Cases Detected and Cured Under Directly-Observed Treatment Short Courses	TB Cure Rate 85%	CDR 32% ** TB Cure Rate 68% **
Goal 7. Ensure environmental sustainability	Target 10: Reduce by half the proportion of people without sustainable access to safe drinking water		
	Proportion of the Population with Sustainable Access to and Improved Water Source	Total population with access to safe drinking water (rural and urban) 84.5%	51%****
	Proportion of the Population with Access to Improved Sanitation		50.8% ****

* Ethiopia Demographic Health Survey, 1997 EC,

** Health and Health Related Indicators, FMOH 1999 EC

*** Report on Progress towards Implementation of the UN Declaration of Commitment on HIV/AIDS, UNAIDS Ethiopia Country Progress Report 2008

**** UNICEF background document on Hygiene and Environmental Health

6. Status of Recommendations

Introduction

During the past few years, there have been a number of recommendations that have prompted responsive actions by the health sector. Recommendations assessed for follow-up during the current review include HSDP II evaluation, 8th and 9th ARM in 1998 and 1999. The follow-up of recommendations are organized around major components of HSDP and health system reform focus areas. In the current review, follow-up of recommendations related to HEP and maternal and newborn health have been looked at in-depth.

In general the health sector has implemented the majority of the recommendations that have been possible in the implementation period of the past two and half years. In some areas, the sector made substantial progress in implementation, while in a few areas recommendations are either dropped or not followed up. In this section, implementations that have not been followed up are presented while the full overview of the most important recommendations and follow-up are summarized in Annex 8.

Service Delivery

HEP

Formulation of career structure for HEWs has not yet been finalized (at planning stage at federal level), the quality of the pre-service training has not improved.

Maternal and Neonatal Health

Proclamation has been passed on providing free services for maternal and child health services. However, the current health system does not guarantee women have access to basic maternal health services such as delivery (women have still to pay substantial amount of money for supplies and drugs). Advocacy for maternal health has not been strategically organized. No strong activists for safe motherhood exist. Not much has been observed in integrating human right approaches in maternal health improvement. In most facilities visited, BEmONC services are not provided. Effective referral and feedback mechanism is not in place, equipment and supplies for maternal health is inadequate. Midwifery training lacks standardization at federal level. Rolling out of safe abortion services is minimal. Integration of HIV/AIDS with reproductive health services is on-going in areas of family planning, PMTCT, but integration has not been done at all levels of the health system.

EPI and IMNCI

The Issues of cold chain equipment maintenance and availability of skilled staff have not been fully addressed. Use of antibiotic for treatment of pneumonia of children in the HEP is not yet initiated and still in discussion at federal level. Youth-friendly services have not yet been scaled-up to all facilities. Contraceptive stock-outs have been addressed fully. Partnership with NGOs and the private sector has been strengthened contributing to improved community distribution of family planning commodities. However health facilities-based family planning methods (surgical methods, IUD) are still weak. Implementation of PLMP is at initial phase. Method mix is still largely limited. Emergency contraceptive has not yet reached most facilities.

Disease Prevention and Control

Utilization has not been assessed. Community DOT has been scaled up. TB detection rate is still low. No study/research on barriers to detection and diagnosis of TB. There has been an attempt to gradually move HIV funding to be used for health system strengthening but not to effective level.

Cross-Cutting Issues
The provision of technical assistance on gender is not made available to the regions. Salt iodization has been initiated but is not universal and the USI has not been launched. HEPR still largely focuses on response than prevention of emergencies and its institutional position needs to be strengthened. Some regions have trained HEPR staff.

Support Systems

Construction
Functionality of constructed/up-graded health facilities is still a problem because of water supply, electricity and staffing.

Human Resources for Health
There is no guidance from the federal level to harmonize hardship compensation, incentive and retention mechanisms. Effectiveness of in-service trainings of B/CEmOC human resources varies from region to region. Most in-service training are still vertical and donor driven rather than based on identified skill gaps and the HRIS database has not been implemented.

Pharmaceutical Supplies and Management
Effectiveness of the roles of DACA, PSLD, PFSA, regional health bureaus and health facilities is not monitored. Harmonization of budget and special pharmacies has not been undertaken.

HMIS & M&E and Operational Research
The piloted HMIS evaluation recommendation for scaling up scheduled for January 2000 (EC) is not yet done and regional HMIS team are awaiting decision to be made urgently. Operational research is lacking at the regional level.

Governance and Finance
Outsourcing of nonclinical hospital services is still in the planning stage. Alignment of budget reforms with HSDP component structure is remain a challenge and the accurate costing of all expenditures is still a work in progress. Draft insurance regulation has not been communicated to the Council of Ministers for endorsement. Planning capacity at health offices has been strengthened but management capacity is a concern. Replacement of RJSC with technical committee with broad membership from public and private sectors has not been done. The functionality of the Joint Steering Committees has been reviewed but proposal to strengthen them has not been concluded.

Harmonization
Predictability of funding is still a problem. Subsequent advocacy has not been effectively made on including more Development Partners in the Code of Conduct signatories. GFATM and CDC have not yet become signatories.

Challenges to Implementation of the Recommendations
The recommendations that have not been implemented or that have been insufficiently implemented, have inherent problems that may be taken as 'pending implementation'. Recommendations that are general and vague and that do not specify *how* they can be implemented are generally executed unsatisfactorily. Recommendations that were not fully accepted or endorsed are either dropped or weakly implemented. As an example the 2005 (GC) HSDP II evaluation recommended replacing the RJSC with a technical committee under the regional committee with broad membership from public and private sectors. At the same time, the HSDP Harmonization Manual (HHM) in 2007 reinforced RJSC.

The ARMs follow a slightly different format than the HSDP evaluations for reviewing progress made, making it difficult to assess follow-ups of recommendations. As an example, ARM 1999 has thematic areas by health facilities while HSDP reviews use HSDP programme components as thematic areas.

Annexes

Annex 1A Performance Indicators of HSDP III: 1997-2000

	Number of Weredas: 819	Results HSDP II = Baseline HSDP III	Results HSDP III			HSDP III Target	MDG Target
		1997 2004-05 GC	1998 2005-06	1999 2006-07	2000* 2007-08	2003 (Nat'l)	2007 (Nat'l)
Demographic Statistics	Total Population	73,043,510	75,067,000	77,127,000	79,220,222		
	Expected pregnancies	2,915,033	2,750,419	2,825,768	2,902,330		
	Expected deliveries	2,915,033	2,750,419	2,825,768	2,902,330		
	Children under-five years	12,077,375	12,419,994	12,738,325	13,103,741		
	Children under-one year	2,431,822	2,800,593	2,495,109	NA		
	Surviving infants (DPT3, Measles, FIC Target 1994 on)	2,587,784	2,561,768	2,504,853	2,715,022		
	WRA (15-49 years)	17,526,883	17,925,310	18,431,848	18,657,103		
Health Status	Infant Mortality Rate (DHS)	77			0	45	
	Under five Mortality Rate (DHS)	123			0	85	67
	Maternal Mortality Ratio (DHS)	673				600	450
	Total Fertility Rate (DHS)	5.4			0	4	
	% < 5 yr underweight / stunted (HMIS)						
	… (-2SD, W/A) (DHS)	47%			0%		
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ (HMIS)	26%	22%	0%	0%		
	% pregnant women TT2+ (HMIS)	43%	53%	0%	0%		
	… (DHS)						
	% ANC Coverage (HMIS)	42%	51%	51%	27%	80%	
	… (DHS)	28%					
	% Births attended by skilled staff (HMIS)	12%	15%	16%	10%	32%	
	… (DHS)	6%					
	% PNC Coverage (HMIS)	13%	16%	19%	11%		
	… (DHS)						
	Contraceptive acceptor rate (HMIS)	21%	30%	28%	20%	45%	44%
	Contraceptive prevalence rate (modern) (DHS)	14%					
	% < 1 yr immunized for DPT3 (HMIS)	70%	76%	77%	37%	80%	
	… (DHS)	32%					
	% < 1 yr immunized measles (HMIS)	61%	66%	68%	32%		
	… (DHS)	35%					
	% Fully immunized < one year (HMIS)	44%	54%	55%	23%	54%	
	… (DHS)	20%					
Service Delivery Outputs: Disease Preventio	TB Case Detection Rate	34%	30%	32%	16%	50%	
	TB Cure Rate %	65%	62%	68%	66%	85%	
	TB Treatment Success Rate %	81%	76%	85%	66%		
	% Hospitals / health centres providing DOTS / MDT	85%	95%	0%	0%	72%	
	HIV Prevalence (15-24 pregnant women)					<4.4%	

	Number of Weredas: 819	Results HSDP II = Baseline HSDP III	Results HSDP III			HSDP III Target	MDG Target
		1997 2004-05 GC	1998 2005-06	1999 2006-07	2000* 2007-08	2003 (Nat'l)	2007 (Nat'l)
n and Control	HIV/AIDS Adult prevalence (%)	4.6%					
	HIV Incidence (%)	1.83%					
	% Hospitals / health centres with VCT	NA				NA	
	Malaria case fatality rate	6%	NA	NA	NA	2%	
Hygiene and Environmental Health	Access to safe water %	36%					
	Access to improved sanitation %	29%	NA	NA	NA	80%	
Access to Medical Services	Potential Coverage Health Facilities (FMOH+NGO)	72%	77%	104%	109%	100%	
	% population within 10km of health post or centre	NA				NA	
	Health Centre / Pop Ratio	1 : 121,739	1 : 118,216	1 : 111,778	1 : 114,812	NA	
	Outpatient visits / pp / yr	0.30	NA	NA	0.32	0.66	
	Admissions / p100p / yr	1.6	1.2	0.8	0.2	NA	
	Doctor / Population Ratio	1 : 67,821	1 : 67,506	1 : 79,267	1 : 56,545	1 :14,000	
	Nurse / Population Ratio	1 : 6,082	1 : 5,953	1 : 5,928	1 : 4,916	NA	
	Midwife / WRA Ratio	1 : 13,682	1 : 16,831	1 : 19,734	1 : 19,975	1 : 6,759	
	HEW / Population Ratio	1 : 26,687	1 : 8,434	1 : 8,608	1 : 3,844	1 : 2,500	
Quality and Management	JSC / RJSC meetings						
	%Tracer drugs available					100%	
	HMIS completeness and timeliness rate					80%	
Efficiency and Finance	Government budget allocation to health (Birr x 1000)	1,643,110	1,184,040	1,527,433	3,920,200		
	% GOE budget allocated to health		17%	16%	29%	'Double'	
	GOE pc budget for health (Birr/pp)	22.5	15.8	19.8	49.5		
	GOE per capita expenditure on health (Birr / pp)	19.1	13.4	15.5	0.0	9.6	
	Total annual per capita expenditure on health (US$)					$9.60	
	Absorptive capacity (expenditure/budget)	85%	85%	78%	-		
	Bed Occupancy Rate	50%	25%	45%	-		
	% fees retained					100%	
Demographic Statistics	growth rate	2.78%	2.77%	2.74%	2.71%		
	pregnant pc	3.99%	3.66%	3.66%	3.66%		
	delivery pc	3.99%	3.66%	3.66%	3.66%		
	under five pc	16.53%	16.55%	16.52%	16.54%		
	under one pc	3.33%	3.73%	3.24%	NA		
	surviving infants pc	3.54%	3.41%	3.25%	3.43%		
	WRA (15-49) pc	24.00%	23.88%	23.90%	23.55%		

* = Performance data have been doubled based on past six months outputs (July – Dec 2000)

Annex 1B Performance Indicators of all HSDPs 1989–2000

Number of Weredas: 819		HSDP I Baseline	HSDP II Baseline	HSDP II Target	HSDP II Final Results	HSDP III Target	HSDP III Result MTR	MDG Target
		1989	1994	1997	1997	2002	2000*	2007
		1996-97 GC	2001-02 GC	(Nat'l)	2004-05 GC	2009-10	2007-08	2014-15
Demographic Statistics	Total Population	57,272,564	67,220,000		73,043,510		79,220,222	
	Expected pregnancies	2,319,539	2,682,445		2,915,033		2,902,330	
	Expected deliveries	2,319,539	2,682,445		2,915,033		2,902,330	
	Children under-five years	8,432,500	11,632,130		12,077,375		13,103,741	
	Children under-one year	1,495,219	2,545,926		2,431,822		NA	
	Surviving infants		2,381,309		2,587,784		2,715,022	
	Women of Reproductive Age (15-49 years)	13,152,237	15,992,002		17,526,883		18,657,103	
Health Status	Infant Mortality Rate (DHS)	105			77	45	--	
	Under five Mortality Rate (DHS)	172			123	85	--	67
	Maternal Mortality Ratio (DHS)	560 - 850		450	673	600		450
	Total Fertility Rate (DHS)	6.4			5.4	4	--	
	% Under five years underweight / stunted (HMIS)							
	… (-2SD, WfA) (DHS)				47%		--	
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)		11%		26%		--	
	% pregnant women TT2+ coverage (HMIS)	34%	25%		43%		--	
	… (DHS)							
	% ANC Coverage (HMIS)	28%	34%	45%	42%	80%	27%	
	… (DHS)				28%			
	% Births attended by skilled staff (HMIS)	9%	10%	25%	12%	32%	10%	
	… (DHS)				6%			
	% PNC Coverage (HMIS)	4%	7%		13%		11%	
	… (DHS)							
	Contraceptive acceptor rate (HMIS)	9%	14%	24%	21%	45%	20%	44%
	Contraceptive prevalence rate (modern) (DHS)				14%			
	% < 1 yr immunized for DPT3 (HMIS)	68%	51%	70%	70%	80%	37%	
	… (DHS)				32%			
	% < 1 yr immunized for measles (HMIS)		42%		61%		32%	
	… (DHS)				35%			
	% Fully immunized under one year (HMIS)		30%		44%	54%	23%	
	… (DHS)				20%			
Service Delivery Outputs:	TB Case Detection Rate				34%	50%	16%	
	TB Cure Rate %		66%		65%	85%	66%	
	TB Treatment Success Rate %		81%		81%		66%	

Disease Prevention and Control	% Hospitals & health centres providing DOTS / MDT			75%	85%	72%	0%	
	HIV Prevalence (15-24 pregnant women)			<7%		<4.4%		
	HIV/AIDS Adult prevalence (%)	3.3%	4.1%		4.6%			
	HIV Incidence (%)	1.47%	1.74%		1.83%			
	% Hospitals / health centres with VCT							
	Malaria case fatality rate		-	15%	6%	2%	NA	
Hygiene and Environmental Health	Access to safe water %	27%		42%	36%			
	Access to improved sanitation %	10%		35%	29%	80%		
Access to Medical Services	Potential Coverage Health Facilities (FMOH+NGO)	64%	62%		72%	100%	109%	
	% population within 10km of Health Post/Centre							
	HC / Pop Ratio	1:222,850	1:163,155	!:135,000	1:121,739		1:114,812	
	Outpatient visits / pp / yr		0.03	0.50	0.30	0.66	--	
	Admissions / p100p / yr		-		1.6		0.2	
	Doctor/Population Ratio	1:38,619	1:45,175		1:67,821	1:14,000	1:56,545	
	Nurse/Population Ratio	1:13,921	1:6,956		1:6,082		1:4,916	
	Midwife/WRA Ratio	1:52,609	1:17,233		1:13,682	1:6,759	1:19,975	
	HEW/Population Ratio				1:26,687	1:2,500	1:3,844	
Quality and Management	JSC / RJSC meetings							
	%Tracer drugs available			80%		100%		
	HMIS completeness and timeliness rate					80%		
Efficiency and Finance	Government budget allocation to health (Birr)	669,718,136	NA		1,643,110,000		3,920,200,000	
	% GOE budget allocated to health					'Double'		
	GOE per capita budget for health (Birr / pp)	11.7	NA		22.5		49.5	
	GOE per capita expenditure on health (Birr / pp)	9.5	NA	18.0	19.1	9.6	--	
	Total annual per capita expenditure on health (US$)	$4.09		$6.00		$9.60		
	Absorptive capacity (expenditure / budget)	82%	NA		85%		-	
	Bed Occupancy Rate				50%		-	
	% fees retained			20%		100%		

Source: Demographic and Health Survey 2000 and 2005; Health and Health Related Indicators 1994 - 1997; HSDP II and HSDP III

* = Performance data have been doubled based on past six months outputs (July – Dec 2000)

Annex 2 National and Regional Performance Indicators (1989 – 2000 EC)

PLEASE CONSULT THE EXCELL SHEET PROVIDED IN A SEPARATE FILE

Annex 3 TERMS OF REFERENCE

Mid-Term Review of HSDP III
(15.05.2008)

I. Introduction

Ethiopia is committed to achieve the Millennium Development Goals (MDGs) by designing and implementing accelerated development strategies and programs. The Plan for Accelerated and Sustained Development to end Poverty (PASDEP) is the national development program that is being implemented to end poverty.

The Health Sector Development Program (HSDP) is the main medium of translating the health component of the PASDEP. It is a 20 years sector wide program which focuses on the prevention and control of poverty related diseases through the adoption of practical strategies to enhance the achievement of the MDGs.

HSDP has been implemented based on five and three-year strategic plan and currently the Government of Ethiopia is implementing the third phase (HSDP III) since 2005/6.

HSDP III is serving as the sector's comprehensive national plan and guiding framework for the detailed planning and implementation of the health sector activities by all level (the Federal, Regional and Woreda) and partners. It has been developed through extensive consultative process and finally endorsed by the government and development partners.

The Regional Health Bureaus have developed their own Health Sector Strategic Plans derived from the national one and Woreda Health Offices have been exercising the development of their own strategic plan.

The cost to implement HSDP III was developed using the Marginal Budgeting for Bottlenecks (MBB) tool which is based on the marginal cost and impact on mortality reduction and was done with different scenarios.

The major goals of HSDP III are improving maternal health, reducing child mortality and combating HIV/AIDS, malaria, TB and other diseases with ultimate aim of achieving the Millennium Development Goals (MDGs) and improving the health status of Ethiopian peoples.

Based on the guiding framework of HSDP III, the implementation of the health care services has been continued by developing annual plans, capacitating the human resources, mobilizing funds, conducting supervisions and review meetings, compiling and evaluating reports. There were also tremendous efforts to improve the health system, as part of the general plan, by developing and implementing guidelines and manuals.

The HSDP Harmonization Manual (HHM) is one of the practical documents developed to strengthen the health system by ensuring proper planning and implementation of activities for the Health Sector Development Program.

The HHM indicates the need for a midterm review of the third five-year health sector development strategic plan. This Terms of References is therefore developed to serve for this purpose.

The general scope of the mid term review of HSDP III

One of the program implementation arrangements in HSDP III is its monitoring and evaluation which includes the mid-term review of the five-year strategic plan.

The Health Sector Development Program needs to be monitored to ensure that the implementation of activities is proceeding as planned and scheduled. It is also used to improve the management, maximum utilization of resources and make timely decision to resolve constraints and /or problems encountered during implementation.

According to the harmonization guidelines, the HSDP III mid-term review is planned to take place on the third year of plan period, i.e., from March to April 2008. But due to some delays this will be done in May and June. It will be conducted by teams of national and international experts according to this Term of Reference developed by the Joint Core Coordinating Committee (JCCC) and approved by the Central Joint steering Committee (CJSC).

Therefore, the mid-term review is expected to assess the relevance of the activities, the progress made, the problems encountered and the experiences gained in the process of implementing the program. The review will use the detailed programmatic indicators & targets of HSDP and assess findings, conclusions and recommendations of the JRMs, ARMs, FMOH-HPN joint consultative meetings, Evaluations of HSDP I and II, new guidelines and manuals of different health service programs, and recent studies and relevant documents in the health sector of Ethiopia as reference documents.

The review is expected to provide pertinent information on the progress of the program, achievements obtained so far, constraints and/or challenges encountered and solutions provided, covering all the seven program components as well as cross-cutting issues of HSDP III. It is also expected to draw best lessons learned and experiences gained and forward recommendations on the overall performance of the program.

II. Objectives of the HSDP III mid term review

General objective:

To measure and document the extent to which the targets set for the HSDP III are achieved, assess constraints and/or challenges encountered and solutions provided, draw best lessons learned and experiences gained, and forward recommendations to improve future management and implementation of activities to attain the HSDP goals.

Specific objectives:

1. To quantify Government budget allocation to the health sector
2. To quantify the total per capita health expenditure
3. To quantify the ratio of budget allocation to utilization/expenditure
4. To measure the essential drug stock-out rate
5. To assess HMIS completeness and timeliness reporting rate
6. To assess the level of HSDP harmonization with the “one plan, one report and one budget” principle.
7. To assess the primary health service coverage
8. To measure the health service utilization rate
9. To assess the contraceptive prevalence rate
10. To assess the proportion of births attended by skilled health personnel
11. To measure pentavalent coverage

12. To measure ART coverage
13. To assess the performance and coverage of community conversations at different level
14. To assess the PMTCT service
15. To measure ITNs coverage rate
16. To assess inpatient case fatality rates
17. To measure TB case detection and treatment success rates
18. To assess the improvement of sanitation access rate
19. To proportionate institutions staffed as per standards

The above specific objectives are for the general study and the proposed areas for the focused study are:

- Maternal and neonatal mortality reduction
- Health Extension Package

III. Expected outcomes:

The final outcome of the whole Review Process will be a **Main Report**, which captures:

7. The strengths and weaknesses of the health system in the national policy context (democratization & decentralization, development of preventive & promotive health service, and other policy focuses) to proceed with the implementation of the HSDP;
8. The level of progress made in achieving both impact and outcome indicators during HSDP III period;
9. The strengths, weaknesses and main challenges of the implementation process of HSDP III key activities in the context of its main goals and major objectives, the national development program (PASDEP) and the MDGs;
10. Identification of best practices and lessons learnt and major implementation problems;
11. Conclusion on achievements to determine whether HSDP III is on track or needs any adjustments in implementation including recommendations on useful measures that will help to improve the implementation of HSDP III in the remaining period of time;
12. Provide recommendations for the formulation of the HSDP IV for issues that require long term implementation

IV. Specific issues to be addressed

The review should focus on the improvements, strengths and weakness of implementation, lessons learned and best practices gained of each components of HSDP.

It should also assess the status of HSDP monitoring indicators and present additional information on implementation progress and challenges.

V. Approach and methodology of the HSDP III mid-term review

The team leader will have a short preparatory visit to Addis where he will be working with the JCCC for the preparation of the study.

The consultancy team is expected to:

- Develop guides and tools for data collection, summarization, organization and analysis in consultation with JCCC. The tools should be commented by JCCC and the FMoH Management committee to assure the review is comprehensive and deep.

- Collect data by conducting document review; interview with governmental, civil society organizations and private sectors relevant to the health sector development program; and visit health service areas.
- Organize and analyze data and write the main report based on the TOR.

Data will be collected by:

A. Review of relevant documents:

- HSDP documents (HSDP I, II and III)
- Periodic reports to the respective Regional Councils, FMOH and others
- Annual consolidated reports
- Reports of the previous JRMs and ARMs
- The HSDP I & II MTR and Final reports
- Demographic Health Surveys (DHS), 2000, 2005
- Relevant policy documents like SDPRP I & II, MDG and MDGs Need Assessment Report, Public Expenditure Review (PER), Civil Service Reform Program (CSRP), Decentralization Policy, Policy on Ethiopian Women, National HIV/AIDS Policy and Strategy, Population Policyand others, HEP, Harmonization Manual, etc.
- Other relevant and recent studies on the health sector of Ethiopia.

B. Semi-structured interviews/discussions with:

- Members of the CJSC and RJSC
- FMOH staff of the relevant departments and teams
- MOFED, FMOE and other relevant Federal Authorities
- RHB staff, Regional MOFED and other relevant authorities
- Staff of health facilities at Regional, woreda and health posts/health centers levels
- Staff of Woreda Health Offices
- Community members/beneficiary assessment.
- CSOs intervening activities relevant with health sector,
- Community and Religious Leaders at National and Regional levels
- Representatives of donor agencies and development partners proactive in the health sector
- Professional Associations (Ethiopian Public Health Association, Ethiopian Economists Associations, Physicians Associations in Private Practice, etc.)
- Institutions of Higher Learning

C. Questionnaires (providing qualitative information) that address the HSDP goals, objectives and the components.

VI. Reporting and Dissemination of Results

The Team Leader will present the mid-term review report to both the HSDP Secretariat and the Joint Core Coordinating Committee (JCCC). Both have the responsibility of overseeing that the review process is conducted in accordance with the TOR and it is their joint responsibility in submitting the final report to the CJSC for guidance. Upon the guidance of CJSC, the report and any other comments as may be deemed necessary by the CJSC will be distributed to all partners (Government agencies, donors, etc.) and will be presented at the ARM 2008 for discussion and final approval.

VII. Team Leader

The Team Leader who shall be a senior specialist in any of the public health fields related to the TOR of this review. He/She will be selected by the JCCC and will:

- Be accountable to both the HSDP Secretariat and JCCC;
- Be responsible for the preparation of the overall review program in consultation with the PPD/JCCC
- Have overall responsibility for the day-to-day direction of the review
- Finalize, in collaboration with the JCCC and management committee, the instruments/questionnaires and introduce these to all team members;
- Assign, in consultation with the JCCC, team members to sub-teams and identify sub-team leaders;
- Identify and discuss any issues/problems with the JCCC;
- Make visit(s) to any of the sub team(s) in the field, if needed;
- Maintain regular contact with team members in the field
- Be responsible for the consolidation and analysis of inputs from team members to produce a coherent report.
- Be responsible for the quality of the report as stipulated by the TOR of the HSDP III mid-term review.

VIII. The Team Members

To permit adequate coverage of all the regions, the review team will consist of six sub-teams, each composed of five to six specialists in the components to be reviewed i.e. a total of 30 to 36 experts. This number excludes the team leader and the members of the JCCC.

As much as possible, preference will be given to specialists already familiar with the HSDP in order to maintain continuity. As much as possible, no part-time team membership will be recruited.

The composition of each sub-team will have appropriate mix of national, international, GOE and donor personnel and will also reflect adequate gender balance.

There will be also representative professionals in the teams from other sectors; Ministry of Education, Agriculture, Water, Information, Finance & Economic Development and Disaster Prevention & Preparedness Agency.

In order to strengthen the teams with professionals of sub-national planning & implementation experiences and perform in-depth analysis of health extension program, staff from Regional Health Bureaus will be included in the teams but they will be assigned in different regions other than their respective work place.

In general, the team will be of two types:

1) Team that develops the design and data collection instrument
2) Team that will participate the field work

Professional mix will consist of at least:

1. Public Health professionals from outside the Ministry of Health with working experience in:

1.1. Planning/ Health Systems (3) at least one with strong sub-national planning experience
1.2. Maternal Health (2)
1.3. Child Health (2)
1.4. Disease control (emphasis on Malaria) (1)
1.5. Disease control (emphasis on HIV/AIDS and TB) (1)
1.6. Community based Health care delivery (3)
1.7. One Public Nutrition Expert (1)
1.8. One Environmental Health Expert
1.9. One Health Economist
1.10. One Pharmacist with health system experience
2. Health professionals from Regional Health Bureaus (11)
3. Representatives from other sectors who had direct or indirect relationship with the health sector (6)
4. One with professional background and experience on logistics
5. One with special experience on gender (this is in addition to the gender balance of the whole team)
6. One with professional background and experience on human resource related to health

This team composition will make at least 36 people + a team leader. With this mix, the tool/questionnaire and guide will be prepared.

The Health economist and the team leader will do more in depth analysis of some other documents during the field work.
This will be further discussed and team members identified with team leader.

Based on the specific tasks assigned by the team leader, a team member is expected to successfully complete the following tasks depending on his/her areas of assignment:

- Each team member shares the duties and responsibilities specified for the review;
- Each member of the team is accountable to the team leader;
- Assess the progress in HSDP III implementation by reviewing and analyzing documents, interviewing appropriate institutions and making site visits;
- Collect information required for the review.
- The review teams will report on their findings on each of the components, as specified in this TOR. The report of the mid-term review of HSDP III will thus be composed of chapters for the components, the cross-cutting issues and the overall governance and management structure.
- Perform other relevant duties assigned by the team leader.

IX. BUDGET:

The total budget required to conduct the review is estimated to be 150,000US$.

X. TIME TABLE FOR THE MID-TERM REVIEW

No	ACTIVITY	TIME SCHEDULE		Responsibility
		Start	End	
1	Develop TOR for the review			
	1.1 Develop draft TOR and circulate to FMOH departments and development partners for comment	Dec 15, 07	Jan 9, 08	PPD & JCCC
	1.2 Incorporate comments and finalize the TOR	Jan 10, 08	Jan 15, 08	PPD
	1.3 Approve the TOR by JCCC	Jan, 08	March, 08	PPD
2	Recruit and deploy consultants			
	2.1. Call for consultancy services and short list	Jan 01, 2008	Jan 28, 08	PPD & UNICEF
	2.2 Recruit qualified international consultants	Jan 29, 2008	March 31, 2008	PPD & JCCC
	2.3. Recruit the national consultants	April 3, 08	April 15, 08	JCCC
3	Develop data collection instrument			
	3.1.Prepare interview guide, questionnaire, document review checklist and detailed methodology and plan of action	April 2nd , 08	April 12, 08	Consultants & JCCC
	3.2. Circulate to reviewers and incorporate comment	April 12, 08	April 17, 08	Consultants & JCCC
	3.3. Develop final tool and implementation plan	April 18, 08	April 21, 08	Consultants & JCCC
4	Logistics preparation			
	4.1. Conduct preparatory meeting with review teams	April 22, 08	April 23, 08	PPD & JCCC
	4.2. Communicate review programme, TOR, data collection tools and methodologies to RHBs			PPD & JCCC

No	ACTIVITY	TIME SCHEDULE		Responsibility
		Start	End	
	4.3. Finalize logistics preparation			PPD & UNICEF
5.	Data collection	May 5 08	June 2, 08	Consultants
6.	Review and collect data			
	6.1. Conduct document review	June 4 ,08	June 20, 08	Consultants
	6.2. Conduct reviews and discussions	June 4, 08	June 20, 08	Consultants
	6.3. Prepare inception report by team leader to HSDP secretariat and JCCC	June 20, 08	June 30, 08	Consultants
	6.4. Compile, organize and analyze data	June 30,08	July 10,08	Consultants
7.	Produce report			
	7.1. Prepare review report	July 10,08	July 14,08	Consultants
	7.2. Submit zero draft	**July 14,08**	**August 10,08**	**Consultants**
	7.3. Incorporate comments and submit final review result/document	Aug 11, 08	Aug 20, 08	Consultants
8.	Disseminate result and use of data			
	8.1. Communicate the findings to stakeholders through forum at all level	September 08	October 08	PPD
	8.2. Publish review report and distribute to all concerned bodies for use	November 08		PPD

Annex 4 Work Programme of MTR Team

DAY	MORNING	AFTERNOON
As part of the preparations, a draft questionnaire will be circulated by the TL to the team members and JCCC. All will provide suggestions for improvements to be discussed by the various thematic groups on Wednesday 07 May in the afternoon		
Friday 02.05.08	Meeting FMOH-RHB Steering Committee. Abebe will present the TOR, the MTR work programme and highlight the important role and responsibility of the RHB in supporting the MTR Team.	
Saturday 03.05		
Sunday 04.05.08	*Arrival most Team members*	*Arrival most Team members*
Monday 05-05-2008	Prepare for the assignment	Arrival ALL team members
Tuesday 06-05-2008 Venue: FMOH meeting room	08.30-09.30 Start of MTR by H.E. Dr Kebede Worku 09.30-10.30 Introduction team members 10.30-11.00 Tea / Coffee 11.00-12.30 Overview assignment (Programme / ToC Regions and Main Doc)	14.00-15.30 Briefing session by various departments of FMOH in 8 groups (plan, implementation, constraints and expectations). Venue: GHION 15.30-16.00 Tea / Coffee 16.00-17.30 Continuation
Wednesday 07-05-2008 Venue: FMOH meeting room	08.00-09.30 Review of tasks to be done at the meeting room of GHION 09.30-10.30 Briefing by all DPs / in 8 groups / Ghion 10.30-11.00 Tea / Coffee 11.00-12.30 Briefing by all DPs / component	14.00-17.00 Review of Questionnaires by 8 thematic groups at GHION and members of the JCCC.
Thursday 08-05-2008 Venue: ECA	09.00-10.00 Security briefing at ECA 10.00.00-12.30 All Teams: Prepare programme in field at ECA (tickets, DSA, cash money, Drivers)	14.00-16.30 Groups to finalize revision of questionnaires per 8 thematic areas 14.30 TL to discuss progress with JCCC (delayed) 16.30 Groups to submit revised and final questionnaire to TL (soft copies)
Friday 09-05 Venue: FMOH meeting room	09.00-12.00 Briefing by NGOs to the 8 groups on their respective programmes and expectations at GHION 11.00 Meeting with Regional team members GHION	15.00 TL to distribute final set of Questionnaires at PPD (soft) with two hard copies for each team
Saturday 10.05	*Departure of the Regional teams (by plane to B-Gumuz and Gambella)* *Regional teams meet to prepare for their work*	*Read and prepare for Regional and Main Report* *4 cars leave Addis for distant destinations (being Mekele, Jijiga)*
Sunday 11.05	*Departure of the Regional teams (by car or plane to Amhara and Somali)*	*Regional teams meet to prepare for their work*
Monday 12.05	Meeting RHB 1 During rest of visit, team can split in sub-groups	14.00 Visit to BOFED and ROCB Visit Secondary Hospital
Tuesday 13-05	08.30 Visit one WORHO Visit DH or HC or HP	Visit 1-2 Kebeles (HP/HEW) Visit Training Schools
Wednesday 14-05	08.30 Visit another WHO (with NGO?) Visit HC / MOFED Office	Visit 1-2 Kebeles (HP/HEW) Visit Vocational Training Centres (HEW)
Thursday 15-05	Prepare debriefing RHB 1 Other visits as required	Start writing first Regional Report 15.00 TL to discuss progress with the JCCC
Friday 16-05	Debriefing to RHB 1	Finalize Regional Report 1 Prepare Presentation of first region
Saturday, 17-05	*Travel to next Region*	*Travel next Region*
Sunday 18.05	*Travel to next region and reading HSDPII Report*	
Monday 19.05	Meeting RHB 2 During rest of visit, team can split in sub-groups	14.00 Visit to BOPED and ROCB Visit Secondary Hospital
Tuesday 20-05	08.30 Visit one WORHO Visit DH or HC or HP	Visit 1-2 Kebeles (HP/HEW) Visit Training Schools
Wednesday 21-05	08.30 Visit another WHO (with NGO?) Visit HC / MOFED Office Jacqueline back	Visit 1-2 Kebeles (HP/HEW) Visit Vocational Training Centres (HEW)
Thursday 22-05	Prepare debriefing RHB 2 Other visits as required Call / Meet Dr Megistu (Pathfinder) or 23/05	Start writing second Regional Report 15.00 TL to discuss progress with JCCC

DAY	MORNING	AFTERNOON
Friday 23-05	Debriefing to RHB 1	Finalize Regional Report 2 Prepare Presentation of two regions
Saturday 24.05	*Travel to Addis*	*15.00 Teams submits both Regional Reports GHION*
Sunday, 25-05	*Free day*	*Free day*
Monday 26-05 Venue: Hotel de Leopol	08.30-09.30 Tigray 09.30-10.30 Oromiya 10.30-11.00 Tea / Coffee 11.00-12.00 SNNPR 12.00-13.00 Afar	14.00-15.00 Gambella 15.00-15.30 Tea / Coffee 15.30-17.00 Harari / Dire Dawa 17.00-18.00 Somali
Tuesday 27-05 Venue: Hotel de Leopol	08.30-09.30 Benishangul Gumuz 09.30-10.30 Amhara 10.30-11.00 Tea / Coffee 11.00-12.30 Addis Ababa	14.00–15.30 FMOH 15.30-16.00 Tea / Coffee 16.00-17.00 Summary Findings 17.00-18.00 Tasks ahead by 8 thematic groups and divide writing tasks
Wednesday 28-05	Writing day individually, based on agreed format by 8 the thematic groups (national holiday)	Writing day individually, based on agreed format by 8 the thematic groups
Thursday 29-05	Continue writing and internal discussions	14.00 Writing resource persons to discuss results and improve on the text (individually) 15.00 Brainstorming: discuss governance with the JCCC
Friday, 30-05	Finalize the various sections	*18.00 Submit soft copies of all sections at GHION*
Saturday, 31-05	08.00 TL editing Zero draft	17.00 TL to edit and bring together Zero draft
Sunday, 01-05	08.00 TL Finalize Zero draft	17.00 Copy zero draft 40 times 225 pages
Monday 02-06	08.30 14.00 Come to receive Zero draft at GHION 12.00 Meeting Hon Minister with selected team	EACH TO READ FULL ZERO DRAFT
Tuesday 03-06	08.30 Discuss Zero Draft internally with the whole team page by page at UNICEF ground floor room 14.00 TL: Meeting HPN Donor Group (Packard F.)	14.00 Continuation of discussion on Zero draft (page by page) at UNICEF ground floor room
Wednesday 04-06	Incorporate comments into First Draft and edit	14.00 Meeting with FMOH senior management
Thursday 05-06	Incorporate comments into First Draft and edit	15.00 Presentation First draft to JCCC
Friday 06-06	Incorporate comments into First Draft and edit International Team members leave country	Incorporate comments into First Draft and edit Most International Team members leave country
Saturday *07-06*	TL to Submit First draft (soft copy) to JCCC 10.50 Chabot and Patricia to return to Kenya	
Sunday, 08-06		Review the draft of the MTR document
Monday, 08-06	Finalize the first draft, including Executive Summary	
Tuesday, 10-06	Finalize First Draft and send to JCCC and Laura	
Friday,13.06.08	JCCC sends written comments to the first draft TL receives comments from RHB	
Friday 20.06	TL sends revised version of second draft back to JCCC with comments incorporated	
Monday 23.06	Second draft discussed by Management FMOH	
Wednesday 25.06	TL presents second draft to Joint Consultative Forum	
Monday 30.06	TL submits final report to JCCC	
Sept 2008	TL Presents MTR report to ARM	

Annex 5 MATRIX OF TEAM MEMBERS AND THEMATIC AREAS

THEMATIC AREAS		I. SERVICE DELIVERY	II. SUPPORT SYSTEMS	III. FINANCE AND SECTOR MANAGEMENT
TEAM ASSIGNMENTS BY REGION AND COMPONENTS / SPECIAL AREAS OF ATTENTION	TRAVEL ARRANGE-MENTS: DATES OF FLIGHTS AND CARS TO AND BACK FROM REGIONS	1. SERVICE DELIVERY: HEP & MATERNAL HEALTH, DISEASE CONTROL PROGRAMMES; ESS. PACKAGE & QOC. 5. IEC AND ENV. HEALTH 9. CROSS-CUTTING ISSUES (Gender, Pastoralists, Nutrition, Emergency Relief and Population issues)	2. FACILITY CONSTRUCTION & MAINTENANCE 3. HUMAN RESOURCE DEVELOPMENT, TRAINING AND CAPACITY BUILDING 4. PHARMACEUTICALS 7. M&E / HMIS & OPER. RES.	6. SECTOR MANAGEMENT; GOVERNANCE & CSRP + PARTNERSHIP ARRANGEMENT HARMONIZATION & MOU / MDG 8. HEALTH CARE FINANCING; + FINANCING SECTOR: HOW MUCH, WHERE, HOW + FINANCIAL MANAGEMENT: FLOW, UTILIZATION BY WHO, REPORTING.
COMPONENTS		**1 + 5 + 9**	**2 + 3 + 4 + 7**	**6 + 8**
TEAM 1 (7) FMOH ADDIS ABABA	Car: Taxi Car: Taxi	Dr Zewdie Abegaz (Gender) Dr Degu Jerene (HIV/AIDS) *Dr Ermias Getahun, (MNCH, @ Addis) WHO* Laura Fontaine (IEC) (Addis only and rest)	(Dr Yayehirad Kitaw (HRH, 15 days at end) Ato Daniel Tadesse (Logistics)	Dr Gakuruh (Governance and donor alignment) Abebe Alebachew (Financing) (Jacueline Anam (Gender and Governance) Ms Gemma Wison-Clark *Ato Mulu Teka (FM/Audit) (@ FMOH*), WHO
TEAM 2 BENSHENGUL-GUMUZ AFAR (8)	Plane: Sat 10.05 Plane: Sat 17.05 Car; Sund 18.05 Car: Sund 18.05	Joanna Nikulin (PMTCT / HIV/AIDS) *Asnake Tesfahun (EPR, epid) (@ both) Unicef*	Dr Mensah Kwadwo (HRH) Yetim Geta (pharm)	Roger Pearson (Cross-cutting) (Afar only)
TEAM 3 (8) GAMBELLA SNNPRS	Plane: Sat 10.05 Plane: Sat 17.05 Car: Sund. 18.05 Car: Sund 18.05	Patricia Schwerzel (HEP) *Dr Fikir Melesse (PMTCT) (@ SNNPR), Unicef* *Selamawit Negash (Nutrition, @ Gambella), Unic* Ato Fekadu Beshah (IEC)	Jan Debyser (Logistics) Dr Sukanta Sarker (training)	Ato Yilma Abdisa (Planning)
TEAM 4 (8) OROMIYA	Car: Mond 12.05 Car: Mond 12.05	Indra Pathmanathan (MNCH) Dr Endale Engida (PH) Dr Thierry Comolet (TB) Ato Eshetu Lemma (Lab support) Ms. Anna Herforth (Nutrition) (full field visit)	Mr Carlo Resti (HRH and Systems) Chet Chaulagai (HMIS and M&E)	*Dr Petros Olango (Governance) (@ Oromiya) freelance* Ato Mekbib Tilahun (FM / Audit)
TEAM 5 (8) AMHARA TIGRAY	Plane: Sund. 11.05 Car: Sat 10.05 Car: Sat. 17.05 Plane: Sat. 24.05	Andy O'Connell (SD and Med Services) Aboubakar Kampo (Malaria) (Amhara only) *Dr Muna Abdullah (MNCH) (@both), UNFPA* Mihiret Hiluf (PH)	Rob Fielding (construction) Dr Guy Clarisse (Systems), Tigray only	Ato Wolderufael Tesfu (FM / Audit)
TEAM 6 (9) SOMALI HARERI DIRE DAWA	Plane: Sund 11.05 Car: Car Plane: Sat 24.05	Bashir Sheikh Mohamed (HEP, Somali only) Dr Abdi Dabar Maalim (emergency) Rahel Gizaw (PH)	Abel Kuiper (Logistics) (Somali only) *Ms Mahlet Mairegu (HRH) (@ All), Tulane*	Dr. Palena Neale (Governance)

@ = Suggested Sub-Team leader, coordinating the visit to the field and the relevant Regional Report(s), details see below;
Bold = coordinators / facilitators to coordinate the write-up of the various thematic areas (see Table of Contents for details):

Thematic Groups for the briefing and team work:

1. HEP + Hygiene + IEC + Cross-cutting
2. Maternal and Child Health
3. Other Service Delivery
4. Construction + HRH
5. Pharmaceuticals and Logistic management
6. M&E and HMIS
7. Financing, Planning, Budgeting and Financial Management
8. Sector Governance and Management

Role of the regional team leaders:

- Coordinate the field visit, present members and decide on visits / schedules to Weredas etc
- Coordinate the presentation for the debriefing and receive comments
- Coordinate the report writing in the regions and make sure it is ready before coming to Addis, submit to TL.
- Coordinate the presentation at FMOH
- Keep records on timesheets for the free-lance consultants

Annex 6 Persons Interviewed

NAMES[55]	RESPONSIBLE FOR
Federal Ministry of Health	
Dr Tedros Adhanom G/yesus	Federal Minister of Health
Dr Shiferaw Teklemariam	State Minister of Health, Programmes
Dr Kebede Worku	State Minister of Health, Operations
Dr Nejmudin Kedir	Head of the Planning and Programming Department
Dr Mekdim Enkossa	Secretary to the JCCC
Dr Rahel Gizaw	Secretary to the JCCC
Kahsu Bekuretsion	PPD, Wereda Based Planning TA, PPD
Michael Miraw	Team Leader, planning and budgeting team
Abdujelil	Team Leader, project coordination and monitoring
Dr. Hassan	Service Delivery
Dr Negist	Family Health
Ato Wendesen	Health Extension Programme / HEEC
Ato Mulu Araya	Hygiene / Environmental Health
Dr. Zerihun	Disease Prevention and Control
Ato Abebe	Human Resources for Health
Dr Million	Emergency Operations
W/o Tsigoroman	Women Affairs
W/o Anchinalu Mekonene	Department of Finance and supplies
	Audit Department
Edmealem Ejigu	Pharmaceutical Supply and Logistic Department
Ato Wondwossen	Pharmaceuticals Fund and Supply Agency
Dawit Dikasso	Drug Administration and Control Agency
Ato Girma	Civil Service Reform Programme
Dr Tsehaynesh Messele	Ethiopian Health and Nutrition Research Institute
Dr Betru Tekle	HAPCO
Ato Mulugeta	HAPCO
Other Federal Ministries	
W/ro Genet	MOFED / Population Council
Ato Admasu	MOFED / Multilateral Department
W/ro Netseru	MOFED, Team leader, Health budgeting team
Ato Degu Lakew	MOFED, Head, Government Accounts
Ato Ahmed Mohammed Ali	Ministry of Capacity Building
Ato Tizazu Asare	Ministry of Education, head planning department
Development Partners	
Dr Theo Pas	Royal Netherlands Embassy, Chair HPN Donors group
Dr Viviane Van Steirteghem	UNICEF, co-chair HPN Donors group / JCCC
Ms Marion Kelly	DFID
Ms Ali Forder	DFID
Ms Hiwot Tadesse	DCI / Irish Aid / JCCC
Mr Faresa Pasquale	Italian Cooperation / JCCC
Dr Sandro Accorsi	Italian Cooperation
Ms. Meri Sinnitt	USAID
Mr Eshete Yilma	USAID / JCCC

[55] In bold are the designated Anchors among the LD.

NAMES[55]	RESPONSIBLE FOR
Ms Tomoyo Miyake	JICA
Dr Melanie Renshaw	UNICEF / NY
Dr Iqbal Kabir	UNICEF / Addis
Dr Fatoumata Nafo-Traore	WHO / WR
Dr Teferra Wonde	WHO / JCCC
Ms Monique Rakotomalala	UNFPA
Ms Helen Amdemikael	UNFPA
Dr Muna Abdullah	UNFPA / JCCC
Dr Luc de Bernis	UNFPA / CST
Dr Gebresellasie Equbagzi	World Bank / Addis / JCCC
Ms Montserrat Meiro-Lorenzo	World Bank / Washington
Non Governmental Organizations	
Ato Leulseged Asfaw	CRDA
Ato Mitiku Abebe	CRDA
Dr Flemina Bisrat	CRDA
Ato Semu Ketema	CRDA
Ms Gemma Wilson-Clark	SCF-UK
	SCF-USA
Dr Mengistu Asnake	Pathfinder
	MSH
Dr Girma	Tulane University
Dr Francisca Stuer	Family Health International
	COHRA
Dr Leulseged	ESHE Project / JCCC
Ato Shelemew Shaula	ESHE project
Ato Emebet Abu Derago	DKT
Mr Bernard Fabre	JSI / Deliver
Dr Carla Zanoli	Comitato Collaborazione Medica
Dr Barbara Kwast	AMDD
W/o Fasika	Ethiopian Red Cross
Dr. Hailu / Assefa bulcha	Carter Foundation
Dr. Yegeremu	Clinton Foundation
Ato Gubena Geb	CESTAS
	Global Fund
Ato Bona Hora	Technical officer, CCM secretariat
	PEPFAR

Annex 7 Documents Consulted

The list of documents below represents only a small portion of the documentation that the MTR accessed. The list of general background documents represents the overall list of publications that all team members used and consulted. The specific and more technical documentation that each team member used for his/her report is provided in this table for each of the HSDP III components. More documentation was provided to all team members as soft copies and has been used according to need.

Those who would like to access this database of documents should consult the team leader, Dr Jarl Chabot via email: j.chabot@etcnl.nl. It is hoped that the FMOH / PPD will use it to further build up its FMOH website.

Author, Year	Title
General Background Documents	
FMOH, undated	Health Sector Development Programme 1997/98 – 2001/02 (HSDP I)
FMOH, February 1999	Joint Review Mission I (JRM 1)
FMOH, March 2003	Joint Review Mission III (JRM 3), period 2001/02 – 2002/03.
FMOH, March 2003.	Report of the final evaluation of HSDP I, full period
FMOH, June 2002	Health Sector Development Programme 2002/03 – 2004/05 (HSDP II)
FMOH, June 2004	Report on the fourth Joint Review Mission (JRM 4), 27 May – 18 June 2004
FMOH, March 2006	Report of the final evaluation HSDP II, 31st January – 6th March 2006. (Vol. I + II)
FMOH, Sept 2005	**Health Sector Development Programme 2005/06 – 2009/10 (HSDP III)**
FMOH, October 2005	Recommendations of ARM 2005 to be included in HSDP III
FMOH, November 2006	Report on the proceedings and results of the eight Annual Review Meeting of HSDP (ARM 8), 02-06 October 2006.
FMOH, October 2007	Annual Performance Report of HSDP III, 2006 - 2007
FMOH, October 2007	Plan of Action to implement the recommendations of ARM 2007 (by component)
Government of Ethiopia, Sept 1993	Health Policy of the Transitional Government of Ethiopia,
Government of Ethiopia, 2005.	Proclamation on health service delivery, administration and management
FMOH, April 2007	HSDP Harmonization Manual (HHM)
UNICEF, June 2007	Final report on the health pooled fund
Joint MOU, October 2007	Management of the health pooled fund
HPN Donors	TOR for the HPN Donors Group
DFID, September 2007	International Health Partnership (IHP) and the global compact
FMOH, April 2008	Compact between the Government of Ethiopia and the Development Partners on scaling up for reaching the health MDGs.
FMOH, November 2007	Scaling up for better health in Ethiopia ("the roadmap')
Lusaka Conference, March 2008	The Lusaka report on IHP+ and Harmonization for Health in Africa (HHA)
MOFED, October 2005	Plan for Accelerated and Sustained Development to End Poverty (PASDEP, 2005/06 – 2009/10)
MOFED, September 2006	Building on Progress: Plan for Accelerated and Sustained Development to End Poverty (PASDEP, 2005/06 – 2009/10), (Vol. I)
MOFED, March 2004	MDG report: challenges and prospects for Ethiopia (Vol. I)
MOFED, December 2005	The MDG needs assessment synthesis report
MOFED, November 2007	Protection of Basic Services (PBS), Aide Memoire of Joint Review Mission

Author, Year	Title
UNFPA, February 2008	Thematic evaluation of UNFPA experience in increasing aid effectiveness through participation in sector-wide approaches.
Service Delivery / HEP	
FMOH, November 2004	Accelerated expansion of Primary Health Care coverage in Ethiopia, 2005-2009
FMOH, August 2005	Essential Health Service Package (EHSP)
FMOH, January 2005	HEP Implementation guideline
FMOH, July 2006	Assessment of the HEP in Tigray
HEEC, June 2007	Health Extension Programme in Ethiopia, profile
Centre for National Health Development, August 2005	Training of Health Extension Workers: first intake assessment (Columbia University)
Yayahirad Kitaw, undated	Assessment of the training of the first intake of HEW
Yayahirad Kitaw, undated	Study on HEW access to information (continuing education and reference materials)
Yayahirad Kitaw, undated	Study on the working conditions of HEW in Ethiopia
Centre for National Health Development, May 2006	Assessment of working conditions of the first batch of HEW (Columbia University)
FMOH, undated	Vocational training centres training HEW
FMOH / HEEC, 2003	HEP training modules
Service Delivery / HIV/AIDS – Malaria - Tuberculosis	
FMOH/HAPCO, undated	AIDS in Ethiopia, 6th Report
HAPCO, September 2006	Technical document for the 6th report
HAPCO, December 2004	Ethiopian Strategic Plan for intensifying the multi-sectoral HIV/AIDS response, 2004 – 2008.
HAPCO, June 2005	Ethiopian HIV/AIDS National response. Consolidated national response of the terminal evaluation of the IDA support for EMSAP.
ABT Associates, June 2007	Proposal to conduct Health, Education and HIV/AIDS resource mapping exercise
FMOH, August 2004	National Strategic Plan for going to scale with coverage and utilization of Insecticide Treated Nets (ITN) in Ethiopia 2004-2007
WHO, February 2008	Impact of the scale up of anti-malaria interventions measured, using health facility based data in Ethiopia (preliminary report).
FMOH, July 2004	Malaria, diagnostic and treatment guidelines for health workers in Ethiopia (2nd edition)
FMOH, July 2004	Guidelines for Malaria epidemic prevention and control in Ethiopia (2nd edition)
FMOH, undated	National Five-Year Strategic Plan for Malaria control in Ethiopia, 2001-2005
FMOH, April 2006	National Five-Year Strategic Plan for Malaria prevention and control in Ethiopia, 2006-2010
World Bank, October 2007	The World Bank booster programme for Malaria control in Africa, a two year progress report
FMOH, August 2007	TB, TB/HIV and Leprosy Prevention and Control; Strategic Plan 2007/8-2009/10
FMOH, July 2005	TB/HIV implementation guideline
Terefa Degefa, April 2008	Factors fuelling the prevalence of HIV.
Service Delivery / Family Health	
FMOH/FHD, July 2005	National Strategy for child survival in Ethiopia
DHS, September 2004	Female Genital Cutting in the DHS surveys, a critical and comparative analysis
FHI, May 2006	FHI / IMPACT final evaluation report
Measure November 2002	Evaluation of programme options to meet unmet need for Family Planning in Ethiopia
FMOH/FHD, September	National Contraceptive Forecast 2006 - 2010

Author, Year	Title
2006	
UNICEF, 2008	The effect of C-IMCI on child health care practices in Amhara Region
UNICEF / WHO, 2006	Pneumonia, the forgotten killer of children
WHO, January 2008	Report on the national situational analysis of Pre-service Midwifery training in Ethiopia.
FMOH/FHD, January 2005	Evaluation report of the Making Pregnancy Safer (MPS) Strategy in Ethiopia
Population Council / UNFPA,	Final report on the Safe Motherhood Community-based survey, Ethiopia.
FMOH, March 2006	National Reproductive Health Strategy, 2006-2015
FMOH, 2007	National Adolescent and Youth Reproductive Health Strategy 2007-2015
FMOH, March 2005	Reproductive Health Needs and Youth Friendly Health Service Assessment in Selected Urban Areas of the Oromiya, Amhara, Southern People and Tigray Regional States
USAID, April 2005	Mid-Term Evaluation of the Family Planning and Reproductive Health Project of Ethiopia
Assefa Hailemariam et al, March 2008	Determinants of family planning practices in Ethiopia, evidence from EDHS 2005: evidence from EDHS 2005.
Ethiopia Society of Population Studies, February 2008	Levels, trends and determinants of lifetime and desired fertility in Ethiopia: evidence from EDHS 2005.
Chalachew Arega, March 2008	Maternal health care seeking behaviour in Ethiopia: evidence from EDHS 2005.
Assefa Hailemariam, January, 2008	In-depth analysis of the Ethiopian DHS 2005, Maternal Mortality
Construction and Rehabilitation	
	No relevant documents or strategies available
Human Resources for Health	
UNDP, undated	HRH, Why we need to act now.
FMOH, September 1996	Health sector Human Resource Development Strategy
FMOH/PPD, September 2005	Health Sector Human Resource Development Framework 2006 - 2010
FMOH / BPR, July 2007	HRD Core process BPR, report Vol. I
FMOH / BPR, July 2007	HRD To be design, Vol. II
FMOH / BPR, August 2007	HRH supply and requirement projection and financial resource requirement Vol. III
World Bank, August 2005	For public service or money? Understanding geographical imbalances in the health work force
World Bank, April 2005	The performance of health workers in Ethiopia, results from qualitative research
Pharmaceutical Services	
GOE, November 1993	National Drug Policy of the Transitional Government
FMOH/WHO, October 2003	Assessment of the pharmaceutical sector in Ethiopia
FMOH, January 2006	Contraceptive inventory and logistic system survey
DACA, August 2006	Pharmaceutical sector Master Plan 2007 - 2011
FMOH, May 2007	Pharmaceutical and Logistic Master Plan (PLMP); Work Plan Year 1
FMOH, October 2007	Pharmaceutical and Logistic Master Plan (PLMP); M&E report Year 1
FMOH, December 2005	Health Commodity Supply System (HCSS), summary design
FMOH, February 2006	Design for a new HCSS (draft for discussion)
FMOH, August 2006	HCSS, Master Plan, Volume I, Main document
FMOH, August 2006	HCSS, Master Plan, Volume II, Year 1 Implementation
ESHE, September 2007	Special Pharmacy Impact Assessment Survey report

Author, Year	Title
UNFPA, January 2007	Reproductive Health Commodity Security (RHCS) 2007 – 2012 (5 years)
Information, Education and Communication (IEC)	
UNICEF, undated	Community Sanitation and Hygiene (WASH approach project)
UNICEF, undated	Advocacy for WASH at wereda level
HSDP?, no author	Hygiene and Environmental Health
HMIS and M&E	
FMOH/PPD, 1997	Health and Health Related Indicators 1997
FMOH/PPD, 1998	Health and Health Related Indicators 1998
FMOH/PPD, 1999	Health and Health Related Indicators 1999
Central Statistical Agency	DHS 2000
Central Statistical Agency	DHS 2005
UNFPA, 2008	ICPD indicators over time
FMOH, undated	Wereda grants and performance monitoring
FMOH, September 2006	HMIS BPR Assessment report, HMIS Core Process
JSI, July 2006	Best practices on HMIS and M&E in Ethiopia and other African countries
JSI/FMOH 2006-2007	Various manuals and technical guidelines
FMOH, December 2007	Evaluation Report of Design and implementation of HMIS and M&E in Ethiopia
Health Care Financing	
Economist Intelligence Unit, April 2008.	Ethiopia Country report
ABT Associates, PHR+, August2006	The system wide effects of the Global Fund in Ethiopia, final study report
GAVI, March 2006	GAVI-WHO-UNICEF Joint Mission to Ethiopia
FMOH, November 2005	Implementation Manual for Health Care Financing Reforms (final)
FMOH/ PHR+, September 2006	Ethiopia's Third National Health Account 2004/05.
FMOH, April 2008	PBS Programme, report on component two, managed by the FMOH
FMOH, April 2002	Strategic assessment study for pooling support to the Ethiopian HSDP II in Human Resource Development and Pharmaceutical supply
HPN Donors, 2005	Resource mapping for HSDP III (2 excel sheets)
SPA, October 2005	SBS, draft note from the Dublin workshop of SPA working groups
USAID, 2006	Vouchers for health: a focus on reproductive health and family planning services
MOFED / FMOH, 2000	Consolidated budget 2000
GFATM, undated	GF round 2 and round 5
PEPFAR, 2007	Ethiopia Country profile
FMOH/PPD, May 2008	Health Insurance Strategy (HI) (final draft)
Cross-Cutting / Gender	
Ministry of Women Affairs, 2006	National action plan for gender equality 2006 - 2010
CIDA Africa, 2006	Gender equality tip sheet, programme based approaches
UNDAF, October 2007	Joint programme on leave no woman behind (Ethiopia)
UNFPA, February 2008	Packard Foundation, Girl's education and linkages with reproductive health
UNDAF, April 2007	Gender Pooled Fund (GPF), proposal in support for gender policy development
MOFED, undated	PASDEP, Gender Indicators
World Women 2005	Statistical tables (5x)

Author, Year	Title
Cross-Cutting / Nutrition	
FMOH, January 2008	National Nutrition Strategy (NNS)
FMOH, April 2008.	Programme Implementation Manual (PIM) of the National Nutrition Strategy (NNP), July 2008 – June 2013
UNICEF, undated	Nutrition and food security
World Bank, March 2008	Project Appraisal Document (PAD) on a proposed grant to the Federal Democratic Republic of Ethiopia for a Nutrition Project.
FMOH, October 2007	Design of nutrition information/surveillance systems (NIS).
UNICEF, 2005	National IDD Survey.
Linkages	Final report on linkages between Breast Feeding, LAM, Complementary feeding and maternal nutrition, 2003 – 2006.
UNICEF, undated	Community Based Nutrition (CBN) information sheet.
IFPRI, November 2005	Framework document for a National Nutrition Strategy for Ethiopia
Chalachew Arega, February 2008	Determinants of maternal nutrition status in Ethiopia: evidence from the EDHS 2005.
Cross-Cutting / Pastoralists	
FMOH/HCF, March 2003	Health Service Delivery in pastoralists areas of Ethiopia
HSDP II, 2006	Pastoralist health care
Dr Abdi Maalim, 2006	Participatory rural appraisal techniques in disenfranchised communities: a Kenyan case study. International Nursing Review, **53**, 178 – 188.
Cross-Cutting / Emergency Relief	
HSDP II, 2006	Emergency Preparedness and Response
UNICEF, July 2004	Managing risk and vulnerability in Ethiopia: a child centred approach
MOFED/DPPE, March 2008	Disaster Hazards, exposures and responses in Ethiopia: a historical account
Cross-Cutting / Population issues	
MOFED, April 2008	National Population Policy Action Plan 2008 - 2015
MOFED, undated	Population related conditions and constraints in the health sector (p. 55-60)
Governance	
FMOH, April 2008	Compact between the Government of Ethiopia and the Development Partners on scaling up for reaching the health MDG.
FMOH, undated	Code of Conduct to promote harmonization in the health sector in Ethiopia
FMOH, December 2004	Ethiopia Harmonization Action Plan 2004 – 2006
MOFED, January 2005	Bilateral Donor Coordination, experience of the Federal Government of Ethiopia
HSDP II, 2006	Overview of recommendations over the period May 2002 – October 2005.
DAG, various dates	Pooled Fund, Annual Reports 2001 - 2004
Min of Justice, May 2008	Draft Law Civil Society Organizations (CSO), summary of provisions and comments
DAG, May 2008	Letter to the Minister of Justice and Minister of Finance
DAG, undated	Guidelines: Harmonising donor practices for effective aid delivery
KfW, February 2004	Private sector participation in health sector cooperation, options and experiences
MOFED and UN Excom Agencies, September 2007	Capacity Building for BOFEDs and WOFEDs
Unknown, undated	Survey on Harmonization and alignment in Ethiopia (Chapter 5)
DFID/DCI, September 2005	Harmonization in the health sector in Ethiopia
NORAD, May 2008.	Donor practices in providing Sector Budget Support (SBS)
Mokoro, June 2005	Accountability for and effectiveness of Aid in Ethiopia (Catherine Dom)
HSDP II, 2006	Protection of Basic Services (PBS) in Ethiopia
JCCC, 2007 - 2008	Various minutes of JCCC meetings

Annex 8 Status of Previous Recommendations

Overview Recommendations (summary) HSDP I Evaluation (2003), HSDP II Evaluation (2006) and the two ARM in 2006 and 2007.					
MONTH /YEAR	**March 2003**	**March 2006**	**October 2006**	**October 2007**	**Comments May 2008**
ACTIVITY /COMP.	**Evaluation HSDP I**	**Evaluation HSDP II**	**ARM 8**	**ARM 9**	**MTR / HSDP III**
Health Service **Delivery** and Quality of Care					
HEP	- Include Community IMCI within HEP. - Include nutrition and EPI in the HEP.	Appoint HEP focal point at wereda level Address expected attrition and career development for HEW	Enrich new guideline for implementation Provide staff to HEP units / strengthen coordination Provide supervision staff Provide essential curative services + supplies Increase CP (Insurance) Strengthen referral system Coordinate/improve relations HEW-CHW Address safe / clean delivery problem Revise curriculum pre-service training Develop career structure	Implement supervision of HEP at all levels Upgrade the skills of HEW (including deliveries) Accelerate production of reference materials for HEW Use voluntary CHW to expand 'model families'. Ensure that HEW are the coordinators of CHW Ensure that all reports pass through the health posts Address problems of housing and clothing / kits of HEW Mobilize more resources!	- HEP focal persons have been assigned in most Weredas. But in some cases, the focal persons are doing other tasks in addition to the HEP. - Attrition has been addressed in some regions by training extra HEWs (e.g. SNNPR). However, most regions that have not yet trained adequate numbers of HEWs have not planned to address attrition of HEWs. - Attention has been given to career structure for HEWs at federal level but this is still in the planning stage. - A number of regions have already achieved the target of 2 HEWs at health post level, some will finalize training by the end of this year. However, expansion of HEP coverage and referral linkages has been hampered by delay in construction of health posts and health centres and provision of Kits - Training on a 1 month curriculum has been given to the first batch of HEWs supervisors. An Integrated Refresher Training (IRT) TOT is also provided by FMOH. However, there is a resource constraint in rolling out the TOT. Equally, supervision by the RHB and WHO is hampered due to resource constraints. At wereda level, there is still insufficient allocation of budget for health by the wereda council. - At the moment provision of essential curative care by HEWs is limited to treatment of malaria and diarrhoea. - Efforts have been made in improving HEW-VCHW collaboration. A guideline has been developed and distributed to improve relationship between HEWs and CHW which includes training of VCHW, harmonization of health messages, reporting and establishing model households. - Safe and clean delivery 1 month supplementary training manual has been developed with technical and financial support from UNICEF in collaboration with FMOH. However, some regions have already conducted the training ahead (e.g. Tigray and Amhara) - The original HEWs training curriculum has not been revised, but a number of refresher/supplementary training manuals have been developed.

Overview Recommendations (summary) HSDP I Evaluation (2003), HSDP II Evaluation (2006) and the two ARM in 2006 and 2007.					
MONTH /YEAR	**March 2003**	**March 2006**	**October 2006**	**October 2007**	**Comments May 2008**
ACTIVITY /COMP.	**Evaluation HSDP I**	**Evaluation HSDP II**	**ARM 8**	**ARM 9**	**MTR / HSDP III**
					- Much attention is given to increasing the number of model households. - There is still no clear flow of reports from health post to health centre. - Problem of housing for HEWs has been addressed but still remains a constraint due to delay in construction. - EHSP is being implemented at the health post level but not as a full package. EHSP is not really used for planning and allocation of resources. - Urban HEP is initiated in some regions (e.g. Dire Dawa, Tigray). Urban HEP is adapted to use diverse staffing backgrounds including those who have already done clinical nursing in Tigray or - Pastoralist HEW equally uses some adaptation, like male HEW in Somali. Variation from original strategy need to be studied whether this can deliver the original objective of the programme.
Disease Control / Malaria	- Expand RBM programme (including drugs, spraying and ITN). - Elaborate guidelines to handle funds from ITN sales.			Follow accelerated delivery and USE of ITN	There has been accelerated ITN distribution. But utilization of ITN needs to be assessed urgently
Disease Control / TB	-Develop national IEC Plan; - Strengthen supervision and on-the-job training & M&E; - Initiate joint TB/HIV activities			Identify causes of low TB Case Detection Rate Scale up implementation of Community DOTS	- Community DOT has been scaled up. TB programme has done trainings to various cadres to strengthen identification of suspected cases. However, TB Case detection rate is still low. There has not been study/research to look at barriers to detection and diagnosis of TB.
Disease Control / HIV / AIDS	- Elaborate Care and Support programmes (including Home-Based Care); - Avail ART and PMTCT drugs and	Strengthen the relation between FMOH and HAPCO. Use GF money for systems strengthening			-There is an attempt to gradually move HIV funding to be used for health system strengthening but not yet to effective levels. - GF is managed to be partially used for health system strengthening.

Overview Recommendations (summary) HSDP I Evaluation (2003), HSDP II Evaluation (2006) and the two ARM in 2006 and 2007.					
MONTH /YEAR	**March 2003**	**March 2006**	**October 2006**	**October 2007**	**Comments May 2008**
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	test kits; - Train staff in STI management - Monitor VCT centres on quality of counselling				
Family Health / Maternal Health	- Advocate for support and commitment from highest levels to enhance reproductive health programmes. - Make family planning services available in all health facilities/communities; - Improve BEmONC services & referral systems.	Create awareness on the importance of Maternal and Neonatal Mortality and Morbidity (MNMM) at all levels (community leaders, decision makers, health managers). Integrate MNMM services from community to facility level (referral), including HEWs. - Develop appropriate human capacity especially in BEmONC and CEmONC. - Develop CEmONC/BEmONC		Ensure supplies for maternal and child health Strengthen referral system Review causes of low coverage of maternal services Upgrade skills HEW Expand B/CEOC Develop comprehensive plan for MM Reduction Integrate MNCH with PMTCT and VCT training - Accelerate the implementation of the comprehensive plan for the reduction of maternal and new born mortality - Develop a joint Plan of Action with MAPPP-E to increase the use of the private sector in safe abortion - Plan and implement sensitization programmes at all levels to increase community and service providers' awareness on	- Advocacy for maternal health has been strengthened but not strategically organized. Maternal and newborn health has never been high on the priority list. No strong activist exist in safe motherhood. The option of linking with already strong movement such as fistula campaigns has not been explored. Fistula patients can be a strong advocates for the need of BEmONC (*'Dead Women do not talk but surviving ones do'* Women deliver*)* - Not much has been observed in integrating human right approach in maternal health improvement. Although proclamation has been passed on providing free services for maternal and child health services, the current health system does not guarantee women have access to basic maternal health services, such as delivery (women have still to pay substantial amount of money for supplies and drugs). - Maternal health services still remains under-funded. - Functionality of Safe Motherhood Technical Committee (SMTC) is very weak. There is a need to evaluate the functionality of the SMTC and propose how to strengthen it on meaningfully and effectively establish partnership with civil society organizations, public, private partners. - Expansion of HEP has benefited women's health in improving awareness, access to family planning, improving linkage with higher level health facilities, at the moment also on providing safe and clean delivery. However, the full package of Essential Primary Health Services is still not implemented by HEWs. - The HEWs do not have/have limited IEC materials in the area of maternal health (except family planning messages). A lot has to be done in this area also using the community conversation methods. - Condoms are available in almost all health facilities however, vasectomy is used in a very few selected areas (NGOs working areas). Male involvement in family planning and reproductive health in general is still weak. - There have been efforts to improve B/CEmONC focusing on in-service training

Overview Recommendations (summary) HSDP I Evaluation (2003), HSDP II Evaluation (2006) and the two ARM in 2006 and 2007.					
MONTH /YEAR	**March 2003**	**March 2006**	**October 2006**	**October 2007**	**Comments May 2008**
ACTIVITY /COMP.	**Evaluation HSDP I**	**Evaluation HSDP II**	**ARM 8**	**ARM 9**	**MTR / HSDP III**
		guidelines, manuals, norms, standards, flowcharts. - Integrate mechanisms and protocols for PMTCT, ANC, PNC, STI, family planning and ITN. - Build capacity for neonatal care, including the provision of equipment and materials. - Develop partnerships for establishment of blood banks; - Elaborate incentive packages for MNMM workers. - champions among development partners and GOE, further building on the Make Pregnancy Safe (MPS) lessons learned, - Training of some specific skilled cadres may need to be revisited, e.g. numbers and pace of training of midwives, numbers and pace of training of health		safe abortion	and provision of equipment and supplies. However, in most HFs visited the signal functions are not being provided. What is worrisome is, when these services are not available the system does not pick it up. Supervision checklist do not contains these functions (e.g. in Amhara a facility with CEmONC trained team in place has not provided information for about a year). There is need to set a standard to qualify health facilities as basic and comprehensive, based on the service they are providing and not based on equipment received or trained team assigned. - Referral system is still weak. Effective feedback mechanism is not in place, Ambulances are few, but even in those areas where there is an Ambulance, it has not being used effectively. Referral plan or service plan is not available at district level. - Equipment and supplies for maternal health is not adequate. Equipment is better at lower level facilities (health centres and district hospitals) than higher level facilities (zonal and referral hospitals). Equipment provision has to be needs based, derived from services expected for that level of health facility. - In most of the health facilities there is inadequate equipments for newborn care and key staff such as midwives mention they have limited skill in newborn resuscitation. - Availability of blood is still insufficient. Regional Red Cross Blood Banks are not fully operational. Some Hospitals have hospital based blood banks, using direct blood transfusion. - No incentive package has been in place for MNMM workers - There is increased recruitment and training of midwives in some regions (e.g. SNNPR, Amhara, and Tigray). However, it lack standardization and qualification at federal level. - Health officer accelerated training is ongoing. Upgrading of health officer to provide CEmONC has been done in Tigray using a 9 months training curriculum. Programme has been evaluated. The FMOH and the FMOE are now planning to initiate a Master's level programme on Integrated Emergency Obstetric and Surgery for health officers. Maximum effort needs to be given to ensure quality of training. - Internship programme for GPs is still not reviewed for inclusion of skills for performing emergency obstetric surgeries.

Overview Recommendations (summary) HSDP I Evaluation (2003), HSDP II Evaluation (2006) and the two ARM in 2006 and 2007.					
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		officers and upgrading of health officers to provide emergency obstetric care. - Health facility capacity to handle common emergency surgeries strengthened. - vehicles to facilitate referrals for remote health centres - The internship programmes for GPs (Medical Officers) should be reviewed for skills for managing both medical and surgical emergencies especially Emergency Obstetric Care			- At federal level there have been efforts to develop a comprehensive response to reduce maternal and newborn mortality (National RH Strategy developed and Programme of Action in progress). However, regions have no comprehensive plan of action on this at the moment. - A lot of efforts have been observed on improving access to safe abortion (awareness raising, training, equipment and supply provision, data collection). The engagement of private sector in provision of Comprehensive Abortion Care is also well observed. - Integration of HIV/AIDS with reproductive health services is observed in areas of FP, PMTCT, but integration has to be in place at all level of the health system (Policy, programme, service delivery, awareness and behavioural change). - Maternal nutrition is not routinely monitored, which contributes to low birth weight and possibly poor lactation performance. Iron and Folic acid tablets not provided to all pregnant women.
Family Health / Youth and Child health	- RHB to initiate youth and adolescent services; - Expand IMCI services (and TOT for IMCI) - Continue NID and include Vitamin A			Improve Adolescent reproductive health (focal persons)	There has been development of national Adolescent and Youth Reproductive Health Strategy 2006-2015. Youth friendly reproductive health services initiated in some health facilities (e.g. Tigray and SNNPR) but there is a need to scale up. - EPI and IMNCI information has been integrated in the National HMIS. - Actions have been taken to ensure cold chain system. However, equipment maintenance and staff skill still need to be addressed. - Use of antibiotic for treatment of pneumonia of children in HEP is not yet initiated. Still on discussion at federal level
Family Health / Family Planning (		- Address recurrent stock-outs of contraceptive commodities, - Strengthen family		Integrate family planning with HIV/AIDS services - Strengthen the integration of family planning service with	- It has been tried to address Contraceptive stock-outs (better forecasting, stock management and delivery trainings), but this still need to be strengthened further. - Partnership with NGOs and private sector has been strengthened contributing to improved community distribution of family planning commodities. However, Health facility based family planning methods (surgical methods, IUD) are still

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ACTIVITY /COMP.	**Evaluation HSDP I**	**Evaluation HSDP II**	**ARM 8**	**ARM 9**	**MTR / HSDP III**
		planning / IEC especially targeting rural areas, sensitive to the socio-cultural diversity and gender issues. -Promote community based distribution and social marketing mechanisms to increase contraceptive coverage in partnerships with NGOs. - Ensure contraceptive security and the family planning logistics system and LMIS, including efforts to integrate them in larger National Commodity Distribution systems. - Explore broadening of the method mix, including emergency contraception in a systematic manner.		HIV/AIDS interventions at all level. - improve the distribution of commodities through the use of better LMIS and more resource allocation - Engage partners in dialogue to use and strengthen the PLMP instead of imposing their procurement procedures - Build procurement and distribution capacity as per the PLMP - Review the status/problems of the utilization of long-term family planning services and take corrective measures	weak. - Implementation of PLMP is still at initial phase; therefore partners still continue to impose their procurement procedures sometimes leading to significant delay in delivery of commodities. - FMOH capacity to manage logistic system has been addressed through BPR process and deployment and assignment of technical assistants, but this still needs ongoing support. - Method mix is still limited to the four common contraceptive methods (OCPs, condoms, injectables and implants). Other options are not available to majority of women. A national review of obstacles to the use of long-term methods has not been conducted. - Emergency contraceptive has not yet reached most facilities.
Hygiene and Environ-Mental Sanitation	- Strengthen support to Environmental Dept; - FMOH to support regulation and licensing;			Launch the national Millennium Sanitation Movement (MSM) at all levels Find causes of low use of HEP in Hygiene	There is increased access of the community in the use of latrine and appropriate waste disposal, but use of latrines is not known.

Overview Recommendations (summary) HSDP I Evaluation (2003), HSDP II Evaluation (2006) and the two ARM in 2006 and 2007.					
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ACTIVITY /COMP.	**Evaluation HSDP I**	**Evaluation HSDP II**	**ARM 8**	**ARM 9**	**MTR / HSDP III**
	- Strengthen Regional PH laboratories.			Improve data collection in Hygiene and Sanitation Put targets in EFY 2000 Core Plan for Hygiene	
Medical Services / Coverage and EHSP	- Solve urgent problem of 6 – 4 tier system; - Provide support to RHB/ WORHO to calculate catchment areas; - Define EHSP before standardising staff and other requirements			Launch the training of Hospital CEO Begin outsourcing non-clinical hospital services Initiate private wings Check construction of 16 blood banks	- In some regions, regional proclamation has passed in establishment of board and appointment of CEOs. Few regions remain dormant on this. - The training of CEO is commencing in most regions after the FMOH has done training and need assessment and identified 8 thematic areas for strengthening hospital management. This is done in 8 facilities in Addis Ababa and 10 facilities in the regions. - A Post graduate study in hospital management is set up in Jimma University in collaboration with Yale University. - Outsourcing of non clinical hospital services is still on the planning stage. No evidence is seen up till now. - Construction of 16 Blood Banks by International red-Cross (IRC) has already been started. However due to 'the current price escalation on construction materials it has been suspended for the time being. IRC expects to make these Blood Banks operational in the coming 6-12 months. - In some regions, health facilities that have generated revenues (e.g. Addis Ababa and Bahir Dar) have used these funds to construct private wings.
Medical services / Quality	- Improve utilization by addressing quality care and the referral system, rather than increasing the number of facilities.			Strengthen Network of PH Laboratories (see HEPR)	- EHNRI has been given a new institutional role in supporting the FMOH in supervising laboratory services and coordination of implementation of Laboratory Services Master Plan. The Laboratory Services Master Plan provides increased access to safe blood in partnership with International Red Cross Society.
IEC	- Develop National IEC/BCC Strategy; - Target production of materials to specific audiences; - Propose coordination for all IEC stakeholders			Develop programme to increase awareness on safe abortion Strengthen 'community conversation' programmes	- Safe Abortion Technical Guideline developed in 2006 within the context of the national Reproductive Health Strategy 2006 – 2015. Trainings on Safe abortion has been given for various cadres. - There is adaptation of Community Conversation methodology and manual to include reproductive health issues. There were many examples people mention the use of Community Conversation in improving access to reproductive health services and information. - Community Conversation was identified as a useful forum to communicate with

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	(technical working group)				the community.
Cross-Cutting / Gender	- Establish Gender units in RHB and provide staff; - Put gender guidelines into practice; - Build capacity in gender mainstreaming for all staff - Contract external support where required				- Some RHB assign a gender focal person. In some cases, the focal person has been given the role of gender focal person in addition to her/his previous assignment. - The provision of Technical Assistance or contracts on gender are not made available to the regions. - There is a need for training and capacity building on gender mainstreaming in programmes. - Need of greater involvement of Women's Association, Universities to bring in Socio-anthropological background.
Cross-Cutting / Pastoralists	- Involve Pastoralists in the setting up of their health services; - Ensure multi-sector approach to pastoralist health care - Adapt services to lifestyle of pastoralist societies			Implement HEP in urban and pastoralist areas	- Pastoralist Health Policy and guideline available in some regions - Implementation of training of HEWs based on adapted programme is ongoing in some regions (e.g. Somali just finished piloting, Afar is at initial steps with many difficulties to be addressed)
Cross-Cutting / Nutrition	- Elaborate National Nutrition Policy - Allocate nutrition focal persons at all levels. - RHB and RC to initiate nutrition activities in health facilities;			Accelerate endorsement of NNS Accelerate enforcement of Proclamation 471 Accelerate development of NNP Improve coordination at policy and operational levels	- NNS developed and approved in January 2008. Programme Implementation manual (PIM) of National Nutrition programme 2008 – 2013 is developed. Strategies to integrate nutrition intervention and services have been initiated. - Linkage with regional DPPC is strengthened - Nutrition still largely dealt with in 'campaign mode' addressing malnutrition. - Greater emphasis need to be put in place for prevention of malnutrition in food insecure areas. - Some initiative have been observed in establishing salt iodization but this is not universal. Programme on salt iodization and other micronutrient interventions is

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	- Strengthen nutrition capacity for all health facilitiy staff; - Launch IEC/BCC breastfeeding campaign; - Coordinate nutrition interventions among all stakeholders			Launch programme of Universal Salt Iodization Strengthen other micronutrient interventions Improve linkages DPPC	still need to be integrated in the HEP and increased public awareness. - Still weak coordination at policy and operational levels - Programme of Universal Salt Iodization launch not yet done - Strengthen other micronutrient interventions: This is only achieved for vitamin A.
Cross-Cutting / Health Emergency Preparedness and Response (HEPR)				Accelerate BPR for reduction of epidemics Prepare manuals and guidelines for HEPR Train field epidemiologists Strengthen institutional position of HEPR in FMOH Define role FMOH in coordination of HEPR Include HEPR indicators in National Core Plan HEPR to address nutrition, mental health, gender based violence Include HEPR in various curricula	- HEPR is still largely focused on response rather than prevention of emergencies. Some regions (e.g. Tigray have trained field epidemiologists to strengthen institutional position of HEPR in RHB). - Strengthening institutional position of HEPR is not seen at federal level but some regions have trained field epidemiologists - Indicators not available.
Cross-Cutting / Population issues					
Support Services					
Construction	- RHB to make	Synchronize	Strengthen resource	Mobilize local	- There has been acceleration of health facility construction. Observations have

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and Accelerated expansion of health post and centre	comprehensive construction plans (including HRD, and preventive maintenance) with other Ministries - Standardize construction plans; - Strengthen pre-construction capacity;	construction, HRH and procurement as part of the health post and centre expansion. Strengthen planning capacity in FMOH Only start new constructions, when existing health facilities have staff and equipment Upgrade HC in remote areas with operating facility and health officer Develop preventive maintenance system	mobilization for construction and equipment Provide Emergency Health Services and B/CEmONC Equip health facilities based on standards	government support to accelerate construction of health post Enforce agreement on EFY 2000 Core Plan with RHB for construction targets Check pledges of the DP to support construction HC Ask DP to use the PLMP Review the cost of construction to address / solve delays	been made on upgrading of health facilities but functionality is still a problem because of water supply, electricity, staffing - There have been resource mobilization efforts both at federal (GF, GAVI, ADP) and regional levels, including community contributions (e.g. in Amhara health posts are constructed using 100% community contributions while in Tigray 30% are built using community funds and 70% from Development Partner funds. - With accelerated programme there is a plan to construct 900 health centres in the current FY. 500 HC is planned to be constructed by federal and the regions are expected to match the number. This seems to be happening with some (around 5%) completed and the remaining to be completed within the next 12 months by GTZ. But the observations indicate that delay is expected, due to delay in site assessment and identification of locations, limited contracting companies in remote areas, increased commodity and supply prices (iron and cement) - There is a need for comprehensive planning not only focusing on construction but also putting the system in place and ensuring functionality of facilities (water, electricity, human resources, equipment) - 5 pharmacy warehouses have been renovated, 6 new primary hub and 7 secondary hub have been built. But still there is a mismatch between available resource (7.3 million USD) and required resource (16 million USD) - Construction of 16 Blood Banks has been initiated in partnership with IRC but completion is suspended due to escalating construction commodity prices. IRC expects to complete the constructions within the next 6-12 months.
Human Resources for Health (HRH)	- Empower HRD with legal mandate to regulate and decide staff deployment; - Delineate responsibilities of partners: MOE, MOCB, Councils - Involve Associations, NGO and private sector in	Develop incentive scheme for hardship areas. Accelerate HR capacity for B/CEmONC Finalize HR Strategy!! Align training of different categories HEWs Provide more	Adopt incentives for retention of HEWS Provide in-service and refresher training	Implement training programmes for wereda HEWs on HEP (Integrated Refresher Trainings/IRT) Develop and implement HRH strategy to address training, deployment and retention issues Finalize restructuring of HR Department within 3	- Some regions (e.g. Afar, Benishangul Gumuz, and Gambella) have initiated hardship compensation in various ways (financial and non-financial). Regions have authority to manage their own HR. But there is no guidance from federal level to harmonize these efforts. - B/CEmOC HR is strengthened largely in the form of in-service training. Effectiveness varies from region to region (e.g. in Amhara none of CEmOC trained GPs are providing the service; therefore the region suspended the training). There is a need to evaluate the quality of B/CEmOC in-service team training. In Tigray health officers trained on a 9 months training has been observed providing CEmOC. - Although there is no HR strategic document endorsed by the FMOH, the BPR

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	training and capacity B. - Initiate study for HRD Strategy - Regulate/license private training institutions; - Redefine confusing responsibilities of HEWs; - Promote training of polyvalent workers (instead of monovalent); - Emphasize quality rather than quality and strengthen Continuing Education; - Reinforce incentive schemes for staff in remote areas; - Increase the number of midwives urgently. - Revitalize RTC with resources, define their tasks - Re-establish national Certificate exams	opportunities for women in recruitment, promotion and training (see CSRP)		months Develop Code of Conduct between FMOH and partners to regulate recruitment of health professionals Ask DP to support training in BEmONC, Surgery, MD training, Anaesthesia, Rx. Establish HRH data base for public and private sector Monitor training programmes for quality Institutionalize retention schemes in the regions	process has been addressing the HR strategy, using two background documents 1. HRH situational analysis (AZIZ) completed 2. HRH implementation manual with work plan for 2007 and 2008. - Alignment of different categories of HEWS has been initiated (e.g. upgrading of health assistants and juniors to a standard diploma level) - Gender issue is being addressed in some regions fairly well. Female HEWs is one important contribution. Involvement of women's associations is observed in Tigray. However, still only 19% of health workers in Ethiopia are women. - In 2007 CSRP issued an increment in basic salary for all civil servants with special attention to health workers with an increment of 20% for diploma to 70% increase for specialists. - Some regions have developed incentive and retention packages particularly for higher category of professions (specialists, GPs, BSc). However, there is a need for federal level harmonization. - Most of in-service training is still vertical and donor driven rather than based on identified skills gap. - No restructuring up to know regarding the provisional HRH Department. - Regulation of hiring of local experts is not done. May not be a rational recommendation. - Human Resource Information System (HRIS) data base not implemented. - No quality assurance of trainings at all level (neither in public nor private).
Pharmaceuti cals and	- Review NDP and 1987 Essential Drug	Merge budget and special pharmacies	Integrate the PLMP and the HCSS and clarify roles	Accelerate procurement and distribution of	- Terms have been made to rationalize pharmaceutical management and distribution system in the context of PLMP. Effectiveness of the roles of DACA,

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Logistic Mgmt	List - Develop Master Plan Pharm. Sector; - Harmonize procurement and supply logistics, including storage and inventory control; - Harmonize donor flow of funds for drug procurement; - Initiate coordinating meetings with stakeholders in Pharm. Sector. - Decide on Indicators for Pharm. Sector	into one harmonized system Streamline procurement of pharmaceutical supplies and equipment	of DACA, PSLD and PFSA Clarify relations between RHB and PFSA Advocate for funding Ensure Cost Recovery (RDF) to support PFSA Initiate Resource Mapping and provide resources for PFSA	equipment and supplies for health posts Improve distribution of commodities for Maternal Health and family planning Finalize transformation of PSA Harmonize PLMP and PSMP implementation Initiate resource mobilization to support the Master Plan Complete HR assessment for PLMP Develop RDF regulations	PSLD, PFSA, regional health bureaus and health facilities need to be monitored. - Harmonization of Budget Pharmacy and Special Pharmacy is not seen in action.
HMIS and M&E	- Bring HMIS and M&E under the same component - Reduce number of indicators and align HMIS with HSDP reporting. - Adopt HMIS from SNNPR and Tigray in other regions - Develop national HMIS Strategy; - Use TASF to strengthen HMIS; - Link HMIS to	Agree on a limited set of HSDP indicators across FMOH and RHB Standardize tools and reporting mechanisms Validate routine data through research Build capacity in gender disaggregated data collection for decision making Strengthen Operational Research	List of indicators approved TB/Leprosy indicators to be clarified Desegregation by gender and age to be addressed Some specific indicators to be added (reproductive health, cataract surgery, malaria, finance and HRH) Address completeness and timeliness ICT use to be phased Involvement of private sector in HMIS to be developed	Conduct evaluation of the HMIS pilot programme Generate more funds for the new HMIS Finalize preparations for legislation of HMIS	Evaluation of HMIS pilot programme is done. The evaluation recommended scaling up the HMIS nationwide. This was scheduled for January 2008, but has not yet been done, due to financial and logistical constraints (as reported in the body of the report). Regional HMIS teams are awaiting decision to be made urgently. - Legislation of HMIS is in draft stage - List of indicators for TB and Leprosy done. - Completeness, timeliness and standardization is ongoing - ICT will be implemented with the new system in place. - Indicator list reviewed and agreed. - Operational research still weak. At federal level is just being initiated.

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	SDPRP indicators				
Finance and Sector Management					
Financing the sector	- Align budget reforms with HSDP component structure - Increase recurrent funds at WHO levels - Elaborate procedures to receive GFATM funds - All expenditures should be budgeted accurately - Undertake regular donor mapping exercise - Strengthen PPD technical capacity	FMOH should advocate for increased allocation of resources by Regional Councils		Assess financial utilization of HIV/AIDS, TB and Malaria programmes and improve information exchange Improve Absorption capacity of programmes	- Alignment of budget reforms with HSDP component structure is still not done / difficult. - Recurrent funds to WHO has been increased through the use of PBS funds. - Attempt has been made to cost all expenditures accurately but still a work in progress - Donor resource mapping exercise is being done - PPD technical capacity has been strengthened through appointment and assignment of technical assistants, project coordinators and HMIS experts - Wereda-based planning exercise has also been a good capacity-building exercise. - Budget absorption capacity has been improved but still remains to be a continued
Planning the sector				Refine the planning tools and the process of the Core Plan. Provide training for 2001 Core Plan Ensure strong Development Partners' commitment to Core Plan Implementation Agreement to be signed by ZHD and WORHO	- Planning tool has been refined but still needs improvement. This is in process and activities are underway.
Health Care Financing	--	Accelerate the implementation of the HCF Strategy in all	Use revenues for staff retention / hosp services		- Draft Health Insurance regulation has been developed at federal level and need to be communicated to the Council of Ministers for endorsement. This regulation applies for 4 hospitals at the moment.

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		Regions.			
Financial Management	--				
Governance	- Review relevance of HSDP I framework, redesign the component structure; - FMOH, RHB and RC should take decisions regarding the Health Sector jointly. - Stimulate inter-regional sharing of experiences; - Improve inter-department communication; - ARM to become forum to discuss performance and to provide information on financial contributions by all stakeholders.	Intensify advocacy and guidance by FMOH to RHB and by RHB to Wereda Offices Strengthen planning and mgmt capacity at all levels Take the diversities in the country into account in planning Strengthen collaboration with MOFED, MOE and Water and Rural Development Ministry	FMOH to produce a consolidated annual sector plan (priorities) Zonal level to be included in FMOH Annual Plan Bottom-up planning to be strengthened Code of Conduct signed and reviewed regularly RBP to be replicated to all regions		- FMOH and RHB meet every 2 months under the leadership of the Minster. - RHB and Weredas also meet frequently - Planning capacity has been strengthened but management capacity is still a concern - Region based planning based on WBP is done - Diversity is taken into account in planning to some extent - Collaboration with MOFED, MOE and MOW/Rural development has improved
Civil Service Reform Programme (CSRP) and Decentralization	- Ownership of Regional HSDP is with RHB and RC; - Advocate staff membership in the wereda Councils		FMOH and RHB to adhere to One Plan, framework		- Wereda Based Planning in second year of implementation - Dissemination of HSDP has been conducted but not fully to operational level.

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Institutional issues	- Chair of FMOH-HPN Group to be part of the CJSC; - Replace RJSC with technical committee under RC with broad membership from public and private sectors.		Frequency of meetings of Joint Steering Committees to be reviewed and harmonized Capacity of HSDP secretariat (PPD) to b strengthened Improve networking between health facilities and hospitals		- Replacement of RJSC with technical committee with broad membership from public and private sectors is not being done. Rather HHM reinforces RJSC. - The functionality of Joint Steering Committee has been reviewed, but proposal to strengthen them has not been concluded. - PPD in the capacity of HSDP secretariat has been strengthened by deploying additional staff and technical assistants
NGO and Private Sector	--			Develop Programme of Action with the Medical Association of Private Practitioners, Ethiopia to enhance safe abortions Strengthen Joint Forum Include PPP on the agenda of next ARM.	
PIM	- FMOH to review PIM with RHB		PIM to be finalized in 6 months and translated		HHM which has replaced PIM is developed and adapted in April 2007. HHM was used for the wereda-based planning for 2001 EFY.
Development Partners / Alignment and Harmonization		DP should step up their efforts to align their planning and budgeting to GOE procedures Improve predictability of funding GOE budget Develop MoU between FMOH / ALL Partners		Disseminate the HHM and have it used effectively Advocate for more signatories to the Code of Conduct (GFATM and CDC) Do annual review of adherence to Code of Conduct Negotiate with DP for more alignment	- 5 DP have already aligned their FY with government FY. Predictability of funding is still a problem. - Code of Conduct has been developed and 13 DP partners became signatory initially. However, subsequent advocacy has not been effective, as only GAVI has been added as signatory making the total of 14 signatory DP. GFATM and CDC have not yet become signatories to the Code of Conduct. - Adherence to the Code of Conduct evaluation has been conducted and report presented at 9th ARM in October 2008. - Negotiation with Development Partners for better alignment has been ongoing and there is much progress. Ethiopia is the 1st wave country for IHP+ road map.

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Others			Promote empowerment of Hosp Boards	Conduct ARM 2008 in Tigray in October 2008. Conduct internal assessment of ARM 2007 (in Bahir Dar) Provide timely TOR	