

PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

Case study from Ethiopia

Abridged Version



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Primary Health Care Systems (PRIMASYS)

Case study from Ethiopia

Overview of Ethiopian primary health care system

With more than 90 million inhabitants, Ethiopia is the second most populous country in Africa, after Nigeria. Numbers of males and females are approximately equal. The rate of population increase is estimated at 2.6% per year.¹ In recent years the life expectancy has been increasing, and is now 64 years at birth.² The population of the country is mostly agrarian and rural, with a low per capita income. Pneumonia is the leading cause of mortality in Ethiopia. Another major health issue in the country is maternal and child health. The maternal

mortality rate is 353 per 100 000 live births,³ and in 2015 the country's infant mortality rate was 59 per 1000 live births. On the other hand, in the same year 86.4% of children were immunized, including pneumococcal and rotavirus vaccine.⁴

Ethiopia allocated US\$ 1.6 billion to health care in 2015. Of total health expenditure, 14.69% goes to finance primary health care (PHC). Households contribute more than one third of the country's health expenditure (Table 1).⁵

Table 1. Key demographic, macroeconomic and health indicators, Ethiopia, 2016

Indicator	Data	Source of information
Total population of country	90 076 012	Health and health-related indicators, Ethiopia fiscal year (EFY) 2007 (2014/2015)
Distribution of population (rural/urban)	19.4% urban	Health and health-related indicators, EFY 2007 (2014/2015)
Income or wealth inequality (Gini coefficient)	30	International Monetary Fund Country Report No. 15/326, Federal Democratic Republic of Ethiopia, 2015
Life expectancy at birth	64	Health Sector Transformation Plan
Infant mortality rate	59/1000	Health and health-related indicators, EFY 2007 (2014/2015)
Maternal mortality rate	353/100 000 live births	Trends in maternal mortality, World Health Organization
Immunization coverage (including pneumococcal and rotavirus vaccine)	86.4%	Health and health-related indicators, EFY 2007 (2014/2015)
Total health expenditure as proportion of gross domestic product (GDP) ^a	2.66%	Health Sector Transformation Plan 2015
PHC expenditure as % of total health expenditure ^b	14.69%	National Health Accounts 2011/2012
% total public sector expenditure on PHC ^c	26.73%	National Health Accounts 2011/2012
Per capita public sector expenditure on PHC ^d	11.57 Ethiopian birrs	National Health Accounts 2011/2012
Out-of-pocket payments as proportion of total expenditure on health	36%	National Health Accounts 2011/2012

a. Total health expenditure ÷ country gross domestic product x 100.

b. Total PHC expenditure ÷ total health expenditure x 100.

c. Public health expenditure for PHC units ÷ total public health expenditure x 100.

d. Per capita public sector expenditure on PHC: public health expenditure for PHC units ÷ total population.

1 Health and health-related indicators. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

2 Health Sector Transformation Plan. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

3 Trends in maternal mortality, 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015.

4 Health and health-related indicators. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

5 Fifth National Health Accounts 2010/2011. Addis Ababa: Ethiopian Federal Ministry of Health; 2014.

Timeline

Modern medicine was introduced to Ethiopia in the 16th century during the regime of Emperor Libne Dingel (1508–1540), and was enthusiastically promoted during the reigns of Emperor Menelik II (1889–1913) and Emperor Haile Selassie (1930–1974). Emperor Menelik invited travellers, missionaries and members of diplomatic missions to introduce medicines and provide medical services, mostly in Addis Ababa, and various programmes and interventions ensued. Emperor Haile Selassie established the Ministry of Public Health, and the first National Health Service, in 1947.^{6,7}

The Alma-Ata Declaration on Primary Health Care (1978), and its call for Health for All by the year 2000, was welcomed by the Ethiopian Government. However, it was clear that a national health policy based on the declaration alone was not sufficient, and in fact implementation of PHC policies was largely unsuccessful at first,⁸ for the following reasons:

- The policies and strategies for the specific elements of the PHC were not clearly defined at national level.
- Regions and health facilities had limited awareness of those elements as defined at the central level.
- There was lack of clarity on health policies in most regions as a result of poor and inadequate dissemination of information on the policies.

The development of PHC in Ethiopia under three political systems – monarchy, socialism and democracy – was characterized by both modification of health policies and strategies from one administration to the next, and the maintenance of a number of deeply ingrained attitudes and practices. A major constraint was placed on PHC development by the heavy emphasis on central, top-down approaches that failed to consider cultural diversity, disease ecology-specific and appropriate strategies, and true community participation, and by the persistence of predominantly urban-based, curative and technocratic health care systems. Basic health needs are strongly influenced by cultural and geographical diversities and must be addressed by adaptable and acceptable health strategies.⁹

Ultimately, the success of PHC in Ethiopia depends not just on policy statements, resource reallocations and expansion

of health infrastructure but also on a fundamental change in attitudes and values regarding the development of human resources and the equitability of social services. It remains to be seen whether the existing Ethiopian Government can maintain momentum in the continuing decentralization and democratization processes, and create a sociopolitical environment conducive to bottom-up PHC development. A plan to achieve universal access to PHC was prepared and embedded in the Health Sector Development Programme III in 2005. This plan aimed to address shortcomings of service coverage within the health system through accelerated expansion and strengthening of PHC services.¹⁰

Governance and structure of primary health care in Ethiopia

Ethiopia's health service is structured into a three-tier system: primary, secondary and tertiary levels of care (Figure 1). The primary level of care includes primary hospitals, health centres (HCs) and health posts (HPs). The primary health care unit (PHCU) comprises five satellite HPs (the lowest-level health system facility, at village level) and a referral HC. This is the point where PHC is administered and primary services facilitated under the health service delivery structure. A primary hospital provides inpatient and ambulatory services to an average population of 100 000. A primary hospital provides emergency surgical services, and is a referral centre for the HCs and a practical training centre for nurses and other paramedical health professionals.¹¹ A general hospital serves as a referral centre for primary hospitals and as a training centre for health officers, nurses and emergency surgeons. Similarly, a specialized hospital is a referral centre for general hospitals.¹²

A further network links community members with the PHC system at community level. For this purpose, the basic structural unit is the health development army (HDA). Organizing a functional HDA requires the establishment of health development teams (HDTs), which comprise up to 30 households residing in the same neighbourhood. The HDT is further divided into smaller groups of six members (households), commonly referred as "one-to-five" networks.¹³ In that regard, the PHCU coordinator of Oromia Health

6 Kloos H. Primary health care in Ethiopia: from Haile Sellassie to Meles Zenawi. *Northeast African Studies*. 1998;5(1):83–113.

7 Seifu T. Ethno-botanical and ethno-pharmaceutical studies on medicinal plants of Chifra district, Afar region, north-eastern Ethiopia. Addis Ababa; 2004.

8 Jira C, Feleke A, Mitike G. Health planning and management for health extension workers. Ethiopia Public Health Training Initiative; 2004.

9 Kloos H. Primary health care in Ethiopia: from Haile Sellassie to Meles Zenawi. *Northeast African Studies*. 1998;5(1):83–113.

10 Sebhatu A. The implementation of Ethiopia's Health Extension Programme: an overview. Addis Ababa; 2008.

11 Teklehaimanot HD, Teklehaimanot A. Human resource development for a community-based health extension program: a case study from Ethiopia. *Human Resources for Health*. 2013;11(39). doi:10.1186/1478-4491-11-39.

12 Health Sector Transformation Plan. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

13 Health Sector Transformation Plan. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

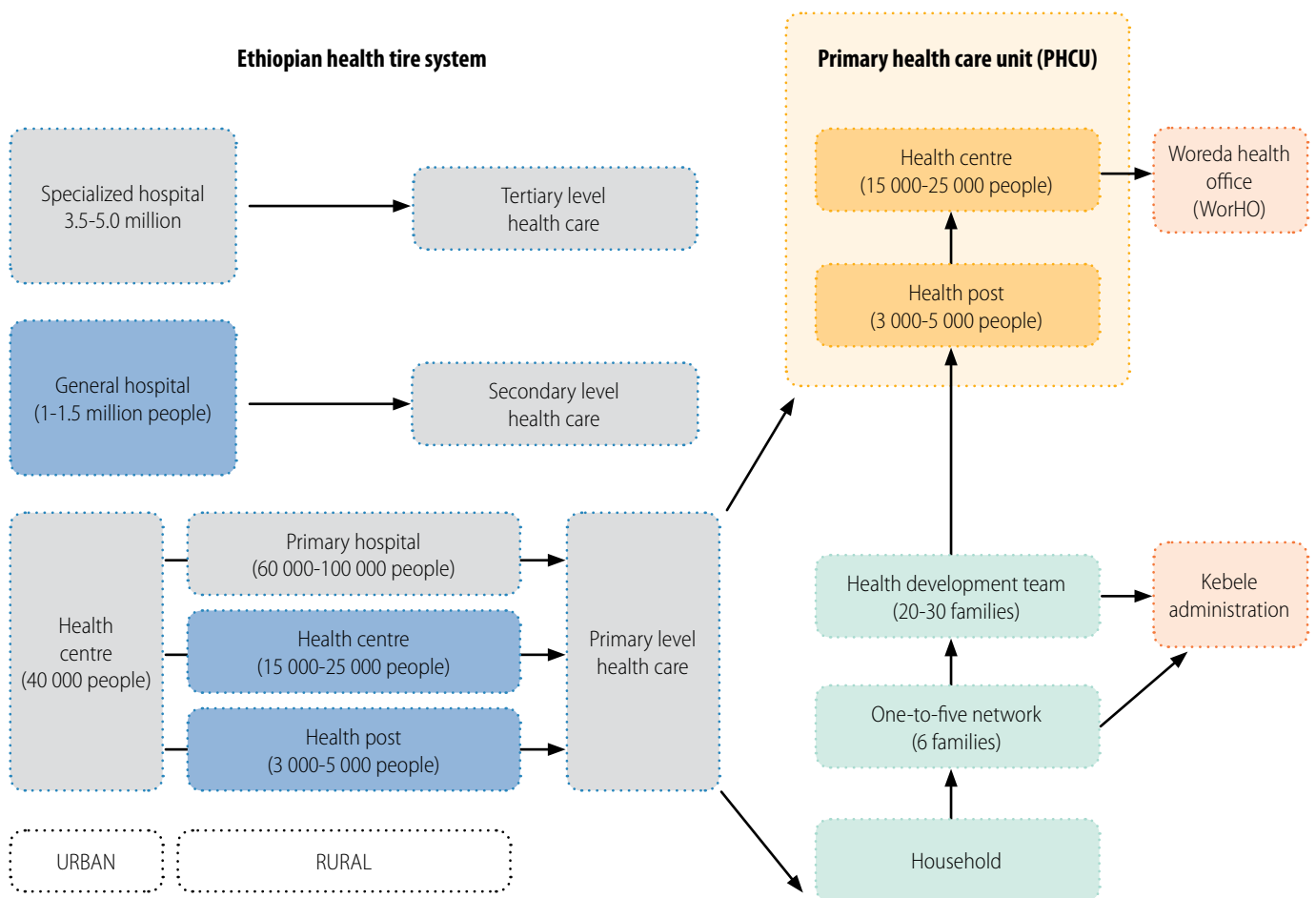
Bureau said: "At the kebele level there is a command post led by the kebele leader. This command post follows up the development groups' developmental work every two weeks. The development group controls the one-to-five networks' activities each week, and the one-to-five networks follow up each household's performance three days per week."

The leaders of the HDTs and the one-to-five networks are selected by the team members. The main criteria for selection of the leaders are their status as model family members, and their trustworthiness as community mobilizers. A model family can obtain community recognition when they implement all the packages of the Health Extension Programme, or perform with distinction among the group members.¹⁴

The formation of the HDTs and the one-to-five networks is facilitated by health extension workers (HEWs) and the kebele administration. The HDT leaders, who operate as unpaid volunteers under the supervision of HEWs, carry out a number of tasks, including helping during immunization campaigns, keeping track of pregnancies and illnesses, and relaying messages between households and HEWs.^{15,16}

The PHCU is the smallest division in the Ethiopian health tier system, and is the unit most accessible to the general population (Figure 1). As previously mentioned, it is composed of an HC and five satellite HPs. The HP is the first level of Ethiopian health service delivery, and provides services at kebele level. On average 5000 people are served by a single HP, and two HEWs serve at each HP. The HPs are accountable for HCs and kebele administration.¹⁷

Figure 1. Ethiopian health system structure



Source: Ethiopian Health Sector Transformation Plan, 2015.

14 Admasu K. The implementation of the health development army: challenges, perspectives and lessons learned with a focus on Tigray's experience. Federal Democratic Republic of Ethiopia, Ministry of Health. Quarterly Health Bulletin. 2013;5(1):3-7.
 15 Health extension program in Ethiopia: profile. Addis Ababa: Health Extension and Education Centre, Federal Ministry of Health; 2007.
 16 Maes K, Closser S, Vorel E, Tesfaye Y. Using community health workers: discipline and hierarchy in Ethiopia's women's development army. Annals of Anthropological Practice. 2015;39(1):42-57.
 17 Health development army guidelines. Addis Ababa: Ethiopian Federal Ministry of Health; 2005.

Each HC provide services to approximately 25 000 people, and has an average of 20 staff. The HC provides both preventive and curative services, and serves as a referral centre and practical training institution for HEWs. An HC has an inpatient capacity of around five beds.¹⁸

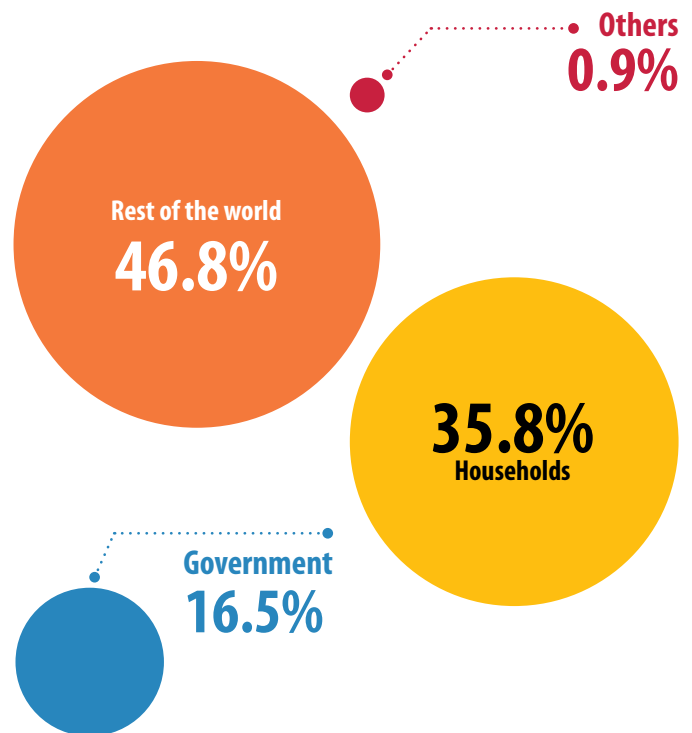
The PHC service is designed to include preventive, promotive and basic curative services. The Ethiopian Government introduced its Health Extension Programme in 2002 to enhance PHC services, especially for the rural population. The Health Extension Programme, which focuses on the preventive and promotive aspects of health care, includes 16 packages under four main programme categories, including hygiene and environmental sanitation; disease prevention and control; family health services; and health education and communication.^{19,20}

The Health Extension Programme initially focused on rural settings. However, preventive and promotive services are vital in the urban areas of the country. Since most of the country's health problems are attributed to preventable infectious and communicable diseases, a 24-package urban health extension programme has been established.²¹ HEWs in the rural areas have completed 10th grade, while health extension professionals in urban areas hold clinical nursing diplomas. The clinical nursing diploma holders are given three months' pre-service training on the basics of the Health Extension Programme and the 24 packages.²²

Financing

Ethiopia's health sector has multiple financing sources, including the government Treasury (federal, regional and woreda/district levels), bilateral and multilateral donors, household out-of-pocket expenditure, international and local nongovernmental organizations (NGOs), private and parastatal employers, and insurance companies. Nearly half of Ethiopian health care expenditure comes from the rest of the world, followed by household expenditure and government expenditure (Figure 2).²³

Figure 2. Ethiopian health care expenditure, 2011



Source: Ethiopian Fifth National Health Accounts, 2011/2012.

More details on the sources of funds for the Ethiopian health system were provided by a key informant at the Federal Ministry of Health (FMOH) Resource Mobilization Directorate:

Most of financial resources for health care come from the government Treasury and revenue, the rest of the world, and household out-of-pocket payments. The resources from the rest of the world come from both loans and donations. Since they are repayable for the creditors, loans are considered as government money. Donor money comes through three channels. Channel 1 comprises resources that come directly from donors to the Ministry of Finance and Economic Development (MoFED). These can be of two types: marked resources, which are resources targeted to one specific programme, and unmarked resources, which are financial resources allocated according to the FMOH. Channel 2 comprises resources that come from donors and go directly to the FMOH. Channel 3 comprises resources from donors that

18 Health Sector Transformation Plan. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

19 Sebhatu A. Ethiopia good practice – the implementation of Ethiopia's Health Extension Program: an overview. Addis Ababa; 2008.

20 Health Sector Development Program II: 2002/03–2004/05. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2002.

21 Fifth National Health Accounts 2010/2011. Addis Ababa: Ethiopian Federal Ministry of Health; 2014.

22 Wabalo MW, Zergaw A, Yirgu R. Attitude and participation level of households towards Health Extension Program (HEP) at Nefas Silk Lafto sub-city, Addis Ababa, Ethiopia. Addis Ababa; 2015.

23 Fifth National Health Accounts 2010/2011. Addis Ababa: Ethiopian Federal Ministry of Health; 2014.

go directly to nongovernmental organizations (NGOs) that have connection with the donors. Out-of-pocket payments are collected as government revenue and reallocated to the health service. Even when health institutions raise financial resources, it is considered as government revenue.

Government health facilities were major recipients of the 2010/2011 spending of health care financial resources, accounting for nearly 34% of total health expenditure. Public PHCUs, which include government HCs and HPs, received nearly 15% of total health expenditure. In addition, the Ethiopian Government has embarked on implementing community-based health insurance (CBHI) schemes in the country. The scheme was implemented as a pilot in selected districts of the four biggest regions: Oromia, Amhara, the Southern Nations, Nationalities and People's Region, and Tigray.²⁴

Currently, CBHI has been extended to 377 districts nationally. Among these, 205 districts have started delivering health services based on the insurance scheme, to the extent that 36% of the population in those districts is covered by the scheme. The representative of a health insurance agency observed: "Initially this CBHI was designed to deliver health services at the PHCU level. But later it was modified to enable clients to obtain referral services at the secondary and tertiary levels of the health system."

In addition to these sources of finance, as the information from Oromia regional health bureau (RHB) indicated, there are other mechanisms to support PHC services at the regional level. At the HDT level, members of the team can make a financial contribution to cover their health issues. But there is no fixed amount of contribution that is officially determined – the members themselves agree on their contributions. The contributions of the households are collected legally, depending on the regional financing guidelines. These resources are used to finance the health affairs of the community.

Human resources

To improve the staffing numbers and composition at various levels, taking into account the human resources for health (HRH) requirements to achieve universal PHC coverage by the end of the Health Sector Development Programme III period, the focus has been on scaling up the training of community-level and mid-level health professionals. With regard to community-level professionals, a total of 31 831 HEWs have been trained and deployed to meet the HRH requirements of the Health Extension Programme. Similarly, the Accelerated Health Officer Training Programme was launched in 2005 in five universities and 20 hospitals to address the clinical service and public health sector management needs at district level. In addition, to address the HRH needs for comprehensive emergency obstetric care and other emergency surgery services at PHC level, a curriculum for a master's programme on emergency surgery has been developed, and training has been started in five universities. To address the critical shortage and maldistribution of doctors, the existing medical schools have been augmented by a new medical school, using an innovative approach, which has opened in St Paul's Hospital Millennium Medical College. A new integrated curriculum that enhances the clinical skills and social accountability of medical doctors has also been developed.²⁵ Information from an interview with a human resources (HR) expert in the FMOH Human Resources Directorate sheds further light on HR allocation:

The FMOH decides the allocation and distribution of HR having qualifications more than a first degree. The HR allocation is based on the tier system and the needs of the health facilities at the three levels. We calculate the HR requirement based on the demand and the caseload of facilities. The HR training is also based on the needs of health facilities at the national level. The deployment of HR to each facility is done in an equitable manner. There are shortages of HR in some clinical specialties and the nursing specialty. Moreover, most high-level specialized doctors and master's holders live and serve in urban areas. The other problem is that professional distribution depends on the regional government budget allocation for HR in health facilities of the region. Sometimes the deployed professionals are sent back to FMOH because of a shortage in budgetary allocation. Although there was no national HR strategy before, we have developed the strategy so that we can monitor the health HR in the country.

²⁴ Fifth National Health Accounts 2010/2011. Addis Ababa: Ethiopian Federal Ministry of Health; 2014.

²⁵ Health Sector Development Program IV. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2014.

Table 2. Distribution of human resources for health, Ethiopia, 2015

HRH category	2015	Projection to 2020
Internists	730	910
Physicians	719	940
Obstetricians	820	1 094
Surgeons	847	1 024
Orthopaedics	283	418
Ophthalmologists	304	524
Dermatologists	202	273
Psychiatrists	304	410
Radiologists	316	415
ENT specialists	210	349
Anaesthesiologists	233	309
Clinical pathologists	210	275
Dentists	633	1 770
General practitioners	10 846	14 792
Health officers	6 345	8 293
Emergency obstetric surgeons	996	1 611
Nurses	41 009	49 362
Midwives	8 635	9 866
Pharmacists	2 037	2 779
Pharmacy technicians	8 704	9 839
Laboratory technologists	1 133	1 567
Laboratory technicians	10 608	12 845
Radiographers	1 954	2 796
Psychiatric nurses	923	1 360
Physiotherapy professionals	550	7 446
Dental professionals	1 145	2 385
Environmental and occupational health workers	1 995	1 561
Biomedical technicians	874	1 256
Public health specialists	1 400	2 158
HIT	7 607	8 849
Hospital managers	650	986
HEWs	33 320	41 664
Total	146 142	183 826

Planning and implementation

Ethiopia's health plans are developed and implemented within the wider context of the country's major development plan – the Growth and Transformation Plan (GTP). The GTP is a five-year strategic plan that is directed towards achieving Ethiopia's long-term vision and sustaining rapid and broad-based economic growth. The first GTP was started during 2011/2012 and ended successfully in 2014/2015.²⁶ The second phase (GTP II) was developed in 2015/2016 and will be implemented over the next five years, up to 2019/2020. The development of GTP II took cognizance of and built on the lessons learned from GTP I.²⁷ Development of the GTP passes through an extensive process of consultation with citizens, the private sector, and civil society, including women's and youth organizations, religious institutions, academia and professional associations.

The GTP has seven pillars, with health-specific planning and policy-making falling under the "Enhancing expansion and quality of social development" pillar. The main elements of this pillar are higher education and adult education, better PHC, improved access to safe water and sanitation facilities, halting the spread of HIV/AIDS and other infectious diseases, better food security and nutrition, and improved housing conditions.²⁸

Over the last 20 years, the five-year health-specific development plan – the Health Sector Development Programme – has been used to guide the planning and implementation of health-related policies and programmes in Ethiopia. The country has successfully completed four consecutive phases of the Health Sector Development Programme since its inception in 1997/1998.²⁹ Records of each phase of the plan – Health Sector Development Programme I, II and III – showed encouraging successes in both health service coverage and the utilization of services at all levels of the health care system in Ethiopia.³⁰ Health Sector Development Programme IV of 2010/11–2014/15 has been completed but is yet to be evaluated exhaustively.

Further, the summary reports of the Health Sector Transformation Plan (to be discussed later), citing the key findings of the preliminary Ethiopia Service Provision Assessment Plus (ESPA+) survey³¹ and other sources, reveal that Ethiopia has performed impressively in meeting most of the Millennium Development Goal (MDG) targets. The achievement of MDG 4, with a 67% drop in under-5 mortality from the 1990 estimate, contributed to an increase in life expectancy at birth from 45 to 64 years by 2014. Maternal mortality was reduced by 69% from the estimate of 1400 per 100 000 live births. HIV new infection and mortality among adults have dropped by 90% and 50%, respectively. The mother-to-child transmission of HIV declined by 50% between 2009 and 2012. Similarly, mortality due to and prevalence of tuberculosis has declined by more than 50%.³²

The national implementation of PHC strategies and expansion of infrastructure have also been carried out successfully over the past 20 years, with 16 440 HPs, 3547 HCs and 311 hospitals constructed. In parallel with the construction of health facilities, investment in human resource development and management has been scaled up.³³

Despite the impressive progress made, Ethiopia still has high rates of morbidity and mortality from preventable causes. The latest five-year health plan – termed the Health Sector Transformation Plan – was developed in August 2015, in line with the country's GTP II. The plan sets ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the different components of the health sector. The plan reflects the overall desire of the Government of Ethiopia to have the highest possible level of health and quality of life for all its citizens, attained through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services of the highest possible quality in an equitable manner.³⁴

26 Growth and Transformation Plan (GTP) 2010/11–2014/15. Addis Ababa: Ministry of Finance and Economic Development.

27 Growth and Transformation Plan II (GTP II) (2015/16–2019/20). Addis Ababa: National Planning Commission.

28 Growth and Transformation Plan (GTP) 2010/11–2014/15. Addis Ababa: Ministry of Finance and Economic Development.

29 Trends in maternal mortality, 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015.

30 Health Sector Development Programme IV. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2014.

31 Ethiopia Service Provision Assessment Plus (SPA+) survey 2014: key findings. Addis Ababa: Ethiopian Public Health Institute (EPHI), Federal Ministry of Health, ICF International; 2014.

32 Health Sector Transformation Plan. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

33 Health Sector Transformation Plan. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2015.

34 Assessing progress in Africa toward the Millennium Development Goals. United Nations Economic Commission for Africa, African Union, African Development Bank, United Nations Development Programme; 2015.

To help achieve this ambition, the Health Sector Transformation Plan includes administrative decentralization to RHBs and district-level health offices. The FMOH is mandated to formulate national policies and strategies, and develop standards in communication with the RHBs. To this end, a joint steering committee has been set up, whereby FMOH and RHB heads meet for consultations every two months to debate policies and strategies and build consensus on management of the health sector. Districts also have autonomy through woreda-based national planning, which allows for bottom-up and top-down planning processes. Resource mobilization exercises are carried out at all levels. Woreda-based national planning provides district administrators with the opportunity to bargain for resources during budget allocation by clearly demonstrating their objectives and targets and the resources required to achieve them.

The key informant interviews with officials from the FMOH and with RHB and district heads indicated the same findings. At district level, an executive committee is responsible for planning. The committee develops its own plan, taking into account the prevailing health problems in the community. Targets are provided from the RHB and FMOH to the lower levels in the hierarchy. As one respondent from Oromia RHB said: "They [the districts] develop their plan under the umbrella of the regional plan."

Regulatory processes

Health care provision depends on efficiently combining financial resources, human resources and supplies, and delivering services in a timely fashion and with equitable spatial distribution throughout a country. Good governance is a critical factor in making such a system function. While governance indicators have been developed for countries in the aggregate, governance indicators for specific sectors, such as health, are often not readily available. Consequently, it is necessary to look for proxies that reflect the quality of health sector governance.³⁵

The "Quality of health services" component of the Health Sector Development Programme IV applies a three-pronged approach to improving the quality of health services.

These comprise supply-side interventions, demand-side interventions and regulatory measures. The supply-side interventions include providing adequate numbers of skilled and motivated professionals, and strengthening the supply chain management system to ensure an adequate and uninterrupted supply of pharmaceuticals at the point of service delivery. An internal quality assurance mechanism would help ensure effective implementation of performance monitoring and quality improvement standards and tools at all levels of the health system. Other plans include placement of community members on health facility governance boards; development of a patients' rights charter; and conducting regular surveys on client satisfaction.³⁶

The health policy of Ethiopia emphasizes training of community-based, task-oriented frontline and mid-level health workers. As a mechanism to retain health workers, the policy supports development of an attractive career structure, proper remuneration and incentives for all categories of workers within their respective systems of employment.³⁷ The basis for accelerated improvement in health has been the rapid growth in the construction of health facilities, the training of health professionals and the allocation of budgetary resources to the sector.³⁸

Standards applied by accrediting entities continue to draw on the expertise of provider organizations, health professionals, purchasers, health planners, consumers, and measurement experts, while being mindful of the burden placed on providers. Through regulatory processes, overseeing provider organizations and facilities should continue to monitor providers, ensure feedback and accountability, and strengthen patient safety and quality improvement.³⁹

Monitoring and information systems

The organizations at each level of the PHC system, and the first-level entities under each kebele (for example the HDTs and one-to-five networks), share their information, thus maintaining the structural linkages between these bodies. HDT leaders collect reports from the one-to-five networks; similarly, HEWs in each HP at kebele level receive reports from HDT leaders, and compile these reports with their own activities to send to HCs. Information from the FMOH PHC

35 Lewis M. Governance and corruption in public health care systems. Working Paper No. 78. Center for Global Development; 2006.

36 Health Sector Development Program IV. Addis Ababa: Federal Democratic Republic of Ethiopia, Ministry of Health; 2014.

37 Girma S, Yohannes AG, Kitaw Y, Ye-ebiyo Y, Seyoum A, Desta H. Human resource development for health in Ethiopia: challenges of achieving the Millennium Development Goals. *Ethiopian Journal of Health Development*. 2007;21(3).

38 National human development report, 2014: accelerating inclusive growth for sustainable human development in Ethiopia. Addis Ababa: United Nations Development Programme; 2015.

39 Success factors for women's and children's health, Ethiopia. Geneva: World Health Organization; 2015.

and Health Extension Programme Directorate indicated as follows: “Official reports are obtained from HEWs at HP level. These HPs report to HCs and HCs give close supportive supervision to HPs. HCs aggregate data from these HPs and compile the reports with their own and report to the WHO.” A health management information system (HMIS) is in place to facilitate information sharing between the parties operating within this structure, starting from the HCs. A study participant from the FMOH PHC and Health Extension Directorate said: “Our HMIS provides disaggregated data at the woreda level, and it requires data verification. We use these data for future improvements.”

Challenges and way forward

The following challenges and problems were identified:

- **Shortage, high turnover and lack of motivation of HEWs.** There is no career and educational development structure for HEWs in the Ethiopian education system, due to a lack of awareness of the need for future development in that regard. However, the FMOH, in collaboration with RHBs and universities, is developing a curriculum for educational and career development of HEWs. One FMOH respondent said: “We have started level 4 training for HEWs. To date, more than 8000 have graduated at level 4. There is also a career mechanism for their development. They can be BSc or master’s holders and can even become family physicians.”
- **Lack of commitment from leaders of HDTs and one-to-five networks.** One HDT leader said: “You know, I am extremely busy with my own routine activities as well as this work, and there is no incentive attached to this job.”
- **Lack of quality of health professionals.** In addition to the low ratio of health professionals to population, the general lack of quality and competency among health professionals has drawn the attention of federal and regional health officials, as well as the communities being served. One respondent from the FMOH stressed the need to conduct quality and competency assessments for both the educational curriculum and the employees in service.
- **Inequitable distribution of health professionals.** The health workforce is inequitably distributed across urban and rural areas. As one individual from the FMOH observed: “High-level specialized doctors and master’s holders live and serve in urban areas.” There are few disaggregated data on the number of professionals working in rural and urban areas.
- **Lack of decentralized planning.** Districts still have inadequate responsibility for their work and financial plans, and very limited autonomy regarding allocation and utilization of financial resources.
- **Limited supplies.** Difficulties arise from the lack of medical equipment and medicine, and deficient supply chain management and quality assurance.
- **Capacity-building for monitoring and evaluation.** At all levels, correct methodologies for applying finance indicators for PHC have to be developed, in line with international standards. Capacity-building is needed at both individual and organizational levels.

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