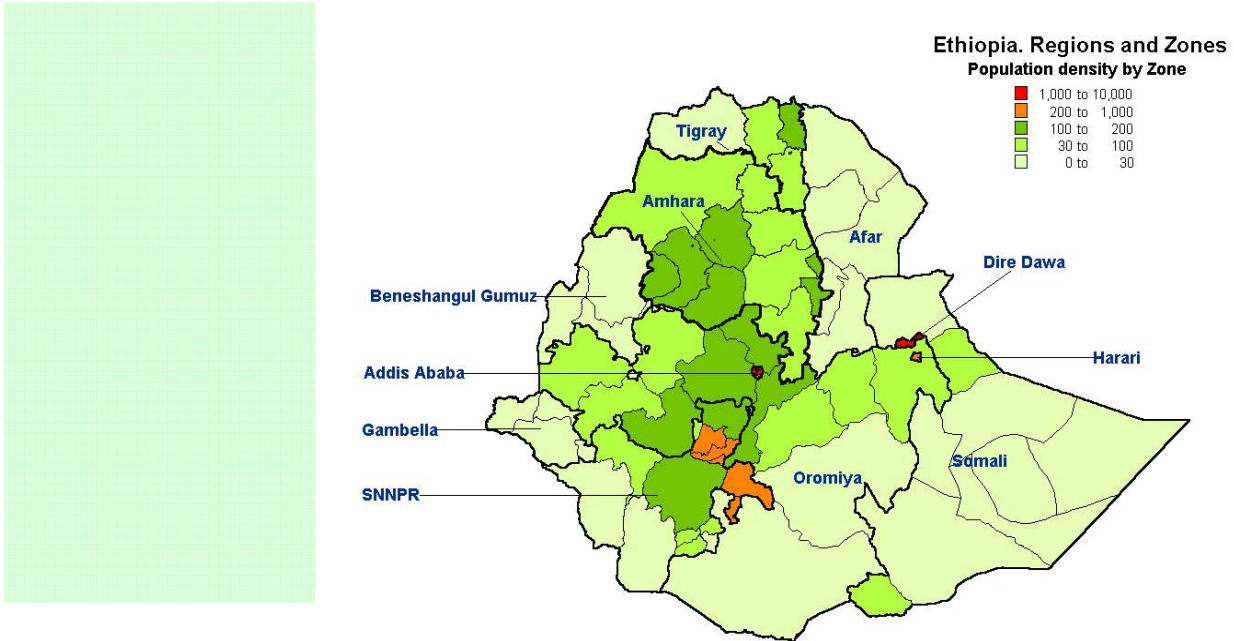




# Ethiopia Strategy Paper



*TB and Leprosy Control Programme Ethiopia. MOH. 2001*

## Situation analysis

Ethiopia has a total population of 71,1 million (2004)<sup>1</sup> and is one of the poorest countries in the world, with a per capita annual income of US\$ 90 (2003). Ethiopia is experiencing recurrent problems as a result of droughts and conflicts. Drought has become a chronic occurrence, affecting the country periodically (once every 7–10 years) since 1983. The current drought is only exasperating the needs resulting from the 2003 drought, leaving presently 3,8 million people in desperate need for emergency food relief and another 5.2 million chronically food insecure assisted through a productive safety net program.

The incidence of certain diseases increases during droughts. The main diseases most commonly encountered are: malaria, diarrhea, intestinal helminthiasis, acute respiratory infections including pneumonia, tuberculosis and skin diseases. Outbreaks of meningitis, measles and diarrhoeal diseases including cholera are also common during droughts.

Periodically, the dry lands experience heavy seasonal rains, which cause flooding leading to internal displacement and increased risk for diseases related to stagnant waters such as malaria and cholera.

The widespread food shortages associated with these natural disasters further results in malnutrition and under-nutrition. In order to address chronic poverty and persisting food insecurity, the Ethiopian government is since 2003 conducting a massive resettlement programme, under which 2,2 million people will be moved to more productive areas.

<sup>1</sup> Health and Health related Indicators, 2003/04 FMOH Ethiopia

Ethiopia is currently hosting some 124,000 refugees from Sudan, Somalia and Eritrea. While there are no official numbers of internally displaced persons, it is estimated that about 168,000 persons have been displaced by conflict and ethnic tension. Refugees and displaced people are especially vulnerable from a health perspective because of their living conditions and reduced access to health services.

It is imperative that the health sector is prepared to meet the additional health burden resulting from natural disasters and man-made emergencies. One of the steps in this regard is for WHO to support Ministry of Health capacity to make nutritional and health needs assessments among vulnerable groups. The other step is to build the required health care services. Additional logistics may also be required to assist the implementation of the programmes in times of emergency and disaster. Mechanisms of monitoring of the nutritional status of children as well as the impact of interventions (nutritional surveillance system) need to be put in place.

In May, a flash update to the Joint Humanitarian Appeal for 2005 was released due the rapidly deteriorating humanitarian conditions in Ethiopia. While the food needs require an additional \$65 million to be met, the non-food needs (including health and nutrition) fall short of \$105 million.

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## Health Status

**Malaria:** In Ethiopia, almost 75% of the land is malarious and an estimated 51 million (68%) of the population lives in areas at-risk of malaria. Malaria is still the leading cause of health problem in the country. In 2004, the disease has been reported as the first cause of illness and death accounting for 15.5% of outpatient visits, 20.4% of admissions and 27% of deaths. The magnitude and periodicity of malaria epidemics in the country has also been on the rise in the past few years. Some 5,4 million cases of epidemic malaria cases are expected in 2005<sup>2</sup>.

**HIV/AIDS/STI:** The HIV/AIDS prevalence rate among adults is 4,4% (2003), ranging between 0,4%-7,3% across the country. Given Ethiopia's large population, this means that up to 2,3 million people may be living with HIV/AIDS. The rapid spread of the HIV infection poses a major challenge to the health and other sectors of the country.

**Tuberculosis:** In 2001, about 93,000 new cases of tuberculosis were reported, with a death rate of 7% among sputum smear-positive cases. With the advent of HIV/AIDS, the prevalence of TB has been increasing. In 2004 the numbers of new cases reported were 117,861 while the estimated incidence is around 262,944. The DOTS strategy is being implemented in most districts, and almost all hospitals and health services provide DOTS services. However, basic health services are only accessible to about 64% of the population<sup>1</sup>.

**Meningitis:** Situated in the African "meningitis belt", Ethiopia is in the dry season struck regularly by outbreaks of meningococcal disease. While difficult to predict the intervals between outbreaks, 3,2 million people are considered to be at risk in 2005.

**Poliomyelitis:** In December 2004, one case of polio was confirmed in the Tigray region linked to the polio outbreak in Sudan in May 2004. Since then, till April 2005 thirteen additional cases have been reported in the north of the country. Ethiopia has been polio-free since 2001.

**Reproductive health:** Ethiopia has a maternal mortality rate of 871 per 100,000 live births, and an infant mortality rate of 96.8 per 1,000 live births (2004)<sup>1</sup>. The identified causes of maternal mortality are mechanic dystocia, eclampsia (high blood pressure during pregnancy), bleeding and sepsis following abortion or delivery. Mothers in drought affected areas find themselves at increased risk due to stress poor nutritional status, poor sanitation and limited access to health services and essential drugs.

**Blindness:** According to the National Plan for Eye Care in Ethiopia (MOH 2001), the estimated prevalence rate of blindness is 1.25%. With appropriate public health measures, two-thirds of these cases could be prevented. They could be due to trachoma, vitamin A deficiency and cataract. According to

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<sup>2</sup> In 1995, there were 1,1 million cases.

the Health and health-related indicator of MOH (2000–2001), cataracts were responsible for 2.4% of all admissions to hospitals in 2001.

**Noncommunicable diseases:** The prevalence of noncommunicable diseases, including hypertension, cardiovascular diseases and diabetes mellitus, is increasing with changes in people's lifestyles. According to the Health and health-related indicators of MOH (2000–2001), hypertension was the seventh leading cause of death in the country in 2001.

**Mental health:** Mental illness is one of the health issues that has not received the attention it deserves. Health workers do recognize that mental illness is on the increase and the government and partners recently commissioned an assessment of the situation. The result, which is believed to serve as background information for the formulation of strategies for addressing mental health, is being awaited.

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## The Health System

Ethiopia is a federal state, divided into nine National Regional States and the two Administrative City Councils:

- (a) National Regional States: Tigray; Afar; Amhara; Oromia; Somalia; Benishangul-Gumuz; Southern Nations, Nationalities and Peoples Region (SNNPR); Gambella; and Harari;
- (b) Administrative City Councils: Addis Ababa; and Dire Dawa.

Each state is headed by a president assisted by heads of various regional bureaux. The state are responsible for their own legislative and administrative functions, except for foreign affairs and defence. The National Regional States as well as the Administrative Councils are further divided into 75 zones, 551 *woredas* (i.e. districts) and approximately 10,000 *kebeles* (i.e. counties). Each region has a Regional Health Bureau (RHB) and *Woreda* Health Office.

In 2004/05, there were 126 hospitals, 519 health centres, 1,797 health stations, 2899 health posts and 1,299 private clinics in the country. Although there is no data available on the number of traditional healers in the country, it is well known that many Ethiopian households use them for various health problems.

The population per primary health care (PHC) facility was 24,513 and this was three times higher than the population per PHC in the rest of sub-Saharan Africa. The total number of hospital beds was 13,469, which meant that there was only one bed for a population of 5,276 and this was about five times higher than the average for sub-Saharan Africa. The limited number of health institutions, inefficient distribution of medical supplies and disparity between urban and rural areas have made it difficult to increase people's access to health-care services.

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## WHO Functions and Planned Action for Ethiopia in 2005

WHO strategic functions in crisis:

- Assessing health situations: WHO measures ill-health and promptly assesses health needs, identifying and monitoring priority causes of ill-health and death
- Co-ordinating the work of health actors: WHO makes sure that decisions are taken, implemented and evaluated in an integrated strategy and on the basis of the real determinants of survival and health
- Filling - or ensuring that others fill - critical gaps in the response to ill health: WHO ensures that critical gaps in the public health response are rapidly identified and filled. WHO calls on its different programmes to suggest the optimum contribution to different needs. Sometimes we can rely on our partners, and sometimes it is only WHO that can do this.

- Building capacity within National Authorities and Civil Society: WHO promotes and supports the reactivation of local systems and the development of human resources, institutions and structures for prompt and coordinated health action in crises and long-term health risk reduction.

### **Overall Goal**

Reduce avoidable morbidity and mortality among vulnerable populations in areas affected by conflict or natural disasters.

### **Overarching Strategy**

In order to address the emergency health needs of Ethiopia, a WHO aims to continue working closely with the Federal Ministry of Health while sustaining and expanding partnerships with UN agencies, regional health bureaus and NGOs

The overall goal and strategic priorities formulated below are in line with the priorities of the Joint Humanitarian Appeal for Ethiopia 2005, as well as with the Flash Update to this appeal of 4<sup>th</sup> May 2005.

## **Function 1: Health Assessment, Tracking and Advocacy**

### ***Strategic priorities***

#### **1.1. To support MoH data collection, analysis for monitoring of diseases and outbreaks trends for prevention and immediate control**

##### *Activities*

- Ensure rapid assessments for outbreak confirmation and control;
- Prepare contingency plans for diseases in target areas and populations;
- Pre-positioning of kits and vaccines to strengthen disease outbreak response;
- IDSR training and sensitization of woreda leaders;
- Strengthen laboratory capacity.

#### **1.2. To support MoH capacity to assess and analyse the health situation, as well as to advocate to gain access to isolated areas**

##### *Activities*

- Support MoH capacity to make nutritional and health needs assessments among vulnerable groups;
- Monitoring of access to and performance of health services;
- Compile assessments made by other actors and analysis health needs;
- Publish information on the web, press releases, etc.;
- Strengthen the monitoring system for the health sector based on indicators for assessment and health analysis.

## **Function 2: Coordinated Emergency Health Action**

### ***Strategic priority***

#### **2.1 To strengthen MOH coordination function, including a system to collect and share information among partners.**

##### *Activities*

- Maintain WHO emergency capacity in Addis Ababa through an EHA focal point;
- Support the MOH in the institutionalisation of a health coordination task force for national emergency preparedness and response;
- Provide essential logistic support to health partners for urgent humanitarian interventions;
- Provide technical guidelines and manuals to NGOs and partners.

## Function 3: Identifying and Filling the Gaps in Disaster Preparedness and Response

### *Strategic priorities*

#### **3.1. To support the prevention of poliomyelitis<sup>3</sup>**

##### *Activities*

- Procure and distribute doses of essential vaccines (measles, polio, TT, DPT & BCG) and vaccination equipment and supplies including cold chain;
- Train supervisors, vaccinators and volunteers for EPI and Polio eradication initiatives;
- Contribute to the supplemental polio vaccination campaigns (NIDs and SNIDs) in 2005 in targeted areas (bordering Sudan and Central African Republic).

#### **3.2. To reduce malaria morbidity and mortality through proper prevention and control measures**

##### *Activities*

- Provide technical support to the task force for malaria control;
- Facilitate procurement of the ACT drugs for malaria treatment;
- Increase access to ACT treatment and prevention through the provision of insecticide treated bed nets to the communities and set up information, education and communication programmes in health zones;
- Train health workers from MoH and other partners, including NGOs, for the management of both simple and complicated malaria cases; targeting conflict areas with the longest transmission season;
- Assist partners to enhance efficiency of treatment protocols at the national and community levels;
- Provide support to hospitalized severe malaria cases.

#### **3.3. To support the prevention and control of other communicable diseases**

##### *Activities*

- Monitor meningitis, AFP, neonatal tetanus and measles cases and initiate mop-ups and outbreak response as and when needed;
- Conduct measles vaccination campaign and vitamin A supplementation in regions with low EPI coverage;
- Provision of essential drugs for the control of communicable diseases.

#### **3.4. To strengthen reproductive health services through emergency interventions**

- Provide supplies and equipment for emergency obstetric care to priority areas;
- Provide training to TBA and hospital staff and community workers in emergency obstetric care and reproductive health;
- Assist partners to find solutions on how to achieve higher coverage for emergency obstetric care, and reduce financial barriers;
- Support improved blood safety through the upgrading of laboratories and promotion of safe blood transfusion;
- Ensure condom availability in the target areas;
- Support the establishment of voluntary counseling and testing centres;

## Function 4: Strengthen Local Capacity for Better Health Outcomes

### *Strategic priorities*

#### **4.1. Building capacity at central level of MoH and key partners**

##### *Actions*

<sup>3</sup> See UNICEF and WHO Special Alert, 9 March 2005.

- Strengthen the capacity of MoH in emergency management through training, technical, financial and logistics support;
- Ensure links exist between the humanitarian strategy and other programmes like the Global Fund for AIDS, the Malaria, TB and 3X5 Initiatives.

#### **4.2. To support the MOH at state level (Regional Health Bureaus and Woreda Health Offices) for better management of health services**

##### *Activities*

- Facilitate the establishment of a multi-sectoral woreda epidemic management committee for the proper implementation of disaster preparedness and response;
- Facilitate the organisation and training of rapid woreda response teams;
- Facilitate information circulation including provision of key documents at regional and woreda levels.

## **WHO RB and EB Ongoing Programmes**

- The WHO Regular Budget for the biennium 2004-2005 for Ethiopia is USD 2,545,120, out of which around 1,742,000 are earmarked to sustain WHO office in the country. The balance (around 1272560/biennium) is spread over 18 programmes extending from disease surveillance through control of communicable diseases, women's health, mental health, essential drugs etc. The implementation of these projects is on-going.
- This RB is supported by around 28,595,016 for the biennium from extra budgetary funds earmarked for special programmes like Polio eradication (around 21,589,151) and combating HIV/AIDS and TB (around 2,422,164). In general given the high level of poverty and under development in the country all programmes are severely under-funded.
- In addition, WHO received support from the Netherlands for the procurement of drugs and vaccine for meningitis control, from Embassy of French, JICA, USAID, DIFID, EC, Russia, Rotary international in response of the polio special alert, and from the Netherlands to strengthen communicable disease surveillance and response. All these projects are ongoing.

## **WHO Implementation Capacity**

- WHO Ethiopia office is well established and enjoys the good collaboration of government line ministries, sister agencies in the UN and NGOs working all over the country. The presence of IDSR surveillance officers assigned to zones and regions all over the country and their skills and expertise, gives WHO country office an indispensable strength to implement emergency health projects. The country office will utilize these well-established relationship and structures and work in very close collaboration with the FMOH, Regional Health bureaus, the woreda health offices, the health institution in the affected regions and other stakeholders, in the implementation of this strategy.
- WHO Country team is supported by the technical and support departments in WHO Regional Office (AFRO) in Brazzaville and their counterparts in WHO/HQ in Geneva.