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**Assessment of Progress and Challenges of Government and NGOs  
Actions in Reducing Child Mortality: The Case of Ethiopia**

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**A Thesis Submitted to the Department of Public Administration and Development  
Management of Addis Ababa University in Partial Fulfillment of the Requirements  
For the Master of Arts Degree in Public Management and Policy.**

**January, 2016**  
**Addis Ababa, Ethiopia**

## ***Acknowledgments***

First of all; I would like to thank the Almighty God .Also I would like to forward my heartfelt gratitude to my advisor Ato Teferi Regassa for his unreserved concern and kindness he has shown me while advising my thesis work at all stages which makes me do more every time . I would also like to thank, with great indebtedness, all my colleagues and classmates with who helped in moral and proof reading of this research.

This Thesis has been successfully completed with assistance and cooperation of many resourceful persons and institutions. I am also indebted to staff members of the Federal Ministry of Health, UNICEF, save the children and JSI Research and Training institute for allowing me to get valuable information without which the thesis would have not been completed. The other thanks goes to Dr. Tariku Atomsa and Dr. Frehiwot G/Hiwot who were my examiners and who let me see the other aspects or side of my research. Throughout this work, in all ups and downs, I had never been alone because of my Families. They had been by my side with full dedication, in time of frustration and pleasure. With sincere gratitude I owe them a lot.

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## Acronyms and Abbreviations

ADLI	Agricultural Development-Led Industrialization
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BEmONC	Basic Emergency Obstetric & Newborn Care
CBN	Community based Nutrition
CBNC	Community based Newborn Care
CIDA	Canadian International Development Agency
CSA	Central Statistic Authority
DPT	Diphtheria, Pertussis and Tetanus immunization
EOC	Emergency Operations Center
EPI	Expanded Program of Immunization
EPHI	Ethiopia Public Health Institution
FDI	Foreign direct investment
FMOH	Federal Ministry of Health
GDP	Gross Domestic Products
GOE	Government of Ethiopia
HAART	Highly Active Antiretroviral Therapy
HDA	Health Development Army
HEP	Health Extension Program
HEWs	Health Extension Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Sector Development Plan
ICCM	Integrated Community Case Management
ICT	Information and Communication Technologies
ITN	Insecticide-treated net
KHDS	Kenya Demographic and Health Survey
LDC	Least Developing Countries
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOFED	Ministry of Finance and Economic Development
MSS	Maternity Support service
NDHS	Nigerian Demographic health survey
NHA	National Health Account
NGO	Non Governmental Organization
NMR	Neonatal maternity Risk
NNP	National Nutrition Programs
NPHCDA	National Primary Health Care Development Agency
OPV	Oral Poliovirus Vaccine
PASDEP	Plan for Accelerated and sustained Development to end Poverty
PHC	Primary health care
PHCU	Primary health care Unit
PMCTC	Prevention of Mother to Child Transmission
PPP	Purchasing power parity
PRSPs	Poverty Reduction Strategy Papers
RHB	Regional Health Beuro

ROW	Rest of the World
STDs	Sexual Transmitted Diseases
UN	United Nations
UNCT	UN Country Team's
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
SURE-P-MCH	Subsidy Reinvestment and empowerment Program
USAID	U.S Agency for international Development
VCT	Voluntary Counseling Testing
WHO	World Health Organization
WHS	Ward Health System

## **Abstract**

This research tries to assess the Progress and challenges of Government of Ethiopia and NGO and it gives the current picture of the progress and challenges of MDG-four, it try to assess the progress and achievement made so far, identify the challenge encountered, opportunities gained and also missed while achieving this goal and will try to show the future intervention are by the government and NGO's. The data collection method was both primary and secondary; the primary data was collected through questionnaire and interview. The Secondary data were collected though UN and Federal ministry of health annual reports and other policy documents those were relevant for this subject. The Findings identify and asses the challenges occurred during the implementation of MDG -4 were it divided in to policy, operational and funding challenges; where those challenges were discussed, analyzed and interpreted in detail. It also Identify the factors for the success of Child Mortality which are: - because of health policy of Ethiopia, because of health Extension Program, because of Cross cutting intervention, because of Community Empowerment, Engagement and Participation. And also discussed and assessed the role of developmental Partners for the success of MDG four. It was identified in the research that policy environment was identified to have both success and challenge factor. Lastly but not the least the researcher tries to point of the limitation of MDGs in terms of setting criteria, the criteria may have been differ from country to country or it should have been set based on the economic development status and the population size of any given country. Finally conclusion and recommendations were given accordingly which is the good work they need to keep and work on the challenges by tackling cultural problems and also by having medicines and vaccine supplies especially in the rural areas.

# Chapter One

## Introduction

### 1.1. Background of the Study

It was evident that at the beginning of the new millennium, world leaders gathered at the United Nations to shape a broad vision to fight poverty in its many dimensions. That vision, which was translated into eight Millennium Development Goals (MDGs), has remained the overarching development framework for the world for the past 15 years. In September 2000, 189 heads of states adopted the UN Millennium Declaration and endorsed a framework for development. The plan was for countries and development partners to work together to increase access to the resources needed to reduce poverty and hunger, and tackle ill health, gender inequality, lack of education, lack of access to clean water and environmental degradation (UN, 2008; WHO, 2009). The declaration established eight Millennium Development Goals (MDGs), set targets for 2015, and identified a number of indicators for monitoring progress, several of which relate directly to health. See Annex I.

Thus, health is at the heart of the Millennium Development Goals (MDGs); Goals 4, 5 and 6 specifically focus on health. Sectors outside of health such as access to safe drinking-water and improved sanitation are also associated with better health outcomes. A numbers of programs are in place to improve water and sanitation, including the Health extension program, where Health extension workers provide education to communities on safe sanitation practices, access to primary education and also the road network has been expanded.

For a nation to implement a developmental frame work like MDGs needs great synergy between the government, the private and the non-governmental organizations. In order to synergize these different actors of health sectors and also non health sector as a one has its own challenge.

According to UNICEF 2013 report, there are signs of progress towards the achievement of the health-related Millennium Development Goals in many countries. In others, mainly Sub-Saharan

countries, progress has been limited because of conflict, poor governance, economic or humanitarian crises, and lack of resources. The effect of the global food, energy, financial and economic crises on health is having severe repercussions on the MDG (Munoz, 2008; WHO, 2009). In fact for measuring the achievements, the MDGs are generally believed to be minimum benchmarks, rather than the ultimate development goals. A lot is expected from the government of Ethiopia and the NGOs since it clearly indicated that the MDG's are the minimum benchmarks and we need to do more in order to Ethiopia to achieve reduction of child mortality in absolute number .

Global Progress on the topic

Pertaining to the above, this study focused on MDG 4 which refers to reduction of child mortality with the following target and indicators.

TARGET: Reduce by two-thirds, between 2000 and 2015, the under-five mortality rate

4.1 Under-five mortality rate

4.2 Infant mortality rate

4.3 Proportion of 1 year-old children immunized against measles

According to World Bank report 2015, the global under-five mortality rate has declined by more than half, dropping from 90 to 43 deaths per 1,000 live births between 2000 and 2015.

- ▶ Since the early 1990s, the rate of reduction of under-five mortality has more than tripled globally.
- ▶ In sub-Saharan Africa, the annual rate of reduction of under-five mortality was over five times faster during 2005–2013 than it was during 1990–1995.
- ▶ Measles vaccination helped prevent nearly 15.6 million deaths between 2000 and 2013. The number of globally reported measles cases declined by 67 per cent for the same period.

- ▶ About 84 per cent of children worldwide received at least one dose of measles containing vaccine in 2013, up from 73 per cent in 2000.

The objective of this paper is to assess the actions of government of Ethiopia and Non-governmental organizations towards the MDG four and see the progresses achieved so far and the challenges encountered to meet the goal. The paper also highlights the potential remedies for the post millennium development programs.

## ***1.2. Statement of the Problem***

The Millennium Development Goals (MDGs) are a culmination of several consultations that have been made since the mid-1990s on several international forums regarding global poverty and human deprivation. At the occasion of the Millennium Summit, in September 2000, 189 heads of States and Governments and 191 nations adopted the Millennium Declaration. The Declaration has mainstreamed a set of inter-connected and mutually reinforcing development goals and targets into a global agenda (UN, 2008). Most of the targets set by the Millennium Declaration were not new. They have been derived from the global conferences of the 1990s and from the body of international conventions that have been codified over the past half-century. The Millennium Declaration centers on democracy, peace, human rights and poverty reduction, among other primary development challenges and eight major goals referred to as the MDGs. There are 21 specific targets set across the eight goals and 60 indicators to monitor these targets (UN, 2008; WHO, 2009). Out of the eight goals three of the goals that are goal four, five and six which encompass five targets and nineteen indicators are related to health.

Many researches and papers shows the global challenges faced and progresses made in terms of achieving the MDGs target and indicators. Developing nations face many barriers to achieving the MDG, of which some are unique and country-specific, and others broadly shared. Common problems faced by many nations can be grouped into six areas: poor starting conditions, weak governance and institutions, conflict and instability, increasing food prices, environmental degradation, and above all the current global economic crisis (WB, 2008). As these factors are interlinked to each other and one has an effect on the other and as a nation only focusing on one goal does not get us anywhere.

This research, by analyzing different publications from different years and various sources, by interviewing experts who have ample experience in the area, tries to assess the progress made and challenges encountered in terms of how the government and NGOs are reacting and giving solutions for reduction of child mortality rate in Ethiopia. On top of that it tried to analyze the gaps of Ethiopian health sector. Is the said progress real? What has been said in different publications and what is really on the ground? Are they saying the same thing? This also triangulated with the primary data that explains in details.

### **1.2.1. Research Questions**

Based on the statement of the problem the following basic research questions were formulated:

- ▶ What were the contextual factors that have played a significant role in under five age child mortality?
- ▶ What are the challenges in achieving the targets of MDG -4
- ▶ What are the opportunities in achieving the targets of MDG -4
- ▶ What were the achievements gained to reduce Child Mortality?
- ▶ What were the mechanisms/ policies used to achieve the MDG-4?
- ▶ Which of the used mechanisms brought success for MDG -4?
- ▶ What were the real contributions of NGOs to reduce child mortality in Ethiopia?
- ▶ What are the areas where further interventions are required by stakeholders to enable the country fully realize the goal.

## **1.3. Research Objectives**

### ***1.3.1. General Objective***

The general objective of the study is to assess the progress, challenges and action of Government and non-government organizations of Ethiopia had made in reducing child mortality as per the MDGs targets and indicators.

### **1.3.2. Specific Objectives**

On the basis of the above main objective, the following specific objectives were set.

- ▶ To assess the progress and achievements made so far in terms of meeting the MDG four targets in Ethiopia due to the health policies of Ethiopia.
- ▶ To analyze the real child mortality reduction between implementation and design of MDGs.
- ▶ To identify the challenges encountered, opportunities gained and prospects for achieving the goal by 2015.
- ▶ To show areas where further interventions are required by government to better achieve the goal.

## **1.4. Scope of the Study**

### **1.4.1 GEOGRAPHICAL SCOPE**

This study is undertaken at Addis Ababa where most of the implementers head office and one of government regional office is located. The head office of the implementers is selected due to the fact that they have ample experts in the area.

### **1.4.2 SUBJECT SCOPE**

Health and health services have improved significantly in Ethiopia since 2000 though Ethiopia remaining a low-income country. Ethiopia achieved the under-five mortality as per the MDGs and is on track to reduce maternal mortality. Moreover, Ethiopia also achieved MDG one. So analyzing and assessing all the MDG's and their progress in this research paper is impractical, hence, the study is focused only on the MDG four in Ethiopia case.

## **1.5 Limitation of the Study**

The major problem encountered was that of delays to fill questionnaire and to undertake an interview, which arose due to busy schedules of technical staffs of the organizations under study. However, this was overcome by making repeated follow up and visit at their head office, until I get the interview and the entire questionnaire distributed fully received.

In addition, this research initially tried to include MDG five which complement my study but I found it difficult to engage my self-doing both MDGs; but this limitation coped without affecting the result of the study findings.

## **1.6 Significance of the Study**

This study is believed to have the following significance:

- This study is believed to contribute to the existing knowledge on the assessment of the challenges and opportunities that are encountered in the achievement of goal four of the millennium development goals i.e. reduction of child mortality, it evaluates and shows the progress to date in reducing child mortality.
- This study is believed to contribute to the existing knowledge on how Ethiopia achieved MDG goal-4.
- This study will serve as a stepping stone to future researchers by providing literature and also by initiating them to undertake further research in this area.

## **1.7 Organization of the Study**

The thesis paper consists of five chapters. The first chapter is about introduction in which discussion is made on background of the study, statement of the problem, objectives of the study, scope and significance of the study. The second chapter deals with the literature review which focus on reduction of child mortality rate and the MDGs are .The third chapter deals with research methods used .The fourth chapter deals with analysis, interpretation and summary of findings. The last chapter, chapter five, provides conclusion and recommendation on the basis of the analysis made in the preceding chapter.

## ***Chapter Two: Review of Related Literature***

### **2.1 Millennium Development Goals**

In September 2000, at the Millennium Summit of world leaders at the United Nations, the General Assembly adopted the Millennium Declaration. The UN working group later consolidated the declaration by setting 8 goals, 21 targets and 60 indicators. MDGs are the world's biggest promises and global agreement to reduce poverty and human deprivation at historically unprecedented rate through collaborative action. (UN, 2013)

The MDG framework adopted a broad Human Development approach encompassing reduction and elimination of hunger and promoting/enhancing health, education, gender equity, and environmental sustainability. It accords a greater role to the public sector and public investment in particular. MDGs include; eradicating extreme poverty(goal-1), achieving universal primary education (goal-2), promoting gender equality and empower women (goal 3), reducing child mortality (goal-4),improving maternal health (goal-5), combating HIV/AIDS, malaria and other diseases (goal-6),ensuring environmental sustainability (goal-7) and developing global partnership for development (goal 8).(UN, 2013).

#### **2.1.1 DEFINITION OF KEY TERMS.**

**Neonatal Death or Mortality:** - is newborn death occurring within 28 days postpartum.

**Under - Five Mortality:** - refers to the death of infants and children under the age of five.

**Infant Mortality:** - is the death of a child less than one year of age.

**Post neonatal mortality:** - is the death of children aged 29 days to one year

**Childhood illness:** - are diseases which occur under the age of five children and they are said to be the leading causes of child mortality, they are pneumonia, diarrhea, malaria and malnutrition.

**Morbidity:** - Morbidity is a measure of disease, illness or injury within a population. Like infant mortality, conditions resulting from prematurity and low birth weight are strongly associated with infant morbidity.

**Stakeholders:** - in this case are the government, the nongovernmental organizations, the UN's and the communities are considered as a stake holder in this research paper.

Ethiopia has made progress in promoting and improving the welfare of its population. Ethiopia achieved MDG targets set for eradicating extreme poverty and reducing child mortality; and on track for achieving universal primary education, combating HIV/AIDS, malaria and other diseases, and developing global partnership for development, while the country is most likely to achieve the targets set for improving maternal health, promoting gender equality and empower women and ensuring environmental sustainability . (UN, 2013)

According to the report in the ministry of health report (2013), Health in Ethiopia has improved markedly in the last decade, with government leadership playing a key role in mobilizing resources and ensuring that they are used effectively. A central feature of the sector is the priority given to the Health Extension Program, which delivers cost-effective basic services that enhance equity and provide care to millions of women, men and children. Ethiopia's unique MDG Performance Fund provides the opportunity for development partners to finance activities which will bring impressive and sustainable results, at a low risk and with low administrative costs.

## **2.2 Strategies Designed For the Implementation of MDG's**

According to federal ministry of Health report 2005, the following listed items are the strategies that contributed for the sustainability of the MDG's

## **A. Integration and Synergy across MDGs**

Interventions have greater synergies through use of a common platform, e.g. the same health center or health worker. At the same time, integrating approaches to health-service delivery can improve outcomes in areas such as maternal and neonatal care, sexual and reproductive health, HIV and malaria. The creation of integrated approaches to addressing the HIV pandemic and violence against women which is endemic in a number of areas, can also contribute greatly to attaining universal access to prevention and treatment especially for AIDS. The lessons of many integration experiences such as integrated Management of Childhood Illnesses, are that integrated services have great potential, but are unlikely to be fully achieved unless the MDG 4, 5 and 6 package of interventions are based on local epidemiology, move beyond health facilities and build linkages with community and public accountability at all levels. Similarly, inter-governmental commitments that integrate two MDGs in their approach provide a good basis for coherent action and synergies at the regional and global levels. Since health centers are often the first port of call for most health related problems, they should be recognized as a key entry point for providing integrated support to affected families as well as for integrating relevant services of other sectors and reinforcing a holistic concept of family care and support.

## **B. Continuum of care**

The continuum of care for maternal, newborn and child health includes integrated health service delivery throughout the lifecycle, including adolescence, pre-pregnancy, pregnancy, childbirth, the postnatal period and childhood. This care is provided by families and communities and through outpatient, outreach and clinical services. To save the most lives, linkages among the time periods and places for care giving are crucial. Use of this continuum of care ensures that women are able to access the full range of services, including appropriate food and nutrients throughout their lifecycle. Given the greater role of women and girls as care-givers and participants in economic and social life, breakdowns in this continuum of care have catastrophic consequences, both for the care women may themselves need as well as the care giving burden that inevitably will fall on them as a result.

### **C. Address the underlying social determinants**

Poverty, poor living and working conditions and gender discrimination are powerful determinants of maternal mortality, morbidity, reproductive and maternal health, increased vulnerability of women and girls to HIV infection and inequity around the world. The intersections between empowerment of women, violence against women, sexual and reproductive health and HIV are indisputable. Women play a key role in care and support to members of the family including operationalizing the right to food. This unpaid care and household work needs to be recognized, included in gross domestic product calculations and supported through maternity protection at the workplace and adequate social care services. In efforts to facilitate access of vulnerable and most-at-risk populations to much needed health, education and social services, social protection measures have been successfully used in some cases.

### **D. Community-based care, community dialogue and communication for behavior change**

In 2004, the Commission on Macroeconomics and Health voiced the need for “close-to-client health system”, through the strengthening of the primary health care approach or through the outreach services, health centers and local hospitals to which the poor and marginalized are most likely to have access. Many community-based child survival, health promotion and preventive strategies including demand creation through support for appropriate communication for behavior change and priority disease interventions have been shown to be cost-effective for improving maternal health and saving newborn, child and mother’s lives. In response to the HIV epidemic, home-based care and care provisioning in households has emerged as a key response in many countries, due to shortages of health care workers, and adequate facilities for providing care. These tasks fall primarily on women and girls. Recognizing the State’s obligations to provide these services within the holistic social protection approach are critical, as are supporting households facing disproportionate share of HIV care.

### **E. Access to current health information**

The past few years have witnessed a substantial increase in availability of Multi-Indicator Cluster Surveys and Demographic and Health Surveys. However, there are still many countries

without adequate, updated, information disaggregated by gender, wealth and location with analysis to guide policy development and program improvement.

#### **F. Social Health Protection**

Improvements and increased resources for the health sector must be coordinated with a view to improving effective access to healthcare services for the entire population. This includes an adequate level of quality of services and treatments that match the medical needs of the population, and financial protection that helps people to avoid catastrophic and impoverishing expenditure for healthcare. Some low-income countries have demonstrated that it is possible, even in low-resource settings, to improve effective access to healthcare through a pluralistic health protection system that coordinates different approaches to healthcare financing and service delivery. The social dialogue with a broad range of civil society groups, including representatives of private sector employers and representatives of both formal and informal economy workers and their families is a key strategy in strengthening social health protection.

#### **G. Partnerships**

Transnational and inter-organizational partnerships have championed and increased funding for a number of diseases and causes. There is, however, a need to reduce transactional costs and ensure adequate representation of those most affected, such as greater involvement of people living with HIV, in decision-making. Partnerships should also involve community based support including through involvement of related development sectors, e.g. education, agriculture as well as local NGOs and civil society organizations and United Nations Development Group.

### **2.3 Interventions out Side the Health Sector for Improving Child Health**

Studies from Ethiopia and different countries that improved child health suggest that traditional health System interventions need to be complimented by those outside the health system. The Following sections summarize some of the experiences from different countries.

### ✓ **Enabling Policies and Political Commitment**

Many of the developing countries that have successfully improved child and maternal health had strong political commitment and enabling policies to ensure equal rights for women in education, voting, and employment; in addition, these countries enacted health-care programs that explicitly targeted maternal mortality reduction. Some countries have accelerated reductions in maternal mortality by focusing resources and policies on critically important health service delivery issues and by concentrating non health resources in specific geographic areas of high Mothers Mortality Rate.

### ✓ **Enhancing provider accountability**

Another important policy intervention is to enhance provider accountability. Some countries are implementing innovative service delivery contracts with the providers. With a quantitative indicator, the “systematic management of pregnant women,” that includes: at least five prenatal checks, a minimum of three postnatal visits, and indicators relating to providing a clean home delivery or the percentage of women who deliver in a hospital. Service delivery performance at each level of care is measured using these indicators, and the results are used to determine facility subsidies, continuation of employment for rural doctors, and promotions for managers.

### ✓ **Developing financing systems that are equitable.**

The effect of fees on use of obstetric services, especially on use of emergency obstetric care, is increasingly being recognized as an important barrier to care. In the 1990s; several countries began experimenting with innovative policy options to reduce financial barriers to child and maternal health-care services. However, because of a very low level of overall utilization by the poorest, the bulk of insurance funds still cover the costs of those who are better off. Inadequate information to families, essential drugs that are frequently out of stock and delays in insurance reimbursements has been identified as important constraints.

### ✓ **Enhancing Community Participation**

Community involvement can enhance the behavioral change initiatives and health education messages by creating a supportive environment for their adoption, particularly in understanding the health needs of pregnant women and her child. A community-based health program and primary care providers functioning as a team—in addition to a continuing education program and

the availability of a referral hospital—was associated with declines in birth rates and infant death rates and with increases in contraceptive prevalence and immunization coverage. Community-driven development (CDD) initiatives hold promise for improving then position of women and, consequently, women's health. Operating through then organization of self-help groups, women in many settings have been able to access community health insurance and other social development schemes (Wilson, 2002).

## **2.4 Promoting Cross-Sectorial Linkages or Cross Sectional Intervention**

Because many of the determinants of child and maternal health are multispectral, programs need to be broad based and go beyond the health sector. Policies and strategies that support cross-sector investments in women's education, roads, power, and telecommunications as well as community-driven development programs (mentioned above) are crucial in improving access and utilization of health services.

**Women's education.** Investing in the education of young girls and women is recognized as the single most far-reaching intervention that carries multiple benefits for society, including being associated with improved maternal and health and reduced mortality (De Brouwere, Tonglet and Van Lerberghe, 1997). The importance of this intervention has been amply demonstrated in Sri Lanka and Malaysia as well as in China where conscious policies were implemented to promote female literacy. Evidence from India indicates the strong influence of education on women's nutrition status, and awareness and use of health services as well as child survival.

**Good roads and communication** foster timely access to lifesaving emergency obstetric care. Several community-driven development programs have successfully demonstrated that women's geographic access to health services can be improved by making arrangements with local transporters and by organizing emergency, interest-free loans that are managed and financed by the communities.

**Water and sanitation** Use of safe drinking water and improved sanitary practices are known to enhance child and maternal health. In addition to reducing the burden of waterborne diseases, improved access to water saves precious time and physical energy spent by women in fetching water for the entire family. Promotion of hand-washing and hygienic practices is key to preventing infection during delivery.

**Improved the nutritional status of women** improving the nutritional status of women only during pregnancy is not the ideal solution, compared to improving women's general nutritional status. The first effort focuses on decreasing energy loss by reducing unwanted fertility, which prevents infections and lessens a heavy physical workload. The second effort focuses on increasing nutritional intake by improving the diet, reducing inhibitors that limit the efficiency of food absorption (such as intestinal worms), and providing food and micronutrient supplements before and after pregnancy. If properly targeted and tailored to market conditions, food supplementation programs can enhance nutritional status, especially for extremely poor women. However, experiences suggest that, generally, food supplementation programs are costly and difficult to maintain.

## **2.5 Health Policy**

Ethiopia, an ancient country with a rich diversity of peoples and cultures has however remained backward in socio-economic and political development, and in technological advances. Conventional health parameters such as infant and maternal mortality, morbidity and mortality from communicable diseases, malnutrition and average life expectancy place Ethiopia among the least privileged nations in the world. In recent times, the country has experienced severe manmade and natural disasters and political disturbances which have caused untold suffering to its peoples. At no time in the past has the country enjoyed leadership of representative government with a defined mandate and accountability. In the field of health there was no articulated policy up to the fifties. Subsequently, references to the development of health with provision of basic health services through a network of health centers and health stations and the need to give due attention to prevention alongside curative services could be discerned. Towards the end of the Imperial period a comprehensive Health Services Policy was adopted through initiatives from the World Health Organization. (FMOH Report, 2000)

The Government believes that health policy cannot be considered in isolation from policies addressing population dynamics, food availability, acceptable living conditions and other requisites essential for health improvement and shall therefore develop effective inter sectorial for a comprehensive betterment of life. In general, health development shall be seen not only in humanitarian terms but as an essential component of the package of social and economic

development as well as being an instrument of social justice and equity. Pursuant to the above the health policy of the current Government shall incorporate the following basic components.

## **GENERAL POLICY**

1. Democratization and decentralization of the health service system.
2. Development of the preventive and promotive components of health care.
3. Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources.
4. Promoting and strengthening of intersect oral activities.
5. Promotion of attitudes and practices conducive to the strengthening of national self-reliance in health development by mobilizing and maximally utilizing internal and external resources.
6. Assurance of accessibility of health care for all segments of the population.
7. Working closely with neighboring countries, regional and international organizations to share information and strengthen collaboration in all activities contributory to health development including the control of factors harmful to health.
8. Development of appropriate capacity building based on assessed needs.
9. Provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford to pay.
10. Promotion of the participation of the private sector and nongovernmental organizations in health care.

## **PRIORITIES OF THE POLICY**

1. **Information, Education and Communication (I.E.C)** of health shall be given appropriate prominence to enhance health awareness and to propagate the important concepts and practices of self-responsibility in health.

### **2. Emphasis shall be given to:-**

- 2.1 The control of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions,
- 2.2 The promotion of occupational health and safety,
- 2.3 The development of environmental health,

- 2.4 The rehabilitation of the health infrastructure and
- 2.5 The development of an appropriate health service management system.
3. **Appropriate support** shall be given to the curative and rehabilitative components of health including mental health.
4. **Due attention** shall be given to the development of the beneficial aspects of Traditional Medicine including related research and its gradual integration into Modern Medicine.
5. **Applied health research** addressing the major health problems shall be emphasized.
6. **Provision of essential** medicines, medical supplies and equipment shall be strengthened.
7. **Development of human resources** with emphasis on expansion of the number of frontline and middle level health professionals with community based, task oriented training shall be undertaken.
8. **Special attention shall be given to the health needs of:-**
- 8.1 The family particularly women and children,
- 8.2 Those in the forefront of productivity,
- 8.3 Those hitherto most neglected regions and segments of the population including the majority of the rural population, pastoralists, the urban poor and national minorities,
- 8.4 Victims of man-made and natural disasters.

## **GENERAL STRATEGIES**

- 1. Democratization** within the system shall be implemented by establishing health councils with strong community representation at all levels and health committees at grass-root levels to participate in identifying major health problems, budgeting planning, implementation, monitoring and evaluating health activities.
- 2. Decentralization** shall be realized through transfer of the major parts of decision making, health care organization, capacity building, planning, implementation and monitoring to the regions with clear definition of roles.
- 3. Inter sectorial collaboration shall be emphasized particularly in:**
- 3.1 Enriching the concept and intensifying the practice of family planning for optimal family health and planned population dynamics.
- 3.2 Formulating and implementing an appropriate food and nutrition policy.
- 3.3 Accelerating the provision of safe and adequate water for urban and rural populations.

3.4 Developing safe disposal of human, household, agricultural and industrial wastes and encouragement of recycling.

3.5 Developing measures to improve the quality of housing and work premises for health.

3.6 Participating in the development of community based facilities for the care of the physically and mentally disabled, the abandoned, street children and the aged.

3.7 Participating in the development of the day-care centers in factories and enterprises, school health and nutrition programs.

3.8 Undertakings in disaster management, agriculture, education, communication, transportation, expansion of employment opportunities and development of other social services.

3.9 Developing facilities for workers' health and safety in production sectors.

**4. Health Education shall be strengthened** generally and for specific target populations through the mass media, community leaders, religious and cultural leaders, professional associations, schools and other social organizations for:-

4.1 Inculcating attitudes of responsibility for self-care in health and assurance of safe environment.

4.2 Encouraging the awareness and development of health promotive life-styles and attention to personal hygiene and healthy environment.

4.3 Enhancing awareness of common communicable and nutritional diseases and the means for their prevention.

4.4 Inculcating attitudes of participation in community health development.

4.5 Identifying and discouraging harmful traditional practices while encouraging their beneficial aspects.

4.6 Discouraging the acquisition of harmful habits such as cigarette smoking, alcohol consumption, drug abuse and irresponsible sexual behavior.

4.7 Creating awareness in the population about the rational use of drugs.

**5. Promotive and Preventive activities shall address:**

5.1 Control of common endemic and epidemic communicable and nutritional diseases using appropriate general and specific measures.

5.2 Prevention of diseases related to affluence and ageing from emerging as major health problems.

5.3 Prevention of environmental pollution with hazardous chemical wastes.

## **6. Human Resource Development shall focus on:**

6.1 Developing of the team approach to health care.

6.2 Training of community based task-oriented frontline and middle level health workers of appropriate professional standards; and recruitment and training of these categories at regional and local levels.

6.3 Training of trainers, managerial and supportive categories with appropriate orientation to the health service objectives.

6.4 Developing of appropriate continuing education for all categories of workers in the health sector.

6.5 Developing an attractive career structure, remuneration and incentives for all categories of workers within their respective systems of employment.

## **7. Availability of Drugs, Supplies and Equipment shall be assured by:**

7.1 Preparing lists of essential and standard drugs and equipment for all levels of the health service system and continuously updating such lists.

7.2 Encouraging national production capability of drugs, vaccines, supplies and equipment by giving appropriate incentives to firms which are engaged in manufacture, research and development.

7.3 Developing a standardized and efficient system for procurement, distribution, storage and utilization of the products.

7.4 Developing quality control capability to assure efficiency and safety of products.

7.5 Developing maintenance and repair facilities for equipment.

## **8. Traditional Medicine shall be accorded appropriate attention by:**

8.1 Identifying and encouraging utilization of its beneficial aspects

8.2 Coordinating and encouraging research including its linkage with modern medicine.

8.3 Developing appropriate regulation and registration for its practice.

## **9. Health Systems Research shall be given due emphasis by:**

9.1 Identifying priority areas for research in health.

9.2 Expanding applied research on major health problems and health service systems.

9.3 Strengthening the research capabilities of national institutions and scientists in collaboration with the responsible agencies.

9.4 Developing appropriate measures to assure strict observance of ethical principles in research.

**10. Family Health Services shall be promoted by:**

10.1 Assuring adequate maternal health care and referral facilities for high risk pregnancies.

10.2 Intensifying family planning for the optimal health of the mother, child and family.

10.3 Inculcating principles of appropriate maternal nutrition.

10.4 Maintaining breast-feeding and advocating homemade preparation, production and availability of weaning foods at affordable prices.

10.5 Expanding and strengthening immunization services, optimization of access and utilization.

10.6 Encouraging early utilization of available health care facilities for the management of common childhood diseases particularly diarrheal diseases and acute respiratory infections.

10.7 Addressing the special health problems and related needs of adolescents.

10.8 Encouraging paternal involvement in family health.

10.9 Identifying and discouraging harmful traditional practices while encouraging their beneficial aspects.

**11. Referral System shall be developed by:**

11.1 Optimizing utilization of health care facilities at all levels.

11.2 Improving accessibility of care according to need.

11.3 Assuring continuity and improved quality of care at all levels.

11.4 Rationalizing costs for health care seekers and providers for optimal utilization of health care facilities at all levels.

11.5 Strengthening the communication within the health care system.

**12. Diagnostic and Supportive Services for health care shall be developed by:**

12.1 Strengthening the scientific and technical bases of health care.

12.2 Facilitating prompt diagnosis and treatment.

12.3 Providing guidance in continuing care.

**13. Health Management Information System shall be organized by:**

13.1 Making the system appropriate and relevant for decision making, planning, implementing, monitoring and evaluation.

13.2 Maximizing the utilization of information of all levels.

13.3 Developing central and regional information documentation centers.

**14. Health Legislations shall be revised by:**

14.1 Up-dating existing public health laws and regulations.

14.2 Developing new rules and regulations to help in the implementation of the current policy and addressing new health issues.

14.3 Strengthening mechanisms for implementation of the health laws and regulations.

**15. Health Service Organization shall be systematized and rationalized by:**

15.1 Standardizing the human resource, physical facilities and operational systems of the health units at all levels.

15.2 Defining and instituting the catchment areas of health units and referral systems based on assessment of pertinent factors.

15.3 Regulating private health care and professional deployment by appropriate licensing.

**16. Administration and Management of the health system** shall be strengthened and made more effective and efficient by:

16.1 Restructuring and organizing at all levels in line with the present policy of decentralization and democratization of decision making and management

16.2 Combining departments and services which are closely related and rationalizing the utilization of human and material resources.

16.3 Studying the possibility of designating undersecretaries to ensure continuity of service.

16.4 Creating management boards for national hospitals, institutions and organizations.

16.5 Allowing health institutions to utilize the income to improve their services.

16.6 Ensuring placement of appropriately qualified and motivated personnel at all levels.

**17. Financing the Health Services** shall be through public, private and international sources and the following options shall be considered and evaluated.

17.1 Raising taxes and revenues.

17.2 Formal contributions of insurance by public employees.

17.3 Legislative requirements of a contributory health fund for employees of the private sector.

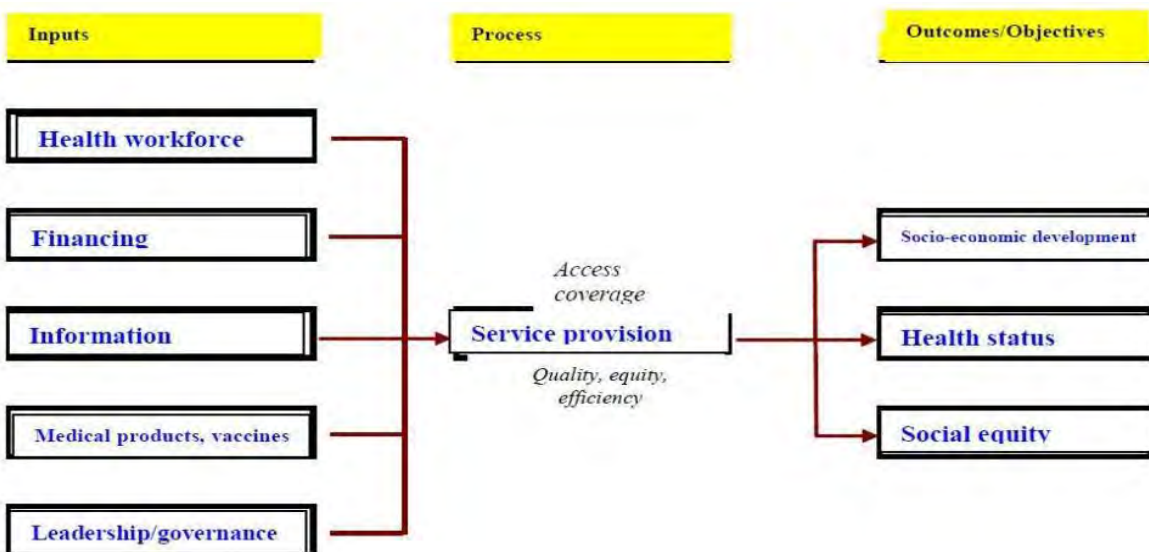
17.4 Individual or group health insurance.

17.5 Voluntary contributions.

## 2.6 Comprehensive Health Sector Development Programs

Although the health policy was formulated and ratified in 1993, its contribution to integration of health care services was minimal until the launch of comprehensive health sector development programs until the late 1990s. In late 1990s, a comprehensive 20-year health sector strategic plan was formulated and implemented in a series of 5-years programs. The aim of the 20 years comprehensive health sector development plan (the four HSDP's) is to provide accessible, equitable and quality health services to all citizens through continuous and consistent consolidation of the health service delivery systems, including, health facility expansion and rehabilitation; human resource development; pharmaceutical supply and management; IEC/BCC activities; health sector governance and management (HMIS, M&E and operational research) and health care financing. In recent HSDP the components that make up the health system are disaggregated in to three thematic areas to facilitate planning, budgeting, monitoring and evaluation.

### The framework of the health sector development plan



Source: Federal Democratic Republic of Ethiopia Ministry of Health: EFY 2005 (2012/13)

**Health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, rational distributions across regions, (there are sufficient staffs; they are competent, responsive and productive).

**Health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

**Health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

**Medical products, vaccines and technologies** are indispensable input components for the health system to operate. These components must assure quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

**Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.

All above 5 mentioned input components aim to provide good services for all people, including health care, rehabilitation services, disease prevention and health promotion. Health services must also satisfy basic criteria of universal coverage, accessible to people (financial and geographical), and services must ensure quality, equity and efficiency. The outcomes and ultimate goals of the health care system are to improve people's health status, making contributions to assure social equity and national socio-economic development.

### **Health Service Delivery**

The four health sector development programs placed the expansion of quality health care service delivery at the center of their plans and actions. The priority areas of health service delivery remained more or less consistent in all HSDPs. However, there were some changes in focus of attention as well as scope of programs and interventions. As HSDPs are progressive and dynamic programs, new programs and interventions were being incorporated, driven either by intentions to accelerate progress towards achievements of MDGs or by the necessity to address new and emerging health concerns.

**HSDP-I (1997/98-2002/03):** During this period the main focus was increasing access and coverage to health care services and improving service quality through intensive training and an improved supply of necessary inputs. Strengthening health care services at facilities, outreach sites and campaigns were some of strategies employed during HSDP-I. Accordingly, routine RMNCH services relevant to child survival such as FP, TT, ANC, PNC, EPI, vitamin A supplementation and growth monitoring and promotion were provided at facilities and outreach sites. Strengthening and expanding the Integrated Management of Childhood Illness (IMCI) program, initiated in 1997, was planned and implemented during HSDP-I. Malaria control through insecticide spraying was planned and implemented.

During HSDP-I, decentralization of health system management begun and was consistently strengthened through subsequent HSDPs. Following decentralization, responsibilities and mandates of each level has been continuously updated. The responsibility of the Federal Ministry of Health's is limited to policy formulation, standard setting and technical support, while the RHB's took the responsibilities for the overall implementation of health programs guided by the HSDPs. The RHB have the overall responsibility of planning, supervising and monitoring and evaluation of the HSDP implementation jointly with the zonal and woreda health offices.

**HSDP-II (2002/03-2005/06):** Although the implementation period of HSDP-II was shorter than other HSDPs by two years, efforts had been made to accelerate the momentum in the expansion of health care service delivery. The most remarkable achievement of HSDP-II was the introduction of the Health Extension Program (HEP) in 2004 with the aim to ensure equitable access of primary health care services. HSDP-II remains the key milestone in improving the performance of the health system so as to make it responsive to the needs of the population.

In HSDP-II the Civil Service Reform Program begun to be implemented across all health system levels. In HSDP-III, the civil service reform program continued. The health reforms have been intensified through the application of a new concept known as Business Process Reengineering (BPR).

**HSDP-III (2005/06-2010/11):** The momentum created during HSDP-II continued and further strengthened during HSDP-III. HEP was extensively scaled up and intensively implemented. At the end of HSDP-III in 2010, HEP enabled Ethiopia to increase primary health care coverage to 90 percent.

The main focus of HSDP-III was to speed up progress towards achievement of MDGs and thus the emphasis has been on the scaling up interventions that were lagging behind the targets. Maternal and newborn health began to receive attention during HSDP-III. More emphasis was given to improve institutional delivery services at health posts and all health facilities by expanding safe and clean delivery services, basic emergency obstetric care as well as comprehensive emergency obstetric care. Moreover, strengthening family planning services including long-term contraceptives was pursued in HSDP-III. National reproductive health strategy outlining key strategies and implementation modalities was issued in 2006. In 2007 newborn resuscitation equipment was introduced at health posts following the initiation of community based nutrition. The community based nutrition program (CBN) is the major component of the NNP and it included: vitamin A supplementation, de-worming, monthly anthropometric measurements, and counseling mothers on nutrition, food preparation demonstrations and intensive behavior change activities using ENA.

**HSDP-IV (2010/11-2014/15):** Despite substantial achievements, there were gaps identified during the implementation of HSDP-III particularly in the areas of maternal and newborn health outcomes. Therefore, more emphasis is given to strengthen the provision of maternal and newborn health services during HSDP-IV. In line with this the road map for accelerating the reduction of maternal and newborn mortality and morbidity in Ethiopia was prepared and issued in 2012.

Strengthening the services related to the treatment and prevention of common childhood illnesses also received emphasis in HSDP-IV. Community case management for common childhood illnesses (ICCM) was rolled out in all health posts beginning from 2010. It was an extension of IMNCI to the community strengthening nutritional interventions had also been the main focus of HSDP-IV. These includes the scaled up of CBN to 40 additional woredas and initiation and rolling out of community based management of acute malnutrition (CMAM) to many woredas (UNICEF, 2012). The program screens children for acute malnutrition and provides therapeutic foods for medically uncomplicated cases and refers complicated cases to health facilities for admission to in-patient therapeutic feeding services. Another important initiative of HSDP-IV was the plan to accelerate the use of appropriate sanitary practices. Kebeles are expected to encourage all households to construct their own latrines and promote the use. In addition,

communities are expected to construct public latrines that can be used by guests and passer-byes, and to make sure that the practice of open defecation is abandoned.

## **2.7 Health Extension Program**

Although, the overall performance of the health sector was improved under HSDP, particularly in urban areas, the success to reach essential services to the people at the grass roots level through HSDP had been a challenge. This was the gap identified based on the findings of HSDP-II midterm evaluation which laid a ground for the inception of health extension program. HEP set up institutional framework for the expansion of national health interventions to the community level. The Health Extension Program is an innovative program that aims to ensure universal coverage for primary health care services. Ultimately the overall goal of HEP was to improve the health status of the population and reduce maternal and child mortality rates targeting households and communities. The establishment of HEP has resulted in rapid expansion of health infrastructures and resource for improving access to basic health care services through active involvement of the community. The program gave priority to the promotion of optimum health, prevention and control of diseases and designed to provide health services in five domains of public health.

Throughout the implementation of all HSDP's strengthening HMIS, monitoring and evaluation systems has been emphasized. Thus intensive efforts have been made to develop the systems, processes and required skills to improve the collection and use of health information for decision making. The general objectives of HMIS is, therefore, to generate timely, accurate and complete health information that enable evidence based decision making. Health Development Army (HDA) has been introduced in 2011 to support the work of HEWs. It is an innovative way of organizing people, to facilitate dissemination of health promotion and disease prevention messages, information and bring behavioral change across a community. The objective of the HDA is (i) to consolidate the gains that were attained as a result of the HEP and (ii) to promote community ownership of the programs through an organized movement using participatory learning and action oriented meetings.

## **2.8 Health Systems Strengthening Strategies**

According to (FMOH, National strategy for infant and young children. 2004) the initiatives to strengthen health systems within the context of country ownership, building more effective and inclusive partnerships for achieving development results as emphasized in Paris Declaration and Accra Agenda for Action and the “Three Ones” are designed to tackle systemic failures to address the health needs of women and children, other vulnerable and most-at-risk populations. Depending on the state of national health systems, they can facilitate or hinder the delivery of health. The health system needs to work in harmony to advance health. The followings are the supporting ground for the success of the MDG four:

### **A) Policy environment:**

First and foremost, a supportive policy environment is needed in order to allow provision of the most effective interventions and strategies, e.g. community case management of pneumonia by community health workers, scale-up investments needed for care of newborns, access to family planning, outreach to most-at-risk populations such as drug users, sex workers and men who have sex with men. Further, an enabling legal and policy framework is necessary to prevent stigma and discrimination that reduces access to health services. Universal access to health and social services is also promoted through adoption of social protection measures (including among others through paid maternity leave for all working women) addressing equity concerns as well as families who are most vulnerable.

Reaching the health MDGs implies a dramatic expansion of key services, and the implementation of mechanisms to increase demand for and use of those services, particularly the rural populations, and the poor and among them women and children.

### **B) Financing of health systems:**

Low-income countries currently spend only US\$25 per capita on health; of this US\$10 comes from out-of-pocket payments and only US\$6 from development assistance for health. The level of financing is low and until recently, very little was allocated to health system strengthening.

### **C) Governance, accountability, management and supervision:**

Greater attention is needed in strengthening management and supervision structures, improving the accountability of public health care systems and focus on governance issues.

**D. User fees:**

Elimination of user fees, removing barriers to access for those who cannot afford to avail health services and community based health insurance schemes for the poor has been shown to contribute substantially to reducing barriers to uptake of health services. Protection against unaffordable health costs and recognizing 6 United Nations Development Group and responding to barriers in accessing health services including transportation, lack of trained health care workers, and other costs related to accessing care in hospitals and clinics will improve uptake of services, particularly by women who tend to have less access to resources and services due to gender-biases in access.

**E. Opportunity costs:**

Even when health services are free, substantial opportunity costs can be involved in accessing the services, such as for transport, food and missed day of work for patient and/or accompanying person. These costs can be prohibitive to accessing care, especially when repeated clinic visits are required for diagnosis, receiving treatment, monitoring etc. Offsetting these costs through provision of food assistance, vouchers or cash to poor patients can markedly increase accessibility of care.

**F. Human Resources for Health:**

In 2004, the Joint Learning Initiative recognized that health personnel are critical for delivering interventions and achieving MDGs through expanded coverage of maternal and child health interventions that are only possible through greatly enhanced worker density of 2.5 per 1,000 populations – 75 countries were below this threshold. To improve capacity to deliver critical health care interventions several improvements are essential, including: better working conditions, adequate staffing, prevention of exposures to occupational hazards, access to occupational health services, reasonable working hours, fair remuneration, engaging the private sector, increased skills training for health care providers and management training for regional health district, health facility, and human resources managers.

### **G. Service quality assurance:**

Pre-service and in-service training program, community outreach and effective supervision will be required to maintain and improve the technical quality, the cultural, gender, ethnic minorities and pro-poor sensitivity of client encounters and the regularity of contact with the health system. Proper task-shifting can improve the coverage of key interventions while maintaining safety and guaranteeing rights. Also, there is a need to establish mechanisms for quality control and feedback on services by clients especially from the most disadvantaged and marginalized families. Addressing stigma and discrimination within health care settings is essential to improve service uptake and effectiveness.

### **H. Supplies:**

An uninterrupted supply of reliable and high quality medical and contraceptive supplies are necessary for health personnel to work effectively and reach populations in need.

### **I. Access to nutrition and nutritious food:**

A significant number of households with young children lack both the knowledge of how to adequately meet the nutritional needs of their young children as well as the means to purchase adequate foods rich in animal proteins and micronutrients. This is often aggravated by the lack of adequate complementary foods for young children or their excessive cost.

## **2.9 The Child Survival Strategy from the perspective of MDG Four**

The overall objective of the Strategy is to reduce under-five mortality to 67 per 1000 by 2015 this being a reduction by two-third from the 1990 rate of 200/1000 live births and 52% from the 2004 rate of approximately 140/1000.

Its specific objectives are:

- To proportionally reduce the neonatal, infant and child mortality rates while achieving the overall objective
- To ensure the greatest possible reduction of mortality among the children of the poorest and most marginalized sections of the population.
- To contribute to the reduction of maternal mortality to achieve the Millennium Development goal by 2015.

- To ensure the availability of quality essential health care for women and children in the Community and health facilities.

The strategy focuses on the health system, but long term gains will also depend on progress in other sectors, including reducing poverty, improving food security, raising levels of maternal education and the status of women in society, and the provision of safe water and sanitation. The main pillar of the strategy is the Health Service Extension Program, which aims to scale up coverage of essential health services to the rural community. Success will depend on this program being rolled out as rapidly as possible while ensuring high quality care and full coordination of its activities and integration with higher tiers of the health service.

The Strategy proposes a management structure which will enable greater collaboration between all concerned bodies. At each level there would be a Child Survival Executive, chaired at national level by the Vice Minister for Health, at the Regional level by the RHB Head and at the district level by the Woreda Health Officer. Their prime functions would be to coordinate the activities of all concerned bodies and to monitor and review progress. A National Child Survival Steering Committee, which will include representatives of all national and international partners in the Child Survival effort, will oversee and provide policy and financial support to the implementation of the Strategy. The national Newborn and Child Survival Technical Working Group is chaired by the Child Health Team Leader of FMOH. It will have the authority to ensure that all the programs at the national level, including the NGOs and partner projects supporting them, develop, promote and abide by one plan for the implementation of the strategy.

## **2.10 Partnerships/Stakeholders for Child Survival**

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

- Their span of control over the generation and allocation of resources;
- Level of political power;

- Scope of participation in the sector; and
- Range of use of services provided by the sector.

The attainment of missions and objectives of MDG-4 is largely dependent on the collective efforts and roles played by the different stakeholders. Therefore, stakeholder analysis in MDG-4 is a critical issue that helps to define the boundaries of all actors in the health system; clarify contributions expected from each actor; and describe areas of possible collaboration to create synergy to achieve the goals and objectives set in MDG's.

There are a number of national and international stakeholders supporting the planning, implementation and monitoring of maternal and child health interventions in Ethiopia some of which include:-

1. UN agencies – UNICEF, WHO, UNFPA, WB
2. Bilateral and Multi-lateral organizations – USAID, Bill & Melinda Gates Foundation, SIDA, CIDA, DFID, EU, Irish Aid, Italian Cooperation, JICA, CDC, PEPFAR partners, CHAI, JHEPIGO, etc.
3. NGOs – IFHP, L10K/JSI, Save the children Federation, micronutrient initiative, World Vision, IRC, MERLIN-UK, etc.
4. Universities – especially medical & health professional training institutions
5. Professional societies – Ethiopian Pediatric Society (EPS) , Ethiopian Society of Obstetrics and Gynecology (ESOG), Ethiopian Public Health Association (EPHA), Ethiopian Nurse-midwives Association (ENMWA), Ethiopian Nurse Association (ENA), Ethiopian Pharmacists Association (EPA), Public Health Officers Association (PHOA), Ethiopian Medical Association (EMA), etc
6. Private sectors – pharmacies, private clinics, private Hospitals, individuals.

Implementation of the strategy requires involvement of national and international stakeholders, including private sector and NGOs, through participation, coordination and mobilization of resources. This calls for advancing the one plan, one budget and one report approach. Partners are expected to advocate for equitable access for evidence-based MNCH interventions, provide financial and technical support including monitoring and evaluation of implementation of high impact MNCH interventions. (Family planning department of FMOH, 2005).

## **2.11 Trend of health expenditure**

The national Health Account (NHA), which is a comprehensive household survey for systematic collection and analysis of health expenditure, is the single important source of information used for health care financing, which is also useful to compare and contrast the health sector expense throughout the MDG period, it will indirectly show the period where the detail attention was given to the sector. According to FMOH, NHA report 2003 In Ethiopia the National Health Accounts have been conducted since 1995/96 with slight changes in the methodology and overall contents of the survey over the years round. There were also efforts to improve the methodology making use of NGOs survey for verification of data in addition to the use of audit report from DPPC and CRDA so as to minimize the under estimation of expenditure due to various reasons. According to Berman (1996); the core concept of the NHAs is tracking flow of funds from one health care actor to another, including public, private, and donor expenditures for practicable controlling and managing the national health system in terms of planning and assisting in decision-making. The national Health Account is a tool to assess resources allocated and its utilization by providing the best framework for modeling reform strategies and for monitoring their effects.

## **CHAPTER THREE**

### **3. METHODOLOGY**

This chapter specifies the research design used, data source, instruments used for data collection, data processing and analysis.

#### **3.1 METHODS OF THE RESEARCH**

In this study, a descriptive survey design method was applied. Descriptive survey method was used because the variables involved in the analysis are quantitative in nature.

Furthermore, Key Informant interview had been conducted with the selected individuals and various relevant documents, policy documents, and annual reports were used to conduct this study.

#### **3.2 DATA SOURCE AND TYPE**

Primary and secondary data were collected from the different NGO's and government offices of the selected individuals and also different reports of UN and others are used.

##### **3.2.1 PRIMARY SOURCE**

The main primary source of data for this study was questionnaires. The questionnaires are both open ended and close ended. In addition to the questionnaires a key informant interview has been undertaken with the selected few experts, so as to acquire primary data about the subject matter under study.

##### **3.2.2 SECONDARY SOURCE**

For undertaking this research, Extensive review of existing reports, articles, national policy, program, health care financing documents since 1990 and also UNICEF publishes progress report on those MDG goals with exhaustive data source they have, and the UN reports regarding the progress of the MDG four.

### **3.3 SAMPLING TECHNIQUES / METHODS/**

Purposive sampling method is used; those who have served long in the child health area; those who have the knowledge and expertise; those who were deciding on different issues. The same is selected from the Federal Ministry of Health and from three developing partners (international NGO's) namely UNICEF, Save the Children and JSI Research and Training Institute Inc.

### **3.4 SAMPLE SIZE**

The study units are limited to all the member staffs UNICEF Ethiopia health section team, Technical staffs of the international NGOs and also the child survival group from the ministry of health , who are directly involved in direct implementation of the child survival unit in Ethiopia. By selecting individuals from the respective organization, a total of 60 are used for the primary component of this research, out of the 60; 50 are for questionnaires and 10 are for key informant interview.

### **3.5 INSTRUMENTS OF DATA COLLECTION**

The research is based on the trend analysis by taking child mortality rate at the inception period to date and also by measuring the efforts of the ministry of health of Ethiopia and the developmental partners. Some of the above issues are described though tables, percentages and graphs.

### **3.6 DATA ANALYSIS METHDS**

The quantitative data acquired through questionnaire were summarized by using SPSS and presented by means of tables and charts. This offers a pictorial presentation to enhance the understanding of the data. The data presented were also analyzed by using percentages and results interpreted accordingly. The secondary data are used to complement the primary data in a way the research is designed.

### **3.7 ETHICAL CONSIDERATIONS**

While undertaking this study, the researcher committed to the following ethical considerations.

Hence,

- Permission was obtained from all concerned offices.
- Information was provided to the respondents about the purpose of the study.
- Consent of respondents was gained before the beginning of the actual work.
- Interview guides was revised, checked and approved by the supervisor.
- Names, identities, and information is withheld unless the respondents agree.
- Withdrawals from participating in the interview were unconditionally accepted.
- Neutrality was exercised in data collection, data analysis, and report writing.
- Incentives were not given to respondents before obtaining information.

### **3.8 QUESTIONNAIRE RESPONSE RATE**

The study used both primary and secondary data sources. Accordingly, questionnaire and interview questions were prepared, and with these data collection tools relevant data were collected. In terms of questionnaire, it was planned to distribute 70 questionnaires and 50 was distributed and 50 questionnaires were collected back from the respondents, which results 100 percent questionnaire response rate. Since this percentage is considered to be enough to proceed, the data was organized and presented as follows in harmony with data collected by other techniques or sources.

# CHAPTER FOUR

## DATA PRESENTATION, ANALYSIS AND INTERPRETATION

### Introduction

This chapter presents the analysis and results of the study on the Assessment of progress and challenge of government and NGO's action towards MDG four. Data were obtained mainly from questionnaire and interview plus different secondary sources (both published and unpublished) have been used. With the aim of triangulating and consolidating the information solicited through various procedures, key informants interviews were conducted with experts in areas of policy makers and program managers/implementers at various levels. A total of 60 key informants and 10 out of the 60 were selected for interview and the rest are through questionnaire, from FMOH, UNICEF, and Save the Children and from JSI Research and Training Institute Inc. (Annex II).

Semi-structured open-ended interview guide was developed to facilitate the interview (Annex II). The interview consisted of main questions /themes/ and specific questions /sub-themes/ under the main thematic areas. Main questions included; perceptions of experts and program managers about the factors that enabled Ethiopia to achieve MDG 4; the reasons why progress is lacking to achieve equivalent reductions in child mortality, major challenges and missed opportunities as well as best practices or lessons learned.

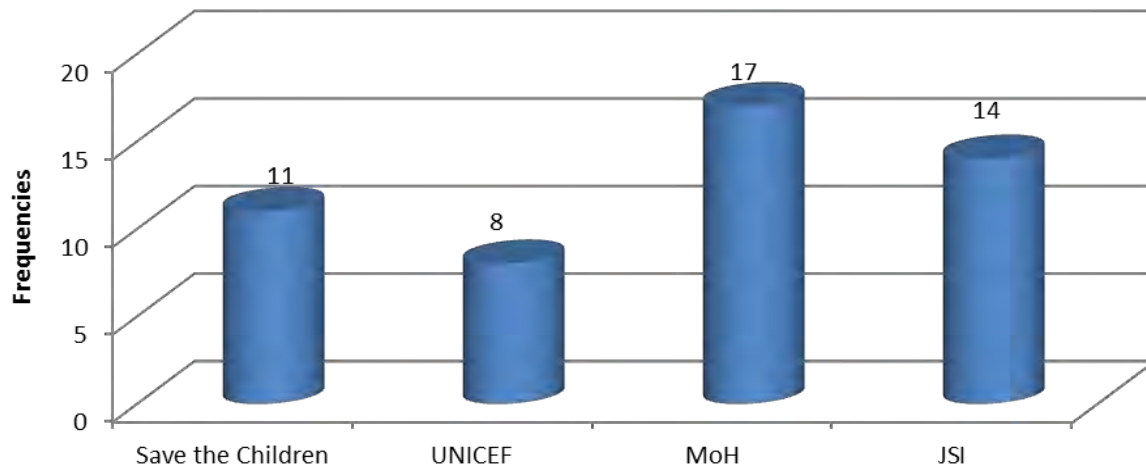
Notes were taken during the interviews, Program and policy documents, reports and other relevant materials were also collected from the key informants during the interviews. To analyze the data collected from the sample study, statistical package for social science version 16 (SPSS 16.0) was used.

In the last section of Chapter three, the response rate of questionnaires distributed is presented. In this chapter the data presentation and analysis of the study is presented. In doing these all, SPSS statistical software package was used in order to increase accuracy in the data organization and presentations.

## 4.1 The Characteristics of Sample Respondents

Different aspect of the sample respondents was considered and included in the questionnaire. In line with this, respondents' organization was identified.

**Figure 4-1: The organizations where respondents were working**

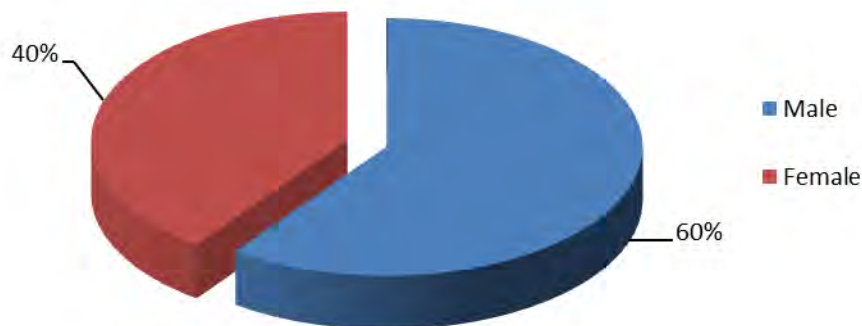


Source: Own field survey data (March, 2015)

As presented above in the **Figure 4-1**, the respondents were from \_Save the children', UNICEF, MoH (Ministry of Health) and JSI Research and Training Institute Inc. Most of the respondents were from MoH (17 respondents), compared to other organizations. However, categorizing other than MoH as International NGOs, most of the respondents were from this category, which was aggregate 66% percent, out of this 8 of them are from UN. There are few NGO's who are working in mothers health's but to there is no local NGO who is working in child health.

## 4.2: Demographic Data

**Figure 4-2: The sex of the respondents**



Source: Own field survey data (March, 2015)

As shown in the above figure 4.2, out of 50 sample respondents, 60% of them were male while the rest 40% of them were female. It indicates smaller numbers of female employees are working relatively in the health sector. Besides this, the questionnaire also assessed the respondents' job position in their organizations. Accordingly, respondents were asked to classify their position as lower, middle and higher level manager. The research showed that most of the respondents (84%) were middle level managers while the 6% and 10% of the respondents were lower level and higher level manager's respectively. This level of combination of managers helps the study to be more realistic. This is presented in the Table 4-1 below.

**Table 4-1: Respondents Job position**

		Frequency	Valid Percent	Cumulative Percent
Valid	Lower Level Manager	3	6.0	6.0
	Middle Level Manager	42	84.0	90.0
	Higher Level Manager	5	10.0	100.0
	Total	50	100.0	

Source: Own field survey data (March, 2015)

On the other hand, the questionnaire also assessed whether the respondents know the MDGs in general and MDG four in particular. Accordingly, the total 49 valid respondents claim that they

knew the MDGs, and also all the 50 respondents confirmed that they knew MDG four in particular. Besides knowing the MDG four, they were asked if they do know its components. Accordingly, all the 50 respondents responded that they knew MDG four components. Therefore, it was found that all the respondents understand the MDGs in general, MDG four in particular with its components.

### 4.3 Policy Impact for the Implementation of MDG Four

**Table 4-2: Respondent's Position title \* Have you ever participated in the drafting guide line for the success of MDG four? Cross tabulation**

		Have you ever participated in the drafting guide line for the success of MDG four?		Total	
		Yes	No		
Respondent's Position title	Lower Level Manager	Frequency	3	0	3
		Percent (%)	6.5%	.0%	6.0%
	Middle Level Manager	Frequency	38	4	42
		Percent (%)	82.6%	100.0%	84.0%
	Higher Level Manager	Frequency	5	0	5
		Percent (%)	10.9%	.0%	10.0%
Total	Frequency	46	4	50	
	Percent (%)	100.0%	100.0%	100.0%	

Source: Own field survey data (March, 2015)

Data was also collected on the identifying the participation of respondents in drafting guideline for the success of MDG four. For the sake of this, respondents were asked to if they had ever participated in the guideline drafting. Their response showed that most (92 percent) of them had been participant while 4 respondents (8 percent) of them did not participated. As shown in the above Table 4-2 cross tabulation, those who had no experience of participation in drafting the guideline for MDG four were some in the middle level managers category.

**Table 4-3: Have you ever participated in the survey of base line and midterm survey of MDG four in Ethiopia?**

		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	46	92.0	92.0
	No	4	8.0	100.0
Total		50	100.0	

Source: Own field survey data (March, 2015)

The participation of respondents in the survey of baseline and midterm survey of MDG four in Ethiopia was also covered in the questionnaire. With this regard, 46 respondents (92 percent) of them replied that they were participants while the remaining 4 respondents (8 percent) of them replied that they were not participants in the survey specified above. This shows the respondents active engagement in this aspect. This data is summarized and presented in the above Table 4-3.

As shown in the **Table 4-4** below, from the total 50 sample respondents considered, it was found that 36 respondents (72 percent) of them had been members of child survival committee that the ministry of health established. Being in this committee means that the participants are aware of any policy or system change always, since the committee is the one which adapts new policy and system. On the other, 14 respondents (28 percent) of the total sample respondent were not members of the committee.

**Table 4-4: Are you member of child survival committee that the Federal ministry of health established?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	36	72.0	72.0	72.0
	No	14	28.0	28.0	100.0
Total		50	100.0	100.0	

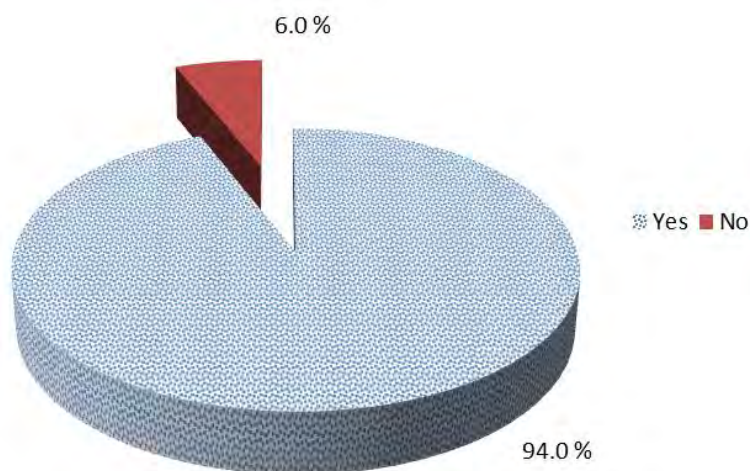
Source: Own field survey data (March, 2015)

Most of the respondents argued that the health policy has also a greater impact in the reduction of MDG four. Because here were great monitoring tools which control each polices are implemented or not. The national health policy, which was ratified early in the 1990s, is considered as springboard for the conception, development and implementation of several health

related programs, strategies and interventions. The policy is highly geared towards disease prevention and health promotion and expanding primary health care services to the rural community. The policy also helped in decentralization, democratization and equitable distribution of health services to the rural poor and disadvantaged population, particularly women and children. Most of the study participants consistently stated the central role of the national health policy in paving ways for the start of subsequent programs and strategies which contributed to the success attained currently.

On the other hand, the distributed questionnaire was devised to collect data on respondents' ideas about government's attention to tackle MDG four. Accordingly respondents were asked the question 'Do you believe there is enough attention given to tackle MDG4 in the government side?' Their response is summarized in the Figure 4-3 below.

**Figure 4-3: Do you believe there is enough attention given to tackle MDG4 in the government side?**



Source: Own field survey data (March, 2015)

As clearly shown in the above in the pie chart, nearly all respondents (94 percent), which is 47 respondents from the total 50 respondents replied 'yes' implying that they considered that government did give enough attention to tackle MDG four. Yet the remaining 6 percent of the respondents (3 respondents out of 50 sample respondents) did reply 'no' to the forwarded

question, which implied they did not consider the government gave enough attention to tackle MDG four.

Even though most of the sample respondents believe that the government had given attention to tackle MDG four, as explained by the Figure 4-13, the respondents also believe that more attention was given by the international NGOs. This was evidenced by all sample respondents response to the question ‘do you think more emphasis is from the non-governmental side i.e. from international NGOs?’ All the sampled 50 respondents replied ‘yes’ implying that more emphasis was from the international NGOs. It is also clear that all the 8 respondents from ministry of health (MoH), a Government Ministry directly responsible to the issue, did agree with this idea, since no respondent disagreed to the question. Even if half of the respondents are from international NGO and they may think that most of the emphasis is from their side, but those non international NGO’s also agree on the idea that makes support their idea more.

Since the development of the new policy with the design, one plan, one budget and one report and also one Monitoring and evaluation techniques throughout the implementation period.

**The major actions of the national partnership were:**

- Hold inter-program meetings to harmonize operation and arrive at a common understanding on selected issues, including: (a) targets year by year; (b) time of key activities; and (c) allocation of resources, taking into consideration the funding gaps and intervention coverage levels;
- Develop and harmonize a coordinated framework for community-level approach to child survival and development that is common for all HEWs
- Develop a common system for supervision, monitoring and reporting
- Conduct bi-annual, quarterly and monthly Joint Program Reviews together with partners
- Activate multi sectorial coordination at Federal level
- Functionalize the coordinating committees in the Regional States

From the primary data most of the participant argued that partners have great impact on the success of child health in Ethiopia.

**Table 4-5: Which do you think has more weight - the challenge or the progress?**

		<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Percent</b>
Valid	Challenge	26	52.0	52.0
	Progress	24	48.0	100.0
	Total	50	100.0	

Source: Own field survey data (March, 2015)

Respondents' view about comparative weight of the challenges and the progress of MDG four implementations in the country was assessed by the questionnaire. Hence, most of the respondents (52 percent) of the total sample respondents thought that they said that health and non-health factors have been the challenge to implement the MDG. Comparative but less number of respondents (48 percent) from the total sample respondents thought that the progress outweigh the challenges, the progress is more visible than the challenge. This is presented in 4-5 above. Even if it is told Ethiopia achieved MDG four but there are still some works to do, as it is indicated in the interview section mentioning that in absolute number the number of children dies every year is still high and some works has to be done.

### **Policy Environment Challenge**

As indicated with most of the participants they maintained that every policy that has been implemented has its own challenge, for example as it was clearly stated in the key informant interview; they admit that the HEP has a great impact but has its own challenge, some of the mentioned one is that most of the HEW are some times over crowded with lots of trainings and it makes difficult for the community to have them around their work area.

### **Operational Challenge**

The operational challenge they mentioned is that sometimes donors used to overlap with the geographical area they are working. Now once the ministry of health is taking the lead and things are getting vibrant, the ministry has a map where which donor is doing in which area. The other challenge mentioned by the participant is some drugs that are vital for the mothers and babies health may be stock out in the health posts, were it makes their work a bit complicated.

The participant also clearly mentioned that they don't face any funding issue when it comes to resources. Funding placed as per the request of the ministry of health as per the intervention area.

**Table 4-6: As the millennium development goals time is approaching to end, do you think Ethiopia will achieve all the targets set in MDG four?**

		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	30	60.0	60.0
	No	20	40.0	100.0
	Total	50	100.0	

Source: Own field survey data (March, 2015)

The distributed questionnaire included a question to assess the respondents' view about the country's achievement of the MDG four as per the time frame. For the question stated as 'As the millennium development goals time is approaching to end, do you think Ethiopia will achieve all the targets set in MDG four?', most of them thought that Ethiopia will achieve all the targets in MDG four in the time frame. As presented in the **Table 4-6**, this was evidenced by the response rate that 30 respondents (60 percent) of the total sample respondents replied 'yes', even though the time approaching they said most of the work has been done and we expect a lot of progress from the sector while it was 20 respondents (40 percent) of the total respondents who replied 'no' by arguing that Ethiopia will not meet all the target set in the MDG four since a lot has been done so for the last ten years for the achievement of this goal with all aspects of the targets and it is difficult to achieve with the remaining period of time response to the stated question ; and also they argue that there is a reason behind for Ethiopia for lagging in achieving all the targets set to in the MDG four, they mention one of the target i.e. the infant mortality rate is one of the reason Ethiopia will not achieve, they said Ethiopia is way behind in this rate and in the activities to decrease infant mortality rate needs to improve.

The government policy enforcement was the other aspect covered in the view of respondents. Therefore, respondents were asked the question 'was there any policy that the government enforces for the implementation of MDG four?' As shown in the table 4-7, all respondents replied 'yes'. This result implied that all of the respondents considered that some government policy enforcement in the implementation of MDG four.

According to UN 2012 annual report, the achievement of the Millennium Development Goals has been uneven across and within regions and countries, however. Most often, it is the poorest and those most marginalized and discriminated against on the basis of gender, age, disability and ethnicity who have seen the least progress. Health plays an important role within the MDGs framework, where three of the eight goals directly (MDG 4–6), and several other goals more indirectly, relate to health. However, that the MDGs focus on only three aspects of health (maternal mortality, child mortality and specific infectious diseases) is too limited and an overarching goal of ‘freedom from illness’ is missing. Others emphasize the need to integrate trained health care providers and the importance of building effective health systems into the list of MDG targets. Several health issues are found to be under recognized, such as non-communicable diseases, mental health, and issues faced by people living with disabilities. Several authors highlight the fact that targets for reproductive health were absent before 2007 and are still insufficient in MDG 5. The respondents also mentioned this as a challenge, because what is set as a target is universal to all, some criteria should have been based on the population and economy of the country, like target set for the development nations may have been differ with the developed one. The researcher also believes on the responds idea, that the targets have been different.

**Table 4-7: Was there any policy that the government enforces while the implementation of MDG four?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	50	100.0	100.0	100.0
	No	0	0.0	00.0	0.0
	Total	50	100.0	100.0	

Source: Own field survey data (March, 2015)

In line with the government’s role in the implementation of MDG four, data on respondents’ view about the role of health extension program was mentioned. Accordingly, nearly all the respondents replied ‘yes’ to the question ‘do you think the health extension program has played a great role in the achievement of goal four?’ That is 48 respondents from the total 50 sample respondents though that health extension program was playing a great role in the achievement of MDG four. Most of the respondents share the same idea that the HEP is the most successful

strategy that was used form the overall strategy of the MDG programs, since the HEP has different roles to which contributed for the reduction of the child mortality in Ethiopia . According to draft report in (EPHI) the acceleration of HEP has reinforced the rapid expansion of health facilities and health professionals throughout the country. The acceleration becomes obvious when training and deployment of over 30,000 HEW in a matter of less than five years is taken into account. It is also important to note that the health extension workers have been supported by various community members such as voluntary community workers and model families before 2010. The health extension program is considered to be the critical means for delivering all the activities deeper to the grass root level. According to UNICEF 2013 report The Health Extension program was introduce under HSDP II in 2002/03 with a fundamental philosophy that if the right health knowledge and skill is transferred, households can take responsibility for producing and maintaining their own health. Substantial investments in human resources, health infrastructure, pharmaceutical supplies and operational costs have been made for the successful implementation of the program.4% of the respondents argue that the success if not only the impact of the HEP but also other program that were launched together with the HEP. As shown in the Table 4-8 below.

**Table 4-8: Do you think the health extension program has played a great role in the achievement of goal four?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	48	96.0	96.0	96.0
	No	2	4.0	4.0	100.0
	Total	50	100.0	100.0	

Source: Own field survey data (March, 2015)

Regarding the challenges the organizations of the respondents‘ faced in implementing the health extension, the sample respondents were asked the questions \_Were there any challenges faced by your organization during the implementation of the health extension program?‘ Their responses are summarized in the **Figure 4-4:**

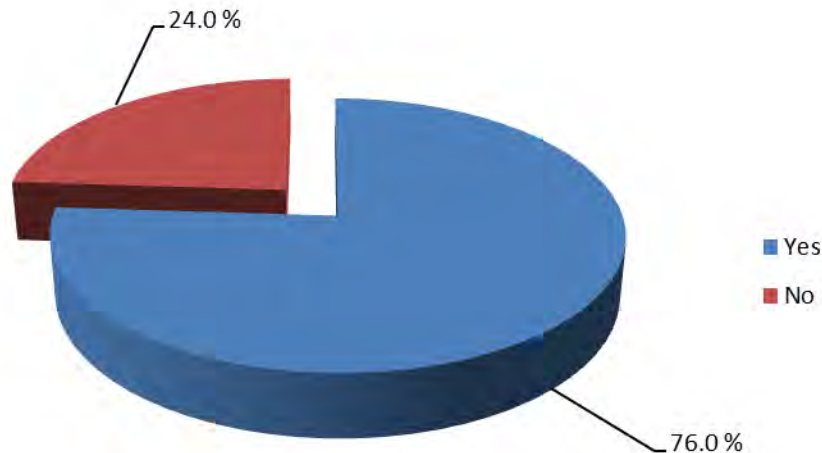
Today in Ethiopia, the HEP is considered as the main vehicle for bringing key maternal, neonatal and child health interventions to the community at grassroots level. Almost all of the activities listed in the national child survival strategies, like ICCM, CBN and many others are being implemented through HEP. Key experts and other program managers who were key informants

of the qualitative component of this study have concurred about their replaceable role of HEP in advancing the health status of the rural population in general and that of mothers and children in particular.

Analyses of trend and levels of key child services from nationally representative surveys in the country since 2000 confirms the fact that HEP has played key role in expanding health services. Most of the high impact child health intervention coverage rapidly increased after the introduction of HEP in 2004. For instance, the coverage for CPR, family planning demand satisfaction, neonatal protection against tetanus , immunization (EPI), nutrition interventions and access to water and sanitation increased by many folds mainly after 2005. According to FMOH 2014, the coverage for new antenatal care clients increased only by 5% (from 26.8% to 28.1%) between 2000 to 2005; while it increased by over 50 percent (from 28.1% to 42.6%) between 2005 to 2011. The coverage for skilled birth attendance remained the same between years 2000 to 2005, while it almost doubled in the years between 2005 to 2011 and increased by 50% between 2011 to 2014. In the same way, the proportion of children receiving immunization, those who sought care for pneumonia and utilized ORS has increased by many folds just after 2005. while after 2005 where the HEP was active, the proportion of households who do not have sanitation facilities drop down to 61.9% and 62.2% respectively.

#### 4.4 Challenges Faced While Implementing the MDG

**Figure 4-4: Were there any challenges faced by your organization during the implementation of the health extension program?**



Source: Own field survey data (March, 2015)

As presented in the above figure, 76 percent (38 respondents) from the total sample respondents recognized that their respective organizations face challenges in the implementation of health extension program. They argue that the challenge they faced during the implementation of the HEP is that some time it was difficult to find the HEW in their health center, due to most of the time they travel to work and also they are engaged in lots of training were the government and other partners are capacitating their skill, so at the time of supervision and some time to have them trained or have them to call for review meeting were some of the challenges mentioned with the respondents. The rest 8% of the respondents says that they did not face any challenge while implementing the HEP.

## 4.5 Child Mortality Reduction Due to Health Sector Development Program (HSDP1-IV)

**Table 4-9: Do you think the series of health sector development program (HSDP) from I to IV has a great impact in the progress of this goal?**

		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	46	92.0	92.0
	No	4	8.0	100.0
Total		50	100.0	

Source: Own field survey data (March, 2015)

On the other hand, the remaining 8 percent (4 respondents) from the total sample respondents considered that their respective organization did not face challenges in the implementation of health extension program.

In order to assess the impact of the series of health sector development program (HSDP from I to IV), the questionnaire included a question ‘do you think the series of health sector development program (HSDP) from I to IV has a great impact in the progress of this goal?’ As a result, 46 respondent (92 percent) and 4 respondents (8 percent) replied ‘yes’ and ‘no’ respectively. The formers reply implied that HSDP series had impact on the progress of MDG goal four, according to FMOH 2014 report the four consecutive HSDPs that have been implemented since 1997/98 are reviewed here with respect to achievements, implementation challenges and lesson learned and doable recommendations for further health sector planning. Records from the implementation of HSDP I and II showed encouraging improvements both in the health service coverage as well as in the utilization of services at all levels of the health care system of Ethiopia. In terms of physical health facilities, the improvements have been the construction of additional 3,135 New Health Posts reaching 2899 in 2003/04. This was from an insubstantial of 76 HPs in 1996/97. The number of Health Centers has also increased from the 1996/07 level of 243 to 519 in 2003/04. Similarly the number of Hospitals has increased from 87 in 1996/97 to 126 in 2003/04. There have been also significant increases in the availability of health workers of all professional categories among which the increase in the number of Nurses and Health officers

have been most remarkable. The end phase in the implementation of HSDP II saw the development of new strategic initiative that brought in the inception, successful piloting, and the launching of HEP at the national level with the aim of universal PHC coverage and institutionalization of the community health services at health post level in the midst of villages. The program has required the training and deployment of all female HEWs and by the conclusion of HSDP II, there have been 2,800 trained and deployed HEWs with 7,138 already enrolled for training in 2004/5.

The 20 years sector plan, HSDP (I - IV) was designed and implemented since 2001 .The four round, comprehensive health sector development plans provided opportunities for better coordination and integration of health sector efforts and enabled development of relevant strategies, programs and interventions that address priority and emerging health issues. Accordingly, several high impact interventions for child survival like; the Child survival strategy, Integrated Community Case Management (ICCM), National Nutrition Strategy and other programs and interventions were formulated and implemented under the umbrella of the HSDP. In a nutshell, the HSDP served as the health sector's comprehensive national plan and guiding framework for the detailed planning and implementation of the whole health sector in general and child health activities in particular.

The participants also highlighted that; the contribution of the HSDP is the birth of health extension program. Health extension program was conceived as a result of the recommendations of Midterm Review (MTR) of HSDP- I in 2003. HEP was introduced in HSDP II. The HEP has an objective of reaching every population segment, particularly the rural poor so as to fill the gaps identified in the MTR. HEP philosophizes that if the right knowledge and skill is transferred to households, members will promote and maintain their own health.

According to UN 2013 report, the reports acknowledge that the HSDP has an inevitable impact on the survival and decrease of child mortality. The researcher also agrees with the participants and with the reports that those programs have a greater impact for the success of health related matters.

In terms of progresses in the implementation of priority health programs including prevention and control of infectious communicable diseases such as HIV/AIDS, Malaria and TB, the

recorded achievement showed that there have been notable sign of improvements during these periods, especially family planning services such as contraceptive coverage which has shown a remarkable leap from the 1996/97 level of 4% to 25% in 2004/05. The following sections provide detailed account of performance of HSDP III in priority programs and health system issues. Health service Delivery and quality of care. While the latter category of respondents' response implied the HSDP program had no impact in the goal's progress.

#### 4.6 Child Mortality Reduction Due to Cross Cutting Intervention

**Table 4-10: Do you know the Cross Cutting Interventions within the Health Sectors?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	46	92.0	93.9	93.9
	No	3	6.0	6.1	100.0
	Total	49	98.0	100.0	
Missing		1	2.0		
Total		50	100.0		

Source: Own field survey data (March, 2015)

As presented in the above Table 4-10, 46 respondents, this is 93.9 percent of the valid 49 sample respondent, knew the cross cutting intervention with in the health sector. indicate that they aware of the cross cutting intervention that are useful for the achievement of MDG four, were they are not directly targeting the MDG four but they supplement the success if the MDG four. some of the mentioned cross cutting interventions including water, sanitation and hygiene (WASH) which involves activities like building open defecation Areas (ODA) free Kebele's, procurement and distribution of medicines and medical supplies, prevention and control of HIV/AIDS, TB and STI programs and the IEC/BCC interventions implemented as means to improving child survival and wellbeing of the society. Most of the respondents give emphases to the WASH and the procurement and distribution of medical supplies where more attached to the MDG four achievement, where the existence of this intervention will indirectly help more for the achievement of goal four. According to UNICEF the improvement in child survival is corroborated by increases in child vaccination coverage, in ownership and use of mosquito bed nets, and in antenatal care coverage, all which have been shown to reduce child mortality and can be considered as cross cutting intervention. On the other hand, the remaining 3 respondents (6.1 percent of the valid respondents) do not know the cross cutting interventions of the health sector.

The participants mentioned lots of cross cutting interventions which are vital for the decrease of child mortality; Participants perceived that the country has recorded fast economic growth with which infrastructures like road, telecom services, education particularly primary education to girls, health facilities, water sources ...etc have been robustly constructed and made available to the population in general and the rural poor farmers in particular. The analyses done on the report on FMOH, also mentioned that the number of deaths averted about 469,000 child lives were saved between 2000 and 2011 as a result of scaling-up of available high impact interventions. The analysis also revealed that reduction in under-nutrition followed by scale-up of immunization and oral rehydration salts for diarrhea have played a great role in averting child deaths in this period.

In Ethiopia, implementation of appropriate policies and interventions targeting determinants of child mortality such as nutrition, education, economic status and empowerment of women has helped to reduce the burden of child under-nutrition. Studies have shown that a severely stunted child faces a four times higher risk of dying, and a severely wasted child is at a nine times higher risk related matters.

The other question included in the questionnaire was intended to collect data about the decentralization of Ethiopian health system. Accordingly, the entire sampled 50 respondent (100 percent) thought that the health system is decentralized. That is, none of them did consider that the country's health system is not decentralization. Since all the sample respondents believe that the system is decentralized no tabular or other statistical tool representation is used.

#### **4.7 Community Empowerment, Engagement and Participation Effect**

**Table 4-11: As an expert in the health sector, do you think their behavior can be improved?**

		<b>Frequency</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
Valid	Yes	48	96.0	96.0
	No	2	4.0	100.0
	Total	50	100.0	

Source: Own field survey data (March, 2015)

The respondents as an expert in the health sector, majority of the sampled respondents (96 percent) thought that the community behavior for health seeking can be improved. They argued that behavioral Change will not come over time, it results from learning - new experiences, new information, and new skills which they give personal and cultural meaning and the information should be available, accessible, affordable and acceptable however, the remaining 4 percent respondent thought that their behavior cannot be improved.

**Table 4-12: Was there community empowerment engagement and participation policy in the system?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	49	98.0	98.0	98.0
	No	1	2.0	2.0	100.0
	Total	50	100.0	100.0	

Source: Own field survey data (March, 2015)

Sampled respondent were also asked the question ‘was there community empowerment engagement and participation policy in the system?’ As shown in the above Table 4-12 , 98 percent of the respondent responded ‘yes’ and that can be implied there was community empowerment engagement and participation policy in the system. So if there is community participation definitely the community health seeking behavior will be changed, since the Besides this response, only 2 percent of the respondents, which was only one respondent, replied ‘no’ implying the absence of the community empowerment engagement and participation policy in the system.

FMOH along with health development partner has been different models of engaging community members in the plan and implementation of health programs. Following the launch of the health extension program ( HEP) in 2005 the engagement of community members in the health service program planning and implementation become more systematic and organized. However, most of the participant highlighted, the types, roles and levels of engagement of the community health workers were not consistent throughout the county. Conscious of these challenges and with the aim of standardizing the community health workers type, roles and level of engagement and to ensure scale up of key positive family and community health practices in 2011 the government of Ethiopia launched the Health Development Army (HAD).

Health Development Army: are networks of women that are led by women who have adopted better health behavior through completing the 16 packages of HEP. Leaders of the network of women influence women under their leadership to practice a healthy life style. Five of such 1-to-5 networks of women form a health development team. The leaders of the networks are selected by the members of the network with the key criteria including being a model family in the community through completing implementation of the 16 packages of HEP and getting trust and respect by the members in mobilizing the community. A social mobilization strategy is developed with an objective of sensitizing and mobilizing the leaders and the community at large to implement the HEP with special focus on maternal, neonatal and child survival. There are social mobilizations committees are established at all level; starting from kebele to federal level. Each of the committees has five to seven members (including political leaders, religious and clan leaders, health managers, party members and representatives of communities/women). The committees use checklists to monitor performances of selected indicators, meet regularly to review progress and make decisions and recommendations to address challenged faced. Both the participant firmly said that community participation is one of the success factors which led to the success of the decreasing of the child mortality rate. Community participation will decrease some cultural effects which led to the death of more children's, as it was mentioned in the key informants interview in chapter three cultural issues can be easily tackled with the help of community members. Those community members also have an impact on the health seeking behavior of the community.

**Table 4-13: Was there enough cooperation from the government to the health sector actors to tackle MDG?**

		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	44	88.0	88.0
	No	6	12.0	100.0
Total		50	100.0	

Source: Own field survey data (March, 2015)

Respondents view on the government's cooperation to the health sector actors was considered by asking a question \_was there enough cooperation from the government to the health sector actors

to tackle MDG? According to 44 of the sample respondents (88 percent), there was enough cooperation from the government to the health sector actors to tackle the MDG. Nevertheless, the remaining 6 respondent, which is 12 percent, there was no enough cooperation from the government to the health sectors actors to tackle MDG. This was evidenced by their response of ‘no’ to the above stated question.

The other issues considered in the questionnaire for the study was about the synergy of the program during the implementation of different MDG’s goals. In that perspective, 84 percent of the sample respondents answered ‘yes’ to the question ‘was there program synergy while implementing different MDG’s goals, so that the resources were used effectively?’ Conversely, 16 percent of the sample respondents replied to the above stated question ‘no’ answer. That is, the latter respondents were considering absence of the synergetic program implementation in order to use the resources effectively. The **Table 4-14** below shows the detail figures of the expiations in this paragraph.

**Table 4-14: Was there program synergy while implementing different MDG's goals, so that the resources were used effectively?**

		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	42	84.0	84.0
	No	8	16.0	100.0
Total		50	100.0	

Source: Own field survey data (March, 2015)

Further the questionnaire distributed included a question ‘does your organization faces any challenge in the implementing the program related to resources?’ This helped to capture the idea of the respondents’ with regard to resources challenges in their respective organization.

**Table 4-15: Name of the organization you are working on currently \* Does your organization faces any challenge in implementing the program related to resource? Cross tabulation/ Funding Availability/**

	Does your organization faces any challenge in implementing the program related to resource?		Total
	Yes	No	
Save the Children	Frequency 0	11	11

UNICEF	Percent (%)	.0%	100.0%	100.0%
	Frequency	0	8	8
MoH	Percent (%)	.0%	100.0%	100.0%
	Frequency	0	17	17
JSI	Percent (%)	0%	100.0%	100.0%
	Frequency	0	14	14
Total	Percent (%)	0%	100.0%	100.0%
	Frequency	0	50	50
	Percent (%)	0.0%	100.0%	100.0%

Source: Own field survey data (March, 2015)

As presented in Table 4-15, 100 percent of the respondents thought their organization did not face any challenge related to resources as presented in the cross tabulation of the above Table 4-15.

#### **4.8 PRESNETION AND DISCUSSION OF KEY INFORMANT INTERVIEW**

Some of the findings that are obtained through an interview has similar concept with the questionnaires has been discussed in line with the findings of the questionnaires and this section presents interview findings that were not discussed along with the findings of questionnaire.

A total of 10 key informants from Federal Ministry of Health, UN and non-governmental organizations were interviewed. Most of these respondents were males whose age ranging from 27 to 65 (average of 46) years. Interviewed respondents are from varying spectrum of educational background and work experience. Educationally, even if majority were public health professionals with Master's Degree, they were nurse, physicians, nutritionists, environmental and health officers, where all had at least a BSc degree.

**Child Health Care Activities, the policies, strategies and programs, either inside or outside the health sector, contributed towards the success.**

Participants from federal level government as well as non-government organizations (NGO) involved to this particulate study presented implementing complementing or similar child health care related activities. In some NGOs; however, mentioned special child health care and related activities. Almost all participants share similar activities to enhancing child health care services, where most of them were focusing on child health care activities. There are also some

interventions focusing both on maternal and child health care services and cross cutting activities to promote and enhance child survival and wellbeing. As it was shown in the table 4.10 there are lots of cross cutting intervention which helps to achieve MDG four.

Among the child health care specific activities implemented by government offices at federal level routine immunization (EPI) services, Vitamin A supplementation, integrated community case management (iCCM) of child illness and periodic deworming for parasites through anti-helminth supplementation were mentioned by many of the respondents. There are also some who mentioned to have programs relating to child nutrition mainly through the Community Based Nutrition (CBN) program for under two children as well as growth monitoring for under five children, others mentioned routine screening for Therapeutic Supplementary Feeding (TSF) based on the life cycle approach. Outreach therapeutic programs (OTP) and Community based newborn care activities are also among those child health care specific programs implemented by some to improve child health care and survival. In the same way, NGO were implementing similar or complementing activities in child health. The activities were like: Child nutrition, iCCM, IMNCI and supporting immunization.

The other interventions related to both maternal and child health care are: family planning, antenatal care, skilled delivery care services, counseling for birth preparedness, post natal care services, PMTCT, Tetanus Toxoid (TT) vaccination and iron folic acid supplementation to pregnant mothers are worthy to mention. In some areas, interventions like, BEmONC and CEmONC services, de-worming of pregnant women and post abortion care services are also implemented to maintain the health of both the mother and the newborn. Very few respondents also mentioned implementation of health surveillance and maternal death surveillance and response activities and enhanced outreach services for maternity services as a key intervention to achieve the goal. This is also indicated in table 4.10 with the cross cutting intervention area.

In the way, cross cutting interventions including water, sanitation and hygiene (WASH) which involves activities like building open defecation Areas (ODA) free kebeles, procurement and distribution of medicines and medical supplies, prevention and control of HIV/AIDS, TB and STI programs and the IEC/BCC interventions implemented as means to improving child survival and wellbeing ; child health specific, maternal and child health care activities and the cross cutting activities are mainly implemented through the health extension program. The health

extension program is considered to be the critical means for delivering all the activities deeper to the grass root level.

In addition to what government is implementing, many of the participants from the NGO offices mentioned that they focus on support to strengthening the federal and regional government health offices' implementing capacity and building the capacity of health professionals, mainly those working in the prevention and control of diseases to curtail or impede the smooth implementation of child health care activities. As UNICEF (2013), report indicates that most of the success comes through the effort of the local and international government of each countries which are in track of for achieving MDG four and also that the decentralization of the system helps them to do their work smoothly than they expected.

### **Successes Factors within the Health Sector/System**

From the various factors mentioned contributing to the obtained results in reducing child mortality in Ethiopia, factors within the health system were highly emphasized and boldly reported by almost all of respondents. In this regard, among the key factors identified within the health sector/system; general health policies and related strategies of the government, child health specific programs, strategies and intervention, child nutrition related programs and interventions, maternal and child health related activities as well as other non-specific health related activities were identified. According to UNCEIF (2010), report this factors were given attention to the real success of the MDG, integration of MDG works that once strategy helps the other goal was the one thing that lead to success.

From those health system related factors, the national health policy drafted in 1991 and the health sector strategy were identified as the key ground work activities that paved the way for smooth implementation of the other subsequent programs, strategies and intervention. Particularly, the health policy which focused on prevention and decentralization was boldly spoken and emphasized to be the leading success factor.

A 47 years old Ethiopian national participant from an NGO working on child health in Ethiopia and related activities confidently speaking said that:

*'..... we can clearly say that ....at the very beginning of drafting a new health policy... the governments' decision and direction to follow a national health policy geared towards prevention and decentralization is a key factors for today's result.... had it not been for it, we might not come to this end, ....the policy has addressed majority of the leading causes of child mortality in our country i.e. diseases such as pneumonia, diarrhea, malaria and malnutrition, as majority are preventable ....'*

The other highly emphasized national level success factor is the rural Health Extension Program (HEP). The program was launched in 2003 with the objective of reaching every population segment, particularly to the poor. The philosophy of HEP is that if the right knowledge and skill is transferred to households they will be able to promote and maintain their own health. The HEP is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. It is expected that almost all of the activities listed in the National Child Survival Strategies are to be implemented through the HEP. It is for this and other reason that nearly all of the NGO and federal level participants claimed that HEP is one of the unique and innovative programs for achievements obtained so far. This is also discussed in table 4.8 of the questionnaire were all of this issues are discussed in detail. HEP is one of the success factor for Ethiopian not only for MDG four but also for all health sector in general , According to FMOH, (2010), HEP is one of the best health tool that ever created that makes all people user of the health service even if are unreachable; since they travel to each and every farmer house to check if there is pregnant women or if there is a new born child so that they will have a follow up until the child is born safe and grow well, until the child fifth year.

The other general key policies and programs for the Ethiopia's current achievement in reducing child mortality are a series of health sector development program (HSDP) from I to IV, the policy of weaving payment for maternal health services and presence of disease surveillance system for epidemically prone diseases were mentioned.

Regarding the specific programs, strategies and interventions specific to child health; majority of the participants mentioned the child survival strategy, rapid expansion and accessibility of immunization (EPI) services to the rural community, the integrated community case management (iCCM) of child hood illness as well as the Integrated Management of Neonatal and Childhood

Illnesses (IMNCI), Vitamin A supplementation and periodic deworming of children were identified by most of the participants in their descending order.

One of the participants from a UN agency working in areas of maternal health said that:

*—... As to my experience in this organization, Ethiopia's rate of progress in family planning coverage and utilization in the last decade is unique , ...the rate of increase jumps the globally recognized annual rate of increase , ....this has a lot to do rapid reduction of child mortality in addition to the maternal mortality reduction role...''*

The other components of success factors in the health system is related to achievements in planning and implementing of various nutrition and related programs, strategies and interventions of which emergency nutrition activities and the National Nutrition Programs (NNP) were boldly emphasized.

Lastly, some the non-specific and related to the MDG four within the health system were identified which include: rapid expansion of health facilities, better community awareness resulting from overall social development in the nation which brought about better health care seeking behavior, improved supplies and human resources for health, deployment of ambulance to district level, improved and coordinated monitoring and evaluation system within the health care and emphasis given to the prevention of chronic disease and increased health service utilization.

### **Successes Factors Outside The Health Sector**

In the way to success factors within the health care system, a number of factors outside the health system were also identified by study participants from federal level and NGO offices. The main success factors mentioned here are mainly categorized as the governments' commitment and implementation of effective developmental policies and strategies, changes in macroeconomic situation in the country, Partnership and collaboration with NGOs and others sector offices and the overall social development seen in the country during the last ten to fifteen years were elucidated.

As far as the role of the federal and regional level governments for child health care and survival is considered, participants mentioned that there was a strong political commitment from the

government officials to prioritize and allocate available resources to the health sector. Many of the high level government leaders were willing to plan, lead and coordinate relevant and effective health policies, work in harmony with international NGOs and other partners, decentralize power to local level administration, allowing grass root level managers and administrators to make decisions supporting child health, focus and commitment on MDGs, actions undertaken to mobilize the community to own their health ...etc are among the few of the roles identified.

The other non-health care system factor supporting better achievements of child survival in Ethiopia is rapid Economic development & infrastructure expansion. This has been identified to have a potentiating effect on the rest of the activities within and outside the health sector. Participants witnessed that the country has recorded fast economic growth with which infrastructures like road, telecom services, education particularly primary education to girls, health facilities, water sources ...etc have been robustly constructed and made available to the population in general and the rural poor farmers in particular. In the same way, construction of higher learning institution including those training health professionals has been expanding quite rapidly, which brought about availability of adequate number of health work force for the country.

A senior level expert in Federal ministry of health participated in this study said:

*'.... In my opinion, availability of health workers to the rural regions is one of the key success factor for the results obtained,.... if you see it some 10 years ago, it was hardly possible to get even mid-level health workers, putting the seniors away.... this is true because of rapid expansion of higher learning institutions in the country, ... nowadays we are getting qualified personnel adequately in every regions....'*

Similarly, due to changes seen in the macroeconomic situation and free market economy, community's access to various media and communication channels has folds increased by many, according to participants. This has brought about better awareness and information to the community, particularly mothers, and hence health care seeking behavior for ill children has increased.

As we all are aware of the economic development, social and cultural advancement has been also explored by the participants as success factors. Social developments mainly in the aspect of Women's education, Reduction in early marriage, Expansion of primary education to rural communities, Religious leaders/institutions' support for social services, better access to media which brought about overall community's awareness for better health, community's decision and agreed norm to use health services, establishment of networking via the women development army, better access and improvement of Water and Sanitation activities and overall capacity building activities for the community are mentioned.

Table 4:16 Additional deaths prevented in children under-five years of age relative to impact year

Additional deaths prevented in children under-five years of age relative to impact year												
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>Ethiopia2000 baseline</b>												
Total (0-60 months)	0	1	4	8	12	27	193	404	718	902	1036	1263
<1 month	0	0	0	0	0	0	4	7	11	12	15	20
1-59 months	0	1	3	8	12	27	190	397	707	889	1021	1242
<b>Ethiopia2000-2005</b>												
Total (0-60 months)	0	3729	7111	10271	16799	22920	23957	24835	25768	26535	27233	28055
<1 month	0	711	1451	2219	3014	4459	4500	4544	4590	4636	4686	4741
1-59 months	0	3018	5660	8052	13785	18462	19458	20291	21178	21899	22547	23313
<b>Ethiopia2000-2011</b>												
Total (0-60 months)	0	3729	7111	10271	16799	22920	34180	55397	68310	76479	89267	102526
<1 month	0	711	1451	2219	3014	4459	4979	5515	5927	6410	7006	7516
1-59 months	0	3018	5660	8052	13785	18462	29201	49882	62382	70069	82260	95010

Source: FMOH Report 2012.

As the table above indicates there is a decline of childhood mortality over the years. The under five- Mortality rate decreased with in the MDG implementation period as it is shown in the table above. The improvement in child survival is corroborated by increases in child vaccination coverage, in ownership and use of mosquito bed nets, and in antenatal care coverage, all of which have been shown to reduce child mortality. No doubts that this is a positive improvement due to the implementation different activities within the MDG frame works. As it can be seen from the table drastic change has been occurred in the middle of the MDG, at first as it can be shown clearly it was not that much, but then it increase gradually and get higher , or more lives are saved each days goes by.

Components of the under 5-Mortality that did not improve and the reason reasons for this lack of progress, and what are the components .Most of the respondents agree that some elements of this goal, mainly the neonatal mortality rate reduction the researcher tries explore from the participant the reasons behind for staying back in reaching this goal while achieving MDG-4 ahead of the schedule.

Accordingly, it was learnt that several reasons and contributing factors were mentioned for the slow progress in the relevant components. In this regard, some of the reasons mentioned include: lack of focus and attention by concerned bodies, highly prevailing and deep rooted cultural practices related to neonatal health, issues related to economic development and good governance and other factors of the health system itself were mentioned.

Regarding the focus and attention issues, participants emphasized that neonatal health care was given less attention and not addressed very well. They also said that less commitment and priorities given by many of the stakeholders for new born health care. Similarly, low commitment and skill of health workers to neonatal care, problems related to prioritizing the problems and decision making, weak and uncoordinated referral system i.e. referring the sick child to the appropriate health care unit, lack of accountability were among some of the reasons raised. As indicated in Table 4.6 the neonatal mortality is still the un progressed component of the MDG four, this component is currently getting attention in order to achieve MDG four at full scale.

Coming to the cultural and awareness gaps, some participants said that there is a big cultural barrier in the community to caring for neonates. They mentioned harmful traditional practices in the rural and pastoralist community regarding neonatal care, mainly feeding of neonates with butter and other solid foods...etc are highly practiced in some communities, which contributed much for early neonatal death. Coupled with these problems is the lack of confidence among the HEW in providing essential neonatal care services and fighting the harmful traditional practices. In the same way, due to cultural and traditional beliefs, most mothers don't want to come to health facilities for delivery services, which ban's them from getting lifesaving neonatal care services.

The other challenges mentioned were related to economic and administrative issues. Participants attributed the fact that neonatal care services need more attention and they are resource intensive practices. Health care facilities for basic emergency obstetric care (BEMONC) and comprehensive care (CEMONC) do require a skilled professional, sophisticated and advanced level equipment's and expensive drugs, which are hardly available in many of the health centers across the nation. Due to this and other economic related reason, achievements obtained in

successfully averting neonatal deaths, though promising and on track to the MDGs, are not best achieved like the MDG4, i.e. reduction in child mortality.

Some participants from NGOs included to this study also that skilled services or “hospital care” and high impact intervention that require high investment or cost, low partners support & health workers commitment, problems associated with demand side- low levels of awareness were also mentioned especially for some remote areas.

### **The Top Three Reasons /Factors That are Leading To The Achievement of MDG4 in Ethiopia**

As a digest of the success factors, participants were asked to identify the most important and key success factors, within or outside the health care system, have identified several factors under categories like Policies and Programs, Child Health related Programs and Interventions, Economic and social development issues and Partnership & collaboration factors.

The health policy which resulted in a 20 years the health sector development programs, segmented in to five years each HSDP I - IV and the subsequent key program for effective and comprehensive implementation of the policy, the health extension program were mentioned as leading success factors for rapid and sustained reductions in child mortality in Ethiopia.

Along with the health policy and the programs, child specific strategies, programs and implementation modalities including: the child survival strategy, EPI programs, IMNCI/iCCM and CBN interventions, wide scale Vitamin A supplementation and special programs in controlling malaria are among the high-flying factors for the successes in child mortality reduction in Ethiopia.

Among the **non-health system factors top listed**; community's involvement in the health sector, rapid economic growth in the nation for the last decade and presence of a well-integrated, coordinated and harmonized support from local and international partners were designated as main success factors. A resultant from the context of rapid economic development; Food security and agricultural development, Development of infrastructures such as road, water, electricity and telecommunication were included; furthermore, poverty reduction programs, political as well as economic empowerment of women, high community participation, rapid expansion of primary

education, availability of ambulance at district level are also recognized to have significant contribution for achieving MDG4.

A young, regional level water, sanitation and hygiene (WASH) coordinator from Gambella who come to a meeting to Addis and attend my interview explains the variation in health service utilization and overall health status across zones in the region says:

*"... in our region, there is a clear Variation across zones and districts by health service utilization and health status, we have reports and observations that peoples in **Mejenger** zone are by far better than **Agnwak** and **Nuwer** in their health status and awareness.... we believe that adequate attention is given to all across the region, but due to cultural and other societal conditions, health services are better utilized, and the holds true for child survival conditions..."*

It was mentioned that various reasons were attributed for the observable inequitable reductions in child mortality as well as health services utilization across regions, zones, residence areas (urban/rural) and wealth status. Among which, inequitable presence or distribution of basic infrastructure, poor focus and commitment of leadership, large presence of unskilled health workers, uneven distribution of partners, difference between mobile and non-mobile communities, high staff turnover in rural and peripheral areas, low commitment of staffs, skill gap especially in rural areas, population mobility in the pastoralist areas, cultural influences, difference in accessibility and utilization of health service around boarder areas ....etc were all mentioned.

**The major challenges/problems/bottlenecks that might have affected the pace of the progress made in program implementation by the regions or certain economic or occupational groups in the country.**

In spite of the success achieved within the last decade in rapidly reducing child mortality ahead of the time, several challenges were faced and a number of opportunities were missed which detruded better success not to be achieved. Among the key challenges identified, factors related to human resources, the health system and infrastructure, partnership and networking as well as societal related factors were reported. Missed opportunities were also identified within the health care system and outside it.

### **Challenges and Missed opportunities**

Among the most frequently mentioned challenges, human resource and related challenge takes the lead. The challenge in this aspect is mainly geared towards proper selection, deployment and retention of health workers for quality and sustainable health services provision, particularly for child and maternal health were emphasized. Thus, most of the participants mentioned challenges related to high turnover of health workers particularly skilled ones and the HEWs, inadequate or deficient clinical skills of many of the health workers to provide lifesaving child health care services, health extension workers lacking clinical skills, overburdening of the HEWs by engaging them in several health care and unrelated activities, lack of commitment and engagement among many of the newly deployed health workers, poor leadership, shortage of highly skilled and qualified health workers for advanced level care, poor or non-existing supportive supervision, lack of accountability among health workers, ethical and behavioral problems were all mentioned related to it.

The other challenge was related to health system & infrastructure. In this respect, the leading challenge is quality of health service, Shortage of supplies like iron and zinc as needed, and class rooms for delivery and infection prevention, gap to cascade the program, lack of one stop shopping service, lack of coordination in the referral system, lack testing kits and other materials, shortage of Ambulances, Weak private/public coordination, shortage of ambulance services to return back home those who delivered in health centers.

### **The key lessons learned from previous practices of Ethiopia**

Some respondents argue that formulating good policies, strategies and programs are not adequate to attain success unless it is reinforced by effective and efficient management, good governance and adequate and sustainable supply of resources and inputs. The Government of Ethiopia has made intensive efforts in improving health system management, governance as well as insuring adequate and sustainable supply of resources and inputs.

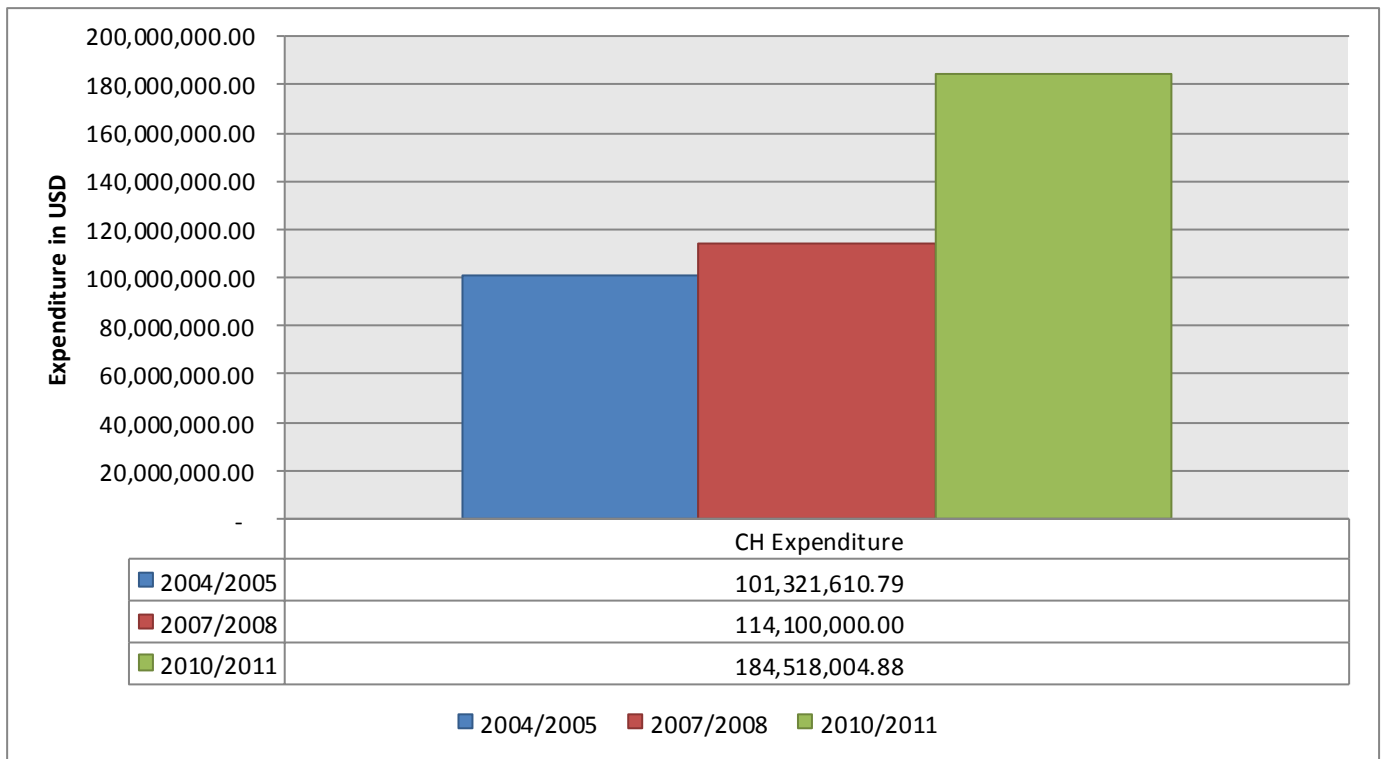
Health management system has continuously being strengthened through engaging a wide range of partners and stakeholders including the community at the grassroots levels, by implementing civil service reform programs and importantly by intensive capacity building efforts. The adoption of one plan, one budget and one report, has been a good opportunity to strengthen

planning, supervising monitoring and evaluation. Many key informants attribute the gains in child survival as the outcome of strong follow up mechanisms.

The government has done a lot in human resource and health infrastructure development. The success attained in human resource development and health infrastructure development can be considered as one of the contributing factor for child survival. A number of measures have also been taken to consistently and sustainably avail the necessary medical supply and equipment's.

According to NHA 2014 report, financial analysis indicate continuous and marked increase, particularly after 2005, in the budget allocated for health sector, which can be considered as one of the key factors that enabled Ethiopia in attaining MDG4. National health account analysis reveals that, both the general health expenditure and per capita health expenditure tripled between 2005 to 2011 compared to earlier periods. In the same period, total child health care expenditure increased by at least 3-4 folds. The strategic shift in financial flow, utilization and accountability, as a result of adoption of the 'one plan' one budget, and on monitoring and evaluation appears to have contributed to the successful and sustainable flow of finance in to the health sector. The Child health subaccounts were not included in the first two (NHA-I) and (NHA-II) (1995/96 and 1999/2000). Thus, the results indicated are only the recent three rounds report reviewed for child health care.

The change in percent of total health expenditure for child health from 2004/05 to 2010/11 has shown a tremendous increase of almost doubling itself over the time interval with percentage (82%). The improvement in the priority health service coverage of maternal and child health services came in consistent to the increment in health expenditure and then to the reduction child mortality. This is better explained graphically in the graph next page.



*Fig.4.5: Trends of total Health expenditure for child health by year in absolute value (USD);*

*Source; NHAs report: 2014; Ethiopia*

## 4.9 SUMMARY OF FINDINGS

Based on the above analysis and findings the following summaries of findings are:-

1. Child Mortality has decrease significantly because of the following factors has been assessed on this chapter:-
  - ✓ Because of health policy of Ethiopia
  - ✓ Because of health Extension Program
  - ✓ Because of Cross cutting intervention
  - ✓ Because of Community Empowerment, Engagement and Participation
2. The Role of developmental Partners for the success of MDG four has been discussed and also their weakness and strength is discussed.
3. Challenges faced while implementing the MDG was also one of the assessed area.
4. Policy Environment was identified as both success and challenge factor.
5. Operational Challenge were also identified and discussed.
6. Limitation of MDGs

## **CHAPTER FIVE**

### **CONCLUSION AND RECOMMENDATIONS**

#### **5.1 CONCLUSION**

In this research which is –Assessment of Progress and Challenges of Government and NGOs Actions in Reducing Child Mortality: The Case of Ethiopia”; tries to assess the work of the GOE and its partners ; also it shows the current picture of the progress and challenge in this specific goal, it investigate the progress and achievement made so far; identifies the challenge encountered, opportunities gained and also missed while achieving this goal and it try to show the future intervention by the government if there is any. The data collection method was both primary and secondary; the primary data was collected though the questionnaire and interview was used in the selected organizations and in the federal ministry of health. The following are the conclusion of the researcher based on the assessment made on chapter four.

HEP an innovative health service delivery system that accelerated access of health care services to the rural community occurred after 2005. Often considered as a flagship program to Ethiopia, the Health Services Extension Program is believed to have been the main vehicle for child survival strategies, programs and interventions.

The presence of close follow ups and strong commitment of concerned local to federal level government bodies has laid a ground for smooth and effective formulation, implementation and evaluation of the programs, strategies and interventions, indicating the fact that the government of Ethiopia had a critical and an irreplaceable contribution for the achievements in the health sector, also political leaders were kept active and were committed and supported to bring this achievement.

It was also identified that the health and non-health factors were behind for the success of this goal which are Policies and Programs, Child Health related Programs and Interventions, Economic and social development issues and Partnership & collaboration factors were from the health related factors and from the non-health related factor which led to the success of this are: rapid economic development; Food security and agricultural development, Development of infrastructures such as road, water, electricity and telecommunication were mentioned; furthermore, poverty reduction programs, political as well as economic empowerment of women,

high community participation, rapid expansion of primary education, availability of ambulance at district level are also have been recognized as the factor .

Having those new policies and programs by themselves did not bring success. But there were also challenges encountered. The Challenges were related to high turnover of health workers particularly skilled ones and the HEWs, inadequate or deficient clinical skills of many of the health workers to provide lifesaving child health care services, health extension workers lacking clinical skills, overburdening of the HEWs by engaging them in several health care and unrelated activities, lack of commitment and engagement among many of the newly deployed health workers, poor leadership , shortage of highly skilled and qualified health workers for advanced level care, poor or non-existing supportive supervision, lack of accountability among health workers, ethical and behavioral problems were all mentioned related to it.

Even if results obtained in child mortality reduction are highly encouraging and needs to be shared for the rest of the world; there still remains a lot of work to bring the mortality rates to acceptable levels (global standards).where the researcher believes as a limitation of the MDG some of the said targets are universal and it should have been at least specific to some continents by considering their population and their living standards. The researcher hoped that the findings of this study can also be used as an input for the post millennium programs to be done on the coming 4 years 2016-2020years.Given the outcome of the research the policy and activity recommendation are given in the next section.

## 5.2 RECOMMENDATIONS

Based on the findings of this research the following are recommended.

- Regarding the factors that improve the child mortality rate needs to be done in large scale and also the GOE is now currently doing a good work regarding the HEP and working with the different partners which makes the health sector more easily accessible for every citizen.
- The Role of developmental Partners for the success of MDG four is inevitable and currently the GOE is trying to harmonize the work that are done with each partner and also it controls who is doing what by strengthening on planning, implementation, monitoring and evaluations were found to have contributed towards the success attained and therefore must be strengthened and harmonized further.
- The challenges mentioned were a lot but activities to tackle cultural constraints should also be given attention as study findings suggests that the major constraints preventing mothers from seeking skilled delivery services are geared towards lack of knowledge, traditional malpractices and awareness related conditions. If there is a way to minimize the high turnover of health workers particularly skilled ones by improving the pay structure and their incentives policies etc. will improve the life of infants and under five children in the rural area.
- Policy Environment was identified as both success and challenge factor, the policy makers should pay equal and considerable attention to both health system and non-health system factors to attain better result in the future. It can be conclude that even if Ethiopia achieves MDG four in advance of the 2015 still the neonatal component of it is not achieved so far. Currently there are a lot of committees that are emerging to monitor Ethiopia progress to date and so they are planning for the post millennium development and what to be done for the next four years starting from 2016-2020, to further achieved the missed components of the MDG.
- Operational Challenge that were mentioned like Shortage of supplies like some drugs were mentioned as a challenge and these things should get attention so that every health

post and health centers can be well equipped with these drugs so that the infants will be treated well on time with in their health center.

- Limitation of MDGs among the key areas left for strategic focus is neonatal mortality rate. The neonatal mortality rate for the country is one of the highest and contributes about half of the overall under-five mortality level and also mention as one of the area that needs improvement so it needs special focus from all concerned bodies and policy makers so that the country could reduce the existing high rate of under-five mortality rate further and rather than setting a goal in terms of percentage it would have been better if the numbers were described abased on absolute number so that it when the numbers are compared to the actual population it would be to the acceptable level.

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## Declaration

*The thesis “Assessment of Progress and Challenges of Government and NGOs Actions in Reducing Child Mortality: The Case of Ethiopia “is my original work. It has not been presented for any university and that all sources of materials used for the thesis sources have been duly acknowledged.*

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January, 2016