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VIEWPOINT

LESSONS FOR THE FUTURE IN THE HEALTH SECTOR IN ETHIOPIA: SHARING EXPERIENCES WITH THE NEW GENERATION

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1. Historical Development and Background

It is possible to shape the future (in spite of Byron "*Alas! It is delusion all: The future cheats us from afar, nor can we be what we recall, nor dare we think on what we are" Stanza for Music*); consequently it is important to think of the future, how it will come about and try to shape its course. Even though it is a very controversial field I share the conviction that "… l'Histoireobéit à des lois qui permettent de la prévoir et de l'orienté" (1), *History obeys to laws which allows to predict and influence/direct it (*loose translation). An important corollary is "Il fautcomprendre le passé pour comprendrel' avenir, c'est indispensable" (2), *One must understand the past to understand the future, it is indispensable* (loose translation). 'Modern' (in the sense of Western/ allopathic medicine; a large number of references will be found in the two books cited above; only direct quotes or new sources will be referenced in this paper to avoid overload) medicine in Ethiopia is reported to have started around 1880 with the opening of mission hospitals in the Bahere Negash region (now Eritrea). After Emperor Menilik's (1889-1913) proclamation on public health, a number of hospitals were started in various cities. By the time of the Italian aggression in 1936, there were 11 hospitals (four in Addis Ababa) and two leprosaria.

In relation to health development, the post-Italian Occupation Ethiopian history could be divided into four periods that more or less parallel the political changes at the time, as follows:

- ***The reconstruction (hospital/clinic based) period*** (1941-1953). Period of reestablishing and rehabilitating of the facilities destroyed during the war period with focus on the limited number of hospitals and clinics; coverage estimated at 25% in 1960s.

- ***The Basic Health Services period*** (1953-1974) Launched in 1952, the strategy was to reach the largest population possible with effective services with minimum qualified staff in the most distant areas with poor communications. The plan was to cover the country with Health Centers (HC) staffed by a Gondar team consisting of a health officer, two community nurses and a sanitarian) and five satellite Health Stations (HS), most often called clinics, run by two dressers and providing service for 50,000 people. By 1974, when the Revolution started, there were only 93 HC, 650 HS and 84 hospitals (Figure 1); professional human resource, doctors in particular, was solely foreigner until the early 1960 and mostly foreigners even in the 1980s; now almost all Ethiopian.

- ***The Primary Health Care period*** (1974 -1991) ushered in by the 1974 revolution. HC staffed by better-trained nurses [(Health Officer (HO) phased out)] and Environmental Health Workers (formerly sanitarians) and HS to be run by Health Assistants (no more dressers) with better training in public health. Community Health Services (CHS), one per Peasant association (about 25,000) staffed by community supported Community Health Agent (one) and one Traditional Birth Attendant (TBA) were also launched but proved unsustainable. By 1991, when EPRDF (Ethiopian Peoples' Revolutionary Democratic Front) forces took over from the Derege regime, there were 167 HC, 2,125 HS and 88 hospitals.

- The ***Sector Wide Approach period*** (1991-) or the ***Health Sector Development Program*** (HSDP 1991-2010) phase started with the advent of EPRDF forces in 1991. The plan was to reach the whole population, by 2015, with a system of primary health care units (PHCU) (one health center and five health posts (HP) for

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each 25,000 people) district hospitals (one for 250,000 people) and zonal referral hospitals (one per million population).

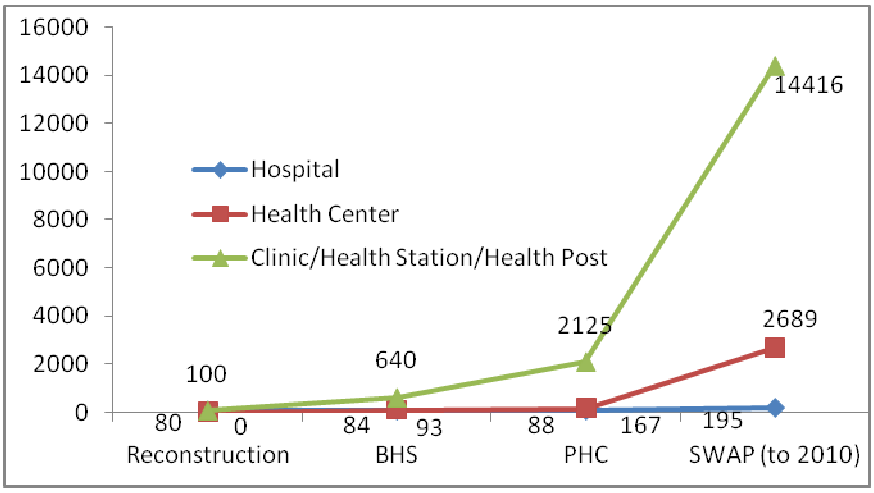

Figure 1: Evolution of Number of Health Facilities 1941-2010 by Period
(Source: Adapted by author from various sources)

2. The Past and the Future

2.1 'Plus ça change'

Learning from the past has always been difficult, the more so in the Ethiopian context. **'Plus ça change',** as the French say, 'plus c'est la même chose'. *[The more things change, the more they are the same (loose translation)]*. Public health policy in Ethiopia clearly shows recurrent themes in all periods. We note definite attraction for foreign medicine - their potions and 'magic' in the earlier centuries, and manifested as uncritical following of their various (sometimes disastrous) paradigm shifts and initiatives in the later periods e.g. malaria eradication. From at least the 1950s, there were conscious and systematic attempts at policy, strategy and plans formulations. All these policy level documents, across the different periods, also stressed what they considered central issues in health development: the primacy of preventive medicine; comprehensive/integrated health care; decentralization; 'integration' of traditional medicine (which continues to be left in the cold); the involvement of missions/NGOs and even the private sector; the need for research etc. Of course, these apparent similarities should be contextualized and there were some marked differences in the contents of the concepts/terms and the implementation processes in the different periods but the intentions/goals were, at least from the health care perspective, similar.

> "Indeed all our pasts are present"
> *Kickbusch 2004 (3)*

Another similarity is the highly ambitious nature of the policies and plans in all the periods. All plans vied for universal coverage in relatively short periods of 10-20 years which were never met in spite of otherwise commendable achievements. The lessons from previous plans were rarely clearly drawn and even less advisedly used to inform the development of the new policies and plans. All did a perfunctory and harried analysis geared mostly to fault finding, condemnation and justification (a posteriori) of the political overthrow of the previous regime. The focus thus was on the wrongs and weaknesses of the previous regimes (which of course were legend) and not on the lessons to be learnt. Thus, experiences tended to be discontinuous and not cumulative.

Reliability and comparability of the available data/information is often questionable. However, it seems clear that very few of the targets set have been achieved. The numbers of health facilities (Figure 1) and human resources have grown over the years. Consequently, the potential health services coverage (however controversial its calculation) has grown substantially (from almost nil in 1941 to 15% in 1974, 40% in 1990 and close to 90% in 2002). However, infant, child and maternal mortality remain very high (Figures1, 2and3). Life expectancy remains low (Figure2). Of more concern, the health services utilization rates seem to be on the decline in spite of the increase of service facilities, service delivery points in particular. Thus per capita annual out-patient visits were estimated at

0.5 per person in 1970, but only at around 0.3 by 2010. Population growth, deepening poverty, deteriorating quality of services etc. could be mentioned as underlying factors but it is a striking illustration of the *'plus ça change'* phenomenon.

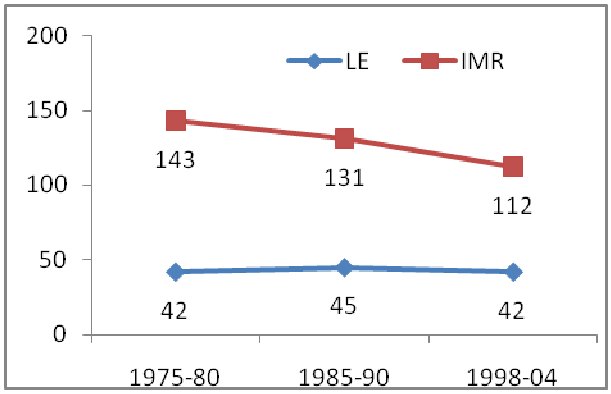

Figure 2: Infant Mortality Rate (IMR) and Life Expectancy at Birth (LE), Ethiopia 1995-2004 *(Source: Adapted from PEFA 2007)*

In all periods the health sector was underfunded and relied heavily on external (donor) input even though external aid, particularly to fund health and education recurrent costs, remained negligible, given the enormity of the task and the rapid rate of population growth. There were also other **'Constants' of the** broader **Ethiopian scene (war, poverty, famine, demography…).** Throughout the period of my reminiscences (the last 50 years), peace, security and stability in Ethiopia continued to be threatened by internal and external forces. Drought, famine, chronic food insecurity and other complex disasters persisted during the whole period and, in fact, aggravated in terms of geographical areas covered and the number of people affected going over 10million in the most recent episodes.

Tradition maintained its clutches with, for example, a number of harmful traditional practices affecting mainly women - reflection of the traditional, marked gender bias - and children. The demographic pressure increased inexorably leading to fragmentation of the land and exerting severe pressure on the already inadequate social services. Instability and insecurity in the Horn continues unabated with increasing potential for failed states and, even though "a resurgent East Africa is certainly plausible…it will be even harder for African countries to succeed" (5).

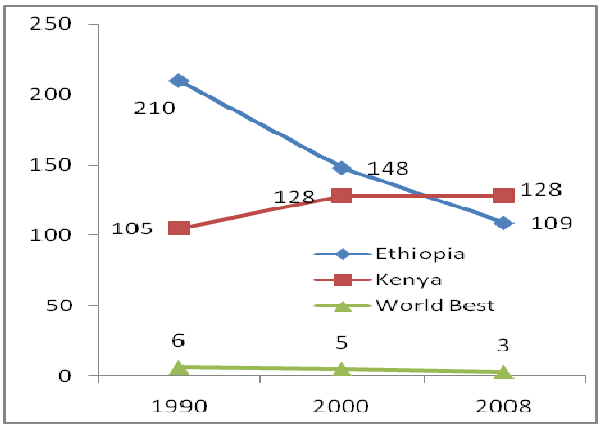

Fig 3: <5 Mortality Rate Selected countries, 1990-2008 *(Source: WHO 2010)*

The continued development of ambitious plans under these conditions seems to be a testimony to the resilience and abnegation of the population - in as much as they were involved - and the temerity of the leaderships. These were spurred, to a certain degree by international hypes on development and poverty alleviation. A UN Secretary General said "The greatest task of the United Nations Decade of Development is … to wipe out mass poverty with its attendant miseries and dangers … But there is no doubt whatever about what can be done. If we have courage and constancy of purpose, a better world for all is within our reach." If this sounds current and if you think it is Kofi Annan 2004 or Ban Ki-Moon 2014, it is only due to the *'plus ça change'* phenomenon. These words in fact were uttered by U Thant in July 1965 in assessing the mid-term achievements of the UN Development Decade 1961-1970. The Decade, as for so many 'pro-poor' initiatives promised a lot but achieved little.

There were of course major political and economic structural differences between the different health policy periods and these had major impact on policy contents and implementation processes. The Haile Sellasie regime promoted 'feudal', autocratic centralism and an (transitional) economic system dominated by 'feudal' relationships. The Derge regime instituted a one-party (Soviet style) power structure and what was later labeled as 'command economy'. Currently, EPRDF is implementing 'revolutionary democracy' through ethnic-based federalism. These different ideological and political approaches have clearly tainted the health policies and plans and the process of their implementation. The constants we notice between the different periods of the modern era should therefore be contexted and nuanced while we draw the lessons.

2.2. A vision for the next 50 years

Ethiopia celebrated its Millennium in 2007, seven years after most others. We know that for many years now several countries have undertaken a large number of studies on the prospects for the 21st century and most of these have now been revised because of the rapid pace of changes, technological in particular, which has been likened to a tsunami (6). We should also try to assimilate and adapt to our reality a vision and mission of public health for the new Millennium (7). One tempting entry point is the health workforce which plays a critical role in appraising and attaining this vision but, as we have tried to indicate in our book on HRH in Ethiopia, planning, even for the next ten years, is fraught with a lot of uncertainties; the more so in the current era of technological revolution with "Much of the jobs we know today will not be around, either done differently or replaced altogether" (8). "The need (therefore) to develop a high tolerance for ambiguity and a readiness to redirect or adjust our course with the changing environment" (6). Ethiopia has for long been following the various paradigm shifts of the powers that be! Even though it is difficult and most probably counter-productive to try to insulate the country from these external influences, it should be possible to be more proactive, and for the country to have a better say on the future of health development in the country i.e. not be dictated by external forces whose agenda might not be concordant with the national interest. The Ministry has recently (2015) developed a well thought-through "Visioning Ethiopia's Path towards Universal Health Coverage through Primary Health Care" on which I had opportunities to comment in other circumstances and will not address here.

2.3 Response by the health sector

Ethiopia's health sector would have to respond to the various challenges of the times (Figure4): persistence/re-emergence of communicable diseases (e.g. malaria, TB and others.) often with resistant strains (the 'post-antibiotic era'?); emergence of new diseases (like SARS, Ebola, Bird -Flu and others; it is not sure if we should continue to classify HIV/AIDS in this category after over 30 years) or disasters/national threats (whether act of terrorism or Mother Nature); the growing burden of chronic diseases (the 'double or triple burden') etc. what some have called "global epidemiologic and geographic transitions" (9); "Complicating the matter are the rapid and profound social, political and economic changes occurring in the world" (7).

> "If you do not think about the future, you cannot have one" *J. Galsworthy, 1928*

Of course technological development, in particular for problems shared with developed countries, could mitigate some of the problems. Technologies are developing rapidly, with tremendous impact on health practice (10). Most of the technologies used now were invented or discovered in the last few decades. Major break-through is expected in nano-technology, gene therapy and the like. These technological developments "are a cause not just for excitement, but for hope" (6). They offer both opportunities and challenges; one example, the temptation to introduce vertical programs to implement new technologies.

Mega-trends – 'large-scale trends'- that are bound to affect the health worker training, the health system in general, in Ethiopia and the world (11), should be taken into consideration if Ethiopia is not to be caught by surprise. Thus, a number of trends – the anticipated shift in demographics and health workforce; the increasing role of information and communication technologies (ICT); growing expectations in accountability in health practice; changes in the health care system (organization and management, see below); new gains in methods of learning, discovery and health care delivery becoming more and more technology-based, team-driven and complex; influences of globalization(12) with serious associated issues of brain 'drain/gain' – should be monitored and proactively strategized (9).

There are also issues with regard to the organization and management of health services. To mention only the most debated ones: 'health in the market place' as Hailemariam (1997) puts it or the role of the market in health, public-private-partnership. In other words, the whole issue of health sector reform promoted by the new (market economy) orthodoxy and exacerbating socially determined health disparities.

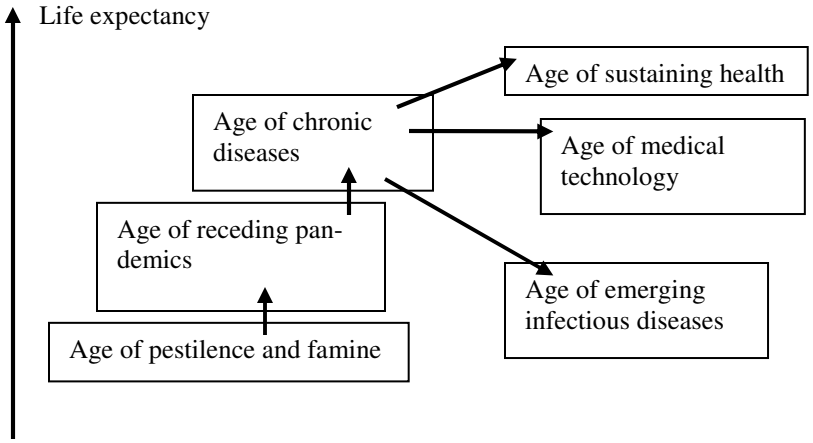

Figure 4: Future stages in health transition
Source: Martens & Huyen 2003

The existing health service will have serious problems responding to these challenges. Hence, an important task that is related to reflections on future health development should be a thorough analysis of the challenges posed by the ever changing health problems and the opportunities and challenges of technological developments. This analysis should then serve to develop a long-term strategic plan such as a 2030 perspective for example. Developments to date in the developed countries does not seem to augur well, "Because of greater demand on health systems (ageing, obesity and disease), the rise of new healthcare markets and strategies (from emerging markets) and increasing technologies and medications to promote and prolong life, fully funded state-based healthcare is unlikely to be sustainable out to 2050" (15); for a contending view see (10). However, even though the problems and hazards with such long perspectives are clear, the long term view required for effective health development should not shirk such a challenge.

3. Traditional medicine

Several aspects of traditional medicine (TM) transcend historical periods. It is:

- used by the majority of the population in all the periods either in parallel, alternatively or concurrently with 'modern' medicine
- practiced by 'professionals' but also, and more importantly, by the people themselves
- easily accessible, affordable, trusted and adapted to the mores of the population
- time-tested and effective for most cases but shrouded in secrecy which, though it has helped to a certain degree to maintain its authenticity and diversity, exposes it to charlatans and abuse.

The importance of traditional medicine was recognized from early on. It was given formal/legal recognition in 1942 (Proclamation No. 27) and a registration and licensing act was promulgated in 1950 but implementation was almost nil. The Derge regime also gave it clear recognition as an alternative health resource and it figured prominently in all major documents (including the 10 Years Perspective Plan), an office for coordination was established and research agenda set but little was actually implemented except for training a relatively large number of TBA. Policy level recognition (Health, Science & Technology … policies) is also high in the SWAp period but TM is quasi absent from HSDP and the coordination office has been downsized and tacked in a research institute. The HSTP (14) seems, once more, to give due attention to strengthening the legal framework and practice of TM but it remains to be seen whether this will fare better than previous policy/plan positions.

Therefore, in all the periods, it could be said that TM had lip-service recognition but little concrete action to institutionalize/integrate it in the mainstream of health care 'system' dominated by allopathic medicine. [Incidentally, in 1982, I conducted a study on self/lay care in Ethiopia which called for institutionalizing/integrating it in main stream health care; unfortunately it seems to have little impact on policy Y. Kitaw (1984). Self (lay) Care in a Developing Country: A study of Three Communities in Ethiopia. Winner of the Jacques Parisot Foundation Award;

Presented at a Plenary of the 37th World Health Assembly May 1984. Special Issue: The Ethiopian Journal of Health Development 2(2): 1-75.]

4. Focus on prevention and control?

Throughout the last 50 years, infectious and communicable diseases dominate the health (in fact disease) scene. Mortality, child and maternal in particular, was high and life expectancy very low (Figures 2 and 3). Interestingly, most of the foreign contacts since Emperor Yohannes (1856) promoted smallpox vaccination. The Italians stressed prevention and control for the indigenous population in order to protect the occupiers. The resonance of this could be heard during the reconstruction period even though it was overshadowed by the facilities-based curative approach. The BHS period was clear on its policy focus on prevention and control. All the plans (2nd and 3rd Five-Year plans) imperiously put prevention and control at the center of the public health effort. The 2nd Five-Year Plan, for example, clearly articulates the 'we cannot afford to expand hospitals, therefore focus on prevention" argument so dear to policy formulators even today (IEG 1962). A Minster could thus say that prevention was "the guiding principle of the Ministry of Public Health" (15).

However, the curative facilities orientation persisted and vertical programs distracted from the more comprehensive and sustainable preventive and control measures (Figure5). Thus, for example, while the smallpox eradication was a qualified success in that, even though eradication was achieved, the program had very little effect on the overall health and health services in Ethiopia, malaria eradication was an unmitigated failure with negative repercussions on the health and services in the country with resonance even today. [In a thesis researched in 1966 and defended in 1968, Yayehyirad Kitaw (1969) Eradication du Paludisme en Ethiopie. Etat Actuel. These, Faculté de Medicine, Bordeaux], I argued that malaria eradication in Ethiopia was ill-advised and was not on track to meet its goals. The thesis was submitted to the Head of MES but shelved. In 1971 a joint government and WHO committee recommended abandoning eradication for control (see Yayehyirad et al 1998)]. Health services, preventive in particular, have little improved at the end of the period and the hospital/urban bias of resources persisted.

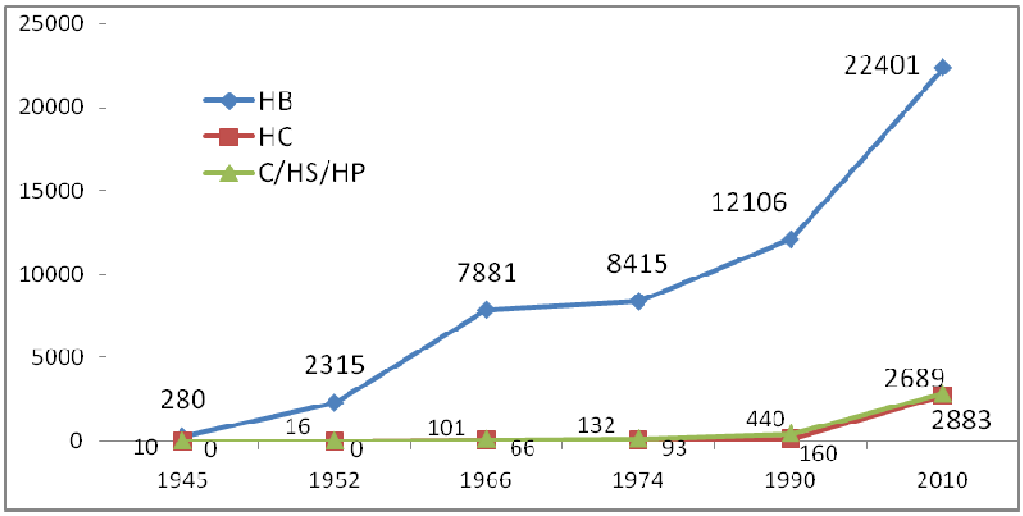

Figure 5: # of Hospital Beds (HB), Health Centers (HC) and Clinics/Health Stations/Posts (C/HS/P/5), Ethiopia, 1945-2010. The graph is drawn with the assumption that the average expenditure on a hospital bed is almost equal that of HC or 5 HS/P.

Again policy formulations during the PHC period were clear on their prevention and control orientation. Anchored on the 'populist' orientation of the Derge, the Alma-Ata Declaration and the 10-Year Perspective Plan, prevention and control were premised as the core activities of the health services. As compared to the previous periods, they were to be more community oriented. However, curative services, hospital-based in particular, continued to dominate. The community health programs, central to prevention and control activities, had problems entrenching themselves in the health and broader socio-economic systems. Thus at the end of the period, community health services had virtually collapsed and the hospital/urban bias in resources allocation still persisted.

The same can be said of the SWAp period up to the end of HSDP III. The policy, strategy and HSDP put prevention and control as priority programs at all levels but the over ten years' experience to the end of HSDP I showed little real shift of resources from hospitals/curative/urban to preventive activities (thorough analysis of the Health Extension Program, which is tooted as introducing a paradigm shift in this connection, is outside the period of our study as its full impact would be felt after 2010). The marked increase in infrastructures (capital investment) seems to have led to thin-spreading of the recurrent expenditures which have remained stagnant. Operational expenditures have, in particular, suffered. The primary looser under these conditions have been preventive and control activities. Thus, the frontline health workers (FLW) strategy has faltered. The EPI program, for example, has fallen far below plans.

HSDP II and III have gone a long way in terms of the very rapid deployment of the Health Extension Program (HEP). More than ever before, the balance between urban and rural in terms of human resources deployment and the attendant salary-related budgetary resources has been reversed. However, HEP has been highly donor dependent, operational budget is limited and problems of career aspirations and attritions are already raring their heads. Overall, as in previous periods, the policy positions and plans and actual achievements do not match. This calls for a thorough review of the lessons from the past in terms of policies, strategies, plans and, as importantly in the Ethiopian context, implementation mismatches in prevention and control activities.

5. Comprehensive/integrated health care

Comprehensive/integrated health care has been the leitmotiv of the health care system in Ethiopia at least from the BHS era. The 5-Year plans of the period clearly put comprehensive services through a chain of HC and HS as the core health development strategy. The Gondar Team was designed to give comprehensive and integrated services. However, some strong vertical programs were introduced, often outside the plan and sometimes in the same document e.g. Malaria and Smallpox Eradication Programs. While the merit of vertical programs in selected contexts cannot be denied, it should not have been at the expense of the long term strategy of comprehensive care system.

Thus in the BHS period, MES overshadowed comprehensive care, in fact all other health services. The BHS approach was made secondary and geared to achieving the goals of the malaria eradication effort, distorting the previously planned distribution of services, adequate funding for comprehensive care and, in general, resources distribution in the health care system. Thus HC and HS did not expand as planned and those built were poorly staffed and financed. The PHC period was better focused on comprehensive care. HC and HS expanded much faster than hospitals. However, quasi-vertical programs, driven as previously by donors, persisted (e.g. EPI) and real resources shift towards comprehensive care faltered. Thus the quality of care at HC and HS remained questionable.

The SWAp period again stressed comprehensive/integrated care and the PHCU structure was developed as the core of this approach. While the number of HC and HP has grown rapidly, the resources shift towards functioning HC and HS/HP has not been commensurate (the number of hospitals has also increased and, in some regions, faster). Thus all HC and HS/HP suffer from under and inappropriate staffing. Growth in recurrent budget has not paralleled the growth in number of facilities and, therefore, operational budgets per unit have become very low. Consequently, quality and utilization have suffered. As in the other periods, the comprehensive care focus is threatened by vertical or quasi-vertical programs. EPI has been swamped by PEI (Polio-Eradication Initiative); HIV/AIDS programs (ART in later times in particular) tended to crowd out other health services. A number of child health (IMCI, the New Global Child Survival Partnership, EPI+, various eradication initiatives -measles etc.) and maternal health (Safe Motherhood etc.) tend to become quasi-vertical.

The two approaches (horizontal/vertical) should not be seen as mutually exclusive. Each has its advantages and shortcomings. As noted over 50 years ago "More authorities are becoming aware that many campaigns for the eradication of diseases have only temporary effects if they are not followed by the establishment of permanent health services in those areas…" (Annual Report of the Director General, WHO, 1951). The issue is therefore to find the right blend and the fact that this seems to have eluded us for more than five decades shows how intricate the issues are. The problem lies in the multiple motivations of the several (and ever growing) actors involved in diseases controls (WHO, other UN agencies, WB, private foundations, numerous bilateral multilateral agencies, private industries, influential individuals including presidents and Prime Ministers, Ministries of Health, Finance etc.). In this cacophony, decision tends to be based on opinion pieces rather than on empirical evidence to the interest of immediate political/financial gains and to the detriment of long-term health gains.

6. 'Decentralization'

Decentralization has been considered a key strategy in all, at least the post-world war, periods. During the Reconstruction Period, it was considered inoperable because of shortage of resources, in particular human resources. Anyway, the newly instated provincial governors considered health of their province as their prerogative and continued to challenge the Bureau of Health dominated by foreigners and their provincial agents who were themselves foreigners i.e. there was a de facto decentralization.

During the BHS period, some embryonic measures were taken in what was called decentralization - more in the form of devolution - towards the provinces. The rationale was that "…in view of communication difficulties, the health services must be… decentralized so that maximum action can be taken by personnel working in isolated places". Awarja self-administration schemes were piloted. Provincial health departments were established but most lacked professional leadership and most decisions remained in the hands of the MOPH. Anyway, real decentralization would have been against the grain of autocratic centralism the Emperor was consolidating.

Decentralization was, again, a policy position during the PHC period. Provincial/Regional Health Departments were strengthened. Awraja Health offices (Awraja Health Management Teams), mostly housed in HC, were established. However, staff shortage was apparent at all levels and while there was devolution of some functions to regional levels, no real decentralization occurred. The Derge toyed with some form of regional and administrative autonomy during the last few years of the period but these had not time to impact on health development.

Decentralization has been a strong motive force during the SWAPp period. As a MOH document underscores, "Arguably, the most significant policy influencing HSDP design and implementation is the government policy of decentralization". It is enshrined in the highest documents of the State - the Constitution - and in all policies including the Health Policy. It is viewed as a political imperative and not, as previously, a management – performance enhancement - tool. Consequently, as in most other countries in similar situations, the health sector had to develop coping strategies to maintain services and progress towards health objectives in the face of 'dramatic' waves of decentralizations.

The first wave of decentralization was to the Regional levels and was done at a rapid pace (almost instantaneously). The rapid pace of decentralization, coupled with the Structural Adjustment Program (SAP), led to the dismantling of the MOH level (also viewed as a remnant of the Derge regime) technical/professional structure in favor of staffing the Regional Health Bureaus (RHB). This led to palpable withering of the technical leadership capacity at MOH level from which it has yet to fully recover. The needs of RHB were not however adequately covered. It took some 2-3 years to develop a reasonable HR capacity at the RHBs and some of the biggest Zonal Health Departments (ZHD).

This was followed by the 2nd wave of decentralization (2005) to woreda levels and was patterned on the political decentralization and carried out to all woredas at once and with immediate effect. Most Wereda Health Offices (WeHOs) had to start from scratch. This was done, in human resource terms, at the expense of the RHBs and ZHDs which had to relocate 60% of the RHB and almost all ZHD staff to the newly created WeHOs. Thus the fledgling RHBs were weakened and the ZHDs almost virtually dismantled. The forced-pace decentralization also meant a drain of technical staff (mostly nurses) from service delivery points to man the new WeHOs, leading to near crisis situation in the biggest regions in particular. In spite of this, most weredas had, for long periods, much less than the minimum staff required.

In the decentralization process, weredas were allocated untied block grants and sectoral allocation was made by the Wereda Council on which health has no direct voice. Budgetary allocation to health suffered with the brunt of the reduction being on operational budget (including pharmaceuticals) of the health delivery points. The decentralization process continues to suffer from these resources (human and financial) constraints. Overall, the transition to a federal state with increased local government autonomy is suffering from a low level of local capacity in terms of planning, management, and budgeting. Effort has been made to support woreda core planning with seconded staff from the center, mostly funded by WHO and UNICEF. Staff turnover is high, which disrupts the continuity of supervision and monitoring of plans, projects, and budgets. Supervision of health centers and health posts is weak in general, owing to a lack of logistical resources and geographical inaccessibility. There is a serious problem in im-

plementing policy and expending budgets in some regions. Thus, while the merits of decentralization are compelling, the process requires careful planning and monitoring as, without genuine empowerment, it could be counter-productive as various studies have shown that decentralization per se is not a panacea.

It should be noted that decentralization, with differing connotations in differing contexts, has been an international agenda in all the periods and most recently, part of the present broader process of political, economic and technical reform related to the neo-liberal modernization of the State. It is not always easy to discern whether the position taken by Ethiopian officials was motivated by genuine internal concerns or as a response to external expectations.

7. Inter-sectoral/multi-sectoral approach?

It is generally accepted that a wide range of factors, many of which are beyond the remit of the Ministry of Health, determine the health of a population. Though circumstances differ from country to country and often from one part of a country to another, health programs depend upon the collaboration of several other sectors - the list could be extensive but the most important from PRSP review include 1) water, 2) sanitation, 3) environment, 4) education, 5) infrastructure, 6) economy, 7) communication/transport… And, "Although the fragmented or distributed nature of knowledge [and practice] is not specific to healthcare organizations or the healthcare sector, it seems to be particularly relevant in this setting" (16). WHO has stressed the need to recognize the intersectoral nature of health, but little concrete action has been taken to effectuate such an approach. For a health program to succeed, the health sector needs not just a helping hand from others, but a genuine partnership whereby ownership of the programs is shared and the stakes of other sectors are clearly recognized. It must be noted that, just as health claims "rights" in other sectors such as trade, so other sectors have rights in the health sector. The aim of intersectoral health policy is to influence these factors.

Recognition of and concern for inter sectoral coordination was expressed early in Ethiopian documents at least for social services. A memorandum from the then Department of Public Health in 1944/45 stressed "Co-ordination and continuity must be observed within the social services, and there must be collaboration between these services, the administrative services, and the spiritual leaders of the people";note no mention of the economic sector – agriculture etc.

During the BHS period, at the early stage, health was seen as a component of a wider community development program. While this could be considered a step towards (though circumscribed to social) intersectoral integration, it seems to have contributed, to a certain degree, to the neglect of the increase in the number of HC and HS.

The PHC period seems to have evolved a better mechanism at the planning level at least. Conscious intersectoral consultation mechanism was instituted at the planning stage. However, there was almost no mechanism, even of an informal nature (after the demise of National Health Development Network-Ethiopia [NHDN-E]), at the implementation level. The plan monitoring and assessment scarcely addressed intersectoral issues.

In the SWAp period, inter-sectoral approach seems to have been sidelined because of the sectoral focus of SWAp. Mention of inter-sectorality in the main policy and plan documents are only oblique and, in practice, the health sector had little interaction with other sectors except with the financial sector. Even relationship with the MOE, with which it shared a Joint Steering Committee in the early years of HSDPI, was tenuous even though most of the training of health workers has gradually been moved to the education sector. That this seems to be a global challenge, "the planning mechanism between the Ministry of Health and the Ministry of Education—where fragmentation is the norm and collaboration remains inadequate" (9) – is not a solace to our predicament.

The HIV/AIDS response has, to a degree because of international partners' pressure, became multi-sectoral. Currently, with the frenzy to introduce and expand ART (PEPFAR in particular) there is the risk that multi-sectoral response along with prevention and control will be marginalized.

Thus the understanding that health cannot be attained by the efforts of the health sector alone and the need for intersectoral collaboration had early recognition at the policy level in Ethiopia. However, practical mechanisms for effective intersectoral collaboration seem to have eluded all periods. Sectoral organization and mandates clearly overshadow policy level intentions of intersectoral collaboration unless, as experience in other countries show,

specific and legally sanctioned implementation measures are incorporated including health-impact assessments on all government policies; specific plans for relevant government departments ("health proofing"); broader ministerial mandates (including e.g. children, the elderly, environment and food). Lessons might be drawn from the water sector which seems to have done better with its WaSH Implementation Framework (WIF).

8. Health Care Structure: Missions, NGOs and the Private Sector

"The debate concerning the appropriate structure for the … medical system goes on. Almost every day, one reads a newspaper or magazine article focusing on the strengths and flaws of our health care network. Should we imitate successful systems elsewhere in the world? How can we insure all of our citizens without bankrupting the economy? How many physicians, nurses, and hospitals do we need and how many will we need in the future? These are just some of the questions that constantly bombard us" (10). If you assume that this is about Ethiopia, think again. It could certainly apply to Ethiopia but, in fact this is about the USA; an illustration that health services delivery is challenging under even the most endowed situations.

To date, the health care delivery in Ethiopia is highly curative oriented and dominated by the public sector (Figure 6),the figure shows distribution of physicians as proximate of service provision as data on services distribution is more difficult to assess but services by the public sector is most probably closer to 60-70% (see, for example, Campos in 12) as compared, for example, most African countries [Personally, I have always believed that health care (preventive and curative) is a public good and therefore should, predominantly, remain in the public domain.].

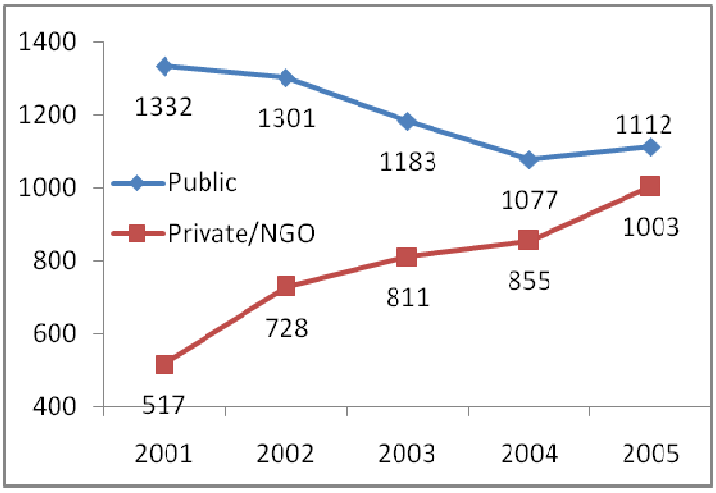

Figure 6: # of Hospital Beds (HB), Health Centers (HC) and Clinics/Health Stations/Posts (C/HS/P/5), Ethiopia, 1945-2010. The graph is drawn with the assumption that the average expenditure on a hospital bed is almost equal that of HC or 5 HS/P.

The role of missions/NGOs has been more preponderant in health services in the early periods. Governments' attitudes in all periods seems to have oscillated between using their good services to fill gaps in public provisions and controlling their proselytizing efforts and other perceived negative activities. In the Reconstruction Period, the Emperor encouraged mission services to fill the gaps left by the withdrawal of Italian and later British services even in the stronghold of the Ethiopian Orthodox Church. This was further strengthened during the BHS period even though mission services tended to focus on hospital or clinic based curative medicine [probably in response to popular demand] rather than prevention and control. Their numbers grew and they provided an appreciable proportion of services. This does not mean that there were no tensions. Ethiopian Orthodox religious communities viewed the incursion of mission health services into Christian areas as Trojan horses. There was also tension between government policy and plans and mission service intentions. Consequently, a number of workshops were held, in collaboration with WHO, about the end of the period to smoothen relationships and expand their participation.

In the early part of the PHC period, in relation with the instability created by the revolution, a number of mission services closed and/or were taken over by government. Subsequently, a number of missions came back and new once (NGOs) sprouted in relation, in particular, with drought and famine relief. However, suspicion was rife with the government suspecting some as being agents of neocolonialism/imperialism and NGOs wary of the government's Marxist/socialist leanings.

During the SWAp period, the number and role of NGOs has grown significantly. The policy and strategy explicitly recognize the critical role NGOs could play. They are represented (by CRDA) in the Joint Steering Committee of HSDP. They are also represented in the National Anti-HIV/AIDS Commission. However, some tension still per-

sists as NGOs claim better involvement in policy and strategies development, take active advocacy measures on certain unsavory issues for the government etc and as the government questions the ethics of some of their programs/managers (e.g. RH) and resources' (financial in particular) management. The suspicion that they engage in activities other than the overt humanitarian still persist.

The private sector both in service provision and training has also grown very rapidly. This has tasked the regulating capacity of MOH and also has exacerbated the shortage of HRH in the public sector and to a degree syphoned off the meager health workforce (Figure 6) from the public sector which provided close to 70% of the services to essentially the poorest segments of the population but had only, for example, 44% of the doctors (Figure 7).

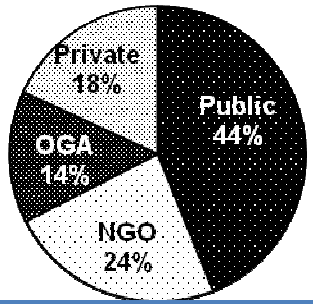

Figure7: Distribution of Physicians, 1997EC (2004/5)

9. Management and M&E [supervision]

From a small beginning as a department/bureau in the Ministry of Interior, the Ministry of (Public) Health has grown steadily to become a sizeable organization with, probably, an over-sized administrative wing, during the BHS and PHC periods.

The Malaria Eradication Service (MES), during the BHS period, had developed a huge autonomous management and logistics system. There were also other autonomous, vertical program managements e.g. smallpox, leprosy. While these vertical management structures were eventually phased out, the MOH structure per se expanded gradually even though plagued by the shortage of well trained professionals.

In the early 1990s, during the EPRDF transition period, MOH was drastically downsized in relation to Structural Adjustment Program (SAP) requirements and in support of staffing the decentralization process to regional levels. Thus, big departments, such as for malaria and HIV/AIDS, virtually disappeared. While the merit of downsizing and decentralizing the over-inflated and over-centralized administrative functions were patent, it seems clear, a posteriori, and this is borne by experiences in other countries, that the technical/professional arms should have been reformed and preserved. In fact, experience has shown the counter-intuitive fact that decentralization requires strengthening the center in professional capacity to properly guide the process. The outcome of the down-sizing has been that MOH is constrained at the policy and strategic leadership level in developing, disseminating, and giving technical support and M&E of health development at regional levels and regulating the expanding private sector. In fact, most departments now function with support in human resources by UN agencies and the implications of this practice of filling the gaps in MOH structure by UN (WHO, UNICEF…) employed/seconded staff should be critically assessed.

Conditions were even worse at the RHB (especially after the transfer of staff to the decentralized woredas) and WeHOs levels as almost all are highly under staffed and most posts are held by under-qualified personnel.

10. Human resources for health

Human resources for health have been a major constraint in all periods. Related to the underdeveloped state of the economy, the country has not been able to train adequate numbers to meet the health needs of the population. Local training programs for most categories were started during the BHS period and scaled up later but the shortages persist; the health workforce density far from approaching the 2.3 per 1000 threshold recommended by WHO (Figure 8) with some regions with less than one midwife per million.

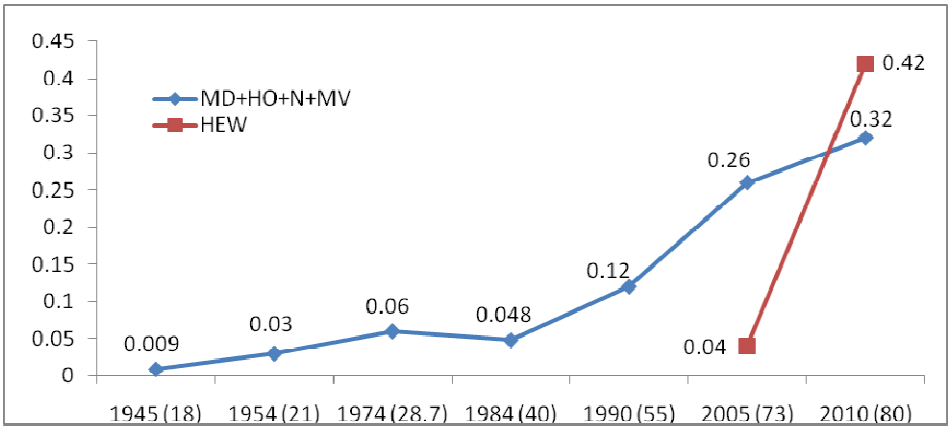

Figure 8: Evolution of Workforce Density (per 1000), in Ethiopia 1945-2010
(Population in millions)
MD=Medical Doctor, HO=Health Officer, N=Nurse, MW=Midwife, HEW=Health Extension Worker)
(Source: Compiled by authors from various sources

There are also problems of iniquitous distribution, inappropriate staffing, inadequate personnel administration, career structures and incentives leading to high turn-over of staff; some of the highest in Africa from the limited studies available (17-19). More recently, there is the issue of 'attrition' to the private sector (Figure 6) and, more ominously, the problem of brain-drain. The enormity of this challenge could be gleaned from the fact that the current worldwide shortage of 7.2 million health workers is projected to reach 12.9 million by 2035 (20). Consequently, inadequacy of HR for health management has plagued the health system in all the periods. Systematic training for management positions was limited and staff turn-over and attrition was high. In trying to alleviate these problems, various attempts have been made in all periods to adopt substitute categories and accelerated training even though details vary (1,15).

Creating substitute categories/task-shifting started early in the 'modern' era with dressers substituting for nurses. Later the Gondar Team (a health officer, two community nurses and a sanitarian) was launched to serve as a bridge towards higher professional provisions in the future. The perception that even coverage with the Gondar Team would take time led to the short-lived experimentation with peripheral/village health workers. With the abandonment of HO training in the PHC Period, nurse (practitioners) were used at the HC level and health assistants (with better public health competence than dressers) at the health stations level. The SWAp period saw the reintroduction of the HO category and the introduction of various junior level categories (clinical nurse, public health nurse, midwife etc.) and of frontline health workers. All these, except the HO, were short lived with frontline health workers in particular being replaced by HEW (Figure 9).

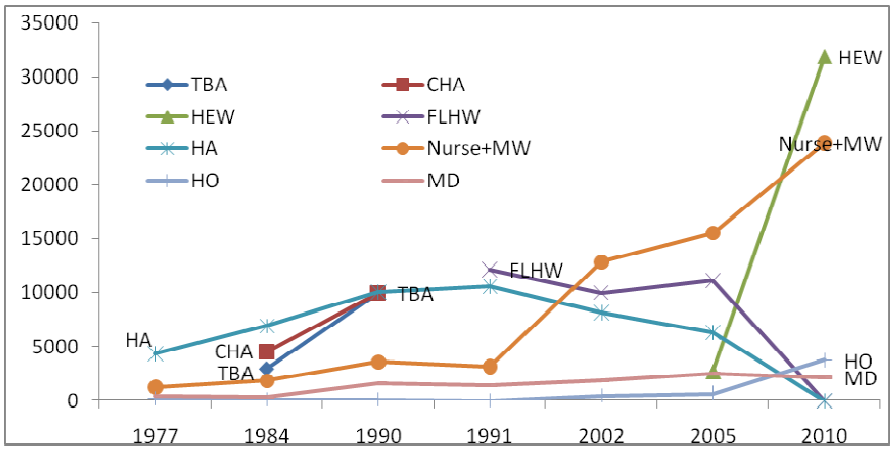

Fig 9: Evolution of Skill Mix: Ethiopia, Selected Years
(Source: Compiled by authors from various sources)

All periods also embarked upon very ambitious acceleration programs of training registering 20% annual growth on average (Figure 10). These often led to major concerns about the quality/fitness for function of the acceleration effort. However, even with the accelerated effort and various mechanisms to reduce attrition, the HRH crisis subsisted (Figure8) proving that there are no quick fixes to the intractable problem of HRD in the context of countries such as Ethiopia.

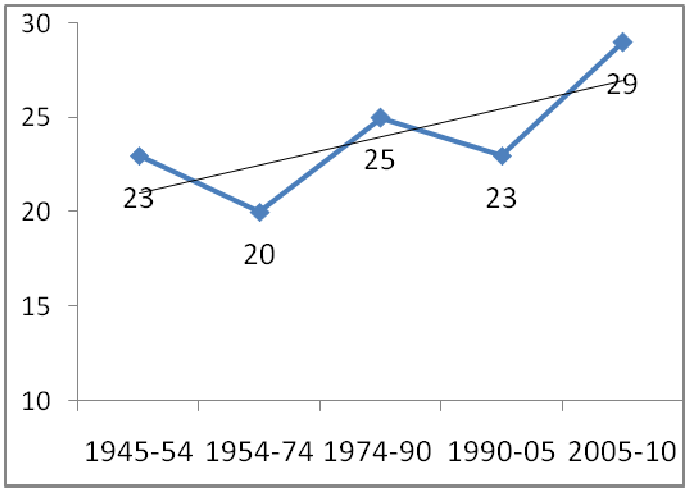

Figure 10: Ethiopia: Average Growth (%) of Health Workforce (MD, HO, nurses, midwives and HA/FLHW/HEW) Per Annum 1945-2010
(Source: Compiled from various sources by authors)

11. The health information management system (HIMS)

The HMIS grew by ad hoc increments (from the various departments depending on issues of focus at differing times). Thus a lot of data – service delivery point returns in particular – were collected. However, except for the inclusion of some of it in Directories or, later, Indicators, very little use was made of the data for policy and plan development at the generating points in particular. Feedback was rare and at the service delivery point (SDP) data collection was perceived as a dreary routine with almost no effort to ensure completeness, accuracy, timeliness and continuity. The various attempts over the years to rationalize the system, including the most recent related to the BPR process, face major challenges of which the most important remains ensuring ownership of the information system (at all levels) in the face of growing dependence on donor/partner funding and reaping the opportunities of the digital age (21).

12. Health Care Financing

Funding of plans in all periods relied heavily on external (donor) input (Figure 11) but in none of the periods, including the current one, has Ethiopia's capacity to raise financing for social-sector development, with or without war, matched the cost of expanding health services and consolidating very run-down existing ones. Thus Ethiopia's health care 'system' remained underfunded in all periods with very low proportion of the GDP expended and therefore a very low per capita expenditure (Table 1); much lower than US$34 recommended by WHO for essential health care.

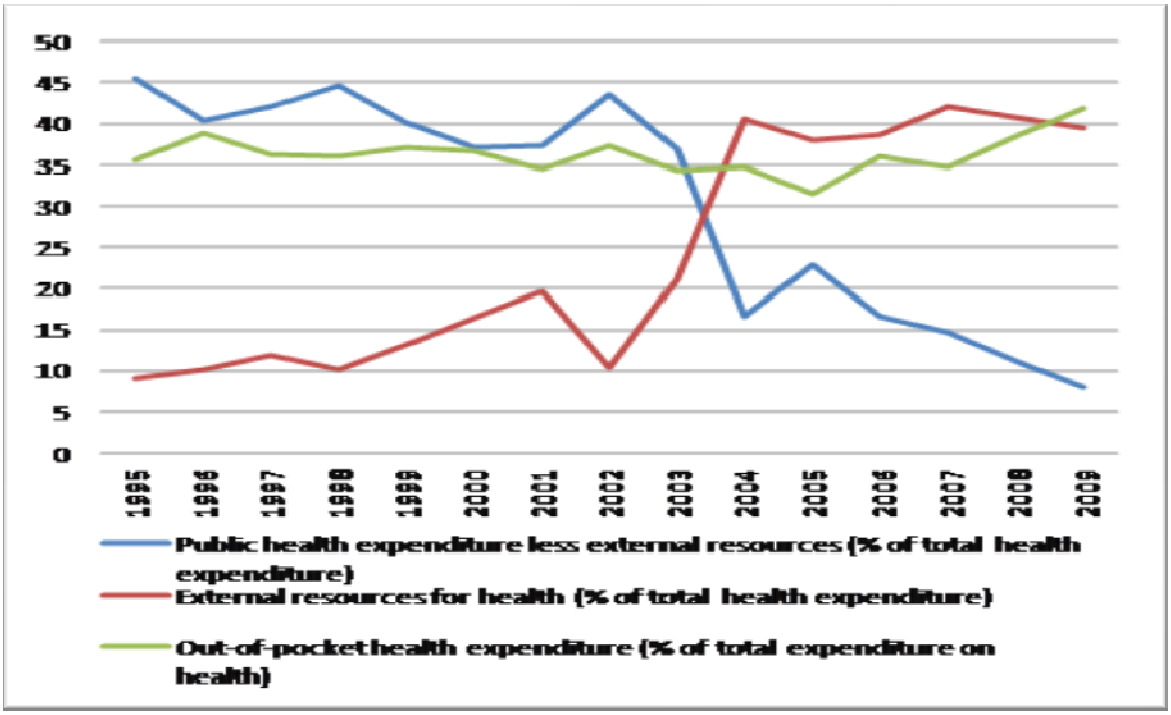

Figure 11: Sources as % total health expenditure.
(Source: http://databank.worldbank.org/*)*

Table 1: Selected Health Expenditure Indicators, 1997 (estimates)

	Ethiopia	Kenya	Norway
Total/% of GDP	3.8	4.6	6.5
Per capita US$ OER	4	17	2238
Per capita US$ ID	20	58	1708

OER= official exchange rate ID=international dollars
Source: WHO 2000

One notable impact, though not the only factor (9), is the very low utilization of health services in Ethiopia which has stagnated at a very low level (compared, for example, to 2.4 per person recommended for Africa) for decades in spite of highly increased coverage (Figure 12).

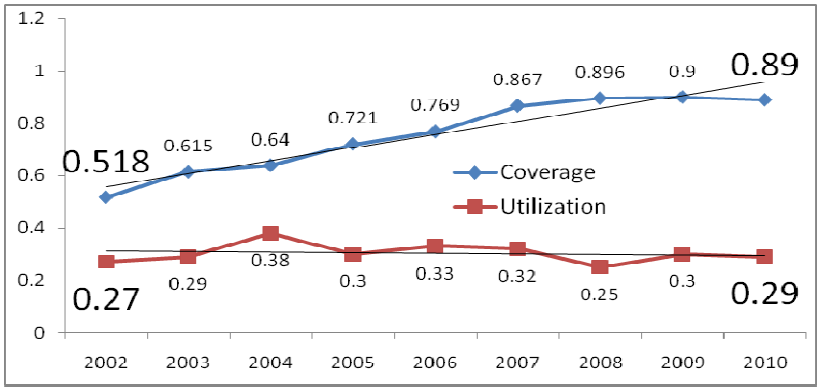

Figure 12: Coverage and OPD Utilization, Ethiopia 2002-2010
(Source: MOH Indicators Various Years)

Ethiopia is committed to covering 55% of the total health budget from domestic resources. With 65-85% of the population (taking account of regional variations) living below the poverty line, the state's capacity to raise local taxes is limited. At the same time, Ethiopia's total debt has increased substantially (to 159 % of GNP in 1997 for example), and while 0.9 % of GDP was spent on health care, 2.3 % was spent on paying interest on external debt (1991–97). In recent years, the HIC initiatives have, to a degree, reduced the burden but the basic issues of dependence remain.

Official Development Assistance (ODA) to Ethiopia is in decline. It fell from 20.6 % of GNP to 10 % (1991–1997). Of the total aid receipts, disbursements for health amounted to 5.7 %, and human-resources development to 8.6 %. External aid, particularly to fund health and education recurrent costs, is negligible, given the enormity of the task and the rapid rate of population growth as it amounted to only 2.3 % of domestic resources and makes up less than 1 % of most regional recurrent budgets.

Experience shows that dependence on external aid is precarious and unreliable. International solidarity posturing [from the UN Development Decades, to Health for All by 2000 to MGDs] is nothing new and has not, mostly, lived up to expectations to date. It could be that the current global process which takes "health out of the confines of religion and charity and makes it a key element of the action of the state and the rights of citizenship… (and the move towards) financing models that are based on rights of global citizens" (3) are more promising. Even more promising, "The Sustainable Development Goals (SDGs) are intended to be universal …[and] reflect the moral principles that no-one and no country should be left behind, and that everyone and every country should be regarded as having a common responsibility for playing their part in delivering the global vision" (22). However, it will be naïve to believe that they will be free from conditionalities(23) and will not flounder on the perennial issues of democracy and governance; civil strives; external aggressions…

13. Back to the future

The main mission of this presentation was to "inform the future". As often said, we look back to the past because we cannot see the future and because a well understood past could be an important foundation for future endeavors. Shaping Ethiopia's health system in a globalizing world implies some visualization of what the future holds in terms of opportunities and threats (7).

We should bear in mind the efforts to develop the post-2015 agenda and Ethiopia's own effort to develop Vision 2030 which have evolved over a long period (23). In looking to the past to inform the future, it is important to draw the main/mega trends that might have enduring effects as a historical perspective could contribute to a better understanding of these mega trends.

As could be surmised from this brief presentation, Ethiopia and the world have seen dramatic developments in the past decades and it seems safe to predict that the coming decades will see even more dramatic developments. "Although no one can predict what the world will look like, it will almost certainly be different, and perhaps dramatically different, from today. It will present new opportunities and challenges(24). Given the limitations of the information system in Ethiopia, a lot of more work will be required to meaningfully grasp these trends. In the meantime, some broad outlines could be drawn from studies elsewhere.

Thus, we should anticipate not only increases in the population but major changes in its composition and structure – increased urbanization, epidemiologic transition/'double burden' (Figure 4). It is close to absolute certainty that Ethiopia's population will be over 120 million by 2030. Almost inevitably, the urban population will grow at very rapid rate, probably reaching 30% by 2030 and, if trends to date in the country and elsewhere in the developing world are plausible indicators, most of these will be living in slums, a staggering 99% in Ethiopia. Ethiopia will not be rid of most of the major communicable diseases (HIV/AIDS, TB or even malaria) and will probably have to face major emerging diseases (Ebola, Zinka to mention only the few most recent) or a 'flambé' of 'neglected' diseases. The shape of the challenges from chronic diseases is already apparent. Thus we should plan to meet these challenges while trying to reap the potentials of the 'population bonus'.

Disparities/inequities in health care are increasing. "Inequality and ill-health are intertwined" and inequities in health are one of the factors slowing progress health development. A major pillar of the Health Policy (1993) is achieving equity in health between regions, rural and urban and male and female. Ethiopia has a long history of user-fee but these were kept relatively low, exemptions were wide-spread and major services such as MCH were free of charge. Recent health care financing reforms promoted by the new (WB…) orthodoxies – what some have labelled "health in the market sphere" – have tended to increase user-fees and regulate exemptions more stringently. As a commonly observed in most rapidly growing economies in particular in Africa (25), there are signs of growing inequities even though Ethiopia , by consumption expenditure Gini Coefficient, is consider one of the least unequal country in Africa in spite of data and measurement problems (26,27). But, in Ethiopia, this is happening in the context of a still very low economic, health and health services access status. Thus, for example, stunting ratio between urban and rural increased from 1.26 in 2000 to 1.60 in 2005 and, as in many African countries, these inequalities tended to be higher for such essential services as access to contraceptives, antenatal care and skilled attended delivery and Ethiopia showed some of the highest and growing disparities along these lines (Figure 13and 14). Thus skilled birth attendance in Ethiopia was 5.6% nationally but much higher for women with secondary education (45%), Tigray ethnicity (43%), residence in Addis Ababa (69.3%) or the highest wealth quintiles (25.4%).

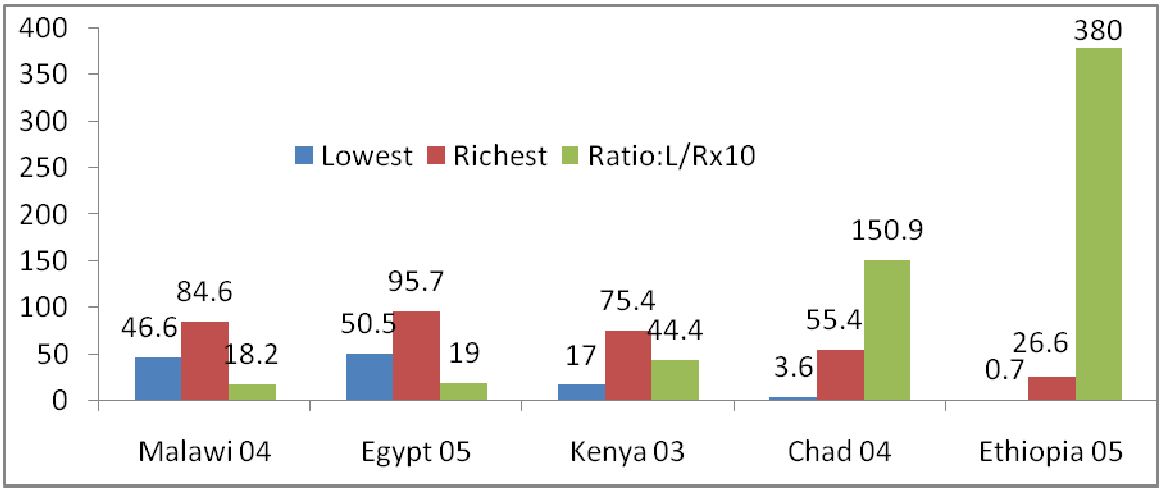

Figure 13: Inequities in Skilled Attendance at Delivery by Wealth
(Source: ECA 2009)

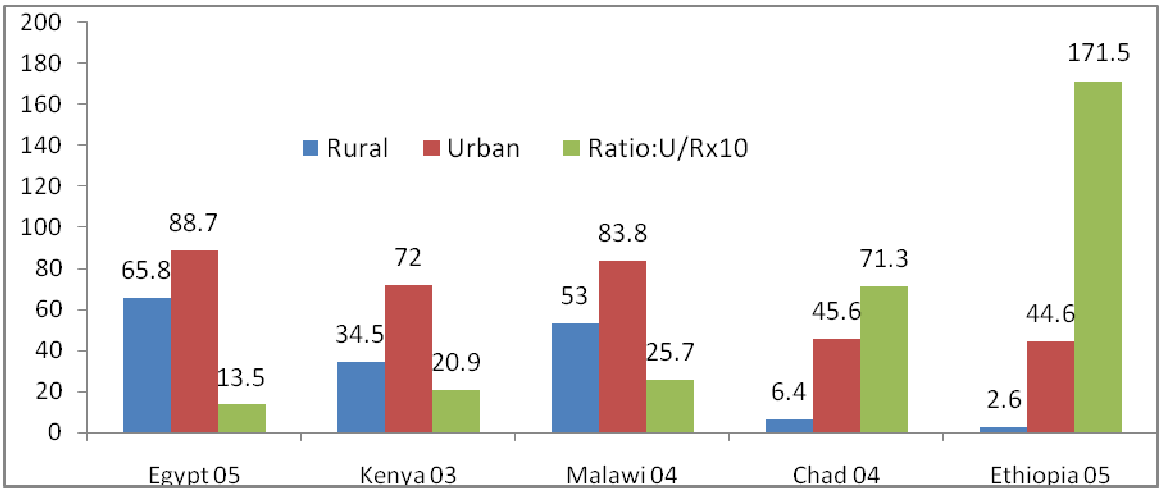

Figure 14: Inequities in Skilled Attendance at Delivery by Residence
(Source: ECA 2009)

The Policy frame (TGE 1993) and the recent initiative in HEP and accelerated PHC coverage; the Health Development Army (a new development not covered in this review); the development of community insurance… are promising but will require major resource mobilization and shift; improved competence of the HRH, HEW and HC staff in particular, and a close and supportive supervision and monitoring of trends to succeed in arresting and denting the increasing disparities.

Medical knowledge is growing exponentially. "…it took 50 years—from 1900 to 1950—for medical knowledge to double. In 1980 and 2010, it took 7 years and 3.5 years, respectively—but in 2020, it is projected that knowledge will double every 73 days" (9). The role of information technology in health care is bound to become pervasive; the need therefore "the right 'infastructure' and institutional capacity" (21). As we hopefully move towards a middle income country status, the delivery and financing of the health system is bound to evolve including the call for Universal Health Coverage. New paradigms of learning, discovery and health care delivery that are increasingly technology-based, team-driven and complex will have to be wedded to traditional methods. Globalization, fueled by "the profoundly disruptive … digitalization" (28), will continue to influence health care in Ethiopia in pervasive ways requiring the development of innovative 'negotiating' capacity (12).

But learning from the past is difficult not only because of the limitations and unreliability of data/information but also because "What we choose to remember is critical, since the narratives that play in our heads shape everything" (29). Thus, even though we have tried to be as comprehensive as possible as recommended for such an assessment the conclusions we are drawing should only be seen as tentative and made in the hope of initiating discussions and a hard look into the past, "not to blame ourselves or our predecessors", but to draw lessons for the future.

> "In moving forward, it is important to learn from the past and, in looking back, it is clear that we can do better in the future" *Margaret Chan WHO 2008*

There is growing recognition – "one of the greatest accomplishments over the past 15 years…: the collective appreciation for our need to invest in health systems strengthening" (31) that a strong health system is an essential element of a healthy and equitable society. It seems clear that, even though palpable headways have been made in recent years, translating this recognition into sustainable development faces challenges. Ethiopia is well placed as a potential candidate for achieving MDGs fast-tracking. It has embarked, as part of the worldwide phenomenon in the 1990s on a major health sector reform in view of revamping its health care to realize the potentials for health improvement. It has launched ambitious and accelerated development programs in health (The Health Services Extension Program, The Accelerated Health Officers' Training Program etc.) in attempts to catch up with times lost because of the Italian Occupation or the perceived neglect of the rural and poor during the Haile Selassie (BHS) period or during the internecine wars during the *Derge* regime. In this respect human resources for health (HRH) are recognized as critical in achieving these goals.

However, it is also recognized that HRH in Ethiopia as in many parts of the world, is in crisis. Undoubtedly, "the most critical issue facing health care systems is the shortage of the people who make them work" (30) and also preparing health workers that are 'lifelong learners' prepared to serve a new (Internet imbued) type of society. More than in any other field in health, anticipation of the future is required in HRD. "To remain relevant, educators would have to anticipate what the health and medical systems would be like in 10, 20, and 30 years, and structure an education that allows health professionals to adapt to unanticipated changes" (12). This does not only mean MDs only but a thought-through task shifting, not seen as only a stop-gap but as "a measure of improving the overall quality of health services" (31). Whatever the case, success will not be guaranteed unless health care workers are carefully selected, well trained and constantly supported.

Some attempts to look into the future have been made but thought-through future scenarios for Ethiopia have yet to be developed. Lessons could be drawn from attempts in the USA (22), Europe and Africa but it is important to develop our own scenarios in view of articulating the implications for health development and, consequently, position ourselves/negotiate for the best deal for Ethiopia in a changing and dynamic world-order. The task would be to develop a 30-50 years perspective possible futures including:

- Evolution of health status of the population including its economic and social determinants
- Responses required in terms of health services
- Optimal organization and financing including proactive leadership (7).

The task would not be easy but the alternative "driving fast blind folded" would be pure madness. It requires expanding the scope of evidence-based policy on which political decisions are justified through lessons from the past. Grand plans however perceptive are only 5-10% of the policy process; the rest is policy adoption and implementation. The implementation effort should focus not only on what but on how, for which lessons could be drawn from the past. Government, EPHA, the new Ethiopian Academy of Sciences and all concerned should develop a mechanism to think-through these issues and design the way forward.

ACKOWLEDGEMENT

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