



## *Knowledge Forum*

### **Lessons for the Future in the Health Sector in Ethiopia<sup>1</sup> Sharing Experiences with the New Generation**

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*“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.  
Lord Byron, Stanza for Music*

Those who do not know their past  
are bound to repeat it.

I have been asked by HWG/EAS to share my experiences in the health sector with budding professionals from diverse background. I feel it is a privilege to have such an opportunity even though I am fully aware of the pitfalls of communication across the generation (and other) divides in current Ethiopia. However, I feel that it is my duty to try because I am of those privileged few to which this country has provided advanced education and the circumstances to serve at various levels of responsibility and exposure and to bear witness to the greatness and tribulations of an old and proud polity. It is also because I believe it is possible to shape the future (in spite of Byron) and that it is important to think of the future, how it will come about and try to shape its course. Even though I know it is a very controversial field I share the conviction that “... l’Histoire obéit à des lois qui permettent de la prévoir et de l’orienter” (Jacques Attali 2006, *History obeys to laws which allows to predict and influence/direct it* [loose translation]).

Even though I am, primarily a health professional, I have been involved, to one degree or another, in the country’s political, social, intellectual life for over half a century. Thus, this varied experience is bound to color and hopefully enrich what I will share as reflections for the future generation on the health sector.

I will start off with a brief historical background and then focus on main reflections for the future.

#### **1. Historical development and Background**

<sup>1</sup> This paper is essentially an adapted version of the final chapters of the books by Yayehyirad Kitaw, Gebre-Emanuel Teka, Hailu Meche, Damne Hailemariam and Messganaw Fantahun “The Evolution of Public Health in Ethiopia” 2<sup>nd</sup> Revised Edition, EPHA, 2012, Addis Ababa and Yayehyirad Kitaw, Hailu Meche and Gebre-Emanuel Teka (2014). The Evolution of Human Resource for Health in Ethiopia, 1941-2010. EPHA, Addis Ababa (see for details and references)..

“What’s past is prologue” (*Shakespeare*) without which understanding the future is difficult. As Jacques Attali (2007) says, understanding the past is indispensable to understand the future (“Il faut comprendre le passé pour comprendre l’avenir, c’est indispensable”). ‘Modern’<sup>2</sup> medicine is reported to have started around 1880 with the opening of mission hospitals in the Bahere Negash region (now Eritrea). After 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 (4 in Addis Ababa) and 2 leprosaria.

In relation to health development, modern Ethiopian history could be divided into a number of periods as follows<sup>3</sup>. My focus in this presentation will be in the periods between 1950 and 2010<sup>4</sup>.

	<b>Suggested for Public Health Evolution</b>	<b>Periodization by historians</b>
Traditional medicine: immemorial	<ul style="list-style-type: none"> <li>• Laying the Ground for 'Modern' Medicine, Up to 1936</li> <li>• The Italian interlude (1936-41)</li> <li>• The hospital/clinic based (reconstruction) period (1941- 1953)</li> <li>• The Basic Health Services period (1953-1974)</li> <li>• The Primary Health Care period (1974 - 1991)</li> <li>• The Sector Wide Approach period (1991 -)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Unification and independence 1855-1896</li> <li><input type="checkbox"/> Decade of consolidation 1896-1906</li> <li><input type="checkbox"/> Power struggle 1908(6?)-1930</li> <li><input type="checkbox"/> Emergence of absolutism 1930-35</li> <li><input type="checkbox"/> The Italian occupation 1936-41</li> <li><input type="checkbox"/> From Liberation to Revolution 1941-74</li> <li><input type="checkbox"/> Reconstruction period 1941-53</li> <li><input type="checkbox"/> From Liberation to Revolution 1941-74</li> <li><input type="checkbox"/> The Derge period (1974-91)</li> <li><input type="checkbox"/> EPRDF regime (1991-)</li> </ul>

◆ **The reconstruction phase (1941-1953)**

Period of reestablishing and rehabilitating of the facilities destroyed during the war period. The facilities were essentially curative and urban and were very small in number. Even in the early 1960s, there were only 80 hospitals with 8800 beds and coverage was estimated at 25%. There were only 4 beds per 1000 inhabitants with high disparity e.g. 80/1000 in Asmara, 56/1000 in Addis Ababa and less than one in most rural provinces. The period being essentially of reconstruction, little attention was paid to health in spite of the establishment of the Ministry of Public Health in 1947. Thus a report of the period (US Technical Assistance) could say "... except for a few foreign advisors, no one in the country has the slightest idea of preventive medicine... To the extent they are interested, it means to them more drugs, doctors and as much as possible paying hospitals".

“To look forward with vision, it is wise to glance backward with perception – not to be bound by history, nor to blame ourselves or our predecessors, but to learn lessons as a spring board to the future”  
*Halfden Mahler, Director General WHO, 1978*  
*(Emphasis ours)*

<sup>2</sup> In the sense of Western/allopathic medicine.

<sup>3</sup> A simplified approach taken to facilitate understanding of current issues; the naming of the phases could be controversial. And, of course, there are overlaps in the periods (for more explanation, see book mentioned in 1).

<sup>4</sup> There have been major changes/developments since 2010, end of HSDP III, but I have limited my discussion to 2010 because the information and analyses of the situation is, currently, more robust for this period.

#### ◆ **The basic health care phase (1953-1974)**

In 1952, the government officially proclaimed the basic health care policy. The strategy was to reach the largest population possible with effective services with minimum qualified staff in the most distant areas with poor communications. Health Centers (HC) with 5 satellite Health Stations (HS) for 50,000 people, were to be established to cover preventive and curative needs of the country especially in rural areas. The HC were to be staffed by a team consisting of a health officer (HO), 2 community nurses and a sanitarian. The Gondar Public Health College was opened in 1954 to prepare these teams. The HS (most often called clinics) were to be run by two dressers. The period saw the preparation and implementation of three 5-year plans all of which, except the 1<sup>st</sup>, had specific chapters for health.

By 1974, when the Revolution started, there were only 93 HC, 650 HS and 84 hospitals (1973 figures)<sup>5</sup>.

#### ◆ **The Primary health care phase (1974-1991)**

This was ushered in by the 1974 revolution. A review of the health (disease) care situation concluded for the need to accelerate expansion of health services to rural areas. This meant more HC staffed by better-trained nurses and Environmental Health Workers (formerly sanitarians) and HS to be run by Health Assistants (HA); no more dressers (which were to be phased out) because HA would have better training in public health and would carry out preventive work. Health Officers were also to be phased out because most did not/would not work in HC and preferred upgrading to MD etc. In general, they were considered as misfits in the 'system'.<sup>6</sup> The coverage figures by HC and HS were kept the same but clear intermediate targets were set. HS were not regarded only as satellites. Thus for a transition period, the target was 1 HC per Aweraja (about 100) and a HS per Woreda (about 600). Community Health Services (CHS), one per Peasant association (about 25000) staffed by community supported Community Health Agent (one) and one TBA were also launched. There was appreciable expansion of these facilities but there were clear problems of quality of services and for CHS of sustainability. By 1991 when EPRDF forces took over from the Derege regime, there were 167 HC, 2125 HS and 88 hospitals.

#### ◆ **The HSDP Period (1991-2010)**

The HSDP phase started with the advent of EPRDF forces in 1991. One of the 1<sup>st</sup> measures of the, then, Transition Government was to issue a Health Policy.

The Health Policy (TGE 1993) emphasizes the equitable access of all people to decentralized, preventive and promotive health oriented integrated PHC. The plan was to reach the whole population with a system of primary health care units [PHCU] (one health center and five health posts (HP) for each 25,000 people) district hospitals (one for 250,000 people) and zonal referral hospitals (one per million population). The target was to cover the whole population with such a system by 2015 and obtain significant improvement in the indicators including close to 50% reduction of maternal mortality rate and infant mortality rate.

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<sup>5</sup> Professional human resource, doctors in particular, was solely foreigner until the early 1960 and mostly foreigners even in the 1980s; now mostly Ethiopian

<sup>6</sup> This is a very simplistic presentation of a very complex problem focusing only on aspects with lessons for HRD. HO have played a critical role in health development in the period.

## 2. The Past and the Future

Learning from the past has always been difficult, the more so in the Ethiopian context.

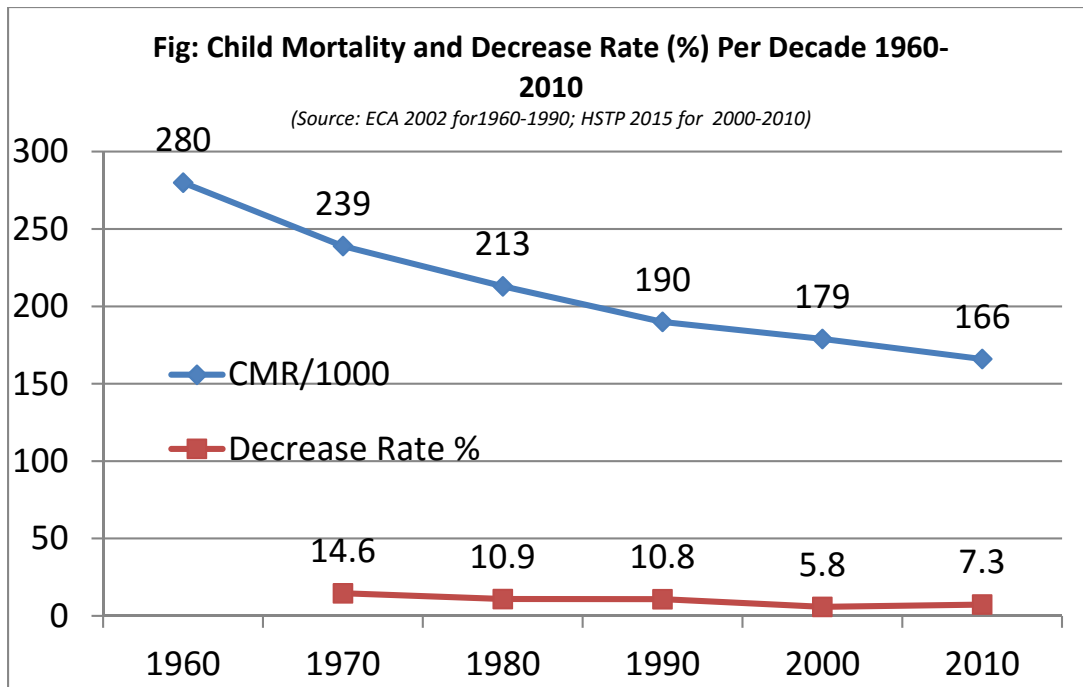
"Indeed all our pasts are present"  
Kickbusch 2004

### 2.1. 'Plus ça change'

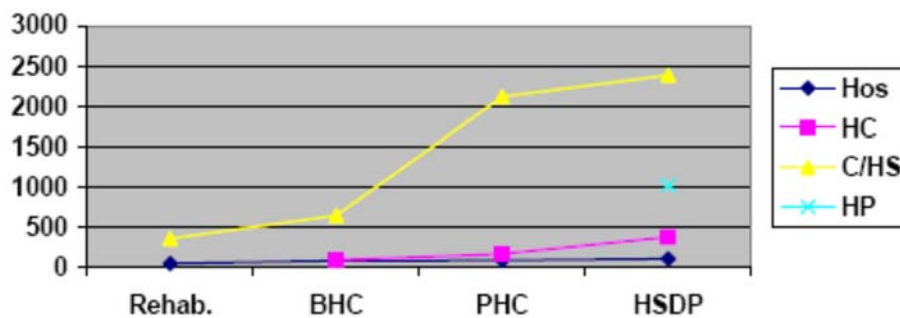
'Plus ça change', as the French say, 'plus c'est la même chose'. [*The more things change, the more they are the same (loose translation)*]. Public health policy in Ethiopia clearly shows recurrent themes in all periods. We note definite attraction for foreign medicine - their potions and 'magic' in 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 early on, at least from 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 process in the different periods. Thus comprehensive/integrated services had different connotation during the BHS, PHC and SWAp periods; decentralization had different configuration during Haile Selassie, the Derge and EPRDF regimes but the intentions/goals were, at least from the health care perspective, similar.

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 hurried 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 and human resources have grown over the years (Fig 1). 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 (Fig ). Life expectancy remains low. 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 ca change*' phenomenon.

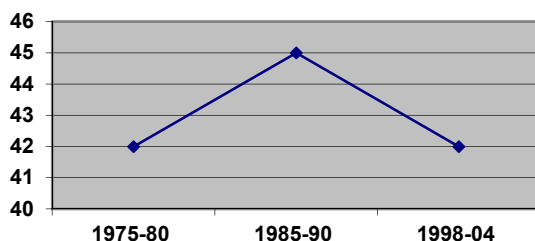


**Evolution of Health Facilities 1941-2002, by Period**



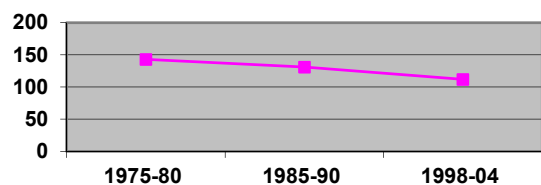
**Fig: Life Expectancy at Birth , Ethiopia 1975-2004**

(Source: Adapted from PEFA 2007)



**Fig: Infant Mortality Rate, 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, is negligible, given the enormity of the task and the rapid rate of population growth.

## 2.2.A vision for the next 50 years<sup>7</sup>

Ethiopia celebrated its Millennium in 2007, 7 years after most others. We know that for many years now many countries have undertaken a lot of studies on the prospects for the 21<sup>st</sup> century<sup>8</sup>.

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

As it has been attempted in various countries, we should try to assimilate and adapt to our reality a vision and mission of public health for the new Millennium. The health workforce<sup>9</sup> plays a critical role in appraising and attaining this vision. Ethiopia has for long been following the various paradigm shifts of the powers that be! Even though it is difficult and 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.<sup>10</sup>

### Response by the health sector

Ethiopia’s health sector would have to respond to the various challenges of the times: 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.

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. Most of the technologies used now were invented or discovered in the last few decades. Major break-throughs are expected in nano-technology, gene therapy and the like. These technological developments offer both opportunities and challenges; one example, the temptation to introduce vertical programs to implement new technologies.

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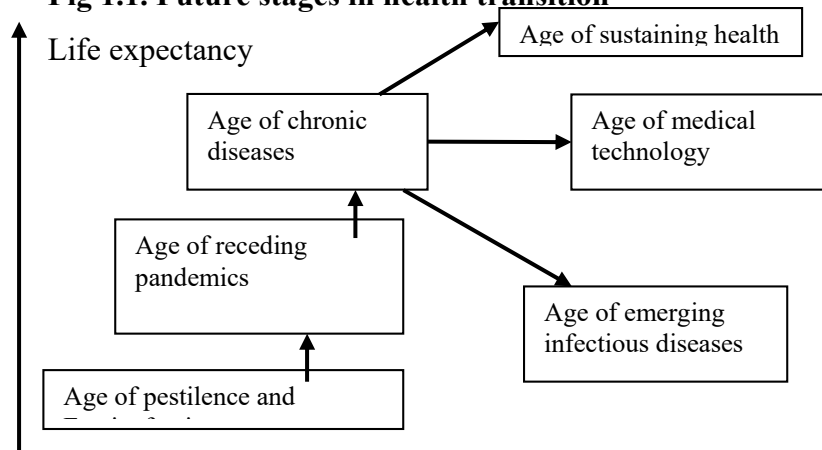
<sup>7</sup> As we have tried to indicate in our book on HRH in Ethiopia, planning, even for the next ten years, is fraught with a lot of uncertainties; the more so in the current era of technological revolution with “Much of the jobs we know today will not be around, either done differently or replaced altogether” (Nazarian 2014). “The need [therefore] to develop a high tolerance for ambiguity and a readiness to redirect or adjust our course with the changing environment” (Hoffman).

<sup>8</sup> Most of these have now been revised because of the rapid pace of changes, technological in particular which has been likened to a tsunami (Schwab 2016)

<sup>9</sup> Health workforce/providers “refer to lay workers, nurses, pharmacists, dentists, physicians and allied health professionals all of whom provide direct care for patients” (WHO 2005)

<sup>10</sup> 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.

**Fig 1.1. Future stages in health transition**



Source: Martens & Huyen 2003

Mega-trends – ‘large-scale trends’ - that are bound to affect the health worker training, the health system in general in Ethiopia and the world (AAMC 2007) - 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<sup>11</sup> with serious associated issues of brain ‘drain/gain’ – should be monitored and proactively strategized (AAMC 2007, Juma 2006, Lurie 2006, IDRC 2006, WHO 2005, Martens & Huyen 2003, WHO 2000b).

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<sup>12</sup>.

The existing health service will have serious problems responding to these challenges. Hence, important task that is related to reflections in 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. Even though the problems and hazards with such long perspectives are clear (Attali 2006, Futursafraicain 2001, GAC 2012), the long term view required for effective health development should not shirk such a challenge.

Health and HRH spill over sectors other than health defined narrowly. “Problems with human resources for public health and health care ... invariably extend beyond the narrowly defined health sector, beyond a single level of policy purview and, increasingly, across borders: this raises the benchmark terms of working effectively across government and stakeholders” (WHO 2008).

### **3. ‘Constants’ of the Ethiopian scene (war, poverty, famine, demography...)**

<sup>11</sup> For issues in globalization and health in Africa see Kitaw & Hailemarim 2012

<sup>12</sup> For evolving issues on health care financing see Evans & Etienne 2010; for issues in the liberal-orthodoxy see Bourdieu 1998, Stiglitz 2003.

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” (NIC 2004).

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 must therefore be contexted and nuanced while we draw the lessons.

#### **4. Traditional medicine**

Several aspects of traditional medicine 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<sup>13</sup>. Policy level recognition (Health, Science & Technology ... policies) is also high in the SWAp period but TM is quasi absent from HSDP<sup>14</sup>, the coordination office has been downsized and tacked in a research institute. 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.

### 5. 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 (Fig 2 & 3). Interestingly, most of the foreign contacts since Emperor Yohannes 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 the policy focus on prevention and control. All the plans (2<sup>nd</sup> and 3<sup>rd</sup> Five-Year plans<sup>15</sup>) imperiously put prevention and control at the center of the public health effort. A Minister could thus say that prevention was "the guiding principle of the Ministry of Public Health" (Ketema 1971). However, the curative facilities orientation persisted and vertical programs distracted from the more comprehensive and sustainable preventive and control measures. 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<sup>16</sup>. Health services, preventive in particular, have little improved at the end of the period and the hospital/urban bias of resources persisted.

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

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<sup>13</sup> 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 37<sup>th</sup> World Health Assembly, May 1984. Special Issue: The Ethiopian Journal of Health Development. 2(2): 1-75.]

<sup>14</sup> The HSTP (2015) 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.

<sup>15</sup> The 2<sup>nd</sup> Five-Year Plan clearly articulates the "we cannot afford to expand hospitals, therefore focus on prevention" argument so dear to policy formulators even today (IEG 1962).

<sup>16</sup> In a thesis researched in 1966 and defended in 1968, [Yayehyirad Kitaw (1969) Eradication du Paludisme en Ethiopie. Etat Actuel. Thèse, Faculté de Médecine, 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).

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 I<sup>17</sup>. The policy, strategy and HSDP I 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. 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 loser 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 etc. 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 in Ethiopia.

HSDP II and III have gone a long way in terms of the very rapid deployment of the 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.

## **6. Comprehensive/integrated health care**

Comprehensive/integrated<sup>18</sup> 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. MES and Smallpox Eradication Program. 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.

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<sup>17</sup> The Health Extension Program, which is touted as introducing a paradigm shift in this connection, is outside the period of our study.

<sup>18</sup> For various concepts/definitions of integration, see Shigayeva et al 2010.

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<sup>19</sup> has grown rapidly, the resources shift towards functioning HC and HS/HP<sup>20</sup> 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 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<sup>2</sup>. 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 us how intricate the issues are<sup>21</sup>. 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.

## 7. 'Decentralization'

Decentralization<sup>22</sup> has been considered a key strategy in all, at least the post world war, periods. Decentralization was considered during the Reconstruction Period but was declared inoperable because 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.

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<sup>19</sup> Not really as part of PHCU in most cases but as stand-alone services approximating the previous HS.

<sup>20</sup>The launching of HEP in HSDP II holds better promises along these lines (see above).

<sup>21</sup> The problem of categorical or highly specialized approach leading to policies and programs addressing the needs of a specific population, illness etc overshadowing a comprehensive approach continues to plague health care even in the most advanced countries (for USA, see Boufford & Lee 2001).

<sup>22</sup> Note that decentralization, with differing connotations in differing context, 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 (WB 1998, Bossert 2000). 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.

During the BHS period, some embryonic measures were taken in what was called decentralization - more in the form of deconcentration - 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 SWAp 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 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 RHBs. 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 ZHDs.

This was followed by the 2<sup>nd</sup> 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 WHOs 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 Wereda Health Offices (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 implementing 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<sup>23</sup>.

### **8. Inter-sectoral/multi-sectoral approach?**

It is generally accepted that a wide range of factors determine the health of a population, many of which are beyond the remit of the Ministry of Health. 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<sup>24</sup>. 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 intersectoral 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”<sup>25</sup>.

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 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

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<sup>23</sup> Various studies have shown that decentralization per se is not a panacea (Bossert 2000).

<sup>24</sup>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... (Keane et al 2006).

<sup>25</sup> Note no mention of the economic sector – agriculture etc

most of the training of health workers has gradually been moved to the education sector. The HIV/AIDS response has, to a degree because of international partners' pressure, become 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).

### **9. 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" (Editorial 2012). 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<sup>26</sup> as compared, for example, most African countries.

The role of missions/NGOs has been preponderant in health services from 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 curative hospital or clinic based 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.

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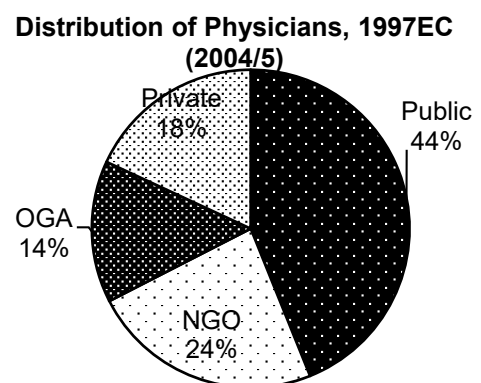
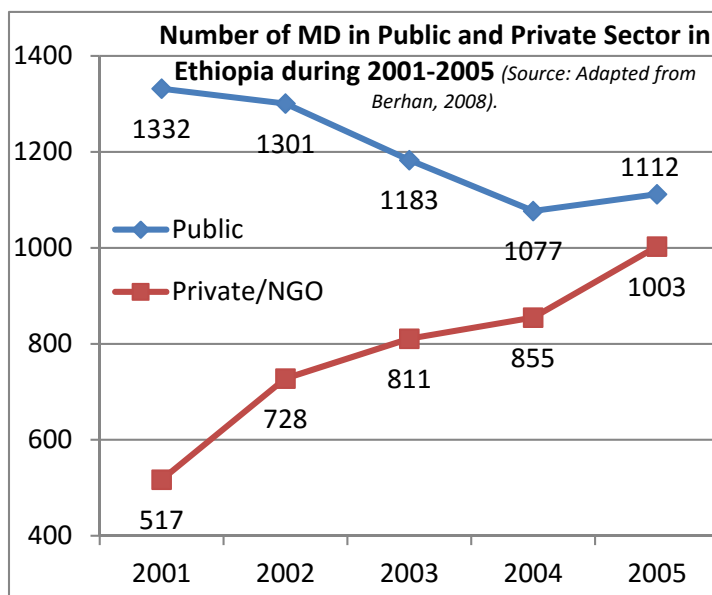
<sup>26</sup> Personally, I have always believed that health care (preventive and curative) is a public good and therefore should predominantly remain in the public domain.

Consequently, a number of workshops were held, in collaboration with WHO, about the end of the period to smoothen relationships and expand their participation<sup>27</sup>.

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 ones (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 persists 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.



<sup>27</sup> Note that (by coincidence?) the 1st missionary health services were started by the Swedes and the promoters of these workshops were Swedish advisors in the MOPH.

## 10. Management and M&E [supervision]

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

The 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 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. In fact, most departments now function with support in human resources by UN agencies<sup>28</sup>.

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

## 11. 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. There are also problems of equitous distribution, inappropriate staffing, personnel administration, career structures and incentives. More recently, there is the issue of 'attrition' to the private sector and, more ominously, the problem of brain-drain<sup>29</sup>. 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 turnover 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<sup>30</sup>.

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<sup>28</sup> The implications of the current practice of filling the gaps in MOH structure by UN (WHO, UNICEF...) employed staff should be critically assessed.

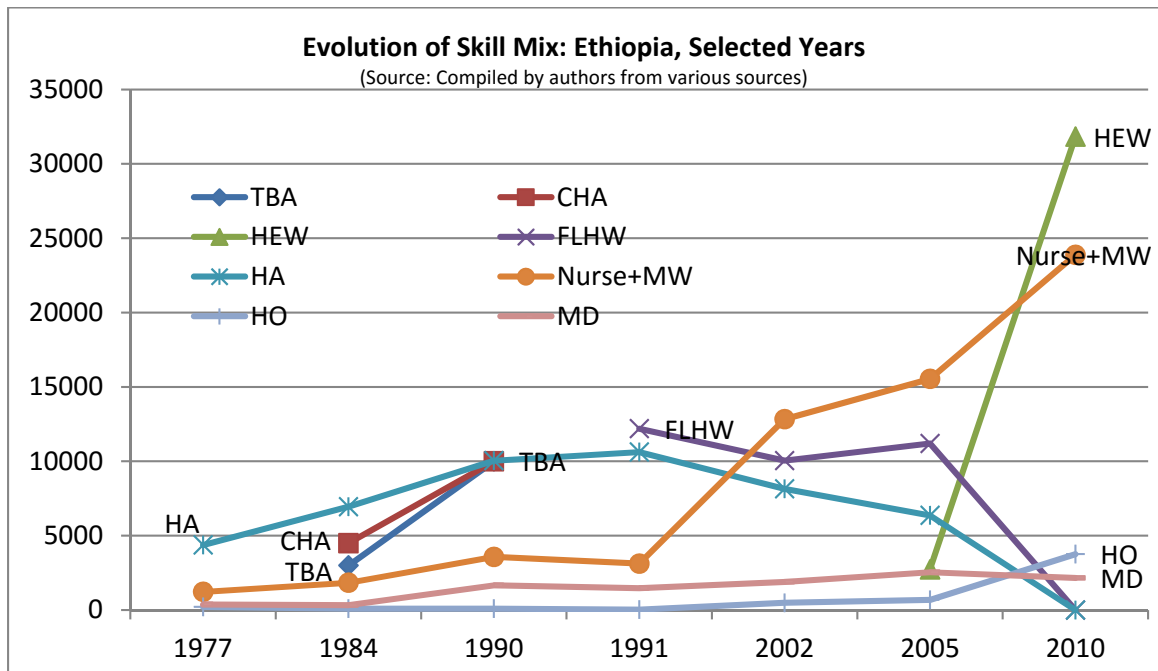
<sup>29</sup> The enormity of the challenge could be gleaned from the fact that the current worldwide shortage of 7.2 million health workers is projected to reach 12.9 million by 2035 (Editorial 2016).

<sup>30</sup>For more elaborate exploration see Kitaw et al 2012



Creating substitute categories/task-shifting started early in the ‘modern’ era with dressers substituting for nurses. Later the Gondar Team 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 (Fig).

All periods also embarked upon very ambitious acceleration programs of training often with major concerns expressed on 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 proving that there are no quick fixes to the intractable problem of HRD in the context of countries such as Ethiopia.



## 12. The health information management system

The **health information management system (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. Feedback was rare and at the 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.

### **13. Health Care Financing**

Funding of plans in all periods relied heavily on external (donor) input 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. 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 to 159 per cent of GNP (1997), and while 0.9 per cent of GDP was spent on health care, 2.3 per cent was spent on paying interest on external debt (1991-97)<sup>31</sup>. ODA to Ethiopia is in decline. It fell from 20.6 per cent of GNP to 10 per cent (1991-1997). Of the total aid receipts, disbursements for health amounted to 5.7 per cent, and human-resources development to 8.6 per cent. External assistance to Ethiopia's recurrent expenditure budget is 2.3 per cent of domestic resources and makes up less than 1 per cent of most regional recurrent budgets. 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.

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 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" (Kickbusch 2004) are more promising. However, it will be naïve to believe that they will be free from conditionalities [see Stiglitz 2003] and will not flounder on the perennial issues of democracy and governance; civil strives; external aggressions...

### **14. 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 endeavours. Shaping Ethiopia's health system in a globalizing world implies some visualization of what the future holds.

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 (The World We Want 2013). In looking to the past to inform the future, it is important to draw the

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<sup>31</sup> HIC initiatives have, to a degree, reduced the burden but the basic issues of dependence remain.

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” (The World We Want 2013). 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 (Martens & Huyens 2003, AAMC 2007).

Thus, we should anticipate not only increases in the population but major changes in its composition and structure – increased urbanization, epidemiologic transition/‘double burden’... It is close to absolute certainty that Ethiopia’s population will be over 100million by 2030. Almost inevitably, the urban population will grow at very rapid rate, probably reaching 30% by 2030<sup>32</sup> 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 (Rice & Rice 2009). 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 (WHO 2005, Maher et al 2010). Thus we should plan to meet these challenges while trying to reap the potentials of the ‘population bonus’.

The role of information technology in health care is bound to become pervasive. As we hopefully move towards a middle income country status, the delivery and financing of the health system is bound to evolve. 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 will continue to influence health care in Ethiopia in pervasive ways requiring the development of innovative ‘negotiating’ capacity (Kitaw and HaileMariam 2012).

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<sup>32</sup> It should be recalled that world wide this is now over 50%.

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” (Meacham 2008, for related issues in Ethiopian historiography, see Zewde 2008). Thus, even though we have tried to be as comprehensive as possible as recommended for such an assessment (Nyoni et al 2008) 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.

There is growing recognition that a strong health system is an essential element of a healthy and equitable society (Backman 2008). It seems clear that, even though palpable headways have been made in recent years, translating this recognition into sustainable development faces challenges (WHO, CMH 2001, Social determinants). Ethiopia is well placed as a potential candidate for achieving MDGs fast-tracking (MOFED and UN Country Team 2004, UN Development Project 2005). It has embarked, as part of the worldwide phenomenon in the 1990s (Alwan & Hornby 2002) 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 (Bossert et al 2007, Kitaw et al 2012).

“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*

However, it is also recognized that HRH in Ethiopia as in many parts of the world, is in crisis (WHO 2006, Nayoni et al 2008, Kitaw et al 2012). Undoubtedly, “the most critical issue facing health care systems is the shortage of the people who make them work” (Bossert et al 2007).

Some attempts to look into the future has been made but thought-through future scenarios for Ethiopia have yet to be developed. Lessons could be drawn from attempts in the USA (NIC 2004) and Europe (Genesotto & Grevi 2007) 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.

The task would not be easy but the alternative “driving fast blind folded” would be pure madness (Futurs Africains 2001). It requires expanding the scope of evidence-based policy on which political decisions are justified through lessons from the past (Robert et al 2012). Grand plans however perceptive are only 5-10% of the policy process; the rest is policy adoption and implementation (Gauld 2011). 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 advise the government on the way forward.