

Final Essay
5/24/82

Health Services - cont

Plan - cont

Health Resources -

Ethiopia

HSR/ETHIOPIA/82.1

DRAFT

INDEXED



Working Group

HEALTH SERVICES RESEARCH
IN SUPPORT OF PRIMARY HEALTH CARE
Report of a Working Group on Ethiopia

in Ethiopia

Sweden
WHO Collaboration
Addis Ababa, 18-27 January, 1982

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1. Introduction

Based on the exchange of information among the Ministry of Health of Ethiopia, the Ethiopian Science and Technology Commission, WHO, SIDA and SAREC on the development of Health Services Research in Support of Primary Health Care in Ethiopia a working group was established. The group that consisted of a national team, and representatives of SIDA, SAREC and WHO met from 18 to 27 January 1982 in Addis Ababa, Ethiopia. The list of participants appears in Annex I.

The aim of the meeting was to identify priority areas and gaps in health services research in support of the Ethiopian strategy of HFA/2000, and develop the necessary programme of health services research including resource requirements. The main goals of Ethiopian health research are to generate scientific information that could be utilized in the formulation of policies, planning, programming and organization of health system based on PHC to achieve HFA/2000; and through the organization and conduct of research, to enhance national capabilities in HSR in order to ensure self-reliant and non-dependent development.

To have a common understanding, the working group reviewed briefly the programmes supported by SIDA, SAREC and WHO and their working arrangements. This was followed by a discussion on the present situation and development in relation to the Ethiopian health services development, the National Health Development Network (NHDN) and UNICEF/WHO Joint Support to Governments for Implementation of PHC (JCHP, "Study"). Furthermore, the organization of the ESTC and its Health Research Council, their policy and the scope of health services research was taken up for discussion. To review and develop further the 24 projects proposed by the nationals in the working group a format was agreed upon and three sub-working groups set up.

The working group, in plenary, considered the management and coordinating mechanism for health services research, ways and methods to increase national capabilities and considered the proposed projects, based on the following criteria:

1. Short in duration and specific in scope. However, the need for selected long-term projects should be recognized.
2. Fact finding and exploring of existing condition in order to identify problem areas.
3. Should be complementary - in order to maximize resource utilization.
4. Should be multidisciplinary in nature.
5. Should have community involvement as much as possible.
6. It should whenever possible be within the technical capability of involved personnel and institution.

2. Review of the present situation and development

2.1 Health care system

Health services in Ethiopia prior to the 1974 popular revolution were primarily institutionalized and disease oriented. As a result it did not meet the health needs of the population. After the 1974 Revolution the Government of Revolutionary Ethiopia, realizing the enormous health needs of the population, considered health as one of the priority areas and clearly stated in the National Democratic Revolution Programme that health is the right of every individual. In line with this programme the Ministry of Health reorganized its health services priority and its administration system. The priority setting in the health services was guided by the basic principle to meet the health needs of the population with maximum coverage in the shortest possible time.

Some of the areas of emphasis include:

- The underserved rural population
- Preventive health services
- The control of communicable diseases
- Maternal and child health care.

While Ethiopia was rearranging its priorities and decentralizing the health services administration, the global strategy of PHC for HFA was developed and Ethiopia adopted this strategy of PHC since it further strengthened her effort towards the goal HFA/2000. To this effect a national policy of PHC strategy for HFA/2000 in the Ethiopian context has already been developed.

Ethiopia with an estimated population of 32 million is divided into 15 administrative regions with Addis Ababa as the fifteenth region. Each region has a Regional Health Department. The regions are further divided into Awrajas (Provinces) and Woredas (Districts). Below the Woredas exist units governed by the people's organizations known as Farmers' Associations, and Urban Dwellers' Associations (Kebeles).

The health service facilities in Ethiopia today include 86 hospitals, 127 health centres and 1430 health stations. The plan calls for the construction of two rural hospitals, 20 health centres and 200 health stations annually to achieve a "coverage" of 85% by 1990. Of the 86 hospitals, 13 are central referral hospitals, 14 regional hospitals located in the regional capitals and 59 rural hospitals.

The health centres are located in rural and semi-rural areas. Health centres are staffed by nurses, health officers in some places, laboratory technicians, health assistants and sanitarians. The long-term plan is to assign medical doctors to the health centres. At present it is these health units that are training Community Health Agents (CHA) and Traditional Birth Attendants (TBA).

The health stations are located at the peripheral levels and are staffed by health assistants. At present, the health stations are staffed by one health assistant, but the plan calls for three health assistants per health station to strengthen and widen the outreach of the health unit. The health assistants in the health stations are the immediate supervisors of the CHA and TBA.

At the community level (Farmers' Associations and Urban Dwellers' Associations), there are trained CHAs and TBAs serving the population. CHA and TBA are trained for three months and one month respectively. Their training and service is primarily in the areas of Mother and Child Health, Health and Nutrition Education, Control of Communicable Diseases, Environmental Health and First-Aid. Although as mentioned above they are technically supervised by the health personnel, administratively they are responsible to their associations and they are compensated for their service by their association as well.

So far there are about 2400 Community Health Agents and about 1600 Traditional Birth Attendants that are trained and deployed. The plan is to have one Community Health Agent and one trained Traditional Birth Attendant for each Farmer Association and Urban Dweller Association by 1990 through training and deployment 3500 of each category every year. This arrangement of the health care delivery system which is a six tier system with the community health service at the base then the health station, health centre, rural hospital, regional hospital, regional hospital is to ensure maximum coverage with the essential services in the shortest possible time within the country's limited resources. This is further strengthened by a systematic referral and supervisory mechanism to meet the health needs of the population and thereby reduce the high mortality and morbidity.

This reorganization of the health care system requires a regular and systematic monitoring and evaluation. Although attempts are made to measure coverage, impact etc., there is a need for more systematic development of health services research. Accordingly the Ministry of Health plans to establish a Health Services Research Unit at the headquarter level. The establishment of the National Health Development Network (NHDN) can be also considered as an important additional mechanism to facilitate HSR.

2.2 Ethiopian Science and Technology Commission

The Ethiopian Science and Technology Commission was established in 1975, under the Council of Ministers to guide, coordinate, assist, encourage research and development for the achievement of national social and economic goals.

2.2.1 Health Research Council

The Health Research Council is one of the six Research Councils in the Ethiopian Science and Technology Commission. The Council after preparing policy, programme and priorities on Health Research and Development has subsequently, been working on health services research.

Among other functions the major responsibility of the Health Research Council is policy formulation and establishing priorities in the area of research and development. It also provides a forum for interested institutions to participate in research and development.

In January 1980 the Health Research Council of the Science and Technology Commission developed the research and experimental development policy on health.

Based on these policies and programme developments a collaborative ESTC/SAREC project was initiated. One example of this collaboration of considerable importance for HSR is the Butajira Rural Health Research Project, initiated in 1980, and the establishment of data processing facilities for epidemiological and clinical research.

The Butajira project initially aims to perform a census and continuous surveillance of vital events in the Butajira Woreda as a basis for further research projects. The Butajira project will also serve as a close reference to a micro-computer project, in which appropriate data processing technology, including hardware, software as well as training packages, will be developed and tested in the field situation.

2.2.2 Health Services Research

The Sixth Sub-Committee of Health Services Research of WHO/ACMR took place in Addis Ababa from 18 to 21 November 1980. Following the participation of Ethiopia in the sub-committee the need of HSR in Ethiopia was realized. The Health Research Council invited the Ministry of Health, the Medical Schools of Addis Ababa and Gondar and health research institutions to a national workshop to examine HSR in the Ethiopian context. The workshop took place from 2 to 5 July 1981 and formulated HSR scope and policy, policy guidelines priority programmes for study. The draft report of this workshop is attached as Annex III.

The highlights of the report are as follows:

(a) Scope

HSR includes the critical evaluation of current health status and health services, the design of alternate health care delivery systems, the implementation of such systems and the evaluation of the effectiveness and efficiency of alternate designs of health care delivery.

(b) Policy guidelines

- (i) In as much as PHC is the main strategy for the attainment of HFA/2000, HSR should assist the development and implementation of effective and efficient PHC programme.
- (ii) HSR should be based on multisectoral approach with the participation of professionals from all relevant sectors of the economy as well as of personnel within the health decision machinery and representatives of the community.
- (iii) HSR should be carried out at all levels of the health care delivery system.
- (iv) As many alternative methods as possible should be utilized in communicating the result of HSR in order to ensure immediate implementation.
- (v) A given HSR should address itself to comprehensive evaluation of health care delivery system including evaluation of existing knowledge and know-how, the health care design (structure, manpower and funding) and the efficiency and effectiveness of health care.

2.3 National Health Development Network

The strategy for health for all should encompass the whole health system, other health-related institutions and sectors. A coordinating mechanism to bring together the health institutions in harmony to support the intersectoral nature of PHC and to facilitate the implementation of a national health strategy should be developed. Such mechanism has been identified as NHDN and is seen as an institutional arrangement whereby a country can mobilize, organize, coordinate, and strengthen its own technical capacities to meet the challenge of achieving health for all by the year 2000.

In Ethiopia this mechanism has been developed recently with support of WHO. The Department of Community Health of Addis Ababa University was designated as nucleus (secretariat) of NHDN. Fourteen departments, institutions and bodies are part of the network and participating in the NHDN Committee and performing related functions. NHDN would be the technical arm of the national policy bodies and will provide information for policy decisions. A working document that covers eight major areas of functions, assigned responsibilities, organizations and commitments of NHDN, WHO and UNICEF, support has been prepared. This proposal was submitted to the Central Planning Supreme Council for approval. It was approved and the NHDN Committee had its first meeting in December 1981 to implement the mandate. A health development Newsletter and a Journal will be developed to disseminate information.

Health Services Research is one of the eight major areas for action and institutions involved in this area are: Central Planning Supreme Council, Health Research Council, Ministry of Health, Ethiopian Nutrition Institute, Public Health College, Gondar, National MCH Centre, Health Science Centre at Jimma, Institute of Pathobiology, Institute of Development Research and Department of Community Health of AAU.

A brief summary of responsibilities, organizations and functions of the NHDN is given in Annex IV.

2.4 UNICEF/WHO Joint Support to Government for the Implementation of Primary Health Care (JCHP "Study")

Ethiopia has been selected by UNICEF and WHO as one of the countries eminently suited to conduct a study on the implementation of primary health care. This was an outcome of the report on the Twenty-third Session of UNICEF/WHO Joint Committee on Health Policy (JCHP), held in February 1981, which has recommended that "Substantial support to be provided over the necessary periods of time to those countries with clear national commitment to put primary health care approach into practice". The aim and scope of the exercise was to ensure the development of PHC in a concerted effort and to accelerate implementation in selected countries. To develop further and ensure the implementation of a national strategy for health for all, a certain critical mass of people is required who are able to formulate such a strategy, carry out the necessary planning, programming and budgeting, ensure the implementation of strategy, monitor it and evaluate it.

A preparatory briefing consultation on JCHP "Study" has taken place with WHO and UNICEF representatives of Ethiopia. The formalization process will take place soon in order to develop a plan of action and specify the necessary steps for its implementation.

Joint collaboration in Health Services Research in Ethiopia, under discussion, should be utilized as an input in the overall PHC implementation efforts.

3. Institutional frame for HSR collaboration

3.1 Administrative mechanisms

The NHDN will be the responsible body for this collaborative programme on the Ethiopian side. The NHDN shall establish a Health Services Research Sub-committee, chaired by the Health Research Council, to act as its technical arm for this programme.

The following alternatives are presented with regard to the arrangements concerning WHO/SIDA/SAREC collaboration with the NHDN.

1. Each organization deals separately with the NHDN through the existing government channels. The working group suggests that this mechanism not be followed for this HSR collaborative programme because it is cumbersome and will work against the objective of the programme.
2. Either WHO, SIDA or SAREC acts as the executing agency for the international support. This has an advantage but seems to need much further negotiations.
3. The NHDN deals directly with each agency for implementation. This seems to be the best mechanism at the present moment.

Whatever alternative is chosen the following arrangements are needed:

- (i) There should be a common format for project presentation and reporting.
- (ii) The NHDN should present requests to all outside collaborators at the same time each year.
- (iii) There should be periodic meetings of WHO/SIDA/SAREC/Ethiopian teams of experts to review activities, coordinate efforts, and make recommendations pertaining to the HSR Collaborative Programme. The NHDN-nucleus will prepare a progress report which will be the basis for its review. The next meeting should take place in January 1983.

3. Policy considerations

In order to facilitate the implementation of this HSR Collaborative Programme, the working group suggests that:

1. The Government shall provide resources for HSR in the form of salaries of the participating national staff, office space, and other administrative support. In addition, in due course, the Government shall make budgetary allocation specifically for HSR.
2. The Government shall relieve from their routine work civil servants from the various participating institutions and departments in order for them to do HSR.
3. The Government shall make all efforts to facilitate that HSR projects are carried out during the time specified in the protocols.
4. The Government shall make special effort to develop the necessary manpower for HSR. An important effort in this area should be the inclusion of HSR concepts, methods and practice in all health training programmes.
5. This collaborative programme in HSR should foster participation in the spirit of equality and partnership, of experts and institutions and could, in the future, include other international and bilateral organizations.
6. WHO/SIDA/SAREC shall consider the establishment of a mechanism for a better coordination of efforts for this collaborative programme.
7. The collaborating organizations/countries should utilize this HSR Collaborative Programme for TCDC.
8. WHO/SIDA/SAREC should make the necessary financial allocation and other arrangements so that the implementation of the collaborative programme should begin as soon as possible.

3.3 Time frame. The collaboration and allocation of resources for these projects will be for 1982-1983 biennium. A review for its continuation will be carried out at the end of this period.

4. Project proposals

4.1 List of projects

The national team had drafted 24 project proposals, grouped in 11 areas, for consideration by the working group. After studying these, five were deferred for support by other mechanisms, and 14 were further developed by the working group.

The titles of the 19 projects were as follows:

Area Health Services Activity Area

No.

1. Studies on the organization and management of the health care system

Project No.

1. Financial analysis of health section
2. Time budget
- 3.^a Study alternative for support and referral in PHC
(this could be considered as part of Area 3 Minimum Package Requirement)
4. Health services coverage

^a This project should be developed or be considered under other projects as identified.

- | <u>Area No.</u> | <u>Health Services Activity Area</u> |
|-----------------|---|
| 2 | <u>Identification of health measures</u> <ul style="list-style-type: none">5. Geography of health and diseases6.^a Health indicators in MCH
(was considered as part of other projects) |
| 3 | <u>Defining minimum health services requirement</u> <ul style="list-style-type: none">7. Minimum package requirement for effective and efficient delivery in PHC |
| 4 | <u>Traditional medicine</u> <ul style="list-style-type: none">8.^a To be developed |
| 5 | <u>Manpower study at the peripheral level</u> <ul style="list-style-type: none">9.^a Should be considered with Area 3
(minimum package requirement . . .) |
| 6 | <u>Studies of community participation</u> <ul style="list-style-type: none">10. Case study of community in health |
| 7 | <u>Intersectoral participation in health</u> <ul style="list-style-type: none">11.^a Governmental administration arrangements for effective intersectoral coordination |
| 8 | <u>Studies on logistical problems in the delivery of supplies and equipment</u> <ul style="list-style-type: none">12. Drug supply in the community health services13. Existing mechanisms of drug supply in Ethiopia
(pilot study) |
| 9 | <u>Studies on health technology for disease control^b</u> <ul style="list-style-type: none">14. Control of syphilis15. Tuberculosis control16. Expanded programme of immunization |
| 10 | <u>Methodological studies in health services research and development</u> <ul style="list-style-type: none">17. National integrated household survey, health component18. A study on risk approach in the delivery of MCH/FP |

^a These projects should be developed or be considered under other projects as identified.

^b Five projects in these areas (two malaria, one bilharziasis, one typhus and one control of diarrhoeal diseases) were considered for possible support by TDR and CDS of WHO and other agencies interested.

Area Health Services Activity Area
No.

11 Institutional support (capacity building)
 General support

19. Support for Health Services Research
 and development capacity building

4.2 Resource requirement

The individual projects were considered in some detail by sub-working groups, members chosen according to their expertise. An agreed format was used in these elaborations. Whenever possible a principal investigator was identified and otherwise an institution was designated. A preliminary costing of the projects was done using the best available information as to price of each trust. It was of course obvious to the working group that all the projects had to be further developed particularly as to their methodology. For some of the projects there are detailed protocols, available from WHO or other sources, which could be adapted. However, for most of the projects the principal investigator has to allocate time for this important component of the projects. A few of the projects on the other hand could be implemented immediately and it was repeatedly emphasized that this was of extreme importance for the success of this collaborative programme in HSR.

The site of the projects has usually not been identified. The working group considered the advantage of pooling the resources in the initial phase and thus making the projects complementary and also easier to coordinate. This has to be weighed against the problem of developing a field research area with extra resources that can not be replicated elsewhere.

The general support for national capability strengthening in HSR is described as project No. 19. It includes employment of a financial manager at the nucleus of NHDN, training inside and outside the country, further development of documentation capacity and supplies and equipment. The cost is divided into local and foreign cost and furthermore a provisional allocation of support from WHO, SIDA and SAREC was attempted, pending availability of funds and approval of the relevant authorities. A similar subdivision was also done for the individual projects. The grand total for 1982-1983 calculated in this way is around one million US\$, half of which falls on institutional capability strengthening. A summary table (Table 1) follows below.

TABLE 1

SUMMARY OF HSR COSTS 1982-1983

(In Ethiopian Birr; one Birr equivalent to about US\$ 0.5)

Project No.	Total cost ^a	Local cost ^b	Total foreign cost ^c	Foreign cost subdivided ^d		
				SIDA	SAREC	WHO
1	70 000	30 000	40 000	40 000		
2	225 000	135 000	90 000		90 000	
4	46 000	46 000	-			
5	34 000	34 000	-			
7	36 000	36 000	-			
10	11 000	11 000	-			
12	25 000	25 000	-			
13	10 000	10 000	-			
14	256 000	171 000	85 000			85 000
15	73 000	58 000	15 000			15 000
16	121 000	61 000	60 000			60 000
17	30 000	20 000	10 000		10 000	
18	225 000	165 000	60 000			60 000
Sub-total	1 162 000	802 000	360 000	40 000	100 000	220 000
19	885 000	286 200	598 800	237 000	99 800	262 000
Grand total	2 047 000	1 088 200	958 800	277 000	199 800	482 000

^a It is estimated that the Ethiopian contribution to this Collaborative Programme, in kind, would be 40% of the total.

^b Contribution by WHO, SIDA, SAREC in local currency.

^c Contribution by WHO, SIDA, SAREC in foreign currency.

^d Provisional subdivision of this column into three agencies subject to further discussion and approval.

5. Conclusion

The working group agreed to propose a two-year Collaborative HSR Programme in support of PHC in Ethiopia. The report of the working group should be submitted as soon as possible to the relevant authorities. New mechanisms have to be established both within the country and between the collaborative organizations to facilitate an early implementation of this programme. The support to strengthen national institutional capability is urgently needed. The Programme should foster participation in the spirit of equality and partnership.

ANNEX I

LIST OF MEMBERS OF WORKING GROUP

National Team

1. Ato Solomon Ayalew - Expert, CPSC and Member Health Research Council
2. Dr Tewabech Bishaw - Head, MCH Services Coordinating Office - MOH and Member Health Research Council (Co-secretary of Working Group)
3. Dr Yayehyirad Kitaw - Head, Department of Community Health, AAU
4. Dr Nebiat Tafari - Chairman, Health Research Council, Ethiopian Science and Technology Commission, Team Leader (Chairman of Working Group)
5. Ato Estifanos Tekle - Expert, MOH and Member Health Research Council
6. Ato Fekade Tsegaye¹ - Head, Health Department, Water and Land Study Authority, National Water Commission

SIDA

1. Mr Hans Ehrenstråle - Head of Section, Health Division

SAREC

1. Dr Lennart Freij - Research Officer
2. Dr Stig Wall² - Consultant Associate Professor, Department of Preventive and Social Medicine, University of Umeå, Sweden

WHO

1. Dr M. Boal - Regional Officer (MCH/HRP), WHO Regional Office for Africa, Brazzaville, Congo
2. Dr Haile Mariam Kahssay - National WHO Programme Coordinator
3. Professor S. Oforu-Amaah² - Temporary Adviser, Member ACMR and ACMR Subcommittee on HSR/MCH. Professor, Community Medicine, Medical School, Accra, Ghana
4. Dr E. Shafa² - Medical Officer, Expanded Programme on Immunization, WHO headquarters, Geneva, Switzerland
5. Professor G. Sterky - Secretary ACMR Subcommittee on HSR/MCH, Professor, HSR, Swedish Medical Research Council, Stockholm, Sweden
6. Dr I. Tabibzadeh - Medical Officer, Division of Strengthening of Health Services (Co-secretary, Working Group) WHO headquarters, Geneva, Switzerland

¹ Unable to attend.

² Attended second week of Working Group.

INDIVIDUAL PROJECT DESCRIPTIONS

Project No. 1

I. PROJECT TITLE: Financial Analysis of the Health Sector
A Nation-Wide Study

II. PRINCIPAL INVESTIGATOR: Solomon Ayalew

Collaborating Institutions/Investigators:

- Ministry of Finance/Azeb;
- Ministry of Health - PPB/Haddis;
- WHO/SHS, Documents;
- SIDA - 16 weeks STC.

III. OBJECTIVES

The overall objective of the study is to determine the total funds allocated to various aspects of health development and services in Ethiopia over a five year period (1976-1980). Specifically the study aims to determine (identify):

- (a) the source of funds e.g. Ministry of Health, other government ministries and agencies, the military and police, the private sector, the communities, foreign aid, etc.;
- (b) allocation/expenditure ratio for selected items e.g. drugs, medical equipment and supplies;
- (c) comparative expenditure between aspects of health development/services (capital/recurrent, medical care/F.H. services) and allocations;
- (d) trends in utilization including shifts between allocations during the budget year.

IV. SIGNIFICANCE AND RATIONALE:

It is not known what amounts of total resources are spent on health in Ethiopia and how these are distributed.

Data derived from the study will help in the design of mechanisms for resource generation, allocation and monitoring resources utilization.

V. METHODS

- (1) Prepare an exhaustive list of all sources of health expenditure in Ethiopia;
- (2) Prepare list of categories of major aspects of health expenditures including aspects of distribution.

VI. (a) WORK PLAN

- (1) Preparation: identification of sources of expenditure - July-August 1982;
- (2) Arrival of experts - September;
- (3) Planning of study (protocol preparation) September - 2 weeks;
- (4) Collection of data - mid September to mid-December 1982;
- (5) Analysis and write up - January-February 1982 (SIDA/STC - 16 weeks).

(b) DURATION - 7-8 months.

VII. RESOURCES

Manpower: National (a) Experts
Principal investigators: 2 m/m
Collaborating investigators:
1 x 2 = 2 m/m

(b) Support staff - 10 m/m

STC - 4 m/m

Finance (Birr)

(a) Remuneration

Nationals: Experts: 4 m/m x 1500 = 6000.-
Support staff: 10 m/m x 800 = 8000.-

STC: 4 m/m x 10,000 = 40 000

(b) Per diem = 3 000
Administrative cost = 5 000
Contingency = 8 000

(c) Local = 30 000
Foreign = 40 000
Total = 70 000

Project No. 2

I. IDENTIFICATION

1. TITLE: Time Budget Analysis - A balance sheet of Community activities in rural Ethiopia

2. (a) PRINCIPAL INVESTIGATOR: Solomon Ayalew

Consultant: Professor Göran Sterky

(b) COLLABORATING INVESTIGATORS:

1. Maternal Child Health Coordinating Office - Ministry of Health
2. Central Statistics Office -
3. Institute of Development Research - AA University

Annex II

4. Department of Applied Sociology - AA University
5. Community Medicine Department - AA University
6. Institute of Development Studies - University of Sussex, Brighton, UK
7. MCH unit, WHO, Geneva

II. RATIONALE

1. PHC projects assume that rural population has free time for use in community action while some preliminary investigations show the contrary. The source of this misleading assumption lies in the narrow view of social life of rural communities. That is while rural communities outside of their life sustaining activities (productive work) are engaged in numerous unproductive activities which command a considerable amount of their time budget only the former is remembered in most planning exercises. Given these circumstances communities may refuse to participate in PHC programmes should they find their time inputs too expensive.
2. PHC aims at a bottom up planning without no technique at hand to harness community views and values for use in PHC strategy.
3. PHC aims at improvements in health and living conditions without an adequate technique for monitoring and evaluating health and development and assessing costs and benefits.

III. OBJECTIVE

The study hopes to lead to recommendations concerning PHC strategy. It aims to show how PHC programmes planned to adjust to local conditions and community aspirations could build the entry point into social and economic development.

IV. SIGNIFICANCE OF THE STUDY

- (1) To provide data for devising appropriate strategies in social and economic planning;
- (2) To devise a methodology for monitoring and evaluating changes in living conditions and improvements in health, through time.

V. METHODOLOGY

1. The major methodological feature of this study is the time budget analysis seeking to collect information on the activities of the rural communities in Ethiopia. This method will eventually involve the collection of data from representative samples of families from the seven major ethnic groups in the country. The data will be collected on four separate occasions covering the four major agricultural seasons of the year. In each season, for a duration of seven days, data will be collected on activities of the members aged five years and above of the sample household. The data collected refers to use of time during 14 hours of the day, from 5.30 a.m. to 7.30 p.m. by the household members for a total of 28 days. The technique adopted will be based on observation supplemented by interviewing by a trained individual whose attention will be wholly devoted to one household.
2. The anthropological method of direct observation will be used to catch some important information that is missed by the above technique.

Annex II

VI. WORK PLAN

Preparatory activities:

- Training abroad;
- Preparation of study protocols;
- Discussion with consultant.
- First phase (June 1981 - January 1982)
 - Visit by consultant;
 - Preparation of study protocols;
 - Designing of questionnaire;
 - Pre-pilot survey;
 - Main pilot survey;
 - Choice of dates at which the survey will be conducted.
- Second phase (February 1982 - February 1983)
 - Mapping, listing and selection of sample households;
 - Collection of data;
 - Visit by consultant;
 - Processing of data (editing, coding and manual processing).
- Final phase (March 1983-1984)
 - Finalization of entire data base;
 - Visit by consultant;
 - Final report preparation;
 - Presentation of final report.

Output: publication of material by 1984.

Project No. 4

I. 1. PROJECT TITLE: Health Services Coverage in Ethiopia

2(a) PRINCIPAL INVESTIGATOR: Dr Asfaw Desta, Addis Ababa University

(b) COLLABORATING INVESTIGATORS/INSTITUTIONS: Mahari Woldab, MOH; Gondar College of Medical Sciences; and WHO (Documents)

II. RATIONALE

The definition and policy on health services coverage is not clear. As a result there have been multiple and sometimes contradictory reports about the "% of the Ethiopian population covered by modern health services". There is therefore a need for clear definition and policy and for measurement of six health service units which will enable continuous monitoring and evaluation.

III. OBJECTIVE

- (a) To define and establish policy on health services coverage in the Ethiopian context based on the objective HFA/2000 and the PHC strategy.
- (b) To determine current coverage by health services.

IV. SIGNIFICANCE

The results of this study should provide operational parameters and information base for future planning of health services expansion.

V. METHODS

- (a) Records.
- (b) Field surveys.

VI. (a) WORK PLAN AND DURATION

- Planning and preparation of study - 2 months
- Collection of data - 3 months
- Compilation and analysis of data - 2 months
- Financial implications of alternative strategies - 2 months

(b) DURATION: 9 months.

VII. RESOURCE REQUIREMENTS

ACTIVITIES	EIRR
<u>PERSONNEL BUDGET</u>	
- Consultant (6 months in 3 years) i.e. 6 w/m	62 000 ^a
- Training cost abroad	18 000 ^a
- Project management (maintenance cost of manager for 3 years)	54 000
- Part-time secretary (2 years)	6 000
Sub-total	<u>140 000</u>
<u>OPERATIONAL BUDGET</u>	
- Travel expense for project manager	10 000
- 30 interviewers (at the rate of Birr 20 per day for 40 days)	24 000
- 4 assisting supervisors (at the rate of Birr 30 per day for 60 days)	7 000
- Preparation of questionnaires, including their printing cost	4 000
- Coding, editing and manual processing	6 000
- 30 table clocks to be used for timing of household activities (at Birr 30 pr/unit)	1 000
- Film projector	10 000 ^a
- Unforeseen expenditure (about 10% of all other costs)	23 000
Sub-total	<u>85 000</u>
Total Explicit Costs	<u>225 000</u>

^a Foreign cost is 90 000 Birr.

VIII. RESOURCES

<u>Manpower:</u>	(a) Experts:		
	Principal Investigators	-	3 m/m
	Collaborating Investigators:		
	MOH	-	1 m/m
	Gondar	-	6 m/m
	(b) Support staff	-	12 m/m

<u>Finance:</u>		<u>Birr</u>	
	(a) Remuneration:		
	Experts - 10 x 1500	=	15 000.-
	Support staff - 8 x 800	=	6 500.-
	(b) Per diem	=	15 000.-
	Administrative cost	=	5 000.-
	Contingency	=	4 500.-
	(c) Total (all local cost)	=	46 000.-

Project No. 5

I. 1. PROJECT TITLE: Geography of Health and Disease in Ethiopia

2(a) PRINCIPAL INVESTIGATOR: Department of Community Health, Medical Faculty -
Addis Ababa University

(b) COLLABORATORS: Ministry of Health, Department of Geography -
Addis Ababa University.

II. RATIONALE

No comprehensive work on the geography of health and disease in Ethiopia exists. The work of Schaller and Kuls (1972) is already 10 years old. The need for such a work at this critical moment of the reorientation of the health services is quite clear. A lot of information which could throw important light on the determination of other options lie scattered and are not easily accessible. The data derived from this study will provide useful and more accessible information to policy makers, planners, educators and administrators.

III. OBJECTIVES

The study aims to:

(a) describe distribution of the important health determinates, health related problems, health services and health problems;

(b) prepare an atlas and other suitable reference materials on the geography and demography of health and disease in Ethiopia.

IV. EXPECTED OUTCOME

- Publication of comprehensive documents which present distribution of disease, health related and health services both in short description and maps.
- Through the collection of available information gaps in knowledge and areas for further studies will be identified.

V. METHODS AND MATERIALS

- Available documents and/or published reports from various sources in the country;
- Collection, review and preparation of maps.

VI. WORK PLAN

- Preparation of the outline of the study - 1 month
- Collection and preliminary review - 2 months
- Write up and mapping - 3 months
- Preparation of final draft - 1 month
- Publication - 2 months

VII. RESOURCE REQUIREMENTS (ESTIMATED COST)

<u>Manpower</u>	<u>Cost</u> <u>Birr</u>
Investigators	12 000
Support staff	3 000
Supplies and equipment	1 000
Printing	15 000
Contingency 10%	<u>3 000</u>
Total (all local cost)	<u>34 000</u>

Project No. 7

- I. 1. PROJECT TITLE: Minimum Package requirement for Effective and Efficient Delivery in PHC at the Health Station Level
2. (a) PRINCIPAL INVESTIGATOR: Ministry of Health
Department of Community Health
- (b) CO-INVESTIGATORS: Other relevant institutions as needed.

II. RATIONALE

The eight components of PHC have been recommended as minimum requirements at the different levels of the health service. The definition of this package at the health station level is critical at this stage of the development of health services in Ethiopia.

III. OBJECTIVE

To study the present situation and develop the required minimum technical package for PHC activities at this level, taking into consideration the community health service activity (community level).

IV. SIGNIFICANCE

Identification of the minimum package required for the health station level. This could also be used in identifying revision of curriculum and training material.

Annex II

V. METHODS AND MATERIALS

- Development of required materials for task analysis;
- Field studies on task analysis of 12 health stations;
- Testing of the developed minimum package.

VI. WORK PLAN

- Preparation of plan of study and material - 6 months
- Case study in 12 health stations in four regions (Shoa, Bale, Kaffa, Gondar) - 6 months
- Analysis and formulation of packages - 6 months
- Reorientation and training in the package for selected number of health stations - 2 months
- Testing of the feasibility of the package - 12 months
(in 2-3 intervals)

VII. RESOURCE ALLOCATION

<u>Manpower</u>	<u>Cost</u> <u>Birr</u>
Investigators	3 000
Consultants (local)	3 000
Support staff	15 000
Compilation of data and analysis (two man/months)	3 000
Development of package and training material (two man/months)	3 000
Miscellaneous	4 000
Contingency	5 000
Total cost (all local)	<u>36 000</u>

Project No. 10

I. PROJECT TITLE: Case Study of Community Involvement in Health

- (a) PRINCIPAL INVESTIGATOR: Dr Seyoum G. Selassie, Department of Applied Sociology, Addis Ababa University
- (b) CO-INVESTIGATORS: Ato Melese Gebre - Ministry of Health, CHS Section
Ato Solomon Ayalew - CPSC Social Department

II. RATIONALE

Based on the policy decision of the Revolutionary Government of Ethiopia regarding socioeconomic development and in line with the Alma-Ata Declaration, community involvement is very essential for the implementation of Primary Health Care. However, at present not much is known regarding community involvement. This study will help to fill the gap of knowledge in the development of community participation in health.

Annex II

III. OBJECTIVE

To describe community involvement in health:

1. Structure of community organization for the promotion of health in the broadest sense;
2. Community output for health measures;
3. Community cooperation in organized health care delivery;
4. Participation in the management and resource generation for health.

IV. SIGNIFICANCE OF THE STUDY

The information derived from the study in comparison with other community development data, will help to determine the parameters for assessment and to identify determining factors for community involvement. This information will also help for programme planning and resource allocation.

V. POPULATION AND METHOD

1. Using the CSO sampling frame, seven sample communities will be selected covering the seven major ethnic groups and the three major life styles which are nomadic agrarian and transitional;
2. Prepare and test data collection protocol;
3. Retrieve and review available collateral data;
4. Conduct study by interview and observation.

(The respondents in the sample communities are the three major community organizations and 10 families in each community.)

VI. TIME FRAME/WORK PLAN

Activities	1st month	2nd month	3rd month	4th month	5th month	6th month
1. Division of Responsibilities and preparation of protocol by investigators						
2. Training of field staff, field testing of questionnaire and briefing of communities						
3. Community study: interview and observation						
4. Compilation of data and analysis						
5. Preliminary reporting						

Annex II

VII. RESOURCE REQUIREMENT

		<u>Estimated cost</u>
		<u>Birr</u>
Principal and co-investigators		
3 m/m x 1500	=	4 500
Per diem for 7 field staff for		
7 days at 20 Br./day	=	1 400
Data analysis and reporting	=	1 100
Dissemination of information		
including feedback 25%	=	3 000
Contingency 10%	=	1 000
Total cost (all local) = <u>11 000</u>		

Project No. 12

- I. 1. PROJECT TITLE: Drug Supply in the Community Health Services Programme (CHSP).
A Situation Analysis
2. (a) PRINCIPAL INVESTIGATOR: ZEWDIE TAMRAT
- (b) CO-INVESTIGATORS: IDR (Dr Fassil Kiros)

II. RATIONALE

There is no sufficient knowledge of the drug situation in the CHSP.

III. OBJECTIVES

The study aims to:

- (a) investigate if and how the policy (understanding) is communicated to and interpreted by the health workers/officials at all levels and the Farmers' Association (FAS) and Urban Dwellers' Association (UDAS);
- (b) determine how the policy/understanding is implemented at the FAS/UDAS level in terms of:
- raising and allocation of funds;
 - kind, volume and cost;
 - sales price;
 - mechanisms of purchase, transport and storage;
 - utilization and accounting.

IV. SIGNIFICANCE

The data obtained from the study provide a comprehensive understanding of the situation and problems of the drug supply in the CHSP and further provide information for policy, funding, logistics and other global problems that may be identified.

Annex II

V. METHODS

Case studies of about 50 FAS and UDAS where the CHSP is functioning.

VI. (a) WORK PLAN

1. Planning and preparation - March 1982;
 2. Data collection - April - 15 June;
 3. Compilation and reporting - 15 June-15 July.
- (b) DURATION: 4.5 months.

VII. RESOURCES

Manpower: (a) Experts

- One principal investigator 2 m/m
- One collaborating investigator 2 m/m

(b) Supportive staff 10 m/m

Birr

<u>Finance:</u> (a) Expert	=	3 000
Collaborator	=	1 000
Support staff 10 x 800	=	8 000
(b) Per diem	=	5 000
Administrative cost	=	3 000
Contingency	=	5 000

(c) Total cost = 25 000 (all local)

Project No. 13

- I. 1. PROJECT TITLE: Existing Mechanisms of Drug Supply in Ethiopia (Pilot Study)
2. (a) PRINCIPAL INVESTIGATOR: IDR;
- (b) COLLABORATING INVESTIGATORS: CPSC
PHARMECOR, or
Ato Alemayehu (Ref. Solomon), or
Ato Woldu, Chemical Corporation

II. RATIONALE

The public and private drug supply mechanisms in the country are not clearly known.

III. OBJECTIVES

- (a) to explore the mechanisms by which the population get drugs - government services, drug shops, marginal practitioners;

Annex II

- (b) to describe the nature of drugs handled through the different system;
- (c) to conduct comparative analysis of the different systems of drug supply with regard to efficiency of drug delivery and price;

IV. SIGNIFICANCE OF THE STUDY

To indicate the best ways of organizing the supply of essential drugs.

V. METHODS

- (a) A pilot study will be done in two regions (e.g. Kaffa & Wollo);
- (b) Exploratory study to identify the different ways of procuring drug (by survey);
- (c) Indepth case studies of different (representative) arrangements.

VI. (a) WORK PLAN

1. Preparatory work - July 1982;
2. Study - August and September 1982;
3. Analysis and report - October 1982.

(b) DURATION: 4 months.

VII. RESOURCES

<u>Manpower:</u>	(a) Experts	
	Principal investigator	1 m/m
	Collaborating investigator	1 m/m
	(b) Support staff	2 m/m

<u>Finance</u>		<u>Birr</u>
(a) Remuneration		
	Experts - 2 m/m x 1500	= 3 000
	Support staff - 2 m/m x 800	= 1 600
(b) Per diem		= 3 000
	Administrative cost	= 1 000
	Contingency	= 1 400
(c) Total cost		= 10 000 (all local)

Project No. 14

- I. 1. PROJECT TITLE: Control of Syphilis. A Model of Systems Approach in the Control of Communicable Diseases.
2. PRINCIPAL INVESTIGATOR: Dr Tewabech Bishaw - MOH, MCHCO

CO-INVESTIGATORS:

Dr Nebiat Tafari	- NMCHC
Dr Mekonnen Bekele	- MOH - Black Lion Hospital OBGYN Department
Dr Widad K. Mariam	- MOH - Yekatit 12 Hospital OBGYN Department
Dr Eyassu H. Gabir	- AAU Department of Internal Medicine
Dr Seyoum G. Selassie	- AAU - School of App. Sociology
Dr Kineferegb Zelele	- AAU - Department of Ethiopian Studies
Ato Dibaba Serdo	- MOH - AAVD Clinic
Ato Haileselassie	- MOH - CL and RI
Ato Zein Ahmed	- AAU - GMC
Ato Bona Hora	- MOH - CDC
Sister Emebet Admassu	- MOH - HED

II. RATIONALE

The prevalence of syphilis in some urban areas can be as high as 15%. It is the fourth common cause of perinatal mortality. Ten per cent. of the perinatal mortality which is about 10 000 deaths per year, 5% of the infant mortality which is about 5000 deaths per year is due to syphilis.

Although there is an increase in health services coverage, since there is no systematic control measure that has been instituted in the health service programme, the prevalence of the disease has not decreased.

Sociocultural factors in Ethiopia are determinants both for the prevalence and the outcome of the success programme.

Among the sexually transmitted diseases syphilis is the most amenable to control measures.

The approach to venereal diseases and syphilis in particular through clinics has proved a failure throughout the world.

Although social consciousness will contribute to the control of the disease, a problem-specific intervention programme is mandatory especially in the initial stage, and the perinatal period provides a unique opportunity to measure the effectiveness of major intervention measures, since it is in this period that the damage and number involved from syphilis is maximal.

III. OBJECTIVE

The overall objective of the study is to devise a model of control programmes for syphilis based on the systems approach that is economically feasible, culturally acceptable and within the technological capability of the country. The study specifically aims:

1. To assess the knowledge, attitude and practice regarding syphilis in different sociocultural milieu.

Annex II

2. To identify major obstacles to prevention of syphilis in Ethiopia;
3. To establish and test a screening method that can be introduced in the primary health care programme at all levels of the health system;
4. To establish and evaluate intervention programmes: educational, legislative, and therapeutic measures under different conditions.

IV. SIGNIFICANCE

The study of syphilis control measures as proposed here will serve as a model for control of other communicable diseases such as tuberculosis and leprosy. The result of the intervention measure will also help to significantly reduce the long-term morbidity and mortality of expected magnitude of 45 000 foetal and infant deaths from syphilis per year.

V. STUDY POPULATION AND METHOD

1. Establishment of a resource group for the management of R and D in syphilis by MOH;
2. Selection of representative samples of gravid women for study with Gondar and A.A. as the focal point;
3. Evaluation of screening methods;
4. Evaluation of intervention measures;
5. Development of alternate models of control;
6. Testing of model in PHC setting;
7. Adoption and implementation of the model in PHC.

Annex II

VII. RESOURCE REQUIREMENT

		<u>Estimated cost</u>
<u>Manpower</u>		<u>Birr</u>
Resource group	48 m/m x 15 000	72 000
2 Research assistants (full time)	800 x 2 x 32	51 200
Consultant	6 m/m, 6 x 10 000	60 000
Per diem	5 x 3 x 30 x 12	5 400
Field worker remuneration	36 m/m x 800	28 800
 <u>Material</u>		
Laboratory reagent	5000 x 5 x 0.50	12 500
Validation of laboratory method		12 500
Training material		3 000
Data analysis and reporting		5 000
Contingency		5 600
Local	171 000	
Foreign	<u>85 000</u>	
	<u>256 000</u>	

Project No. 15

- I. 1. PROJECT TITLE: Operational Study on the Control of Tuberculosis in the Context of PHC
2. (a) INVESTIGATORS: Tuberculosis Control Programme;
- (b) CO-INVESTIGATORS: Central Laboratory and Research Institute;
Internal Medicine Department, Medical Faculty;
Ministry of Health.

II. RATIONALE

Tuberculosis is one of the major communicable diseases still having high morbidity and mortality in Ethiopia. Though efforts for its control have been made since the last three decades, there has not been any significant outcome, on the contrary it is getting worse. Recently the Ministry of Health has made a thorough assessment of the Tuberculosis Control Programme, and reviewed its policies, objectives, strategies and to that effect has started some institutional rearrangement that will enable a meaningful control. However, in the absence of the knowledge of the epidemiology of the disease and the gaps in knowledge measures will not be feasible. Thus the need for research in this area is very crucial. The Tuberculosis Control Programme and the Central Laboratory and Research Institute are doing something along this line and there are plans for a national prevalence sample survey. So, this proposal would reinforce the already planned survey.

Annex II

III. OBJECTIVES

- To determine prevalence rate of TB;
- To study and improve the operational aspects of control measures in the context of PHC and health care delivery system.

IV. SIGNIFICANCE

- Information on the prevalence of TB;
- Establish appropriate system of case finding, case holding and other control measures which could be replicated on national scale;
- Develop simple and appropriate criteria for case finding and diagnosis and treatment.

V. METHODS AND MATERIALS

- The study will be conducted in three localities (highland, midland and lowland - seminomadic) with a total population of 15 000;
- Sputum collection and examination by direct microscopy;
- PFD survey;
- Review control programme under operation in the study areas and devise appropriate control system and perform follow up.

VI. WORK PLAN

- | | |
|--|------------|
| - Preparation of study and review of available information and develop detailed plan of action | - 2 months |
| - Field work and establishing appropriate control measure | - 6 months |
| - Follow-up study after a year | - 3 months |
| - Final write up | - 3 months |

VII. RESOURCE REQUIREMENT

<u>Manpower</u>	<u>Estimated cost</u>
	<u>Birr</u>
Investigators	15 000
Local experts 2 m/m	3 000
External expert 1 m/m	10 000 ^a
Support staff 6 m/m	9 000
Support staff per diem	21 000
Supplies and equipment	5 000 ^a
Contingency 10%	10 000
Local cost	58 000
Foreign cost	<u>15 000</u>
Total	<u>73 000</u>

^a Foreign.

Annex II

Project No. 16

1. 1. PROJECT TITLE: PROGRAMME REVIEW: EPI/MCH
2. INVESTIGATORS: Ministry of Health - MCH Coordinating Office
CDC/EPI
Regional Health Department
Community Health Department, Faculty of Medicine
National MCH Centre.

II. RATIONALE

Since the Ethiopian EPI Programme was launched in January 1980, there has not been any independent systematic evaluation that would make recommendations for its improvement.

III. OBJECTIVES

- (1) To study the organizational set-up of the EPI Programme and some other aspects of MCH and their inter-relationships with the PHC programme;
- (2) To examine the target, schedule and strategy of EPI;
- (3) To assess the cold chain and logistics of the programme;
- (4) To determine immunization coverage;
- (5) To assess community participation in EPI;
- (6) To investigate the causes of non-attendance and defaulting in EPI;
- (7) To examine the system of surveillance of target disease especially measles, polio and neonatal tetanus;
- (8) To assess recording and reporting methods;
- (9) To assess the adequacy of training and identify gaps;
- (10) To examine the methodology of health education in relation to EPI;
- (11) To determine the coverage and extent of utilization of other MCH services;
- (12) To investigate the reasons for non-utilization of MCH services.

IV. SIGNIFICANCE

To recommend ways of improving the delivery of EPI/MCH services within the PHC programme in order to effectively achieve the EPI objective by 1990 and Health for All by the Year 2000.

V. METHODS

The method to be used will be the standard WHO/EPI/MCH Programme Review (Evaluation) protocol, in which cluster sampling is employed. This involves a team of six senior nationals and six international experts. The evaluation is conducted at central, regional and peripheral levels of the Health System.

VI. WORK PLAN

1. Planning or pre-review visit by 2 experts from WHO/Geneva and Brazzaville.
Duration: 1 week
2. Programme review by a team of 6 nationals and 6 international experts.
Duration: 3 weeks
3. Report preparation by 2 members of the team.
Duration: 1 week

VII. RESOURCE ALLOCATION

<u>Description</u>	<u>Costs</u> (Birr)
1. 6 outside experts' travel and per diem (\$ 5000/expert)	60 000 ^a
2. 12 senior national staff (1500 Birr/person for one month + 30 Birr/day for 7 days)	20 000
3. 20 junior national staff (800 Birr/person for one month)+ 20 Birr/day for 7 days	19 000
4. 6 divers (800 Birr/person for one month + 20 Birr/day for 7 days)	6 000
5. 1 secretary shorthand stenographer for 1-1/2 months	1 000
6. Stationary and other supplies	5 000
7. Contingencies	10 000
Total	<u>121 000</u>

There are other items for research in the field of EPI which will assist in further development of the programme in Ethiopia. The detailed protocols and costing would be worked out at a later date. These may include:

- (i) Development of a field training and demonstration area;
- (ii) Development of testing of training materials for field level health workers;
- (iii) Development and testing of teaching aids such as films, slides and posters;
- (iv) Further research on the present protocols for immunization coverage, cost-effectiveness of the programme, vaccine effectiveness, etc.;
- (v) Comparative costs of different strategies - fixed vs. outreach/mobile teams;
- (vi) Costing including the cost of the fully immunized child;

^a Foreign.

Annex II

- (vii) Vaccine delivery systems advantages and disadvantages of different systems such as collection system, distribution system;
- (viii) Development of new supervision techniques;
- (ix) Development and testing of new health education techniques;
- (x) Field testing of surveillance of target diseases specifically neonatal tetanus, polio and measles;
- (xi) Community health worker involvement in EPI;
- (xii) Research and development of:
 - Immunization registers;
 - Home based records;
 - Immunization records at health centre and village level;
 - Computerization of records;
 - Use of birth certificates;
- (xiii) Studies in community participation:
 - Reasons for non-attendance and non-completion of immunization;
 - Corrective measures and their effect (evaluation);
 - Effect of different health education methods of stimulating participation e.g. radio, TV mailing letters, motivational home visits;
- (xiv) Field testing of sentinel reporting methodologies.

Project No. 17

- I. 1. PROJECT TITLE: Methodological Studies for the "Ethiopian National Integrated Household Survey Programme - Health"
- 2. (a) PRINCIPAL INVESTIGATOR: Department of Community Health, Addis Ababa University;
- (b) CO-INVESTIGATORS: Ministry of Health, Statistics Division.
Central Statistical Office (CSO)

II. RATIONALE

The CSO is planning to launch a national health survey as part of the integrated household survey which is of importance for the socioeconomic development plan of the country. Preliminary contracts and discussions with CSO have indicated a number of issues on the validity, sensitivity and specificity of the method of collection of information on the health aspects is unsolved and should be tested and improved before it is widely used.

III. OBJECTIVES

- (1) Define and standardize (in the Ethiopian context) the terminologies used in the survey;
- (2) Study the reproducibility, sensitivity, specificity and related technical issues in the measures used in the survey.

Annex II

IV. EXPECTED OUTCOME

To enhance the consistency and validity of the health interview surveys of CSO and develop guidelines.

V. METHODS AND MATERIALS

- (a) Study and evaluation of the questionnaire designed by CSO;
- (b) Compilation of terms and measures required for the survey, definition and standardization;
- (c) Systematic listing of requirement of the questionnaire and of the survey in general;
- (d) Field testing and validation of terms and measures;
- (e) The study will be conducted in Haicotch and Butajira Awraja in one Peasants' Association (about 200 houses).

VI. WORK PLAN

Preparation of the study	= three months
Field work	= one month
Compilation, analysis and final report	= six months.

VII. RESOURCE REQUIREMENT

<u>Manpower</u>	<u>Cost</u> <u>(Birr)</u>
Investigators	9 000
Local expert	15 000
External expert	10 000 ^a
Support staff	800
Per diem for support staff	4 000
Data analysis	2 000
Contingency 10%	2 700

Local cost = 20 000

Foreign cost = 10 000

Total 30 000

Project No. 18

I. TITLE: A Study on the Risk Approach in the Delivery of MCH/FP Care in Ethiopia

PRINCIPAL INVESTIGATORS:

1. Dr Teklesion Woldemariam - NMCHC
2. Sister Asressu - MOH

^a
Foreign.

Annex II

CO-INVESTIGATORS:

- | | |
|-------------------------|-------------------------------------|
| 1. Dr Widad | - Dept. OBGYN - Yekatit 12 Hospital |
| 2. Dr Hagos Beyene | - Dept. of Ped. Black Lion Hospital |
| 3. Dr Mekonnen | - Dept. OBGYN, Black Lion Hospital |
| 4. Dr Carmella Abate | - Dept. of Ped. Black Lion Hospital |
| 5. Dr Tewabetch | - NMCHH |
| 6. Ato Mehari Woldab | - MOH - PPB |
| 7. Ato Desta Shambo | - AAU - DCH |
| 8. Dr Nebiat Teferi | - NMCHC |
| 9. WHO - MCH Specialist | |
| 10. Dr Adugna | - Gondar - CMS |
| 11. Sister Tsehay | - MCHCO - Gondar |
| 12. Prof. Goran Sterky | - Consultant |

II. RATIONALE OF THE PROJECT

- (1) The Government of Ethiopia has identified that MCH/FP as priority health problems and is committed to Primary Health Care;
- (2) No epidemiological information on pregnancy outcome and early childhood development;
- (3) There is a very high infant and maternal mortality and there is a need to develop an effective intervention method;
- (4) The risk approach aims at identifying potential risk factors; undesirable pregnancy outcome and early infant and childhood development. This will facilitate early and appropriate intervention measures.

III. THE OBJECTIVES OF THE STUDY

Main Objective: To test this managerial strategy i.e. the risk approach, in the Ethiopian context for improvement of coverage and quality of MCH/FP Care.

Specific Objective: The study specifically aims to:

- (a) develop an epidemiological method to identify the factors that influence the natural history of pregnancy and its outcome and infant and childhood development;
- (b) assess the individual and community at risk and develop the risk profile;
- (c) implement and evaluate an intervention strategy.

IV. SIGNIFICANCE OF THE STUDY

At the end of the study the information gathered will help in:

- (a) providing information for policy statement and priority decision;
- (b) developing local strategies for the implementation of MCH/FP Care;
- (c) developing a WHO collaborative centre in perinatal care in Ethiopia.

Annex II

V. POPULATION AND METHODS

- (a) The study would constitute both urban and rural population. Addis Ababa for urban study. For rural Gondar province and Butajira Awraja;
- (b) The study design could be either a prospective cohort study of a group of pregnant women relating pregnancy outcome and early child development to socioeconomic and medical factors, or
a retrospective case reference study contrasting a group of normal deliveries (reference) in terms of potential determinants. For methodological reasons both studies should be done;
- (c) The sample size - 3-4000 pregnancy. A minimum of 1000. This depends on the rareness of a disease, factors to be analysed and heterogeneity of the population.

VI. TIME FRAME WORK FOR THE STUDY

- (a) meeting of the investigators and co-investigators and development of the protocol - one month;
- (b) training of field staff, field testing of questionnaire and briefing of community - second and third month;
- (c) community study - 2 years;
- (d) data collection - 1 month;
- (e) compilation and data analysis - 3 months;
- (f) reporting of the findings and proposals for intervention - 1 month.

VII. RESOURCE REQUIREMENT

<u>Manpower</u>	<u>Estimated cost</u>
	<u>Birr</u>
Principal Investigator 12 m x 1500	18 000
Co-investigators 24 x 1500	36 000
2 field researchers 15 x 2 x 800	24 600
MCH consultants 6 x 10 000	60 000 ^a
Per diem for training 20 x 40 x 14	11 200
Per diem for investigators 10 x 3 x 3 x 2 x 30	5 400
Per diem for co-investigators 7 x 10 x 30	2 100
Secretary salary 1 x 800	800
Training material	5 000
Field work remuneration 800 x 60	48 000
Contingency	14 500
Local = 165 000	
Foreign = 60 000	
Total	<u>225 000</u>

^a Foreign.

Project No. 19GENERAL SUPPORT 19. Support for Health Services Research and Development Capacity Building1. Employment of Personnel

	<u>Birr</u>
1.1 Temporary consultant to HSR	
Sub-committee (10 000 Br x 2 m/m)	20 000 (WHO)
1.2 Financial manager for NHDN (2000 Br x 24 m/m)	48 000 (Pool)
1.3 Teaching support to release researchers from teaching responsibilities:	
- to be employed locally (1500 Br x 18 m/m)	27 000 (Pool)
- to be employed from outside (10 000 Br x 6 m/m)	60 000 (SAREC/SIDA)
1.4 Computer operator (800 Br x 12 m/m)	<u>9 600 (Pool)</u>
Sub-total	164 600

2. Training

2.1 Within the country

- Workshop on research methodology

Per diem 20 people x 7 days x 30 Br x 3 times 14 000 (Pool)
(including 10% support cost)

Consultant for 3 m/m 30 000 (Pool)

- Training of 100 field workers during 2 years period

Per diem: 100 people x 20 Br x 10 days 22 000 (Pool)
(including 10% support cost)

Consultation fees to CSO 2 100 (Pool)

2.2 Outside the country

- Seminars and workshops 60 000 (WHO/SIDA/SAREC)

- Long-term training

3 epidemiologists (and/or biostatisticians) for 3 man years . 90 000 (WHO)

Social scientists 7 man years 210 000 (WHO/SIDA)

Computer operator 5 m/m 13 000 (SAREC)

Computer programmer 6 m/m 15 000 (SAREC)

- Re-entry grant *

Sub-total 456 100

* Action to be taken some time in the future.

Annex II3. Developing the Documentation Capacity of University Libraries

	<u>BIRR</u>
3.1 To expand ESTC/SAREC Retrieval Project of the Medical Library to cover the Kennedy Library, Ethiopian Studies, and the Institute of Development Studies	**
3.2 Dissemination of information	
- Photocopy machines including running costs	9 800 (SAREC)
- Fees for use of photocopy machines in other libraries	500 (Pool)
- Providing WHO documents	*
- News Letters (employment of journalist)	*
- Journal of Health Development	*
- Dissemination of current HSR literature	<u>8 000 (Pool)</u>
Sub-total	<u>18 300</u>
4. <u>Supplies and Equipment</u>	
4.1 Also see section 3 above	
4.2 Transport facilities	
- 3 "Suzuki" four wheel drive cars	60 000 (SIDA)
- Car fuel for two years	50 000 (Pool)
- Maintenance for two years	15 000 (Pool)
4.3 Publication	
- Assuming 10 projects of 100 pages each will be completed in two years, printing cost of 3 000 copies will be	30 000 (Pool)
- Mailing cost	<u>6 000 (Pool)</u>
Sub-Total	<u>161 000</u>

* Action taken by the NHDN.

** Action to be taken by ESTC/SAREC.

Annex II

5. Mobilization Fund: 10% of all other costs
(Pool, SAREC, SIDA, WHO) 85 000 Birr

SUMMARY TABLE: GENERAL SUPPORT

(IN BIRR)

Activities	Source of Finance			SIDA	TOTAL
	Local (Pool)	WHO	SAREC		
1. Manpower support	84 600	20 000	30 000	30 000	164 600
2. Training	68 100	215 000	48 000	125 000	456 100
3. Capacity bld. in documentation	8 500	-	9 800	-	18 300
4. Supplies and equipment	101 000	-	-	60 000	161 000
5. Mobilization fund	24 000	27 000	12 000	22 000	85 000
	286 200	262 000	99 800	237 000	885 000 ^a

^a Capital cost appears high because it is not spread over the life of the project.

DRAFT

ETHIOPIAN SCIENCE AND TECHNOLOGY COMMISSION

REPORT OF THE NATIONAL HEALTH SERVICES RESEARCH WORKSHOP

I. BACKGROUND TO THE WORKSHOP

In revolutionary Ethiopia, over the five years, there has been a concerted effort to lay the foundation for an indigenous, self-reliant and non-dependent development in science and technology. In no other field of scientific endeavour is the need to formulate a system of science and technology for application to development under a given set of conditions more apparent than in the field of health. This is so because the mass health problems responsible for excessive rates of morbidity and mortality in a typically developing country like Ethiopia stem from the prevailing economic, social and cultural conditions.

Increase in coverage by an improved quality of health care is one of the major social goals of progressive governments. Ethiopia, as signatory of the 1978 Alma-Ata Declaration, is not only committed to increase the quantity and improve the quality of health care but also to meeting the goal: "health for all by the year 2000". At a time when the scope and coverage of health services are rapidly expanding, there is need for innovative approaches in the identification and analysis of problems, in the application of ready-to-use medical and related health knowledge and in the evaluation of the impact of health intervention programmes. Inasmuch as health is the product of complex interactions of a multitude of environmental factors, research and development into alternatives in health care content and delivery calls for multi-faceted approach where biological factors are considered together with economic, socio-cultural, scientific and technological determinants.

The draft policy of health research and development as formulated by the Health Research Council of the Ethiopian Science and Technology Commission identifies six steps in the development of health science and technology. Research and development commences with problem identification, in the form of assessment of the health needs of the people. This is followed by evaluation of health problems including description of natural histories of specific health problems, analysis of contributing factors and effectiveness of existing intervention programmes. The foregoing activities would indicate areas in which innovative measures need to be developed experimentally. The resulting, apparently effective intervention programmes are then incorporated into the health care delivery system after their technical competence, economic feasibility and cultural compatibility have been evaluated. It was fortuitous that this draft policy merges with the concept of Health Services Research that has been developed within the WHO system.

Over the past decade and a half there emerged the concept of Health Services Research (HSR) defined as "the systematic study of the means by which basic medical and other relevant health knowledge is brought to bear on the promotion of health of individuals and communities under a given set of conditions". The above definition emphasizes that HSR is concerned with country and community specific problems and the results of research and development activities are likewise specific to socio-cultural, economic, technological milieu in which they are conducted. The outputs of HSR include the objective assessment of the health needs and resources, analysis and prediction of trends, and interventions which include health policy, planning strategy, organization and the management of health care delivery system. The methodology of HSR employs a multi-disciplinary approach where all factors thought relevant to health are considered simultaneously. The content and methodology of HSR demand the participation of personnel from academic and research institutions together with personnel from the health decision machinery and members of the community. Such participation not only ensures the relevance and implementation of the research results but also paves the way for a continuous generation of indigenous self-reliant and non-dependent science and technology in health.

Following the participation of Ethiopia in the WHO ACMR's Subcommittee on Health Services Research (HSR), the Health Research Council, realizing the fundamental importance of HSR invited the Ministry of Health, the Medical Faculties and Addis Ababa and Gondar health research institutions to a workshop to examine HSR in the Ethiopian context.

II. FORMAT OF THE WORKSHOP

A list of key documents from WHO sources and from the Health Research Council of the Ethiopian Science and Technology Commission were sent to potential participants prior to the meeting.

The meeting was opened by comrade Haile Lul Tebicke, Commissioner, Ethiopian Science and Technology Commission who spoke on the "Dynamics of Research and Development". Comrade Haile Lul stated that for effective implementation of national research and development capacity the development of appropriately trained research manpower, the building up of research and development infrastructure comprising of institutions and their laboratories, the establishment of operational access to information sources, and the provision of adequate funds were some of the identifiable essential steps. He further emphasized that research and development capacity can best be sustained through the pursuit of effective research. He further indicated that because of the very nature of health service research which is based on participative dialogue between professionals and the people in joint search of solution to health problems, health service research in revolutionary Ethiopia will be expected to pay significant dividends. He further expressed hope that through health service research we may effectively break out "of the environmental, biological and cultural constraints that now have us locked in a vicious circle of disease-malnutrition-susceptibility to disease-mental and physical debility, low productivity, poverty and disease".

Comrade Wogayehu Sahlu, Permanent Secretary, Ministry of Health, reviewed current status and outlined the projected development in health services in Ethiopia. He indicated that the Ministry of Health was cognizant of the importance of Health Services Research in the formulation of health policy, in design, measurement and evaluation of health services and is accordingly in the process of establishing an HSR unit within its headquarters. He pointed out that the current workshop was being held at a time when the Ministry of Health was engaged in an all out effort to achieve the goal of Health for All by the Year 2000 (HFA/2000).

Comrade Nebiat Tafari reviewed the current status of health research and development and outlined the projected development in health research and development in Ethiopia. He cited that the Health Research Council of the Ethiopian Science and Technology Commission which began work in September 1979, has prepared a draft policy of Health Research and Development. The health goals to be achieved through the utilization of research and development are the health problems of the masses: control of communicable diseases, eradication of malnutrition, undernutrition and promotion of adequate nutrition, the improvement in the coverage and quality of health care, provision of specialized health care to special groups of the population particularly women in the reproductive age-group, infants and children. The guiding principles in the design of research and experimental development as envisaged in the draft policy include: (a) Involvement of all relevant sectors of the economy inasmuch as health is at once the result and the prime force of development. (b) A comprehensive problem-oriented approach in order to define precise intervention programmes. (c) Utilization of appropriate technology in order to ensure continuity of activity, increase the relevance of the results of research and consequently enhance their application and assure non-dependent, self-reliant development. (d) Finally, community participation since the beneficiaries and final effectors of health are the people.

After a brief discussion on the above papers, the participants divided into two groups to examine the Health Services Research in the Ethiopian context under the following headings:

- (a) scope and policy;
- (b) priorities and programmes;
- (c) capacity building.

III. SUMMARY OF DISCUSSIONS

A. Health Service Research, scope and policy guidelines

(i) Definition

In an attempt to define Health Service Research (HSR) in the Ethiopian context, the historical development of HSR within the WHO system and health research policies in Ethiopia were considered. Although the Workshop failed to achieve consensus on a formal definition of Health Services Research, it recognized the following attributes:

- (a) HSR seeks to identify ways and means by which existing medical knowledge is applied efficiently and effectively to solve the health problems of the masses.
- (b) HSR addresses itself to health care design measurement and evaluation. For effective conduct of research and implementation of the results therefrom, the participation in the research activities of individuals within the health decision machinery as well as representative of institutions of training, of research, and the community are essential.
- (c) HSR, inasmuch as it is confined to the search of ways and means of applying existing knowledge, the above definition implies that such knowledge and know-how exist and are relevant to a given health problem manifesting under a set of conditions.

(ii) Scope

The scope of HSR is contained in the definition. HSR includes the critical evaluation of current health status and health services, the design of alternate health care delivery systems, the implementation of such systems and the evaluation of the effectiveness and efficiency of alternate designs of health care delivery.

(iii) Policy guidelines

- (a) Inasmuch as primary health care (PHC) is the main strategy for the attainment of Health for All by the Year 2000 (HFA/2000), HSR should assist the development and implementation of effective and efficient PHC programmes.
- (b) HSR should be based on multisectoral approach with the participation of professionals from all relevant sectors of the economy as well as of personnel within the health decision machinery and representatives of the community.
- (c) HSR should be carried out at all levels of the health care delivery system.
- (d) As many alternative methods as possible should be utilized in communicating the result of HSR in order to ensure immediate implementation.
- (e) A given HSR should address itself to a comprehensive evaluation of health care delivery system including evaluation of existing knowledge and know-how, the health care design (structure, manpower and funding) and the efficiency and effectiveness of the health care delivery.

B. Priorities and programmes

Area 1 - Studies on the organization and management of the health care delivery system

- (a) Structure and functions
- (b) Planning, programming, budgeting and manpower
- (c) Process of decision-making
- (d) Resources generation, allocation and utilization
- (e) Support and referral systems
- (f) Monitoring and evaluation
 - Effectiveness and efficiency
 - Utilization of health services by the community

Area 2 - The identification of the health needs of the community (health measurement)

- (a) The risk approach
- (b) Problem identification

Area 3 - Defining the minimum health service requirements - e.g., the content of the minimum package

Area 4 - Traditional medicine - role, organization and possibilities for integration with the modern health care delivery system

Area 5 - Manpower studies

- (a) Staffing pattern and distribution
- (b) Definition of role and function
- (c) Curriculum development and training
- (d) Working conditions and career development

Area 6 - Studies of community participation

- (a) Formulation of the concept of community participation in the Ethiopian context
- (b) Mechanism of community participation
- (c) Requirements for effective community participation
- (d) Community control: concepts, mechanisms

Area 7 - Studies of intersectoral participation in health

- (a) Identification and mobilization of those sectors which can contribute to the health of the community
- (b) Mechanisms of intersectoral approach to health

Area 8 - Studies on the logistical problems in the delivery of supplies and equipment

- (a) Procurement and distribution
- (b) Adequacy and of quantity and relevance
- (c) Utilization
- (d) Inventory

Area 9 - Studies on health technology

- (a) Evaluation of the health technologies in use for appropriateness, i.e.
 - Specificity to the problems
 - Compatibility to the culture
 - Feasibility with regard to cost and the available technological bases of the country
- (b) Survey of available health technologies: endogenous and exogenous
- (c) Generate, adopt appropriate technology

Area 10 - Methodological studies in HSR

C. Capacity building

Area 11 - Assessment of existing HSR capability

- (a) Structure and institutional arrangement
- (b) HSR manpower
- (c) Funding

IV. CONCLUSIONS AND RECOMMENDATIONS

Organized health research in Ethiopia is as a whole at an early stage of development. A brief examination of the current status of health research in Ethiopia reveals certain outstanding obstacles among which are:

- (a) lack of trained manpower with tradition and experience in research;
- (b) lack of information on knowledge and know-how;
- (c) improper institutional arrangement, i.e. between institutions of service, training and research;
- (d) inadequate resources allocation, i.e. materials, manpower and funds;
- (e) lack of policy, plan and programme of research.

Considering the above as critical impediments to the establishment of an effective health service research, the Workshop recommends:

- (1) Organization - The National Health Research Council of the Ethiopian Science and Technology Commission act as coordinator in the national effort to build a health service research network. Such a network should start with a unit within the Ministry of Health.
- (2) Strengthen the capability of existing training institutions so as to produce qualified manpower (epidemiologists, biostatisticians, sociologists, health economists, etc.) for health service research.
- (3) An information system should be established with special emphasis on data acquisition, processing, storing, retrieving and dissemination. Exchange of information amongst researchers, service personnel and communities both at national and international levels.
- (4) Promotion and facilitation of research - e.g. creating incentives and career structure.

NATIONAL HEALTH DEVELOPMENT NETWORK (NHDN) - ETHIOPIA

The National Health Development Network - Ethiopia was established by the National Development Revolutionary Campaign and Central Planning Supreme Council through the active support of the Ministry of Health, the Commission of Higher Education, Addis Ababa University and other related agencies.

The Concept and Objective of NHDN

PHC demands an integrated health development structure. The normative ends of the PHC approach must influence the choice of methods, determine how and by whom they are employed and stimulate the necessary flow of information among all the concerned parties. In addition developmental activities of PHC are too often overwhelmed by the day-to-day activities of the health sector which gain precedence. It is therefore necessary to have a special mechanism for focusing all technical efforts on the promotion and development of PHC.

An NHDN is seen as an institutional arrangement whereby a country can mobilize, organize, coordinate and strengthen its own technical capacities to meet the challenge of achieving health for all by the year 2000. It is a major means, in particular, for developing countries to enhance their indigenous capabilities to make their own choices by collective and systematic utilization of their existing institutions, and if necessary to develop new ones. Implicit in the concept is the ideal of appropriate division of labour, avoidance of redundancy, and waste, identification of and filling of existing gaps in work and, above all, coordination to ensure working towards the same goal.

The PHC approach makes significant new demands on health policies, planning, research, training management and other mechanisms, which must be involved with a much wider range of social, political and economic issues, usually of an intersectoral nature. It is doubtful that any one single centre or agency could fulfil all these demands. Therefore, a wider range of national organs must be drawn into the effort.

It is important to note that NHDN is not conceived as the only answer to all the problems and issues of health development. It does not replace nor does it preclude or even compete with other organizational structures. It provides a mechanism for technical support of a multisectoral character.

The idea of establishing an NHDN for Ethiopia has been around for sometime now. Recent developments (e.g. the development of the graduate programme in public health, the decision to establish the National MCH Centre, and a large multidisciplinary training centre in Jimma) and the ever-mounting evidence of the need for concerted effort in planning, promoting, monitoring and evaluation of PHC have made it imperative that an NHDN be organized as soon as possible.

Functions of the Ethiopian NHDN

The NHDN is an institutional arrangement whereby Ethiopia can mobilize, organize, strengthen and coordinate its technical capacities to meet the challenge of achieving H/2000 through PHC and will therefore perform the following functions:

- act as a permanent mechanism of technical support of multisectoral character to policy makers and, in general, to national decision makers for health policy formulation and implementation;
- provide technical support to multisectoral health planning;

- promote and support the development of a national health information system that will ensure the right kind of information for decision making at various levels of the health system;
- promote and support health manpower development appropriate to H/2000 through technical support to formulating health manpower policy and plans, reviewing and monitoring of training programmes, training of teachers and tutors, developing a nationwide infrastructure for continuing education of all health workers. . . ;
- support the development of mechanisms for monitoring and evaluation of progress of PHC;
- give technical support to promote and carry out HSR;
- promote TCDC in PHC;
- in general promote PHC through the above functions as well as seminars, workshops . . . and the mass media and various associations.

Structure

The NHDN consists of a number of institutions organized in an NHDN Committee with the Department of Community Health, Addis Ababa University acting as a focal point or nucleus.

The NHDN Committee is chaired by the Head of the Department of Social Services of the Central Planning Supreme Council and consists of: the National Revolutionary Development Campaign and Central Planning Supreme Council, Central Statistical Office, Ethiopian Water Commission, Health Research Council, Institute of Public Administration, Planning and Programming, Bureau of the Ministry of Health, Ethiopian Nutrition Institute, Central Laboratory and Research Institute, Gondar College of Medical Sciences, National MCH Centre, the future Health Sciences Centre - Jimma, Institute of Pathobiology, Institute of Development Research and the Department of Community Health (AAU).

The Functions of the Committee are to:

- (a) elaborate further the functions of the NHDN and establish its own internal regulations;
- (b) designate membership of institutions to NHDN;
- (c) formulate policies of NHDN and establish plans of action;
- (d) allocate functions and activities to members of NHDN;
- (e) distribute funds allocated to NHDN;
- (f) monitor NHDN activities, effectiveness and efficiency;
- (g) create subcommittees, working groups etc., as needed.

The Nucleus will:

- identify additional institutions and/or units that could be included in NHDN;
- identify additional roles and functions for NHDN in order to further the achievement of the objectives of the network;
- coordinate the efforts of the different elements of the network in carrying out the functions of NHDN;
- publish the NHDN Newsletter (in Amharic) and the Health Development Journal;
- act as a prime mover as well as a catalyst for the efforts of NHDN;
- recruit and employ the necessary personnel;
- act in general as focal point and secretariat for NHDN activities.

The NHDN has identified activities for 1982-1983 and is laying down a general outline of areas of work and development up to 1985.

GLOSSARY

AAU	Addis Ababa University
ACMR	Advisory Committee on Medical Research
AFRO	African Regional Office of WHO
CHA	Community Health Agent
CHSP	Community Health Services Programme
CPSC	Central Planning Supreme Council
CSO	Central Statistical Office
EPI	Expanded Programme on Immunization
ESTC	Ethiopian Science and Technology Commission
HFA	Health For All
HRC	Health Research Council
HSR	Health Services Research
JCHP	WHO/UNICEF Joint Community on Health Policy
MCH	Maternal and Child Health
MOH	Ministry of Health
NHDN	National Health Development Network
PHC	Primary Health Care
SAREC	Swedish Agency for Research Cooperation with Developing Countries
SIDA	Swedish International Development Agency
TBA	Traditional Birth Attendant
TCDC	Technical Cooperation Among Developing Countries
UNICEF	United Nations Children's Fund
WHO	World Health Organization