

Project AID 9459
 Italian contribution to the Health Sector Development Program (HSDP) 2011-2012
 Evaluation 2016/17
 Synthetic Report



Primary Hospital Ziway

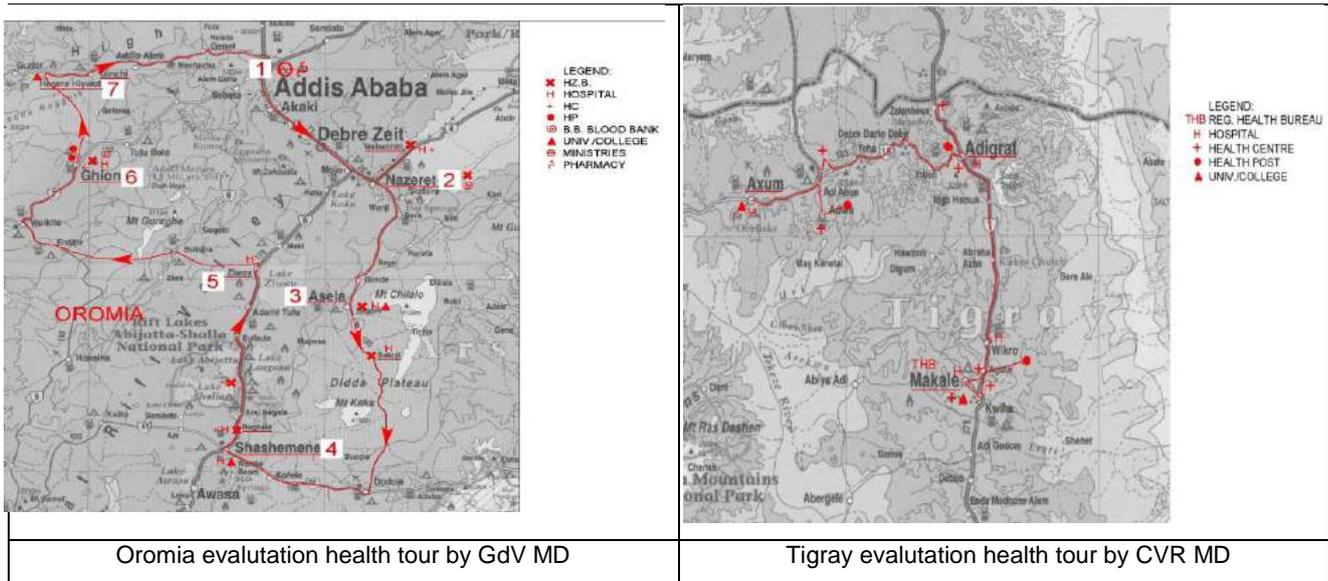
This evaluation summary report resumes the outcomes of the project: *Italian contribution to the Health Sector Development Program (HSDP) 2010-2012 - Aid 9459*, financed by the Italian Ministry of Foreign Affairs and International Cooperation (MAECI), as a multi-donors contribution to the Millennium Development Goals Fund (MDGF) and as bilateral support to HSDP IV, with a free-grant-budget of € 8,200,000.00, from March 2011 to September 2014, implementing the primary rural health system in Oromia and in Tigray in the achievement of the 3 health Millennium Development Goals (MDG) 2015:

- G4: reduce 2/3 the under-five mortality rate,
- G5: reduce 3/4 maternal mortality ratio,
- G6: halting and reversing the Tb/HIV/Malaria incidence;

to improve the quality of life in Ethiopia, especially in mother & child sector, supporting the health rural policy, the health staff upgrading, the Health Management Information System (HMIS) with procurement & equipment too.

Dr. Gianluca de Vito and Dr. Carlo Resti (MDs) with the Ngo Vpm & AOSCF collaboration, drew the Evaluation Health Report, with the assistance of Mr. Edao Simba under the Ceseco International leadership. The Authors wishes to thank the MAECI-DGCS-Office IX in Rome, the Italian Embassy, the AICS, the TAMU in AA, together with the FMOH and Regional Authorities, the Health Directors & Operators in the field.

The full version Report Evaluation is published on the MAECI web-site



Relevance: Project Aid 9459 has followed the FMOH rural health strategy, during HSDP IV, to achieve the MDGs 2015, reducing the mother & child mortality, contrasting Hiv/Malaria/Tb (G4/G5/G6). So the project targets were relevant to improve the population’s health in Oromia & Tigray, considering the Ethiopian low development rates on the Health Development Index (HDI-UNDP) 2015. Relevant is the organization of the skilled birth attendance, decreasing mother-child recurrences & the domestic deliveries. At the same time the family-planning & contraception policies (CAR) is an innovative national strategy to contrast the early marriage, reducing birth in vulnerable conditions, both well accepted by the local civil society, with the institutionalization of the Women Development Groups (WDGs). Relevant is the increased young women health professionals (HEWs) in the HPs, as fundamental instrument to involve the isolated communities in the governmental rural welfare, with gender priority.



Efficiency: the 50% annual international aid, integrated at the National Health Account (NHA) to support HSDP IV, achieving the 3 health MDGs 2015, is an efficient governmental result, also meaning local credibility. The implemented rural health network, with: a) adequate catchment areas in the HPs and HCs, (not yet reached for the hospitals); b) emergency 24/hs. surgical duty in the PHs (some in construction), with the free ambulance hospital transport from the HCs and blood transfusion regional service; c) rural pregnancy protection, gender contraception contrasting teenager early marriage and pregnancies, avoiding domestic delivery; d) skilled health professionals, as the IESOs in the 24/hs surgical duty in the all PHs; was an efficient low-cost health plan, emphasized by the MDG Report 2015 to improve health at the rural population.



Health Woreda meeting in Tigray



Health Zone meeting in Oromia

Effectiveness: the infant under 5yrs. mortality (U5MR) with 217 deaths x 1000 new-born in 1997, is decreased at 80 infant deaths during HSDP IV, approximately the target of 75 in Sub-Saharan Countries, with the achievement of the G4 (APR/EFY/07). The Mother Mortality Rate (MMR) from 990 pregnant deaths x 100,000 new-born in 1990, decreased at 676 mother deaths in 2011.

However no actual MMR has been reported on the latter APR/07, as a result still in progress to G5. Anyway the mothers & children participation at the pre/post natal and at the family-planning/CAR services, confirms preventive & care effective action, documented by the preventive and curative high performances.

The percentage health-Staff/people ratio was also increased at 147%, during HSDP IV, improving the health accessibility of the population, almost doubling the OPD performances per capita (0,48) from 2002 and also in comparison with the specific Vb 0,3 project's indicator (APR/EFY/07). The complex organization of the 24/hs surgical hospital duty in the PHs allows to treat correctly the obstetric emergencies, almost the 11% of the total deliveries.

Particularly the increased number of the HPs (16,447) and the HCs (3,586) has reached the standard catchment areas, but not so for the hospitals (PHs), many of them still being in construction (HHR1/FY/08).

The HMIS monitors constantly the federal health situation to the local & international authorities, *to reach the level of a middle-income economy.* (MoFED/2010). A remarkable result of efficacy documents: 64 yrs. of life-expectancy of the Ethiopian population and 65 yrs. for the females (UNDP 2014).



Asela Health University



Sashamane PH

Impact: during AID 9459, the community participation in the pre/post-natal, preventive & curative rural services, had a remarkable gender impact in the government's health policies, involving a huge numbers of WDGs, as the civil-society protection to the mother & child sector, achieving G4 & G5.

The G6 results are still in progress, impacting a considerable numbers of vulnerable patients, mostly Hiv/Tb, previously excluded from any kind of health assistance.

The MDGs 2015 guidelines, in fact, envisaging free health in the mother & child sector, reversing the incidence of Hiv/Malaria/Tb too, has achieved higher performances than the targets preview (APR/EFY/07).

The gender impact was massive in family-planning & contraception policies (CAR), to prevent teenager early marriage and pregnancy (APR/EFY/07). During HSDP IV the doubled percentage of OPD (0,48 per capita) in EFY/07, over the Vb 0,3 project Indicator, has implemented health accessibility with a successful rural impact.

The HMIS also, publishing regular health dates, was an important scientific instrument to emphasize the primary health rural low-costs plan (MDG Report 2015).



New PH (Bekonji)

New hospital equipment

Sustainability: the HSDP IV, supported by Aid 9459, realized many sustainable health developing activities both quantitatively & qualitatively in the mother & child sector, comparison the poor previous health situation, geared toward the meeting (G4/G5/G6) of the MDGs 2015.

The complex management of the 24/hs surgical duty in the PHs, with graduated technical staff (IESOs and Anesthesiologists), appears sustainable in the short term addressing the previous inadequate emergency assistance at the 11% obstetric recurrences, over the total birth; becoming effective in long term, once completed the primary hospital's rural network, granting health support at the communities involved in their productive familiar activities.

Monitoring the pregnancies, the ANC services, with HMIS registration, allows a sustainable management of the obstetric complications and emergencies. And so did, family-planning & contraception (CAR) provided in all the HPs, HCs & HPs, mostly serving an adequate catchment areas.

Such preventive gender services are sustainable decreasing the demographic rise & reducing early marriage and pregnancy.

In conclusion the action carried out by HSDP has therefore been sustainable both from professional & managerial point of view, taking into consideration the Ethiopian life expectancy increase up to 64 yrs. for men, to 65 yrs. for women (UNDP 2014).

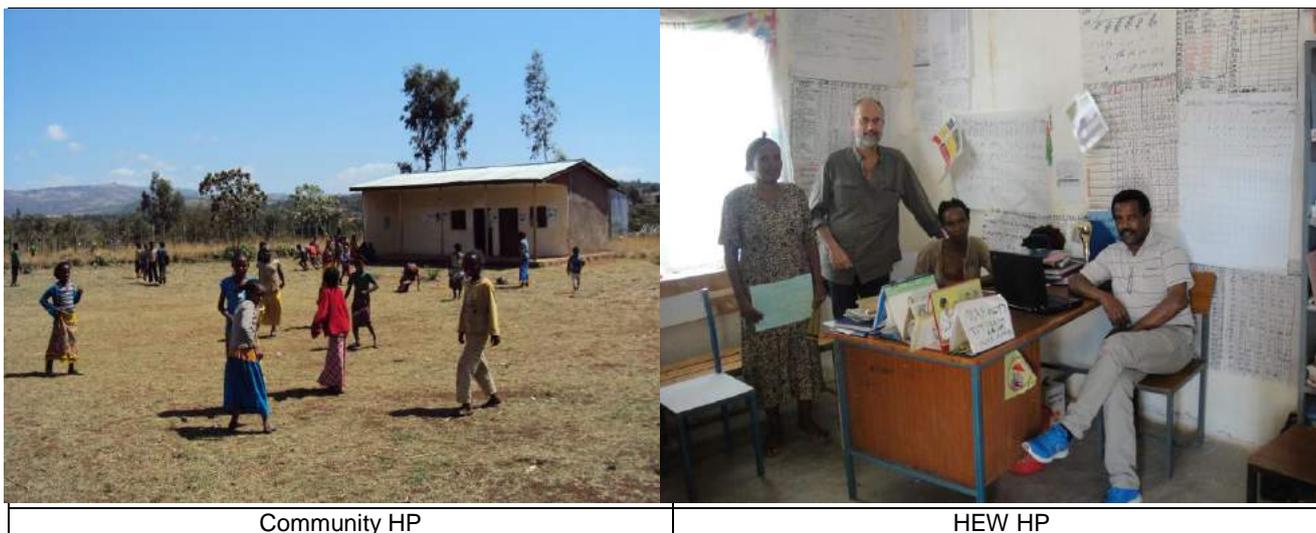
However it must be again pointed out that: a) the low federal annual budget per capita (Usd 16,1) is under the WHO standard and still limits the rural health assistance.

At the same time the Ethiopian primary rural health system is an example of low-cost rural health plan (MDG Report 2015); b) the international contribution, up to 50% of the NHA, has permitted to realize correctly HSDP IV to achieve the G4/G5/G6.

Hopefully, the unsustainable budgetary situation should change during the SDGs 2030. Such modifications will be the next governmental priority, beginning with the new *Health Sector Transformation Program* (HSTP), focused on the economic sustainability of the rural health system.

Among the foreseeable measures, adopted by the government, collective health insurances and the imposing VAT to increase the governmental NHA own percentage.

Up to now, the federal health system in accordance with the international donors, depending on the 50% of international contribution, doesn't have yet a sustainable own domestic economy.



Community HP

HEW HP

Lessons learned

L 1 - Relationship: the evaluation, as mandatory part of the project cycle management, is frequently seen as an unwanted meddling, causing initial diffidence in the local partners, especially if part of the resources (C1) is a multi-donor contribution (to MDGF) and a bilateral low contribution, (as example the C2a to Oromia), compared to the annual regional health budget.

Such contribution (C2) for the 2 regions, instead of being employed into specific health sectors, was parcelled out into too many issues. However the local counterpart much appreciated the repairing of ambulances, their maintenance and health essential supplies procurements.

L 2 - The primary health rural network (HP-HC-PH): albeit the remarkable widening of the basic rural primary health system in Oromia & Tigray, the staff harmonization to the standards are still in progress, especially in hospitals (PHs) with the actual too large catchment areas.

It was also noted that many new health-buildings, realized in elemental constructions, were poor quality and already need of renovation and maintenance interventions.

The hospital waste disposal is not regulated. The waste is simply burnt in external incinerators, without filters and close to the wards.

L 3 - Biomedical equipment: the new biomedical equipments, mostly in the PHs, are frequently poor quality and not provided with the necessary maintenance and repairing guarantees (Ultrasound & Radiology).

The diagnostic instruments suffer from such limits, reducing the quality and the hospital appeals, together with the confidence of the newly trained technical staff.

Particularly, the ultrasound instruments are frequently out of order, damaging the ANC service and the early diagnosis of the obstetrical complications and their referral planning as well.

The film Radiology equipment, (especially for trauma), producing lots of chemicals polluted liquids in the environment, is frequently out of order, lacking of qualified maintenance and films.

The X-rays protection is also insufficient both for the patients and the operators.

L 4 - Health staff training:

A) Too frequent use of (free) upgrading of the employed staff. The newly health students, on the other hand, did not enjoy any facilitation. They also were not sure to be employed after graduating. It was also difficult to evaluate the training quality.

B) The treatment of obstetric surgical urgencies, about 11% of the total deliveries, should be monitoring. Such surgical invasive activity, when not properly broached, due to lack of diagnostics (see L2) and/or surgery expertise limits (L3), deeply affects the targets G4 and G5, causing the major damages.

The IESOs are working without having any tutoring and/or surgical monitoring on the job. Much more attention should be given so, to the education of such innovative professionals IESOs, at the top of primary health rural network, instead too much upgrading and/or many different specialisations.

In both educational cases, it was impossible to check the quality of the upgrading courses or the level of preparation of the staff that was being upgraded.



Recommendations

R1 for L2 and L3: HC net buildings & equipment (HPs-HCs-PHs):

- A) Choose the specific health facilities, to be renovated or built, from scratch and the technological upgrades in advance.
- B) Purchase easy handle and strong medical equipment, provided with warranties and including maintenance services.
- C) Implement ordinary and extraordinary maintenance of the structures and ambulances.

R2 for L4: Health operators staff training:

- D) Share the upgrading plan for the employed staff, and relate it to the maintenance of the basic health services provision. Carry out staff turn-over only after letting the newly employed and the old one work together for a while. Fund specific training activity in just one sector at time, thus avoiding the too high fragmentation to cause poor training results. Altogether C3 could be used also for the specialist local training, supported by clinical consultants (locals & expatriates).
- E) Upgrade the evaluation of the training quality by giving out questionnaires or interviews, with the assistance of the Tamu. Part of C3 could support external clinic-consultants in educational monitoring.
- F) Within the limits of the earmarked for the training funds, pinpoint essential professional roles and/or single training issues, such as the hospital obstetric emergencies, to follow the improving of care action (as examples: pre-natal ultrasound service and/or the Obstetric BEmOC and CEmOC).

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Tamu Staff & Evaluators - Addis