

# Financial Resource Flows for Population Activities

Report of a case study in Ethiopia

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The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.



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# Preface

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In the Programme of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Programme of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Programme of Action. This means four categories of population activities:

- family planning services;
- reproductive health services;
- STD and HIV/AIDS activities;
- basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analyzing population data will cost US\$ 17.0 billion in 2000, and increase to US\$ 21.7 billion in 2015. Two-thirds should be paid by the recipient countries, one-third will be paid by the international donor community.

The case study in Ethiopia was conducted from 10/11/1998 to 28/11/1998, and forms part of the UNFPA-NIDI project which measures global financial resource flows for population activities. For this purpose, questionnaires were sent during June and August 1998 to public and private donor organizations in developed countries, and to government departments and

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national NGOs in developing countries. Collecting all this information from a broad range of respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. For better illustrations of the problems, seven case studies were carried out during 1997 and 1998. The case studies will complement our knowledge about financial flows for population activities that were obtained through the mail enquiry.

Data for this report were gathered in November 1998 by two persons: Ms. Marja Exterkate, from the UNFPA/NIDI Resource Flows Team, and Mr. Kassaye Demena, Communications Consultant. Valuable help was provided by Ms. Linda Demers, UNFPA representative and Mr. Duah Owusu-Sarfo, UNFPA deputy representative at the Ethiopia UNFPA office.

Due to the complexity of international and national resource flows in population assistance, and the relative short duration of the study, it is possible that this report contains significant omissions or errors. The authors will welcome any comments or corrections.

Ms. Marja Exterkate and Mr. Kassaye Demena  
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# 1. Demography of Ethiopia

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With an estimated 57 million inhabitants in 1997, growing a little less than three per cent per year and a per capita income of US\$ 110 in 1996, Ethiopia is one of the poorest and most populated countries in Africa. It is a land of geographical and cultural contrasts. Through two decades of recurring drought and civil war, the country became impoverished. It is estimated that over 70 per cent of the population live below the poverty line (NOP/UNFPA, 1997, p. 3). It is characterized by a diversity of cultures, languages, and habitats (UNFPA, 1998, p. 4). Table 1 provides some basic national demographic indicators for Ethiopia during the last 25 years. These figures are national averages, and do not show the variations across the regions and population groups.

*Table 1. Basic national demographic indicators*

	1970	1984	1990	1994	1996/97*
		census		census	
Population (million)		40.1		53.5	57
Average annual growth rate	2.5	2.9	2.9***		2.6
Per cent Urban*				14	14
Crude Birth Rate				44.4	40.5
Crude Death Rate	20	15.2			14.8
Total Fertility Rate		7.5	7.7***	6.7	6.1
Contraceptive Prevalence Rate			4.0		9.8
Infant Mortality Rate	153	110		116	105
Maternal Mortality Ratio					1,400
Life expectancy at birth		50.8		49.8	49.7
male					
Female		53.1		51.8	52.4

Sources: \* Ministry of Health 1998, p.4, p.7, p.9; MEDAC, 1997, p.4.

\*\* 1990 national family and fertility survey.

\*\*\* 1988.

The high growth rate, particularly since the 1980s has been largely due to the country's youthful population. In 1984 for example, 46 per cent of Ethiopia's population was 15 years and younger. Women of reproductive age (15-49) constitute 44 per cent of the total female population (Ministry of

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Health, 1998<sup>a</sup>, p. 11). Another factor contributing to the increase in population growth is the decline in the Crude Death Rate which dropped from 20 to 15.2 between 1970 and 1984. Infant mortality also declined during the period, dropping from 153 to 110 deaths per 1,000 live births between 1970 and 1984. Life expectancy at birth has also increased from 43.9 years in 1970 to 46.9 years in 1981 and to 51.9 years in 1984 (Ministry of Health, 1998<sup>a</sup>, p. 11). Since then however, life expectancy has declined, until 1994. More recently, life expectancy for females shows some improvement. The 1990 National Family and Fertility survey suggested a national TFR of 7.7 and a contraceptive prevalence of 4.8 per cent. Fertility has declined to slightly more than 6 children per women in 1997, and estimates of the CPR show an increase to ten per cent.

Nearly two decades of civil war and centrally planned economic mismanagement ended in 1991 with an economy in crisis. In 1991, per capita income was lower than in 1960 (Ministry of Health, 1998<sup>b</sup>, p. 2). The Transitional Government of Ethiopia (1991) launched a market oriented economic policy in 1992 and has undertaken a number of policy measures and reforms to change the structure of the economy (Ministry of Health, 1998<sup>b</sup>, p. 2). In August 1995, power was transferred to the elected Government, which established the Federal Democratic Republic of Ethiopia. However, Ethiopia's socioeconomic indicators continue to show a very low level of economic and social development (UNFPA, 1998, p. 4).

Administratively, the Federal Democratic Republic of Ethiopia is subdivided into nine Regional States (Tigray, Afar, Amhara, Oromia, Somalia, Benishangul- Gumuz, SNNPR (Southern Nation, Nationalities and Peoples Region), Gambella and Harari) and two Administrative Councils (Addis Ababa, Dire Dawa). These regions and councils are further subdivided into 62 Zones and 523 Woredas (districts). There are also two zones and seven Woredas classified as special (Ministry of Health, 1998<sup>b</sup>, p. 1). Increasingly, administrative and financial authority is being given to the Regional States, as part of the decentralization efforts of the Government.

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## 2. Methodological issues

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Data for this report were gathered in November 1998 by two persons: Ms. Marja Exterkate, from the UNFPA/NIDI Resource Flows Team, and Mr. Kassaye Demena, Communications Consultant. Valuable help was provided by Ms Linda Demers, UNFPA representative and Mr. Duah Owusu-Sarfo, UNFPA deputy representative at the Ethiopia UNFPA office.

The specific objectives of the case study in Ethiopia are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail inquiry;
- to use the findings of the study as benchmarks for studying the quality of data gathered through the mail inquiry in other countries;
- to investigate the roles of Government, NGOs, private sector and the international community in the field of population activities;
- to gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programmes within the country? And how?

The Ethiopian case study was planned after the global data collection period to gather data on financial flows for population activities for 1997. During August and September, questionnaires were sent to 21 government departments, nine regional population offices, one population and health bureau of the Dire Dawa Council and 14 Ethiopian NGOs. The response was 39 per cent (eight government departments, six regional population offices, of which three did not have any population activities in 1997, and three Ethiopian NGOs).

The two major reasons for the low response were firstly the high turn over of staff, remain some posts vacant for a long time and secondly the fact that no specific budget line exists for population activities at Government departments, which means that the questionnaire could not be filled in.

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None of the departments in the Ministry of Health responded in the mail inquiry, but during our visit, we got some estimates from two departments, but no additional detailed data could be retrieved during the case study. It is realized that this is a serious shortcoming.

From 10/11/98 to 28/11/98 interviews were held with representatives from ministries, international donors (bilateral and multilateral), and national and international NGOs in Addis Ababa. Annex 1 provides a list of all persons and organizations contacted during the case study. With a few exceptions, the co-operation of all respondents was very positive.

During the case study it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years:

- In line with the ICPD PoA, more and more projects are integrated development projects. Therefore, expenditures for the four separate categories, as defined in paragraph 13.14 the ICPD 'Programme of Action' are often very difficult to distinguish, and are fairly often rough estimates. In line with this, there is the problem that the four population activity groups which are used to categorize financial flows are not completely mutually exclusive. Especially the lines between reproductive health, family planning and sometimes HIV/AIDS prevention activities are not always obvious.
- Most government expenditures are expenditures related to staff, housing (particularly for those living in rural areas), office and office supplies, utilities, free radio and television airtime for broadcasting population messages, as well as tax-exemptions on contraceptives, medical equipment and related materials, data-processing-facilities and vehicles. These indirect or in-kind expenditures are often hard to measure.
- The Government budget in Ethiopia has no separate budget line for population activities or for reproductive health.
- The Regions in Ethiopia are autonomous, and accountable to the regional council, and not to the national Government. Within the short time period of this study, it was not possible to get information from the Regions.
- Brain drain in the public sector causes enormous problems.
- Annual data collection through the questionnaires as is currently done within the UNFPA/NIDI projects, needs to be revised in order to cover expenses at the regional level. Perhaps, extending the data-collection period would overcome the major problems.

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## 3. Official Population Policy and Programmes

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### 3.1 | National Population Related Programmes

Ethiopia's population growth has for a long time been a cause of concern. However, official policy was never declared until five years ago. The National Population Policy was launched in April 1993 by the Transitional Government (MEDAC, 1997, p. 1). This policy was promulgated in line with the new economic policy, which recognized that the formulation and implementation of a population policy was an integral part of macro-economic planning and was necessary to ensure a balance between population and economic growth (UNFPA, 1998, p. 5). The National Office of Population (NOP) was initially established in 1994 in the Office of the Prime Minister, and transferred to the Ministry of Economic Development and Co-operation (MEDAC) in 1995. Its main objective is to develop programmes, co-ordinate the overall population programme at the national level, give technical assistance, and mobilize external resources. In nine Regional States and one Administrative Council (Dire Dawa), Regional Offices of Population (ROP) have been established during 1995 and 1997 to co-ordinate the implementation of the policy at regional level. At the federal level, implementation will be carried out by the sectoral ministries. Within the national policy, the ten regional population structures set their own priorities, and are quite autonomous. Although they do not receive direct financial subsidy from the Federal Government, they can get technical assistance. The regions as administrative entities, do receive an amount from the Federal Government, in addition to own generated financial resources. They are at liberty to use the federal subsidy in accordance with their own regional development priorities. A National Health Policy was adopted in September 1993, which aims at decentralization of health care, expansion of facilities, and the implementation of comprehensive and integrated primary health care based on community-level health facilities with an emphasis on prevention (UNFPA, 1998, p. 5). The Family Health Department in the Ministry of Health and the Regional Health Bureaux are responsible for reproductive health at federal and regional levels respectively.

Until recently, Ethiopia's health system was highly centralized, with services being delivered in a fragmented way via vertical programmes (Ministry of Health, 1998<sup>a</sup>, p. 14). As management of public sector services becomes

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decentralized, regional, zonal, and district (woreda) departments will be increasingly strengthened (Ministry of Health, 1998<sup>a</sup>, p. 15). Decentralization of the public health system has provided regions with the opportunity to define priorities within reproductive health that reflect their own needs (Ministry of Health, 1998<sup>a</sup>, p. 32). Efforts are underway to introduce or expand the delivery of reproductive health care services and supplies through community-based agents and distributors (Ministry of Health, 1998<sup>a</sup>, p. 38).

The Government of Ethiopia has ratified the Convention on the elimination of all forms of discrimination against women, and has established a supportive policy and institutional framework for the advancement of women and the achievement of gender equality (UNFPA, 1998, p. 5). The announcement of the National Policy on Women in September 1993, the promulgation of the new constitution in 1995, and the establishment of the Women's Affairs Office in the Prime Minister's Office in 1994 clearly demonstrates the Government's progressive views on issues of gender equality and women's empowerment (UNFPA, 1998, p. 5). Women's Affairs Departments have been established at all major sector ministries, and at the regional level, Women's Affairs Bureaux are established. The offices are responsible for co-ordinating the gender dimension of population IEC and advocacy activities. The most active ones are in the Ministry of Labour and Social Affairs, with the emphasis on family, women, children, youth, elderly and disabled, and in the Ministry of Agriculture, where the emphasis is on integrating family life education in the training centres for rural development agents. The Ministry of Education also plays an active role in promoting gender concerns within its population education programmes for in-school groups.

Although there are separate policies for population, women, health, and others (like education, social policy, HIV/AIDS, *et cetera*) all of them reinforce each other, and are interrelated. However, the integration of population issues in the national development planning process is still weak. Goals set for the year 2001/02 and 2015 are given in table 2.

What follows is a brief summary of the main items of the national population policy.

*Table 2. Demographic goals for the years 2002 and 2015*

Indicator	Goal for 2002	Goal for 2015
Contraceptive Prevalence Rate	15-20%	44%
Total Fertility Rate		4
Annual natural population growth rate	2.5% - 2.7%	
Infant Mortality Rate	90 -95	
Maternal Mortality Ratio	450-500	

Source: 2002: Ministry of Health, 1998, p.4; Ministry of Health, 1998<sup>a</sup>, p.13.  
2015: National Population policy

The major goal of the National Population Policy is "the harmonization of the rate of population growth and the capacity of the country for the development and rational utilization of natural resources to the end that the level of welfare of the population is maximized over time" (National Population Policy of Ethiopia, p. 26). To implement this policy, the National Office of Population co-ordinated the drafting of a Plan of Action for the years 1994-1999 (MEDAC, 1997, p. 1). Since then, several important changes have taken place: at the national level, the process of regionalization and the decentralization of authority and responsibility (MEDAC, 1997, p. 1); at the international level, the ICPD conference in 1994 which placed emphasis on reproductive health. After these changes, the Plan of Action was revised and updated, replacing it with the National Population Programme (MEDAC, 1997, p. 1).

Some of the specific objectives include (National Population Policy of Ethiopia, pp. 28/29):

- reducing the Total Fertility Rate to approximately 4.0 by the year 2015;
- increasing the prevalence of contraceptive use to 44.0 per cent by the year 2015;
- reducing maternal, infant and child morbidity and mortality rates as well as promoting the level of general welfare of the population;
- increasing female participation at all levels of the educational system;
- removing all legal and customary practices militating against the full enjoyment of economic and social rights by women including the full enjoyment of property rights and access to gainful employment;
- ensuring spatially balanced population distribution patterns;
- mounting an effective country wide population information and education programme addressing issues pertaining to small family size and its relationship with human welfare and environmental security.

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The National Population Policy and Programme contains three interrelated thematic areas to be implemented in the years 1997 to 2001:

1. Reproductive Health/Family Planning;
2. IEC and Advocacy;
3. Population and Development Strategies.

*ad. 1. Reproductive Health/Family Planning*

The objectives of this component are to (MEDAC, 1997):

- integrate and strengthen reproductive health services (family planning, safe motherhood, adolescent reproductive health, prevention and treatment of STDs/AIDS, prevention of unsafe abortion and its complications, screening of reproductive tract infections, infertility, sexual health and discouragement of harmful practices) in all health institutions and establish community level distribution centres.
- strengthen the capability of reproductive health service delivery institutions through training and provision of materials and commodities.
- establish and implement management information system to expedite reproductive health programme implementation.

The Ministry of Health integrated family planning with mother and child health activities in 1980 (MEDAC, 1997). In spite of this, only 30 per cent of pregnant women receive antenatal care in 1997 and less than ten per cent of pregnant women deliver in health care facilities in the same year (Ministry of Health, 1998<sup>a</sup>, p. 12). Services hardly available are post-abortion care, appropriate STD detection and treatment, safe delivery and postnatal care, and emergency obstetric care (Ministry of Health, 1998<sup>a</sup>, p. 42).

Although the range of contraceptive methods theoretically available in Ethiopia is broad, this hasn't resulted in higher contraceptive prevalence nor has it translated into a broad method mix (Ministry of Health, 1998<sup>a</sup>, p. 51). The contraceptive prevalence has increased from four per cent in 1990 to currently about ten per cent. Unmet need is as high as 56 per cent. Of the total number of users, 72.3 per cent is using pills, 7.4 per cent condoms, 18 per cent injectables, 1.5 per cent IUD, 0.41 per cent Norplant, and 0.39 per cent other methods (Ministry of Health, 1998, p. 14).

In Ethiopia, abortion is illegal, except on certain medical grounds (Ministry of Health, 1998<sup>a</sup>, p. 13). Nevertheless, abortion is widespread and generally performed by untrained persons (Ministry of Health, 1998<sup>a</sup>, p. 13). Complications due to unsafe abortions account for 54 per cent of all direct

obstetric deaths (*ibid.*). Studies indicate that abortion is most common among single women, teenager students and factory workers (*ibid.*), and that 86 per cent of women seeking menstrual regulation were in the range of 15 to 29 years.

Harmful traditional practices such as marriage by abduction, sexual violence, early marriage (at an age of 15-16), and female genital mutilation (FGM) are still common. Female genital mutilation is practiced in one form or another by at least 73 per cent of Ethiopia's population (Ministry of Health, 1998<sup>a</sup>, p.20). The type of circumcision practiced does vary greatly by region, but in general, sunna (or clitoridectomy) is the most common form of circumcision followed by excision (*ibid.*).

#### *ad. 2. IEC and Advocacy*

This area will be used to increase knowledge, understanding and commitment of policy makers, community leaders, families, couples and interest groups at all levels, and focuses at achieving attitude or behavioural change in areas as family, sexuality, reproduction, gender and environment. Furthermore, it tries to increase knowledge on family planning methods and usage.

IEC activities on health have been going on in the Ministry of Health ever since 1988. In 1995, the department responsible for the IEC activities was given a semi-autonomous status within the Ministry of Health, and named the Health Education Centre (HEC). The centre co-ordinates IEC activities on health concerns in the country, in collaboration with other departments in the Ministry of Health (i.e. those related to reproductive health, epidemiology, HIV/AIDS), as well as the relevant body in the Ministry of Education and the regional health bureaux. The centre has its own printing press, audio-visual facilities, and is responsible for the production and distribution of IEC materials on health. It also has a research, evaluation and training unit, and provides technical support in health education activities to other government departments, regional health training bodies, NGOs, missions, churches, *et cetera*. The centre is also involved in health education curriculum development as well as in programmes for in-service training of doctors, nurses, and community health workers. Reproductive health is now incorporated in most of the curriculum of national training institutions for health assistants, nurses and midwives. There is a training centre in most of the regions.

#### *ad. 3. Population and Development Strategies*

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This area is subdivided into three components: data collection, research, and training. Through the data collection sub-component, the country's socioeconomic and demographic databases at national and regional levels will be strengthened, and the capacity for generating, analyzing and disseminating these data will be improved and strengthened. The research part aims at generating greater understanding of socio-cultural, economic, and demographic relationships. Training mainly focuses on population programme management, and integrating population into development.

The Central Statistical Authority (CSA), which was established in 1961, is the principal source of data on population, and has conducted a number of national surveys, and the 1984 and 1994 Population and Housing Censuses. It is an autonomous agency responsible to the Ministry of Economic Development and Co-operation (MEDAC). The Population Analysis and Studies Centre was created in 1988. The centre is responsible for collecting, analyzing, and dissemination population data.

In 1987, a Population and Development Planning Unit (PDPU) was created in MEDAC, with the objective of integrating population activities into development planning. Its main role is to conduct training, organize workshops and seminars at national and regional levels.

The Institute of Development Research at the Addis Ababa University serves as an umbrella for the academic research programmes of the University. The two population-related units here are:

The Demographic Training and Research Centre, (DTRC) was established in 1982 with funding from UNFPA. Its activities started in 1987. The DTRC is the only training and research institute dealing with population issues and the growing importance of population in policy making and planning. Furthermore, it is the only institute that provides advanced training in demography and population studies. Training is done on various levels, graduate, undergraduate, and in-service training. Research is done by both students as well as staff, and focuses on population, health, and nutrition; population, environment and sustainable development; policy, programme, and project assessment, monitoring and evaluation.

The Centre for Research, Training and Information on Women in Development (CERTWID) was established in 1991/92 with funding from UNFPA. Studies deal with gender, population and development. The idea is to make CERTWID a focal point on gender matters.

### 3.2 | HIV/AIDS Programme

HIV/AIDS has emerged as a serious public health problem in Ethiopia. The first reported seropositive cases were identified in 1984, while the first AIDS case was reported in 1986. Currently, there are 2.6 million HIV infected persons in Ethiopia, which is 8.5 per cent of the world total (DKT fact sheet, 1998). It means, that 7.4 per cent of Ethiopian adults have HIV (*ibid.*), in urban areas this is even as high as 17 per cent. 75 per cent of the new HIV infections was transmitted through multiple partner sexual contact and 25 per cent are due to perinatal transmission (Ministry of Health, 1998<sup>c</sup>, p. 6). Although, through April 1998, 57,000 cases of AIDS were reported to the Ministry of Health, the actual number of AIDS cases might probably be around 400,000 by the end of 1997 (Ministry of Health, 1998<sup>c</sup>, p. 2). 90 per cent of the reported AIDS cases occur to adults between 20 and 49 year of age (*ibid.*). Besides the human tragedy, this will also have an impact on the economic situation as well.

Although the National HIV/AIDS Control Programme within the Ministry of Health has been operational since 1987, the HIV/AIDS surveillance system is weak and sentinel surveillance activities have not been carried out since 1993 (Ministry of Health, 1998<sup>a</sup>, p. 13). Before 1991, the HIV/AIDS department had more than 40 well-trained people, but after 1991, when the decentralization started, most people were transferred to the regions, and the central level was left with three people. Thus, between 1991 and 1995, there was hardly any activity taking place in the HIV/AIDS Control Programme. In 1996, partly due to a reassessment of the situation, activities started again. IEC campaigns have resumed, 65 HIV screening laboratories have been opened, and a number of anti-HIV clinics for in-and out of school groups were established. Counselling centres have also been set up, and promotion (social marketing) of condoms is in full progress. Two regions, Amara and Tigray have established a HIV/AIDS co-ordinating body outside the Ministry of Health. NGOs play a very active role in the HIV/AIDS programme.

A national policy on HIV/AIDS was endorsed in August 1998. It focuses on programmes to prevent the spread of HIV/AIDS, to take care for those with HIV/AIDS, and to reduce the adverse socioeconomic consequences of the epidemic. IEC campaigns will focus on awareness creation. Persons with HIV/AIDS will be involved through education, counseling and peer group discussions to help themselves to live with HIV/AIDS and to communicate to the community (Ministry of Health, 1998<sup>c</sup>, p. 38). The policy calls for

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prevention and control measures, blood testing, sentinel surveillance, and ensure the human rights of people with AIDS. Strategies to follow are grouped in ten areas: IEC; STD prevention and control; HIV testing and screening; sterilization and disinfection; HIV/AIDS surveillance, notification and reporting; medical care and psycho-social support; research and development; HIV and human rights; regional and international relations; policy implementation and co-ordination. A concept five year multi-sector HIV/AIDS strategy plan is currently being developed with assistance of UNAIDS.

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## 4. Financial Flows

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It we look at Ethiopia's health budget, it is impossible to distinguish our population categories from the total health budget, as no special budget lines do exist for family planning/reproductive health or HIV/AIDS activities. Despite the fact that there are different departments which are responsible for some of the specific areas, e.g. the Family Health Department is responsible for reproductive health, the Epidemiology and AIDS Department for AIDS activities, there is only one health budget, without allocations to the several departments. The health sector is financed by the Government itself, the international donor community, health insurance, and community contributions (Ministry of Health, 1998<sup>b</sup>, p. 6). Table 3 gives a summary of sources of funding for the health sector in 1986 and 1996.

The total health budget increased from 357 million Birr in 1986 to 988 million Birr in 1996. Although this looks like a dramatic increase, the US\$ equivalent shows a decline: from US\$ 173 million in 1986 to US\$ 156 million in 1996. Government financing in the total health financing increased from 23 per cent in 1986 to 43 per cent in 1996. In 1996, total health sector expenditures represent less than three per cent of GDP. Of this amount, 43 per cent was contributed by the Government, 17 per cent by international sources, and 39 per cent from fees-for-services payments (Ministry of Health, 1998<sup>a</sup>, p. 13). Today, approximately 6.45 per cent of government expenditures are allocated to health. On a per capita basis, this works out to be about US\$ 1.20 per person- a minimal sum (Ministry of Health, 1998<sup>a</sup>, p. 14).

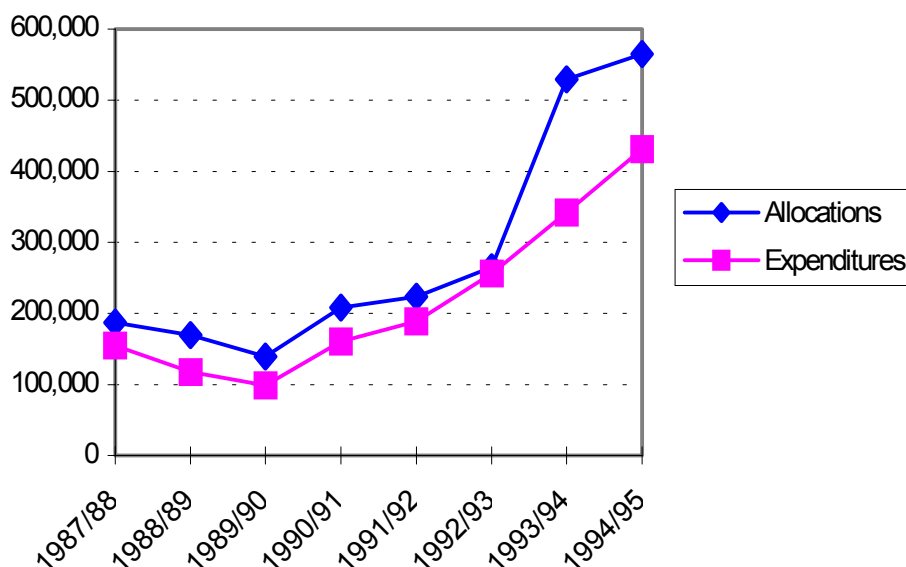
From 1987/88 to 1994/1995 Government and donor allocations for health have increased from 188 million Birr (US\$ 91 million) to 565 million Birr (US\$ 103 million). Expenditures fluctuated from as high as 97 per cent to a minimum of 65 per cent (see also figure 1).

Table 3. Sources of funding in the Health Sector in Ethiopia, 1986 and 1996 (in million Birr)

	Fiscal Year 1986				Fiscal Year 1996			
	Recurrent	Capital	Total	%	Recurrent	Capital	Total	%
Individual private payments:	226.5	0.0	226.5	63	388.4	0.0	388.4	39
Fees paid to MOH facilities	19.0	0.0	19.0	5	79.7	0.0	79.7	8
Fees paid to other facilities	207.5	0.0	207.5	58	308.7	0.0	308.7	31
Government of Ethiopia	79.0	3.4	82.4	23	281.7	142.0	423.7	43
External assistance	20.0	22.0	42.0	12	75.2	95.9	171.1	17
Health insurance	0.6	0.0	0.6	0	5.0	0.0	5.0	1
Other local sources	5.7	0.0	5.7	2	-	-	-	-
Total	331.8	25.4	357.2	100	750.3	237.9	988.2	100
Total health as share of GOE			12.6				10.2	
Total health as share of GDP			3.2				2.7	

Source: Ministry of Health, 1998<sup>b</sup>, p.6

Figure 1. Total health allocations and expenditures, 1987 – 1995  
(in '000 Birr)



Since 1992 there have been major changes in the structure of the Government budget to the health sector (Ministry of Health, 1998<sup>2</sup>, p.7). The most significant change is in the control over health expenditures, which has shifted to the regions. Since 1994, the region's share of the national health expenditure ranged between 83 and 88 per cent. In 1996, the regions commanded 83 per cent of the recurrent budget and 95 per cent of the capital budget.<sup>1</sup>

Also for future funding, the Government has decided that around 80 per cent of the funds will be allocated for activities at the regional levels. Allocations or expenditures at the Central level are made for curriculum development, guidelines, training, *et cetera*. The Central level is not in charge of any service delivery. Allocations or expenditures for service delivery are done at the regional and lower levels.

<sup>1</sup> *Capital budget* includes construction and upgrading of health facilities (including staff housing in certain cases), of training facilities, and of zonal and woreda health offices and drug stores, and training of primary health workers and primary midwives. *Recurrent budget* includes expenses on salaries, drugs, and other non-personnel expenses.

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In the following paragraphs, the role of the Government, International Donor Community and national NGOs will be discussed in more detail. The last paragraph looks into the nearby future.

#### **4.1 | Role of the Government of Ethiopia**

Questionnaires from eight Government departments (out of 21) were returned with data on expenses for population activities during 1997 (Women's Affairs Department at the Ministry of Agriculture, Women's Affairs Department in Ministry of Labour and Social Affairs, National Office of Population in MEDAC, Population Unit at CSA, CERTWID, Ethiopian Press Agency, Inst. for Curriculum Development at the Ministry of Education, Mass Media Training Institute). From another two departments within the Ministry of Health, we obtained some estimates during our visits: the Health Education Centre and the AIDS department. Three regional offices of population: SNNPRS, Oromia, and Amhara provided information as well. Another three regional offices reported that they did not undertake any population activity in 1997 (Afar, Gambela, Benshangul-Gumuz). The non-response, of especially the Family Health Department in the Ministry of Health is a serious shortcoming, as they are responsible for the reproductive health activities. It is difficult to estimate the actual contribution of the Government in monetary terms. For these 13 respondents the total came to US\$ 2.3 million, which means US\$ 0.04 per person. It is suspected though that even from this amount, some part still originally comes from donors. It has to be noted that 75 per cent of the amount originates from the census fieldwork, executed by the Central Statistical Authority (CSA). If one excludes the census project, only US\$ 412,000 would be left as national contribution to the population activities, distributed as two per cent family planning IEC, five per cent reproductive health IEC, 38 per cent HIV/AIDS IEC, and the remaining 55 per cent being research, coordination, *et cetera*.

#### **4.2|Role of the International Donor Community**

The Ministry of Economic Development and Cooperation (MEDAC) is responsible for the overall coordination and management of donor inputs. All donor funding, which may be earmarked for certain programmes should go to MEDAC at the federal level, which in turn makes the decision to which Ministry the funding goes. Ministries themselves are not allowed to approach the donors directly.

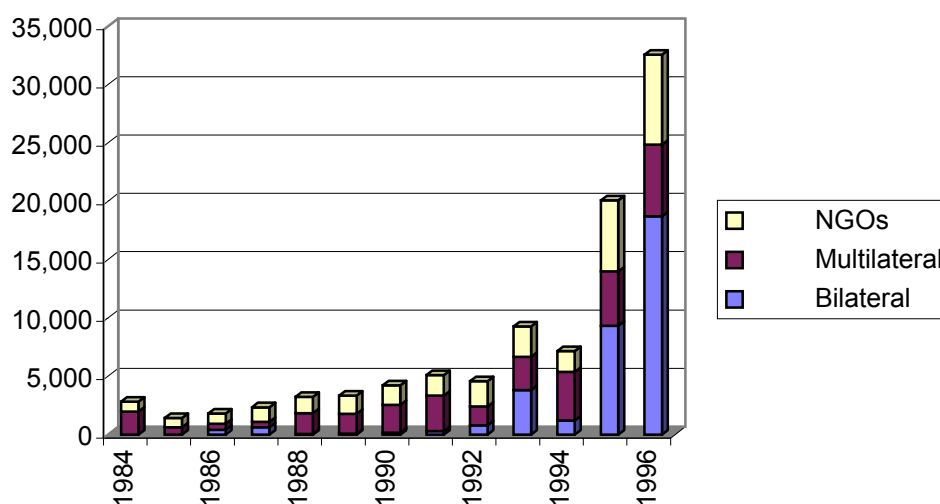
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In figure two we can see that total donor funding for population activities has gone up from US\$ 2.8 million in 1984 to US\$ 32.6 million in 1996 (Global Population Assistance Reports, 1993 and 1996). Especially, since 1995, the amount almost tripled. The channel of funds has been fluctuating from one year to another, but a global trend can be noticed towards increasing bilateral assistance.

In 1996, 40 per cent of the total donor funding was spent on family planning activities, 25 per cent to reproductive health, 28 per cent to HIV/AIDS activities, and seven per cent to research.

The UNFPA has been the principal donor in population activities, followed by USAID, the Netherlands, UNICEF and WHO. Attention will be paid to activities of some of the major donors.

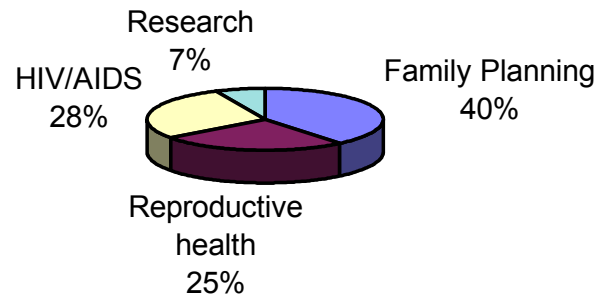
*Figure 2. Donor expenditures by channel of distribution in Ethiopia, 1984 - 1996 (in '000 US\$)*



Source: UNFPA, Global Population Assistance Reports.

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Figure 3. Donor expenditures by population category in Ethiopia, 1996



Source: Mail inquiry RF96.

#### 4.2.1. Bilateral Donors

##### **USAID**

USAIDS' Essential Services for Health in Ethiopia programme, started in August 1995, and will last till 2002. The total budget is US\$ 70 million, plus US\$ five million annually for field support. It combines program and project support: of the US\$ 70 million, US\$ 30 million is given as non-project support (e.g. legalization issues, aids policy), US\$ 40 million for project support, of which 26.5 million via BASICS<sup>2</sup> to the government, and US\$ 13.5 million to NGOs (via Pathfinder). The overall objective is to increase the use of primary and preventive health care services. The total programme consists of four main areas:

1. Policy reform: health care financing reform, increasing of budgetary resources to the health sector.
2. Increase the use and demand of modern contraceptives:
  - Supporting service delivery through NGOs: this goes through Pathfinder (see over there);
    - Expanding the contraceptive social marketing: this goes through DKT (see over there);
    - Increase knowledge of modern contraceptives: through Johns Hopkins University/Centre for Communication Programs to the National Office of Population, but this hasn't come off the ground (US\$ 300,000 a year);

<sup>2</sup> BASICS (Basic Support for Institutionalizing Child Survival) is USAID's largest child survival project. BASICS provides technical assistance to countries' priority health programs.

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- Increase the capacity of the Government to deliver family planning services: through all kind of training programmes;
  - Increase awareness of the importance of population factors in social and economic development: through RAPID.<sup>3</sup>
3. Strengthening the National AIDS control programme, with the AIDS-impact model for policy makers (through the Futures), which is used to project the consequences of the AIDS epidemic in terms of number of indicators such as people infected, number of AIDS cases and deaths, number of AIDS orphans and health care costs.
  4. Delivery of integrated services at the community level in the Southern Nations and Nationalities Peoples Region (SNNPR). This project is also delivered through BASICS. Reproductive health is integrated with items as malaria, EPI, ARI, *et cetera*.

USAID provides contraceptives to Pathfinder and DKT.

Plans for the future include more emphasis on the integration of HIV/AIDS, through expanding activities with UNAIDS, Pathfinder, and BASICS.

### **The Netherlands**

The Netherlands emphasize their funding in Ethiopia in the area of HIV/AIDS, and is concentrated in the Northern and Southern regions. 10 per cent to 15 per cent of the funding goes to national NGOs. The major projects are:

- Ethiopian Social Marketing Project for Family Planning and HIV/AIDS: a project executed by DKT (US\$ 1 million a year, ending next year).
- Recently, the first phase of a four year Ethiopian-Netherlands AIDS Research project was finalized. This was a US\$ 7.4 million project of which 63 per cent was allocated for research, 21 per cent for training and 16 per cent for infrastructure development. In January 1999, the second phase will start, with a budget of US\$ 30 million for four years. The emphasis will be on research.
- Small NGO projects: US\$ 50,000 a year.
- HIV/AIDS prevention and family planning project in the Southern part of Ethiopia (1996-2001) implemented by CARE. An amount of US\$ 1.5 million is allocated by the Netherlands.
- The project aims at changing sexual behaviour. Due to under capacity, implementation has been low at 30 per cent.

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<sup>3</sup> RAPID stands for Resources for the Awareness of Population Impacts on Development. The Futures Group International is the prime organization on each of this project.

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- In September 1996, a three-year “Youth Counselling and Family Planning services for youth” started, with a budget of US\$ 144,000. The objective is to support youth centres in Addis Ababa to provide family planning and other health information. The project is implemented by the Family Guidance Association of Ethiopia (FGAE).
- Through the National Committee on Traditional Practices, a survey was conducted on harmful traditional practices (US\$ 75,000 for three years).
- Within the Health Sector Development Programme, US\$ 500,000 is budgeted for HIV/AIDS activities, and possible contribution to UNFPA's fourth country programme of US\$ 1.5 million for the procurement of contraceptives is currently being discussed with MEDAC.

#### **Norway (NORAD)**

The Royal Norwegian Embassy only opened its premises in 1994, so activities of NORAD have only started recently. All funding of NORAD goes through UNFPA. Since 1995, respectively US\$ 2.5 million, US\$ 2 million, (1996), and US\$ 4.5 million (1997) have been contributed. Other health related activities are executed through Norwegian NGOs: water and sanitation, primary health care, health sector development.

#### **Germany (GTZ)**

Since October 1995, GTZ carries out a three-year project on Integrated Community Family Planning project in four zones in the Amhara region. The project is executed through the Ministry of Health. The budget is US\$ 1.4 million.

#### *4.2.2. Multilateral Donors*

#### **UNFPA**

UNFPA started its assistance to Ethiopia in 1973 (PRSD, 1992, p. 1). Until now, three country programmes of assistance have been implemented.

Major support areas in the first country programme (1981-1986) for US\$ 9.2 million, were demographic training and research, strengthening of the MCH/FP programme of the Ministry of Health, development of IEC programmes, and assisting the Government with the 1984 population and housing census. The Demographic Training and Research Centre at the Addis Ababa University was established in 1982 with UNFPA assistance. The second country programme from 1987-1992 (US\$ 10 million) had the objectives of strengthening and expanding MCH/FP service delivery (41.5 per cent), strengthening IEC programmes for family planning service delivery and family life education (22.5 per cent), and developing a national capability to collect and analyze demographic data. A Population Analysis

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and Studies Centre was created in the Central Statistical Authority in 1988, in order to conduct more in-depth analysis of the census. The Centre for Research, Training and Information on Women in Development (CERTWID) was established in 1991/92 with funding of UNFPA.

The third (1993-1997) (US\$ 29.3 million), supported the 1994 Census of population and housing, capacity building, and the population policy formulation. In general, the major part is directed to family planning/reproductive health (65 per cent of the allocation), IEC (ten per cent), data collection and analysis (18 per cent), and population policy development (three per cent), population dynamics (two per cent), and women, population and development (two per cent).

In general, most of the funds allocated for contraceptive procurement and medical equipment are actually spend. Implementation for areas such as training are unfortunately much lower.

The fourth country programme (1998-2001) will start this year, and is budgeted for US\$ 30 million, of which US\$ 24.8 million will come from UNFPA regular sources (UNFPA, 1998).

It's goal is "to assist the Government of Ethiopia in improving the health and well-being of the Ethiopian people by strengthening the implementation of population and development and reproductive health policies and programmes" (UNFPA, 1998, p. 3). It provides support in the following core programme areas:

1. Reproductive Health (US\$ 24.4 of which US\$ 19.2 million from regular sources);
2. Population and Development Strategies (US\$ 4 million);
3. Advocacy (US\$ 1 million);
4. Programme coordination and assistance (US\$ 0.6 million).

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### **WHO**

WHO in Ethiopia focuses on technical assistance in the areas of Safe Motherhood Initiative, the Mother and Baby Package, and adolescent reproductive health. In addition they give financial assistance in health related areas, and they fund the National HIV/AIDS Programme, through a biennial extra-budgetary programme on STD and HIV/AIDS Control (US\$ 1 million). Their main counterpart is the Ministry of Health.

### **UNICEF**

Work of UNICEF which is related to our categories, fall into two categories:

1. Health and Nutrition.
  - a. Primary Health Care Development, which contains a safe motherhood sub-project (US\$ 100,000 for the current fiscal year).
  - b. HIV/AIDS: e.g. an AIDS Prevention Promotion Programme among in- and out-of-school youth (10-19 years old). Although US\$ 2.5 million is allocated for the HIV/AIDS activities for the period 1994 -1999, the actual implementation rate is estimated to be around 50 to 60 per cent.

2. Gender and Development.

Gender and Development promotion project with the Women's Affairs Office in the Prime Minister's Office, Ministry of Agriculture, and MEDAC.

### **World Bank**

Currently, the World Bank is not implementing special population programmes, but does play a keyrole in the Education Sector Development Programme (ESDP), and the Health Sector Development Programme (HSDP). These two programmes have recently been approved for US\$100 million each (IDA loan) for a five year period. The World Bank committed US\$ 35 million for the current fiscal year for the HSDP, but whether this will be spend to MCH related activities is not certain, as the World Bank fills in the gap which is left by other donors.

Another related IDA credit from the Bank is going to the Ethiopia Social Rehabilitation and Development Fund (ESRDF; 1996-2001), an intersectoral fund to serve the poorest communities. The objectives of the ESRDF are:

- to support community initiatives to construct or rehabilitate, and maintain basic economic and social infrastructure (e.g. health facilities) and services necessary for improved incomes, health and productivity;
- increase community capacity to identify development priorities, manage project implementation, and maintain ESRDF financed assets;

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- support measures beneficial to environmental conservation and rehabilitation;
- respond to the needs of vulnerable groups especially poor women.

It focuses on sustainable developmental initiatives and will support the establishment of a Welfare Monitoring System to improve the collection and analysis of information used to guide poverty reduction efforts, and track the impact of policy measures on the poor.

Of the US\$ 242 million which is budgeted for the ESRDF, US\$ 120 million is allocated by the World Bank, 30 million by Government and community, and the remaining should come from other bilateral donors. The community should pay ten per cent of the costs, but these can be in-kind. There is a national coordinating committee, with central and regional offices. The money is given as a grant to the community.

Last year, the Bank finalized a Family Health Project, which had started in 1989. This project was a US\$ 43.8 million project, of which the World Bank funded US\$ 33 million (of this, 94.6 per cent was disbursed), and the Government US\$ 10.4 million. The project was aimed to increase the quality, coverage, and cost-effectiveness of MCH services; to increase the availability and use of family planning services; to strengthen the institutional capacity of the Ministry of Health. The project consisted of six components: MCH/FP, manpower development, health education and IEC, institutional development, pharmaceuticals, and studies. The project came to a standstill from 1991 to 1993, and in 1993/94 the project was re-designed. One of the major changes is that responsibilities for the implementation and management was given to the regions. This was a complete shift from the earlier central management.

#### *4.2.3. International NGOs*

##### **DKT**

DKT started about nine years ago in Ethiopia, with social marketing of condoms. Two years ago social marketing of pills was added to their activities. They have achieved a remarkable success. DKT is the only social marketing organization in Ethiopia, and has close partnership with the Government. Activities take place in every region, zone, and woreda, through shops, pharmacies, clinics, bars and kiosks. Advertisement focuses on behavioural changes. In addition DKT provides training for providers, trainers, doctors, TBAs, *et cetera*. The office also has a special NGO and research unit. Condoms are supplied to the Army as well.

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USAID provides the commodities, which are repacked locally. Other sources of income are from SIDA and the Netherlands Embassy. The Government of Ethiopia pays the taxes for the commodities, and facilitates the activities in offering e.g. advice in logistics management and distribution.

The budget for the current year is US\$ 1.6 million for the operating budget, US\$ 1.7 million for condoms, and US\$ 100,000 for pills. The budget has been increasing rapidly over the last years. In the future, activities of DKT in Ethiopia will continue, as there are currently 2.6 million HIV infected persons in Ethiopia, which is 8.5 per cent of the world total. Their future activities include introduction of a second brand of condoms, pills, and social marketing of injectables. They work closely with OSSA (Organization for Social Services for AIDS). All in all there are about 210 people working for DKT Ethiopia (80 in packing, 70 sales staff, 30 in marketing, 30 in administration).

### **Pathfinder**

Pathfinder started in Ethiopia in the mid-1960s with supporting the Family Guidance Association of Ethiopia. Pathfinder works on two lines:

- 1) direct support to Ethiopian NGOs which deliver reproductive health/family planning services, through technical assistance, financial assistance, equipment and service delivery. At the moment seven NGOs are supported this way.
- 2) provides institutional support for the Consortium of Family Planning NGOs in Ethiopia (COFAP): e.g. development of standards in training, service delivery, data collection, and quality improvement.

Pathfinder's programmes include:

- Clinic based programme;
- Community based reproductive health programmes (CBRH): These programmes are run by CBRH committees, which are in turn people from the community who had received some training;
- Adolescent reproductive health programme;
- Workplace programme (i.e. in factories);
- Market place programme (information through open air markets);
- Outreach programmes.

A total of 27 clinics are under direct and indirect support of Pathfinder, and 135 public clinics are linked to the project (e.g. CBRH who refer to closest Government clinic).

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In 1995, USAID selected Pathfinder to coordinate the Essential Services for Health in Ethiopia programme, which started in 1995. This programme is implemented with AVSC which provides technical support in the provision of Norplant, and voluntary surgical contraception, and FHI, which provides technical assistance in the area of research, monitoring and evaluation.

For the future, plans are developed to integrate HIV in manuals and curriculum development of counseling modules and to increase partner NGOs from 7 to 12. Emphasis will be on consolidation, expansion, and integration of services at clinical level; strengthen linkage of TBAs and CBRH. Another new project which they hope to start soon is to support private-for-profit clinics: training, providing equipment, supplies to deliver reproductive health services, establish a management information system, IEC, and counseling.

Income of Pathfinder comes from USAID and from private foundations. A lot of expenditures are in-kind, e.g. equipment, supplies, technical assistance, rather than in-cash.

### **4.3 | Role of National NGOs**

National NGOs have been active in Ethiopia's health sector for a long time (PRSD, 1992, p. 49). However, only a few NGOs participated in population-related activities during 1987-1992 (PRSD, 1992, p. 49). In 1994, the Department of Family Health had identified more than 70 NGOs involved in family planning activities (Ministry of Health/UNFPA, 1997, p. 40). In the absence of recent fertility and family planning surveys, it is difficult to determine what proportion of family planning clients use NGO services (Ministry of Health/UNFPA, 1997, p. 11). The study, conducted by the Ministry of Health/UNFPA (1997), estimated that NGOs serviced 15 per cent of family planning clients in 1995.

In terms of couple-years of protection, NGO clinics generated nine per cent, the Ministry of Health clinics 76 per cent, and 15 per cent was generated by the contraceptive social marketing programme (Ministry of Health/UNFPA, 1997, p. 40).

Even though NGOs do not represent the major provider of reproductive health services, they play an important role in extending coverage to (isolated) communities, to new areas, such as youth involvement, and to sensitive areas such as HIV/AIDS and FGM.

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Major NGOs in the population field:

### **Consortium of Family Planning NGOs (COFAP)**

COFAP is an umbrella organization, established in 1993. 34 NGOs involved in population activities are part of the Consortium, of which 19 international NGOs and 15 national ones. The overall aim is to encourage NGOs and the government to integrate family planning and reproductive health with other development issues. Its main objectives are:

- networking and assisting in coordination among FP/RH NGOs.
- representing the interest of FP/RH service provider NGOs.
- assessing policies and their implications for FP/RH activities.
- encouraging other NGOs to be involved in FP/RH service delivery.
- mobilizing financial, material and technical resources for FP/RH activities.
- taking joint action initiatives.
- facilitating the sharing of experiences in programme development, capacity building, management, monitoring, and evaluation.
- collaborating with the government to identify priority areas and assist in implementing the National Population Policy.

Until now workshops were organized, and community based reproductive health education materials were developed. COFAP also provides national NGOs with contraceptives.

All funding comes from USAID through Pathfinder, which is also responsible for the procurement of contraceptives, medical equipment and supplies for COFAP. The government gives technical assistance, and pays the taxation of contraceptives. The problem is that COFAP has not been able till date to get a legal registration.

Future plans relate to expansion of FP/RH services, mobilization of resources and development of a strategic plan.

### **The Family Guidance Association of Ethiopia (FGAE)**

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The FGAE is the oldest, and most important NGO in the area of family planning activities: it has formulated and implemented population activities since 1966. It became a member of the IPPF in 1971. The head office is in Addis Ababa, and it has seven branch offices, covering the whole country. Each branch clinic covers around two base clinics. These 15 base clinics offer a wide range of family planning services, which are being expanded into other related reproductive health areas (e.g. diagnosis and treatment for STDs, gynaecological tests, infertility management). They also serve as referral clinics and training centres. In addition, they have 7 youth centres or clinics, 36 outreach clinics, and around 360 community based sites. They work with paid staff and volunteers. 57 per cent of the services are delivered through grass-root level activities. Additionally the organization advocates population concerns, motivates couples, and trains workers.

FGAE serves eight to ten per cent of the family planning users through its clinics. Originally, 70 to 75 per cent of the acceptors were pill users, but this came down to 45-50 per cent in 1997, at the favour of other methods: 25 per cent injectables, eight per cent Norplant, seven per cent IUD, ten per cent condoms, 4.4 per cent surgical contraception

In order to increase the contraceptive prevalence rate, more and more outreach or CBRH services need to be done.

FGAE receives their contraceptives from USAID, through Pathfinder, or from the Ministry of Health, which in turn receives them from UNFPA.

Although all income comes from donors or own revenues, all imported goods and materials are tax-exempted, so indirectly the government does contribute. In the past the bulk of income came from IPPF/London, but nowadays, FGAE receives money from more donors. Income is increasing with the activities.

### **Marie Stopes Ethiopia**

The Ethiopian programme started in 1990 with one clinic in Addis Ababa. In 1994, three more clinics were opened: two in Addis and one in East Ethiopia. Recently they opened three more clinics in other major towns: Awasa, Bahir Dar, Jima, and another one in Sheshemene is soon to be opened.

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*Table 4. Income and Expenditures of FGAE, 1996 and 1997  
(in thousand US\$)*

	1996	1997
Income:	1,392	1,553
Of which:		
External sources	1,310	1,470
Self-generated	82	83
Expenditures:	1,103	1,234
Family planning activities	84%	47%
Reproductive health activities	11%	27%
HIV/AIDS activities	5%	24%
Basic research	-	2%

Services offered in the clinics include family planning, diagnosis and treatment for STDs, gynaecological tests, and infertility management.

Service delivery goes through:

1. clinical based programme family planning services, STD treatment, gynaecological examinations, infertility management, and child health services like growth monitoring, EPI, diarrhoeal treatment.
2. outreach programmes, offering family planning services (in Addis Ababa):
  - a. Community Based Health Programme around one clinic: through three health posts,
  - b. Community Based Reproductive Health Programme around the other two clinics (funded by Pathfinder),
  - c. Community Based Service Programme: to highly marginalized groups, e.g. internally displaced people,
  - d. HIV/AIDS and STD prevention programme for out-of-school youth: awareness creation, condom distribution, STD management (funded by USAID).

Plans for the future are focused on projects in Dire Dawa, e.g. a workplace programme, and an adolescent programme for in-school students.

The clinics in Addis Ababa are self-supporting. They charge affordable users-fees. Furthermore, MSI receives income from DFID, Comic Relief, and Marie Stopes International. In 1996, the budget was roughly US\$ 637 thousand, of which 84 per cent is self-generated (mainly users-fees), and only 16 per cent comes from international sources.

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Of the expenditures of roughly US\$ 210 thousand, 86 per cent goes to family planning, eight per cent to reproductive health, two per cent to HIV/AIDS prevention, and three per cent to research.

#### 4.4 | Role of Private Sector

Households in Ethiopia make a substantial contribution to private practitioners, traditional healers, private pharmacies and other in the health sector (Ministry of Health, 1998<sup>b</sup>, p. 7). Households also make payments to government facilities in the form of users fees, which have been collected by the Ministry of Health since 1950 (Ministry of Health, 1998<sup>b</sup>, p. 7).

Preventive services like ante-natal care, on the other hand, are currently hardly provided by the private sector.

#### 4.5 | Future Perspectives

##### 4.5.1| *Health Sector Development Programme*<sup>4</sup>

The Government of Ethiopia, together with the donors, has prepared a first phase of a 20-year Health Sector Development Programme (HSDP), to be implemented for five years, from 1997/98 to 2001/02 (which is 1990-1994 according to the Ethiopian Calendar). The objective is the development of a health system, which will:

- improve the coverage and quality of health services;
- be primarily implemented and managed by regional, zonal and woreda level health officials;
- be financially sustainable.

The health system eventually needs to provide comprehensive and integrated primary health care services, based at community-level health facilities, and appropriate first-referral and other hospital services. The primary health care services should include health promotion, prevention, and basic curative services). The focus will be on communicable diseases, common nutritional disorders, environmental health and hygiene, reproductive health care, immunization, treatment and control of basic infectious diseases (e.g. upper

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<sup>4</sup> This section is based on the Program Action Plan for the Health Sector Development Program, Ministry of Health, The Federal Democratic Republic of Ethiopia, August 1998.

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respiratory tract infection and tuberculosis), control of epidemic diseases (e.g. malaria), and the control of STDs, HIV/AIDS.

The total costs of the first phase of the HSDP are estimated at 5,002 million Birr (about US\$ 737 million), of which 55 per cent will be funded by the Government, 43 per cent by international assistance (14 per cent by an IDA credit, 29 per cent by other donors), and two per cent by user fees.

Of the total external aid of US\$ 313.4 million, US\$ 100 million will be funded through an IDA credit of the World Bank. About two-third of the allocations are recurrent, and one-third is capital.

*Table 5. Indicative Financing Plan for the HSDP (in '000 Birr)*

	1997/98	1998/99	1999-2002	Total	Total
Ethiopian calendar:	1990	1991	1992-94		(in '000 US\$)
Programme costs:	776.3	1,033.4	3,192.3	5,002.0	737.8
Amount financed:					
Government	447.0	486.8	1,839.7	2,773.5	409.1
User fees	19.6	20.1	63.7	103.4	15.3
External Aid	309.7	526.5	1,288.9	2,125.1	313.4
Financing sources					
(% of total):					
Government	57.6%	47.1%	57.6%	55.4%	
User fees	2.5%	1.9%	2.0%	2.1%	
External Aid	39.9%	50.9%	40.4%	42.5%	

Source: Program Action Plan for the Health Sector Development Program, Ministry of Health, The Federal Democratic Republic of Ethiopia, August 1998, p. 22.

The HSDP is divided over eight components:

1. Service delivery and quality of care (51.4 per cent of the total budget): to increase the coverage and quality of promotive, preventive and curative services.
2. Health facility, rehabilitation and expansion (27.5 per cent): to increase the access to and to improve the quality of health services through the rehabilitation of existing facilities and construction of new facilities.
3. Human resource development (3.1 per cent): to rationalize the categories of personnel, increase the supply of manpower, and improve the productivity of staff.
4. Strengthening pharmaceutical services (14.2 per cent): to ensure a regular and adequate supply of effective, safe and affordable drugs of high quality in both the public and private sector.

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5. Information, Education, Communication (1.3 per cent): to support the development and implementation of a national IEC plan and strategy.
6. Strengthening health sector management and Management Information Systems (1.9 per cent): to improve skills in the areas of policy formulation, planning and budgeting, financial management, programme implementation, and monitoring and evaluation for staff of the Ministry of Health and the regions.
7. Monitoring and Evaluation (0.6 per cent): to monitor improvements in the service delivery, quality and financial performance; and to evaluate the impact, effectiveness, and cost-effectiveness of HSDP components.
8. Health care financing (0.2 per cent): to improve public health sector efficiency and to generate additional and new sources of revenue.

In summary, 81 per cent is allocated to improve direct health services, 17 per cent to human resources and pharmaceuticals, and 12 per cent to support services.

8.8 per cent of the total budget is allocated for the Centre to cover the Ministry of Health and its services, 91.2 per cent is allocated to the regions. The allocations to the regions have been computed on the basis of certain criteria, amongst which population size and the revenue earning capacity. The Planning and Projects Department in the Ministry of Health will be responsible for the central component, the organization for all procurement for regions and Ministry of Health co-ordinating the overall implementation, and to give support to the regions, while the regions will be responsible for most service provision.

All donors' proposals need to fit in the framework of the HSDP. Funding will be co-ordinated within the sector wide framework. There are three channels through which donors can attribute to the HSDP:

1. budgetary support: disbursement and accounting functions are with the Ministry of Finance and the Regional Finance Bureaux. MEDAC and the Regional Bureaux of Economic Planning and Development will play a special role in approving and supervising the capital budget.
2. to the sector ministry: most bilateral and multilateral agencies use this channel: money goes to MEDAC, and in turn to the concerning ministry or region. Financial bodies are bypassed.
3. through the donor's own channel, e.g. through other implementing agencies.

Donor commitments for the HSDP in the coming fiscal year are given in Annex 2.

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Sweden and Norway are the two countries that have planned to fund the programme through the first channel, so directly to the Ministry of Finance.

SIDA pledged roughly US\$ 13 million for the coming three years, NORAD US\$ 2.8-3.5 million a year.

USAID also puts US\$ 30 million through channel one, under the condition that it should be used to pay debts; channel two is used very limited (e.g. construction of ware houses, commodities, in-country training); most goes through channel three.

The Netherlands have budgeted US\$ 500,000 for HIV/AIDS activities.

#### 4.5.2. National Population Programme<sup>5</sup>

The National Office of Population has drafted a National Population Programme. Although there is an apparent overlap between the National Population Programme and the HSDP in areas of reproductive health development planning, anything regarding reproductive health as contained in the National Population Programme, is now part of the HSDP.

The National Population Programme, as discussed earlier in the report, and which is being implemented in the years 1997 to 2001, gives a budget for the several components. Funding should come mainly from the 4th country programme of UNFPA (which is approved for US\$ 30 million). The estimated funding needed for the implementation of the activities amounts to US\$ 47 million, of which 42 per cent should go to Reproductive Health/Family Planning, 23 per cent to IEC and Advocacy, and 34 per cent to Population and Development Strategies. For co-ordinating the monitoring and evaluation of the programme, a total of US\$ 200,000 is estimated for the five years. Table 6 gives a more detailed overview of the budget breakdown.

Table 6. Components of the National Population Programme, 1997 - 2001, in thousand US\$ (requested budget)

	1997	1998	1999	2000	2001	Total
<b>Total IEC and Advocacy</b>	<b>1,000</b>	<b>4,800</b>	<b>3,250</b>	<b>1,350</b>	<b>300</b>	<b>10,700</b>
Of which: Capacity building	550	3,250	1,300	400	0	5,500
Multimedia messages	450	1,300	1,700	750	0	4,200
Research	0	250	250	200	300	1,000
<b>Total RH and FP</b>	<b>4,122</b>	<b>3,578</b>	<b>3,377</b>	<b>4,530</b>	<b>4,283</b>	<b>19,889</b>

<sup>5</sup> This section is based on the National programme for the implementation of the national population policy of Ethiopia, Ministry of Economic Development and Cooperation, July, 1997

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Of which: Integrate and strengthen FP services	3,678	3,207	3,000	4,153	4,165	18,203
Strengthen technical capability	70	50	50	50	50	270
Institutionalize FP counselling	9	16	2	2	2	31
Encourage NGOs and private sector	14	5	0	0	0	19
Establish adolescent health services	180	120	105	105	10	520
Establish MIS	172	180	220	220	56	846
<b>Total Population and Development</b>	<b>289</b>	<b>5,533</b>	<b>4,033</b>	<b>5,333</b>	<b>953</b>	<b>16,141</b>
Of which: Data collection	0	4,904	3,278	1,980	0	10,162
Research	0	332	446	450	460	1,688
Training	289	297	309	2,903	493	4,291
<b>Co-ordinating Monitoring and Evaluation</b>	<b>10</b>	<b>40</b>	<b>45</b>	<b>50</b>	<b>55</b>	<b>200</b>
<b>Grand Total</b>	<b>5,421</b>	<b>13,951</b>	<b>10,705</b>	<b>11,263</b>	<b>5,591</b>	<b>46,931</b>

Source: National programme for the implementation of the national population policy of Ethiopia, Ministry of Economic Development and Cooperation, July, 1997

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## 5. Concluding remarks

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The Government of Ethiopia is certainly committed to the ICPD Programme of Action. The economic situation at the moment however makes it very difficult to allocate reasonable amounts to the activities in line with the ICPD. Therefore, funding for population activities are almost completely donor driven, but through indirect ways the Government of Ethiopia does contribute quite a reasonable amount: salaries, buildings, commodities are tax exempted.

The very new political structure since 1991, with autonomous regions, plus the new policies since 1993, need their time to be effective.

The health budget does not give a breakdown by population activities, neither were estimates made by the mission. Reproductive health is a fairly new concept in Ethiopia, still unknown by a lot of people: the concept is vague, and often mistakenly interpreted as family planning. Within the policies, and the HSDP, it will be integrated with primary health care, and not treated separately.

The role of NGOs could be much stronger.

The implementation rate is low: the impression was given that between 30 per cent to 70 per cent of the allocated funds were used. Two major reasons for the low implementation were heard at almost all places:

### 1. Not enough manpower

Brain drain in the public sector causes enormous problems. Reasons for manpower shortages:

- during the process of decentralization, a lot of staff from the national levels were transferred to the regional levels.
- high staff turn over, no job security.
- people exchange the public for the private sector, because of low salaries and high frustrations in the public sector.
- people might not be capable for the job they are doing.
- no full time staff are assigned for population programme implementation.

### 2. Systems:

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Sub-departments or institutes have no power over their money. Although the system is highly decentralized, within the organizations, structures are still very centralized. For example, the research institutions at the University are at a difficult position, as they do not have their own accounts. They are dependent from the financial department of the University, which is responsible for finances of the university as a whole. Due to under-staffing at the financial department, the situation does not look good.

With the low capacity at the moment, Ethiopia faces an enormous challenge to start implementing the national policies.

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## **Annex I. Persons contacted**

### **Multilateral Organizations**

Ms. Linda Demers	UNFPA representative
Mr. Duah Owusu-Sarf	UNFPA deputy representative
Dr. Abonesh Hailemariam	Family Health and Population Programme Officer, WHO
Mr. Kayode S. Oyegbite	Chef, Health and Nutrition, UNICEF
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### **Government of Ethiopia**

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Mr. Sisay Worku	Head, Population and Development Planning Unit (PDPU), MEDAC
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### **Donor countries and organizations**

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Association of Ethiopia  
Family Guidance Association of Ethiopia  
Country Director, Marie Stopes International  
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**Annex II. Donor Commitment for HSDP for FY 1998/99, in '000 Birr**

Donor	Activities to be supported	National	Centre	Region	Total Commitment
UNFPA	4 <sup>th</sup> Country programme	166,391			166,391
USAID	Service delivery		2,800	9,835	12,635
	Facilities			1,260	1,260
	Human resource development		1,050	350	1,400
	IEC		1,190		1,190
	Health care financing		2,520		2,520
	MIS			175	175
	Monitoring and evaluation		3,850		3,850
	Technical assistance		3,150	3,430	6,580
	Supplementary resources:				
	Service delivery		2,275		2,275
	Pharmaceuticals		350		350
	IEC		350		350
	Others		10,427	700	11,127
SIDA	General govt support	20,000			20,000
Austria	Human resource development and health facility rehabilitation and expansion			5,000	5,000
	Pharmaceuticals	20,100			20,100
Netherlands	National Drug Plan	2,000			2,000
	National AIDS Control	6,000			6,000
	National Tuberculosis Control Programme	6,600			6,600
	Integrated Rural Development	1,200			1,200
	Communicable disease control	6,048			6,048
WHO	Water supply and sanitation	728			728
	Fellow ship				0
	Strengthening training	1,467			1,467
	Essential drug use	1,456			1,456
	IEC material production and distribution	634			634
	Health Information System	3,090			3,090
	TBC			1,599	1,599
Italy	PHC and hospital management			7,923	7,923
	Construction of 10 health centres			1,599	1,599
	Construction of health centres			2,224	2,224

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UNDP	PHCU expansion and rehabilitation		4,890	4,890
	Strengthening IEC	298	935	1,233
	Pharmaceuticals	520	1,927	2,447
	Human Resource Development	755	2,591	3,346
	Health delivery and quality	1,137	3,678	4,815
	Monitoring and evaluation	224	661	885
	Health Management and Information System	638	2,156	2,794
UNICEF	EPI	1,344	21,056	22,400
	ORT/ORS	84	1,316	1,400
	Procurement of vitamin A capsules and training	462	7,238	7,700
	Procurement of essential drugs and training		3,500	3,500
	Youth empowerment	42	658	700
	Dracunculiasis eradication		700	700
GTZ	Family Planning Contraceptives		10,300	10,300
KfW	Supply of Contraceptives	6,400		6,400
NORAD	Medical equipment, spare parts and capacity building	16,333		16,333
Ireland	PHC, training equipment	3,100	13,064	16,164
World Bank		105,000		105,000
NORAD		15,000		15,000
Japan	Medical equipment provision	1,750		1,750
<b>Grand Total:</b>		<b>383,297</b>	<b>33,466 108,765</b>	<b>525,527</b>

Source: Health Sector Development Programme, annex 6 Donor Mapping, pp 72 -78