Ethiopia extends health to its people

Courtesy of Ethiopian ministry of health

Dr Tedros A Ghebreyesus

Dr Tedros Adhanom Ghebreyesus was appointed health minister of Ethiopia in 2005, having worked at the ministry of health since 1986. As a malaria researcher, he has published articles in leading scientific journals, including a prize-winning study of malaria incidence among children living near dams in northern Ethiopia in the *BMJ* in 1999. He is chair of the UNAIDS board and was chair of the Roll Back Malaria Partnership from 2007 until May this year. He earned a Doctor of Philosophy in community health from the University of Nottingham in 2000, and a Master of Science in the immunology of infectious diseases from the University of London in 1992. He completed his undergraduate studies in biology at the University of Asmara in 1986.

At a time when aid effectiveness is under scrutiny, Ethiopia is embracing a new approach to make health aid work – not least with an innovative programme to train and deploy thousands of 'health extension workers' in communities across the country.

Q: What was the greatest challenge when you became health minister?

A: Significantly improving and strengthening our health system – building and expanding our health infrastructure, rapidly scaling up our health workforce and revamping our information systems. We want to achieve universal access to primary health services of an acceptable standard to all Ethiopians. We are working to meet these challenges, first, through social mobilization at the grassroots level, led by our community-based health extension workers. Second, by accelerating expansion of our infrastructure through a major government-led effort that aims to have in place 3200 health centres by 2010 – including 2500 new ones over half of which are under construction. By December 2008, 11 446 health posts had also been constructed against our target of 15 000 to bring primary health care to all communities.

Q: In 2005, Ethiopia's total health expenditure per capita was about US$ 6, much lower than the average US$ 24 for sub-Saharan countries. Has this increased?

A: Government health expenditure increased to 11% from 7% of the total budget three years ago. External resources and partners' contributions have also increased. The issue of long-term sustainability is well recognized by our government and that is why we have been prudent in choosing where to target our investments. We are investing in high impact low-cost interventions aimed at addressing the most pressing health problems. Hence, the priority we have given to primary health care delivery. By the end of 2008, we had trained and deployed 30 190 health extension workers. By engaging health extension workers as full-time salaried civil servants, we have moved away from volunteerism and this has been a key success factor.

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Q: Ethiopia seems to be far from meeting the Millennium Development Goals (MDGs) on child and maternal health.

A: We are progressing well on child health. Overall, under-five child mortality has been declining considerably – from 200 per 1000 live births in 1990 to 123 in 2005. Also, as of June, 2007, infant immunization coverage had reached 81%, measles immunization coverage 71%, and full immunization had exceeded 80%. We are confident that these levels have increased since then. MDG 5 – reducing maternal mortality – remains our greatest challenge. We aim to further reduce the current maternal mortality ratio of 671 per 100 000 (compared to 1040 in 1990) live births down to 267. Our strategy includes ensuring that at least one-third of the 3200 health centres are appropriately staffed and equipped to provide comprehensive maternal care. Also, the 16 blood banks being built around the country will help ensure an adequate supply of blood for dealing with post-partum haemorrhage – the leading cause of maternal deaths in Ethiopia. Our Health Extension Programme of community health workers is also already having a significant impact by providing services directly to women and developing an effective referral system. Given these aggressive efforts, our Government's commitment and the strong support of our partners I believe achieving this target is possible, although admittedly very challenging.

Q: Ethiopia is using money for single-disease programmes to build and reinforce health systems. How did you justify this?

A: The Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance are flexible financing mechanisms working on the basis of performance-based funding and country ownership. Both are having significant impact by helping countries expand service delivery. We simply explained to them that we could not expand service delivery without building up our health system at the same time – and they were willing to listen and to support us based on our needs. The Global Fund's 2008 institutional strategy reaffirmed its commitment to support country-led programmes that address the three diseases in ways that contribute to the strengthening of national health systems. Similarly, GAVI introduced a health systems support programme in 2007 to help countries expand immunization services by addressing critical health system constraints. Ethiopia was one of the first countries to receive a grant under this scheme.

Q: How did Ethiopia increase provision of treatment for people with HIV/AIDS, from 1% to 50% in just three years?

A: This would not have been possible without our commitment to a robust multi-sectoral HIV/AIDS response and without increased investments by partners – particularly the Global Fund, PEPFAR [US President's Emergency Plan for AIDS Relief] and the World Bank – investments in direct response to priorities set by our government. Our multi-sectoral approach based on community health workers has yielded good results. HIV incidence has been declining slightly over the last few years. At present, some 150 000 people are on antiretroviral treatment, compared with fewer than 1000 in 2005. And the number that started treatment to date has exceeded 200 000. Surveys show that people are more aware of HIV/AIDS, changing their behaviour and using counselling and testing services more and more.

Q: How will you achieve your ambitious plans to reduce malaria by 2010?

A: We have made substantial progress in recent years with strong support from our partners. The challenge is to sustain and build on this. We have successfully pursued the aggressive 'scale-up for impact' approach centred on prevention through the mass distribution of bednets, and complemented by appropriate use of indoor residual spraying and other vector control measures as well as early diagnosis, prompt treatment and epidemic prevention and control. The goal is to reduce national malaria morbidity and the mortality burden by 75% by 2010. We are confident that this can be achieved. By the end of 2008, we had distributed 20.4 million insecticide-treated bed nets. Also, an initial assessment by WHO in 2007 found that malaria-related deaths, as well as overall morbidity and malaria-related hospital admissions have been declining dramatically. Our own reports concur with those findings.

Q: Your country is ranked number 138 out of 179 countries on Transparency International's corruption index. How do you ensure that donor funds actually reach the projects for which they are intended?

A: While Ethiopia was ranked 138th in 2007, it notably moved up to 126th in 2008. This is a relative indicator of 'perceptions' of transparency and corruption. It cannot be an accurate reflection of reality and I do not believe that this is the case in our country. A recent World Bank study in Ethiopia underscored the significant discrepancy which often exists between the perceptions and reality of corruption. The study which focused on the construction sector – known worldwide to be one of the most corrupt sectors – found that while the perceived level of corruption in Ethiopia's construction industry was high, in reality it was actually remarkably low. No level of corruption can be acceptable. We try to make sure funding reaches the intended beneficiaries by focusing on the *results*. Global Fund grants, for example, are awarded on technical merit and adherence to a set of strict performance-based criteria. We would not have been awarded further grants had we not demonstrated satisfactory and verifiable results.

Q: Why are case detection levels for tuberculosis so low?

A: Tuberculosis incidence may be lower than the WHO estimate because it was based on a larger estimation of Ethiopia's total population. Our Tuberculosis Programme reported a case detection rate of 35.5% for the period July 2007–June 2008, and this figure is likely to have improved since then. We are doing well in terms of treatment success rates. For the period July 2007–June 2008 we registered an 84% treatment success rate – a significant achievement considering that the international recommendation is 85%. Our progress on tuberculosis has been relatively slower for several reasons, key among which is the fact that we have not had an effective mechanism in place for active case finding at grassroots level. But the rapid scale up of our health extension workers programme over the last couple of years is changing this. We are also strengthening our lab network and addressing inadequacies in our documentation and reporting systems.

Q: What can the International Health Partnership (IHP) achieve where other aid initiatives have failed?

A: In recent years we have seen unprecedented levels of funding to tackle health problems in developing countries, but its delivery has been poorly coordinated. This has led to a duplication of effort among partners, huge transaction costs and reporting burdens on countries and, as a result, impact has been limited. The IHP aims to simplify this complicated global health aid environment by channelling previously fragmented health sector support into a common mechanism that is managed at the country-level. The aim is to make the money work more effectively and efficiently and to improve accountability in an effort to maximize the impact of the contributions from diverse partners in accelerating progress towards the health-related MDGs.

Q: What plans have you made in case donor funds for health are reduced or withdrawn?

A: Efficiency gains made through our country 'compact' with the IHP can offset the impact of reduced external funding in the short to medium term. Still, many fear that the financial crisis may mean a reduction of overall international development assistance. But the way in which world leaders have quickly come together to address the global economic downturn inspires optimism. In the same way much can be and must be done to sustain and accelerate progress on the health-related MDGs. In terms of contingency planning, we are trying to make greater use of domestic resources for health. For example, we are developing a comprehensive health insurance system.

Q: What has Ethiopia's 'compact' with the IHP so far achieved?

A: We have reviewed and re-costed our health sector plan and identified funding gaps. An additional US$ 2.8 billion will be needed over a two-year period to achieve our MDG-based health targets. This includes funds for maternal and child health, antiretrovirals for HIV and insecticide-treated nets for malaria. We are unifying partners to support one national plan for health. Our latest milestone is last April's joint agreement, which commits seven major partners to pool their investments to this end. ■