

1: Codes of Practice (Occupational Safety and Health)

Building on the lessons learned in implementing the earlier plans and to be highly responsive to the current socioeconomic landscape, the Government of Ethiopia has developed Health Sector Transformation Plan (HSTP), which is part of the second Growth and Transformation Plan (GTP II).

Preventive, promotive and curative components of health services in the country have shown a remarkable improvement, meeting equitable and quality health components of health care for all parts of the population [1] and encouraging private and nongovernmental organization participation in the health sector. The health sector follows a 5-year rolling plan as part of the national development plan. Since 1991, three consecutive phases have been completed and currently the country is implementing the fourth comprehensive Health Sector Development Programme HSDP. The health system has had a huge transformation over the past two decades, with a dramatically improved potential access to care through the accelerated expansion of health facilities. An innovative community-level health service, the Health Extension Programme was introduced by training and deploying female health extension workers and institutionalizing community health care at the health post level. Over the past decade, the Government of Ethiopia has given priority to the expansion of health facilities, especially those of primary health care. In order to expand comprehensive obstetric care services further to the community level, the Government is planning an accelerated expansion of primary hospitals in each woreda. Recently, the Ministry of Health has introduced a three-tier health care delivery system. Level one is a woreda health system comprised of a primary hospital for 60 000 people, health centres for 15 000-25 000 population and their satellite health posts for 5 000 population, connected to each other by a referral system. The primary hospital, health centres and health posts form a primary health care unit. Level two is a general hospital for 1 000-10 000. Over the past two decades, the private sector and private-for-profit sector has rapidly expanded. The major health system response focuses on the primary health care approach: In general, service coverage has increased over time, although the performance is not uniform across programmes. Owing to economic, sociocultural and geographical factors, health care utilization is still low, with a 0. Overall, there is a global deficit of 2. To monitor the performance of its health services, the Government has designed and adapted a new health management information system and implemented it country wide. However, this health management information system is inadequate for data generation and dissemination and for decision-making at different levels of the health system. The Government has initiated and is implementing community-based health insurance and social health insurance schemes to address financial barriers to accessing health services. To improve the quality of health services, the focus is on the provision of quality health services at standard health facilities at all levels, including speedy delivery and effectiveness of services, patient safety, ethical considerations and professionalism, with adequate numbers of health workers and sufficient finance and pharmaceuticals. Quality improvement has become an integral part of service delivery in the health system, thus the Federal Ministry of Health has established a quality management committee and designed a reference manual to guide its implementation. Although the majority of maternal deaths could be prevented through appropriate reproductive health services before, during and after pregnancy, only one fifth of all deliveries are currently attended by a skilled health professional. However, TB control is still far from reaching the international standards for Millennium Development Goal achievement. The TB case detection rate is still below the international target, while the treatment success rate has almost reached targets.

2: Health Sector Transformation Plan - Ministry of Health - www.enganchecubano.com

The health sector transformation plan, in line with our country's second growth and transformation plan (GTPII), has set ambitious goals to improve equity, coverage and utilization of essential health services.

Inter-sectoral Collaboration and Public-Private Partnership Measuring progress towards Universal Health Coverage: Transforming data into information and information into action: During this period, our country has made huge strides in improving access to health services and improvements in health outcomes. The lives of millions of children have been saved, millions of new infections and death from communicable diseases such as HIV, malaria, and tuberculosis have been averted. All this was done while building a health system that can sustain the gains over the long term. Despite the impressive progress made, Ethiopia still has high rates of morbidity and mortality from preventable causes. There is also disparity in uptake and coverage of high impact interventions amongst different regions and woredas. The quality of health care in terms of improving patient safety, effectiveness, and patient-centeredness, in both public and private facilities, is often inconsistent and unreliable. A focus in quality and equity requires a shift in the status quo to drive improvements at national scale over the next five years. A national health care quality strategy will be developed to guide our investment towards safer, more effective, more accessible, and more equitable care for every Ethiopian by We will also produce annual reports about the state of health inequality in Ethiopia to bring political attention and accountability in the sector. Reproductive, maternal, newborn, child, adolescent health and nutrition will continue to be top priority for the next 5 years. The targets set in the HSTP are in line with the global aspirations. The fight against communicable diseases is not over yet. We will focus on the most at risk population groups to combat HIV. The fast-track cities initiative towards will also be implemented to reach all people living with HIV, put and retain them in treatment, and achieve viral suppression. Efforts will also be strengthened to improve case detection and cure rate of all forms of TB. The risk of multidrug resistant TB is also on the rise. In addition to prevention strategies, investments will be made to improve access to diagnostic and treatment facility. Ethiopia aspires to achieve subnational elimination of malaria from its mid and low lands in the eastern part of the country. While malaria control measures will be scaled up and sustained, the country will implement strategies to pave the way for malaria-free Ethiopia by The government of Ethiopia has demonstrated its political commitment to fight neglected tropical diseases. Further integrated investments will be made to significantly reduce the burden of NTDs. Prevention strategies will be designed and implemented by integrating the interventions into existing health infrastructure. National scale up and integration of mental health services into primary health care will also be implemented. The promotion of hygiene and sanitation through the health extension program will be strengthened to scale-up open defecation free kebeles. A national sanitation marketing strategy will be implemented to generate demand and create access to supplied for construction of improved latrines. A special attention will be given for urban sanitation and a multisectoral approach will be used to address the complex sanitation issues in our cities. A significant investment will be made to improve our capacity for health emergency risk management. The investment will focus on creating capability to prevent, detect, and contain potential outbreaks. We will build workforce with the aim of boosting the standing and surge capacity to manage health emergencies in our country. In the HSTP, we have identified four interrelated transformation agendas. These are transformation of quality and equity of health care, woreda transformation, a movement towards compassionate, respectful, and caring health professionals, and information revolution. We believe that the successful implementation of the transformation agendas will help achieve the stretched targets we set in the HSTP. With the endorsement of SDGs, and global focus on sustainable development, I believe that Ethiopia is well positioned to push for attainment of these global development goals. Hence, I call up on our people, health professionals, civil societies, development partners and all stakeholders to put a coordinated effort to realize the HSTP goals. I have no doubt that with the unwavering political commitment of our government, engagement and ownership of health programs by the community, the steadfast commitment of our health workers for our people, and the support of our development partners, we will prevail in succeeding to meet the HSTP goals.

Kesete-Birhan Admasu Minister 11 Health Sector Transformation Plan Executive summary In the past two decades, the Government of Ethiopia has invested heavily in health system strengthening guided by its pro-poor policies and strategies resulting in significant gains in improving the health status of Ethiopians. As a result, Ethiopia has done remarkably well in meeting most of the MDG targets. Among the notable achievements include achievement of MDG-4 with a 67 percent drop in under-five mortality from the estimate, that contributed to an increase in average life expectancy at birth from 45 in to 64 in A 69 percent decrease in maternal mortality from a high estimated base of per , live births. Generalized malaria outbreak has not been witnessed for the last decade. Similarly the country has achieved the targets set for tuberculosis prevention and control. The significant gains made are as a result of the political commitment and strong leadership at all levels of government, community engagement and ownership of health programs, and the unprecedented support from development partners. It has also been the primary vehicles to drive improvements in hygiene and sanitation. Health extension workers are tasked to transfer knowledge and skills to families they serve so that households have better control over their own health. This philosophy of training and graduating model families, who have demonstrated behaviour change and improved uptake of high-impact health interventions, have been scaled up to reach close 3 million families across the country. A health development army that mobilizes these model families to enhance community engagement and solidarity movements has been established during HSDPIV. Despite the varying degree of success in different localities, the HDA has proved to be a successful strategy to engage community, identify locally salient bottlenecks that hinder uptake of services, and scaling up best practices. Over the last 20 years, the country has successfully implemented its strategy of expanding and rehabilitating primary health care facilities. To this effect, 16, health posts, 3, health centers and hospitals have been constructed. In parallel to the construction of health facilities, investment in human resource development and management has been scaled up; reformed supply chain and logistics management to ensure continuous availability of health commodities at an affordable price in a sustainable manner; and strengthen coordination and partnership. Though good trends are observed, the country is still facing a triple burden of diseases consisting of communicable diseases, non-communicable diseases and injuries. This burden coupled with the ever increasing demand urges the Government to be increasingly focused on addressing equity in access to health care, quality in health services provision and in strengthening community engagement and ownership in health decision-making and management. The overall desire of The Government of Ethiopia is to have the highest possible level of health and quality of life for all its citizens, attained through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services of the highest possible quality in an equitable manner. The HSTP sets out four pillars of excellence which are believed to help the sector to achieve its mission and vision. Excellence in health service delivery 2. Excellence in quality improvement and assurance 3. Excellence in leadership and governance 4. Excellence in health system capacity These four areas of excellence are further decomposed in to fifteen strategic objectives categorized under two driver perspectives business process and learning and growth and two results community perspective and financial stewardship. The strategic objectives are linked each other with a cause-effect relationship and every strategic objective has set of performance measures and strategic objectives. It has also set target to stabilize and then reduce deaths and injuries from road traffic accidents. To achieve these and other impact and outcome targets set for the coming five years, a list of strategic initiatives are set such as: The substantial inequalities still existing in health outcomes based on differences in economic status, education, place of residence and gender need to be addressed. A detailed roadmap with innovative strategies will be developed to ensure that every Ethiopian is reached with essential, quality services. The possibility of establishing a centre or institute for health equity will also be explored. Information revolution “ this is reforming the methods and practice of collecting, analyzing, presenting and disseminating information. It is a radical shift from traditional way of data utilization to a systematic information management. It includes advancing the data collection, aggregation, reporting and analysis practice; promoting the culture of information use at place of generation; harnessing ICT; improving data visibility and access; and strengthening verification and feedback systems. Woreda transformation “ Woreda health offices need to be transformed into high-performing entities that translate

the national aspirations into a reality. Therefore, woreda transformation aims at narrowing the gap between the high and low performing woredas. It has three components: The Caring, Respectful and Compassionate health workforce – this is multi-pronged approach and is a that calls for a mechanism to persistently remind health professionals the values, hopes, and aspirations that brought them into healthcare. It also requires a culture change and a change in attitude, manner, and approach of health care delivery. The overall costing for HSTP implementation is prepared in two scenarios: In general, the ultimate purpose with this plan is to improve the health status of the peoples of Ethiopia in an equitable manner. The HSTP is cascaded to all levels and will be translated into annual operational plans using the Woreda-based health sector annual plan. Its implementation will be consistently monitored using the agreed monitoring framework in a coordinated manner. The development of the Health Sector Transformation Plan is guided by a roadmap prepared jointly with all relevant stakeholders under the leadership of the Ministry of Health and Regional Health Bureaus. The roadmap clearly stipulated the major steps of the development process, planning approach and methodology and communication strategy. It also clearly indicated the roles and responsibilities of all actors giving due emphasis for the involvement of all relevant stakeholders, including the private sector to ensure commitment by all for the implementation of the strategic plan by having a shared vision. The review findings showed that the country has made tremendous achievements from implementing high impact interventions mainly through its flagship community focused program known as the Health Extension Programme. The objective of the long-term envisioning exercise was to define a framework for subsequent strategic actions which will enable Ethiopia to achieve the best health outcomes that would be expected of a lower middle income country by and to achieve at least median health outcomes of an upper middle income country by The feedback received from these consultative workshops were carefully documented, reviewed and incorporated accordingly. The remainder of this HSTP document is organized as follows: Country profile Ethiopia is the oldest independent and second most populous country in Africa. It has a unique cultural heritage with a diverse population mix of ethnicity and religion. It served as a symbol of African independence throughout the colonial period, and was a founding member of the United Nations and the African base for many international organizations. The country occupies an area of 1. More than half of the country lies above 1, meters. The predominant climate type is tropical monsoon, with temperate climate on the plateau and hot in the lowlands. There are topographic-induced climatic variations broadly categorized into three: Demographic Profile Projections from the population and housing census estimate the total population for the year to be 90 million CSA, 2. Ethiopia is the home of a variety of nations, nationalities and peoples with more than 80 different spoken languages. The average size of a household is 4. The pyramidal age structure of the population has remained predominately young with While the sex ratio between males and females is almost equal, women of reproductive age constitute The average fertility trend has shown significant decline in recent years from the level of 5.

3: Ethiopian Health System - Health Care in Ethiopia Health Care in Ethiopia

EFMHACA Ethiopian Food, Medicine, Health Care Administration and Control Authority Growth and Transformation Plan. Pharmacy benefits management.

Safety and health in ports Revised 20 August The text revises and updates the edition of: Guide to safety and health in dock work and Safety and health in dock work, An ILO code of practice second edition, Code of practice on safety and health in shipbuilding and ship repair Revised edition 18 April The Meeting of Experts drafted and adopted a Code of practice on safety and health in shipbuilding and ship repair. In accordance with established procedures, this Code of practice will be submitted to the th Session of the Governing Body of the ILO Octoberâ€”November for its consideration. Code of practice on safety and health in opencast mines 26 March The original code of practice, "Safety and health in opencast mines", was published in This revised code reflects the many changes in the industry, its workforce, the roles of the competent authorities, employers, workers and their organizations, and the development of new ILO instruments on occupational safety and health OSH , including the Safety and Health in Mines Convention, No. To this effect, the new code is based on the principles of the Convention, including risk assessment, addresses issues such as the interaction between large-scale and small-scale artisanal miners and also comprises a section on automated machinery, a development that has great potential to change the work carried out by nearly all workers in opencast mines worldwide. Safety and health in the use of machinery 08 November This code of practice sets out principles concerning safety and health in the use of machinery and defines safety and health requirements and precautions applicable to governments, workers and employers, and also to designers, manufacturers and suppliers of machinery. Safety and health in agriculture 21 March This code of practice is intended to raise awareness of the hazards and risks associated with agriculture and promote their effective management and control; to help prevent occupational accidents and diseases and improve the working environment in practice; to encourage governments, employers, workers and other stakeholders to cooperate to prevent accidents and diseases; to promote more positive attitudes and behaviour towards occupational safety and health OSH in agriculture throughout the sector; ensure that good workplace health and safety practices are applied to all workers in the workplace regardless of age or gender. Safety and health in underground coalmines 13 May This new code, which reflects the many changes in the industry, its workforce, the roles of the competent authorities, employers, workers and their organizations, and on the development of new ILO instruments on occupational safety and health, focuses on the production of coal from underground mines. The original code of practice on safety and health in coalmines was adopted by the Governing Body in Surface mining is covered by the code of practice, Safety and health in opencast mines Safety and health in the iron and steel industry 09 February This new code, which reflects the many changes in the industry, its workforce, the roles of the competent authorities, employers, workers and their organizations, and on the development of new ILO instruments on occupational safety and health, focuses on the production of iron and steel and basic iron and steel products, such as rolled and coated steel, including from recycled material. It does not deal with the mining of raw materials for iron and steel production nor does it deal with the fabrication of commercial steel products. The original code of practice on safety and health in the iron and steel industry was adopted in Safety and health in shipbreaking: In so doing they provide advice on the transformation of a mainly informal economy activity into a more formal organized one. Security in ports 01 January The objective of this code of practice on security in ports is to enable governments, employers, workers and other stakeholders to reduce the risk to ports from the threat posed by unlawful acts. Safety and health in ports 17 December The practical recommendations in this code are intended to provide relevant guidance to ILO constituents and all those responsible for or involved in the management, operation, maintenance and development of ports. This code of practice replaces two former ILO publications: Workplace violence in services sectors and measures to combat this phenomenon 15 October This code focuses on the prevention of workplace violence and its direct adverse consequences. The objective of this code of practice is to provide general guidance in addressing the problem of workplace violence in services sectors. The code is intended to serve as a basic reference tool for

stimulating the development of similar instruments at the regional, national, sectoral, enterprise, organization and workplace levels, specifically targeted at and adapted to different cultures, situations and needs. Managing disability in the workplace 01 January This code has been drawn up to guide employers to adopt a positive strategy in managing disability related issues in the workplace. It is intended to be read in the context of national conditions and to be applied in accordance with national law and practice. Safety and health in the non-ferrous metals industries 04 September This code of practice provides practical guidelines for ensuring that the safety and health of all those involved in non-ferrous metals production, in large and small enterprises, are afforded the highest priority. It is the product of collaboration between the ILO and its tripartite constituents, as well as cooperation with its international partners. Safety in the use of synthetic vitreous fibre insulation wools glass wool, rock wool, slag wool 01 January This ILO code of practice defines major principles and approaches concerning safety requirements and precautions in the use of insulation wools glass wool, rock wool and slag wool. It provides practical control measures to minimize occupational exposure to fibres and dusts from insulation wools, prevent irritation and discomfort, and avert any long-term health risks involved in working with such products. The code promotes an integrated approach, taking account of the fact that synthetic vitreous fibre insulation wools do not appear in the workplace in their pure forms but rather as a product with mixed components. Emphasis is placed on addressing all the hazards arising from the product insulation fibres, binders and other materials , taking account of real work situations.

4: Ethiopia: Analytical summary - Health system outcomes - AHO

Health in Ethiopia has improved markedly since the early s, with government leadership playing a key role in mobilizing resources and ensuring that they are used effectively. A central feature of the sector is the priority given to the Health Extension Programme, which delivers cost-effective basic services that enhance equity and provide.

Health profile General health indicators The health status of Ethiopia is poor, even when related to other low-income countries including those in sub-Saharan Africa. The population suffers from a huge burden of potentially preventable diseases such as HIV, malaria, tuberculosis, intestinal parasites, acute respiratory infections and diarrhoeal diseases. The health indicators are generally poor, though there are improvements observed. Statistics on hospital admissions are not readily available. Other conditions responsible for admission include tuberculosis, malaria, respiratory infections, trauma, pregnancy-related conditions and complications of measles. Determinants of ill health Poverty: Lack of access to safe drinking water: Bacillary dysentery water borne disease affected 63, people in the same year with deaths same source. Lack of sanitation facilities: Disposal of waste is a particular challenge to the authorities at all levels and is not sufficiently addressed. High rate of migration: Large segments of the population are migrating for climatic, economic and social reasons and sometimes because of social unrest. According to the National Labour Force Survey, The health system is unable to provide health care for more than half the population. Much of the rural population has no access to any type of modern health care service. However, when there is physical access to the facility, it is reported that some facilities are staffed with health workers of low qualifications and drugs and clinical supplies are not available at many health facilities all of the time. There seems to be gross inequalities when it comes to access to health services amongst different regions of the country. Low agricultural productivity and recurring droughts contribute to nutritional deficiencies. The same survey found 3. These strategies served as a basis to elaborate implementation programs jointly with the regional owners and international partners. After presentation of these programs to a Consultative Meeting in , constructive advice was obtained and a plan of action was elaborated, creating favourable conditions for enhanced cooperation and joint implementation with technical assistance from a number of partners. These two documents define the objectives, the strategies, activities and the responsibilities of all actors at various levels. This is the sector-wide approach in action! The main objectives of the HSDP for the period are: Improve service quality through training and an improved supply of necessary inputs. Strengthen management of health services at federal and regional level. Encourage participation of the private sector and the NGO sector by creating an enabling environment for participation, coordination and mobilisation of funds. The five-year health program is designed to emphasize the preventive aspects of care and to develop comprehensive and integrated primary health care services. The focus is on communicable diseases, common nutritional disorders and environmental health and hygiene. In particular this program aims to support activities for improvement in reproductive health care, family planning, immunisation, control of epidemic diseases such as malaria and tuberculosis, and control of sexually transmitted diseases. The current vertical programs will be gradually phased out as capacity at woreda level increases. The proportion of health expenditure attributable to the utilization of the private health services both modern and traditional is not fully documented, but is believed to be considerable. The overall budget includes categories for capital development and recurrent costs. The per capita expenditure on health in Ethiopia is about USD 1. Health sector expenditures in Ethiopia have tended to emphasize on urban-based, curative services rather than rural-based, preventive primary health care services. The regions whose populations predominantly live in urban areas tend to have more budget allocation per capita than the predominantly rural counterparts. The budget allocated by the government to the health sector is highly inadequate and there is a considerable dependence on donors and other partners to supplement the resources of the MoH. However, there has been a corresponding increase in health expenditure on drugs and other non-salary items. The decrease in the proportion of health budget allocated to salaries may have led to the stagnation of salaries, leading to high attrition of staff. Health delivery system In , there existed a total of hospitals all denominations , health centres HC , 2, health stations HS , health posts HP and 1, private clinics in Ethiopia. There is no data

on the number of traditional healers available in the country, whose services many Ethiopian households use for various health problems. The population per primary health care facility is 27,, which is three times higher than in the rest of sub-Saharan Africa. The total number of hospital beds is 11,, which means that there is only one bed for a population of 4,, which is about five times lower than the average for sub-Saharan Africa. Currently as part of HSDP, the existing six-tier health care management system is being transformed into a four-tier system characterized by a PHC-unit 1 HC and 5 satellite HPs , the district hospital, zonal hospital and specialized hospital. The limited number of health institutions, the poor distribution of medical supplies among regions and the disparity between urban and rural areas are all responsible for the inaccessibility of health care services to the population. In Ethiopia, drugs that are required to reduce morbidity and mortality from common illnesses are mostly in short supply, the majority of which are imported and expensive. According to the mid-term review of the Health Sector Development Program, , problems related to essential drugs utilization include inadequate budget, weak drug supply system, poor logistic support for distribution and irrational drug use. The HCs are on average staffed by at least one medical officer, several nurses and health assistants who have 18 months basic health training , one laboratory technician and one pharmacy technician. At the average health station, there are three health assistant staff. The physician per population ratio is one per 48, and the nurse per population ratio is one per 12, one third and one sixth, respectively, of the average of the rest of sub-Saharan Africa. Overall there are 20 trained HWs per ,, a very low ratio even for sub-Saharan standards. There are presently 14 nursing schools in the country with an annual output of nurses. Based on the present number of trained health workers, a population growth rate of 2. The medical and nursing schools and training institutions for paramedical professionals are available in the country and do make attempts to increase the annual output of trained personnel to meet the demands. However, the quality of some trained manpower is believed to be unsatisfactory. An evaluation of the human resource system has been recommended by the mid-term review of the HSDP.

5: UNICEF Ethiopia - Health - Health

Denkew, Director General of Food, Medicine and Health Care Administration and Control Authority of Ethiopia (FMHACA) and Dr Shimelis Admasu, Deputy Director General, Food, Beverage and Pharmaceutical Industry Development Institute.

Abstract Background Effective and enforceable national regulations describing the manufacture and re packaging, export and import, distribution and storage, supply and sale, information and pharmaco-vigilance of medicines are required to consistently ensure optimal patient benefit. Expansion of pharmaceutical industries in many countries with advancement in transport technologies facilitated not only trade of genuine pharmaceutical products but also the circulation of poor quality medicines across the globe. This legislation formed the legal basis for official establishment of drug regulation in the history of Ethiopia, enabling the regulation of the practice of pharmacists, druggists and pharmacy technicians; manufacturing, distribution, and sale of medicines. The mere existence of this legal framework does not guarantee complete absence of illegal, substandard and falsified products as well as illegal establishments in the pharmaceutical chain. Therefore, the objective of the research is to assess the pharmaceutical regulatory system in Ethiopia and to reveal possible reasons for deficiencies in the pharmaceutical chain. **Methods** An archival review, an in-depth interview of key informants and an institutions-based cross-sectional survey study were conducted during March to April. The comprehensiveness of the pharmaceutical law to protect public health relative to three selected African countries South Africa, Tanzania and Uganda and European Union, and implementation was assessed. The legal framework for pharmaceutical regulation of Ethiopia was founded to fulfill all the medicines regulatory functions potentially enabling to combat illegal, substandard and falsified medicines and illegal establishments. From the institution-based cross-sectional study, it was revealed that there exist illegal sources for medicine in the pharmaceutical market. The main reasons for their existence were regulatory factors including weak regulatory enforcement. **Conclusions** From legislative point of view, the medicines regulatory framework in Ethiopia fulfils all regulatory functions required for effective medicines regulation. Medicines are important aspects of public health and must be available and accessible to the public. To improve access to medicines, good governance is crucial and contributes to health systems strengthening. Good governance in the pharmaceutical sector refers to the formulation and implementation of appropriate policies and procedures that ensure the effective, efficient and ethical management of medicine regulation, in a manner that is transparent, accountable and follows the rule of law 1. Since the mid-1990s, many new pharmaceutical products have flourished and trade in the pharmaceutical industry has taken on international dimensions. However, the circulation of toxic, substandard and counterfeit drugs on the national and international market has increased. This is mainly due to ineffective regulation of production and trade in pharmaceutical products in both exporting and importing countries. The use of these poor quality medicines may also threaten the health and lives of patients 5. WHO estimates that from one million deaths that occur from malaria annually, 100,000 would be avoidable if the medicines available were effective, of good quality and used correctly. Moreover, inefficiencies in medicines regulatory system can delay entry of needed medicines in a market; hence, a barrier to access for users and to the profits and growth of the pharmaceutical business 7. The problems of ineffective regulation have global implications 8 and minimum requirements for effective medicines regulation should exist in any country to counter poor quality medicines 9. The situation is severe in sub-Saharan African countries where there are limited resources and pharmaceutical manufacturing capacity with a high disease burden. Thus, parallel, unregulated medicines markets are posing serious risks for individual and public health. As far as Ethiopia is concerned, there is no comprehensive evaluation of the basic medicines regulatory framework and associated unregulated medicines and their sources. Ethiopia is one of the sub-Saharan African countries where the pharmaceutical sector is being guided by a national medicine policy. The rapid growth and development of pharmaceutical sector after the downfall of the Dergue regime in Ethiopia has led to the majority of pharmaceuticals and medical supplies being provided by both the public and private sectors. Currently, there are 32 plants small and large scale involved in the manufacturing of

pharmaceuticals and related products of which only 12 are manufacturers of generic finished pharmaceutical dosage forms. The remaining are involved in the small scale manufacturing of medical devices, supplies, laboratory reagents, cosmetics, and disinfectants. Some primary data sources reveal that poor quality pharmaceutical products are in the market because of inefficiencies in pharmaceutical regulatory functions in Ethiopia. In the area of post-registration testing, low income countries tended to collect fewer samples and report higher rates of products failing testing. For example, the result of trend analysis on the quality control laboratory tests carried out in Ethiopia for samples submitted from the year 2007 shows that most failures of samples submitted for post-marketing surveillance (PMS) was higher. Such public health problems should thus be investigated through critical evaluation of the legal basis and implementation of the pharmaceutical regulatory framework in Ethiopia. Regular regulatory systems assessment is important for the policy makers in designing or updating policies and strategies to prevent public health from medicines whose safety, efficacy and quality are not ensured and authorized to circulate in the market. The legal basis of the existing pharmaceutical regulatory system in Ethiopia was critically reviewed in comparison with relatively good regulatory systems of three African countries (South Africa, Tanzania and Uganda) and the current EU regulatory system. The comprehensiveness of the legislation to protect the public health was critically evaluated and its practical implementation was assessed through institution-based cross-sectional survey.

Methods and Materials The study was conducted to critically assess the legal framework of the pharmaceutical regulatory system based on Proclamation No. 494/2005. An archival review, in-depth interviews with key informants selected from institutions involved in the pharmaceutical sector and institution-based cross-sectional survey using semi-structured questionnaires developed based on WHO guideline were used to gather data [18]. A critical review on the drug regulation was undertaken followed by semi-structured interviews with key informants from academia, industry and EFMHACA to supplement information gathered from the legal sources. For the review process, archival review guide was used as a data collection tool. The tool was developed based on WHO guideline [20] and contains detail description on the general content of the medicine legislation and a checklist for the functions of the medicine regulatory authority as evaluation points. Therefore, the selection of the three African countries was based on this literature while EU was selected for its strict medicine regulatory system. Overall, records on legal framework, resource for implementation and implementation reports in protecting public health were assessed. Moreover, references on quality of products from the national market were included. The purpose of in-depth interview was to get details and new insights from the right sources. A total of 12 key informants selected from different institutions in Ethiopia (EFMHACA, custom authority, Ethiopian pharmaceutical association, Ethiopian druggist association, Ethiopian pharmaceuticals manufacturers association and academia) were interviewed. Interviewees were based within different institutions and from various disciplines: Several of the individuals interviewed were expert participants with work experience of more than 20 years while the minimum work experience was 10 years. Points of interview included: Institutional-based cross-sectional survey was conducted to assess the implementation of those regulatory functions described in the legislation. The institution-based cross-sectional study was conducted during March to April to assess the existing regulatory system and its implementation status in Ethiopia. Selected pharmacy professionals from EFMHACA with work experience of two years and above as well as technical managers and marketing personnel of the regulated institutions were included in the study. From each of the institutions, two study participants were purposively selected. One hundred and ninety-seven technical and marketing managers participated in the study, making the total number 199. Descriptive analyses were conducted and outputs were presented using frequency tables and charts. Similarly, summaries were made from the archival review findings on the critical features of medicine regulation. A multivariable logistic regression was used to investigate the relationship between the different reported factors for the existence of illegal pharmaceutical business.

Results The legal basis of pharmaceutical regulation in Ethiopia: An overview of medicines regulatory framework in Ethiopia, Tanzania, Uganda, South Africa, and EU is presented in Table 1, while the legal framework of the respective medicine regulatory authorities is presented in Table 2. For all the countries, there exists a well-defined law for medicine regulation with clearly articulated objectives of protecting public health from unsafe, inefficacious and poor quality

medicines. Table 1 An overview of the medicine regulatory framework in the selected countries.

6: Global Health | Ethiopia | U.S. Agency for International Development

Primary Health Care Unit PLWHA .. People Living with HIV/AIDS The Federal Democratic Republic of Ethiopia has nine Regional States: Tigray, Afar, Amhara.

There are many reasons why women do not use health services in Ethiopia. Although the government just approved and promised to implement a national insurance plan, citizens have to pay out-of-pocket until the plan is established. Finding transport, a lack of money, and the distance to a health center are stated as the greatest barriers in accessing health services. Many are also concerned about arriving at a health center only to find there is no health worker or no drugs that they need. After spending the time and money, and taking off work, this is a legitimate concern that would deter anyone from seeking health care. Twenty-nine percent of women also worried about receiving permission to seek health. The table below displays the statistics regarding barriers to health that women in Ethiopia cited DHS, , p. Employment and wealth contribute significantly to level of autonomy. Three out of ten women received no pay for their work, nothing. And, although education is important as well, it is most valuable when it opens doors for employment for women. Women with the highest educational attainment and best reading abilities belong to the highest wealth quintile.

In the Demographic Health Survey, women with more than secondary education and women in the highest quintile reported the least barriers to accessing health care. Not only is policy in Ethiopia not gender-forward refer to the page on this blog for more information, but there is also a gap in the awareness of policies that do protect women. Furthermore, there is no feminist movement or ideological progression that speaks for gender equality in Ethiopia. In order for women to believe they have agency and power to make their own decision regarding health, they need to be empowered in addition to being economically dependent and educated. Women who believe that their husbands are justified in beating them for fewer reasons are also more likely to use contraception depicted in the table below, taken from the Demographic Health Survey. Women who are more empowered have more decision-making power and believe their husbands are less justified in beating them utilize other reproductive health services more often than women who are less empowered. The table below, taken from the Demographic Health Survey, represents this data p. Ethiopia demographic and health survey Ethiopia demographic health survey Federal Democratic Republic of Ethiopia. The criminal code of the federal democratic republic of Ethiopia, proclamation no. Retrieved November 14, , from [http:](http://) The revised family code [Ethiopia], proclamation no. Venture Strategies Innovations, Inc. Accessed 5 December

7: Health in Ethiopia - Wikipedia

1) *Ethiopia has no national health insurance plan. Although the government just approved and promised to implement a national insurance plan, citizens have to pay out-of-pocket until the plan is established.*

However, there has been encouraging improvements in the coverage and utilization of the health service over the periods of implementation of Health Sector Development Plan, the health chapter of the national poverty reduction strategy, which aims to increase immunization coverage and decrease under-five mortality at large. The HEP is designed to deliver health promotion, immunization and other disease prevention measures along with a limited number of high-impact curative interventions. Ethiopia had the lowest level of expected human capital among the 20 largest countries with less than 5 health, education, and learning-adjusted expected years lived between age 20 and 64 years. This put it in th place, an improvement over its position in when it was th. The effort to control tuberculosis began in the early 60s with the establishment of TB centers and sanatoria in three major urban areas in the country. From the very beginning the CO had serious problems in securing sufficient budget and skilled human resource. In , a well-organized TB program incorporating standardized directly observed short course treatment DOTS was implemented in a few pilot areas of the country. An organized leprosy control program was established within the Ministry of Health in , with a detailed policy in . This vertical program was well funded and has scored notable achievements in reducing the prevalence of leprosy, especially after the introduction of Multiple Drug Therapy MDT in . This has encouraged Ethiopia to consider integration of the vertical leprosy control program with in the general health services. This finding indicates that the actual TB prevalence and incidence rates in Ethiopia are lower than the WHO estimates. Additionally, the survey showed a higher prevalence rates for smear positive and bacteriologically confirmed TB in pastoralist communities. However, pertaining to its methodology, the survey did not produce further disaggregated sub-national estimates. Maternal and child health[edit] Maternal and child health program is a priority agenda of the government of Ethiopia and this has been clearly indicated on the currently being implemented strategic plan of the FDRE Ministry of health. Though Maternal and child health program is still one of the target area which needs much organized, systematic and focused effort, clear progress has been witnessed over years as per the Demographic health survey report of the country. The recent DHS [1] in the country shows these steady changes. Maternal health status could be assessed with many indicators of which Modern contraceptive use, skilled delivery and maternal mortality are some of the majors. Modern contraceptive use by currently married Ethiopian women has increased over 15years prior to the DHS. The total fertility is declining but the changes are not that significant. The pregnancy related mortality has also dropped over the last three surveys and this could be attributed to the improvement on skilled delivery and family planning. The fact that Ethiopia is on the verge of eradicating polio could be a good evidence for that. Childhood mortality has declined substantially since . However, the change in neonatal mortality is not significant compared to post neonatal and child mortality. Reducing child mortality MDG 3 has been achieved previously and if the effort is maintained the target of decreasing the under-five mortality to 25 could be met by the end of the target. Traditional medicine[edit] The low availability of health care professionals with modern medical training, together with lack of funds for medical services, leads to the preponderancy of less reliable traditional healers that use home-based therapies to heal common ailments. High rates of unemployment leave many Ethiopian citizens unable to support their families. In Ethiopia an increasing number of "false healers" using home-based medicines have grown with the rising population. However, only about ten percent of practicing healers are true Ethiopian healers. Much of the false practice can be attributed to commercialization of medicine and the high demand for healing. Both men and women are known to practice medicine from their homes. It is most commonly the men that dispense herbal medicine similar to an out of home pharmacy. Before the onset of Christian missionaries and Medical Revolution sciences, traditional medicine was the only form of treatment available. Traditional healers extract healing ingredients from wild plants, animals and rare minerals. AIDS, malaria, tuberculosis and dysentery are the leading causes of disease-related death. Largely because of the costs, traditional medicine continues to be the most common

form of medicine practiced. Many Ethiopians are unemployed which makes it difficult to pay for most medicinal treatments. Many physical ailments are believed to be caused by the spiritual realm which is the reason healers are most likely to integrate spiritual and magical healing techniques. Traditional medicinal practice is strongly related to the rich cultural beliefs of Ethiopia, which explains the emphasis of its use. The first is attributed to God or other supernatural forces, while the other is attributed to external factors such as unclean drinking water and unsanitary food. Most genetic diseases or deaths are viewed as the will of God. Miscarriages are thought to be the result of demonic spirits. Nearly four out of five Ethiopian women are circumcised. There are three levels of circumcision that involve different degrees of cutting the clitoris and vaginal area. Many of these practices are done with an unsanitary blade with little or no anesthetics. It can result in heavy bleeding, high pain, and sometimes death. Today there are three medical schools in Ethiopia that began training students in two of which are linked to Addis Ababa University. Although there have been huge leaps and bounds in medical technology there is still a large problem in the distribution of medicine and doctors in Ethiopia.

8: Ethiopia Health Sector Transformation Plan (//20) | Global Financing Facility

The first Growth and Transformation Plan (GTPI) culminated with registering remarkable achievements in real GDP growth, infrastructure development, social development and capacity building at all levels.

Lady Cop/Lady Killer Java 2 Platform, Enterprise Edition Gis tutorial basic workbook Imam Muhammad Sayyed Tantawi, Sheikh of Al-azhar The Works Of Charles Kingsley V28 German existentialism. A Vicky Hill Exclusive! Javascript syntax cheat sheet On happiness and human potentials World Naturalist Guide 1996-1997 Reading literature (Quercus content reading program) Partners in learning Lessons in language work for fifth and sixth grades Dimensions of International Comparative Physical Education and Sports Guide to European Compressors and their Applications (European Guide Series (REP)) Pinel john p.j biopsychology 9th edition 2014 google Hanuman chalisa book in telugu Recruiting singers Site Planning Set 1 Humoral factors in host defense Nor scarlet but gold Enduring Identities Voices Prophesying War Waiting for a Baby The fifty shades trilogy The Spanish Adventure III: October 1808-January 1809 The Life of Henry the Fourth, King of France and Navarre The golden wreck. Ap macroeconomics multiple choice practice In the studio with Simon Michael What You Pay Attention to Expands Helping young children understand peace, war, and the nuclear threat Hearing and sounds The life and times of Margaret of Anjou, queen of England and France Getting Started with SAS/AF(R and Frames Hv 800 bluetooth headset manual Introduction to mathematical biology rubinow Quarter millennial celebration of the city of Taunton, Massachusetts, Tuesday and Wednesday, June 4 and 5, What kind of systems improve healthcare? Start your own senior services business