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1. EXECUTIVE SUMMARY

This study is commissioned by Christian Relief and Development Association (CRDA) and examines the participation of NGOs/CSOs in the Health Sector Development Program (HSDP) of Ethiopia. It is undertaken at the beginning of 2004 with a purpose to generate information about the participation of NGOs/CSOs in the health sector, identify factors and conditions affecting the success and/or shortcomings of their participation, and strengthen collaboration between Government and NGOs/CSOs in realizing the goals of the HSDP. The study employed qualitative methodologies of key informant interview and review of relevant documents.

Within the last few years, Ethiopia has experienced an increase in the number of NGOs due to a combination of reasons. Close to 400 NGOs in Ethiopia manage health projects or projects that potentially contribute in the alleviation of major public health problems in the country. Most NGOs operate in Oromiya, SNNP, and Amhara Regional States and Addis Ababa city administration. NGOs are involved in health service delivery, health service rehabilitation and expansion, human resource development, pharmaceutical services, strengthening health management and information system, operation research, IEC and health care financing. Most health institutions that are directly managed by NGOs are located in SNNP and Oromiya Regional States. NGOs finance curative, preventive and rehabilitative health services. They manage first and second level health units [health posts, clinics, health centers and hospitals] in the health care delivery system of the country. NGOs own 7% of the health institutions and according to the NHA report of Ethiopia they contributed 10% of the national health expenditure of 1992 EFY. Based on CSA welfare survey, 3.3% of respondents of the survey that reported to visit health institutions during an episode of illness do so at health institutions managed by NGOs. The respondents of this survey are households and individuals reported to be sick within 3 months prior to the study period. Hence, the survey excludes preventive clinical services that target healthy individuals: Family planning services, immunization programs, VCT services, etc. Additionally, NGOs are involved in upgrading, rehabilitation, and expansion of government health institutions. NGOs manage 3 nursing schools in the country, and finance human resource development of public health institutions.

The participation of NGOs in health policy and national program formulation is limited, though there is a positive trend of improvement in this line. There is a huge diversity among NGOs operating in the health sector in Ethiopia. They differ in terms of program priority/goal, international linkage, level of experience and program expertise, profile of target population, source of fund and scope of geographic/program coverage. Hence, ensuring their participation in policy/program formulation requires coordination and networking among NGOs.

NGOs have several comparative advantages in their participation in the health sector when compared to the government and private sector. They are key partners to ensure community mobilization, community-based health care, and in institutionalizing early warning system for early detection of public health problems with a potential to affect large segment of population. Health institutions that are directly managed by NGOs can potentially bring several lessons to the health care system. The future of clinics/health stations managed by NGOs is major concern to interviewed organizations. There is a need to negotiate with respective RHBs for a step-by-step down or upgrading of clinics.

The main Achilles' heel for NGOs managing health projects is related to financial sustainability, community "dependency", and obtaining fund for "traditional health problems" that allows working in community priority areas.

2. COUNTRY CONTEXT

With a population of close to 69 million, a young population characterizes Ethiopia. Seventeen percent of Ethiopians are less than five years of age, and 63.7% is younger than 25 years. Females constitute almost half of the total population of Ethiopia. The crude birth and death rates are estimated at 40 and 12.6 per thousand, respectively with a rate of natural increase of 2.7% per annum (DHS, 2000). Life expectancy at birth stands at 51 years.

Malaria, acute respiratory infections, nutritional deficiency diseases, tuberculosis, diarrheal diseases, maternal and perinatal complications, and HIV infection are major public health burdens in the country. The 2001 national welfare monitoring assessment shows that 27.2% of the surveyed population had health problems at least once over two months prior to the interview period. Episode of illness are highest among the rural population than urban. This two months prevalence of illness

ranges from the lowest [17%] in Addis Ababa, to 38% in Benshangul Gumuz Region. The same survey shows that one out of three children under the age of five years had health problems over two months prior to the survey period.

Though there is some indications for improvement in the survival of Ethiopian children within the last 15 years, Ethiopia is among the countries with the highest under-five mortality. The Infant and Child Mortality Rates of the country are 116 and 171 per 1000 live births, respectively- indicating that almost one in every six new born does not survive to celebrate his/her fifth birthday. Ethiopia has one of the highest prevalence of child malnutrition in the world. Prevalence of stunting stands at 52% among the under-fives, while 26% experience severe stunting, 11% experience wasting[1]. Both caloric and micronutrient deficiencies are common in the country, and account for 29% of both direct and indirect premature deaths. In 1996, nutritional deficiencies are estimated to directly account for 7.8% of deaths and 9.3% of discounted life years lost. Forty four percent of children are estimated to have sub-clinical vitamin A deficiency, and 22% are iodine deficient. AIDS in children is a marginalized issue in Ethiopia, the extent of which is not known. The GoE estimates that 200000 children are living with HIV. Though the largest proportions of PLWHA are adults, children are increasingly becoming primary victims of the AIDS epidemic.

Based on the limited data available, the Maternal Mortality Rate of Ethiopia is estimated to be 871 per 100000 live births (MoH, 2001/02). WHO estimates that pregnancy and birth account for 25% of deaths among women within the age group of 15-49 years. The high MMR is related to high fertility rate (5.9), early and frequent pregnancies, and lack of timely access to adequate emergency obstetric care. Additionally, a huge gender gap in life's opportunities and access to services exist at the root of the high maternal mortality, poor women's general health, and limited access to health care by women. Ethiopian women are at risk of adverse health conditions across their life span, and the estimated high MMR is among several statistical displays of the situation of their health. Women have fewer opportunities for education, earn lesser income compared to men, and in most parts of the country tradition does not allow them to own, have control over, or inherit property. The lack of time, disposable income, and information by women limits their access to health services.

[1] *Central Statistic Authority. 2000. Ethiopia Demographic and Health Survey.*

Though most public health problems of Ethiopia are potentially preventable, the abject poverty millions are exposed to offers a fertile ground for a high burden of disease. The gross national product of the country is barely over 100 USD. Ethiopia has a high illiteracy rate. Sixty-two percent of males and 77% of females [above six years of age] have no education (DHS, 2000). Poor sanitary and housing conditions are threats for the well being of millions in the country. Only 12% of Ethiopians have access to proper excreta disposal facilities. Twenty percent of Ethiopians, 76% of urban and 20% rural, has access to safe drinking water (MoH, 2001/02). Consistent with its inadequacy and the distance one has to travel to fetch it, the use of water is often confined to drinking and cooking purposes with limited use for personal hygiene.

Only 51% of Ethiopians have geographical access to medical services, and it is much lower for rural residents due to the tendency of health institutions and professionals to concentrate in urban locations. DPT_3 immunization coverage is 52%, and the antenatal coverage rate stands at 34% (MoH, 2001/02). Significant proportions of Ethiopians do not seek modern medical care during an episode of illness. Females are less likely to do so when compared to men. This gender difference in seeking health care is consistently observed in urban and rural areas and across all expenditure quintiles. The country has the least health professionals to population ratio, even when compared to other developing countries. The health care delivery system of Ethiopia is underdeveloped. Major contributing factors are:

1) Health services are poorly distributed and underutilized;
2) Quality of care suffers from inadequate infrastructure, scarcity of trained health personnel and shortage of drugs and pharmaceutical supplies;
3) Funding is inadequate; and
4) Capacity for planning and management is weak.

Further down the hierarchy of the health care tier and away from major urban locations, shortage of human resources, equipments and pharmaceuticals are major issues. Due to the socio-political reality of the country, Ethiopia has inherited a centralized, hierarchical and standardized health care system. For most parts of the history of the country, policies, practices and treatment guidelines were often developed at national level by MoH and passed to implementing offices.

3. INTRODUCTION AND BACKGROUND

In most parts of the world, NGOs have played key roles in improving the health status of the population and access to health services. Often in the forefront to address "sensitive" health needs such as reproductive health, family planning, sexual activities of adolescents, STIs including HIV, domestic violence, and unsafe abortion; 20-30% of health needs in developing countries are met by NGOs. In Sub-Saharan Africa, NGO-hospitals provide 43% of medical services in Tanzania, 40% in Malawi, 34% in Ghana and 9% in DRC. NGOs' medical services in Asia account for 26% in Taiwan, 15% in India, 13% in Bangladesh and 12% in Indonesia. Additionally, there is a global recognition that NGOs' health institutions provide a large potential for improving health and health care delivery systems of developing countries. In several countries, NGOs were able to introduce cost-effective, need-based and flexible health programs. Their flexibility, autonomy and responsiveness offer timely and effective Primary Health Care services.

Sustaining national health systems is increasingly a challenge for many governments in the developing world. Health reform is advocated for, in order to maximize the use of scarce resources, and improve efficiency and effectiveness of the health care delivery system. Hence, co-operation among the public and non-governmental sector is suggested to be one of the strategies to improve efficiency and affordability of national health services (WHO, 1987). In most developing countries, both the public and the non-governmental sector health establishments employ various cost recovery strategies. The difference between the two establishments is often related to ownership of the health care institution and "perceived higher quality of health services" provided by NGOs. NGOs with a not-for-profit principle often operate at low cost and achieve acceptable levels of adequate health and medical care. They often operate under rather difficult conditions in remote and insecure areas, where state-owned institutions are, so to speak, non-existent (Van Lerberghe et al, 1990 and 1992). Furthermore, in several developing countries, NGOs have a good track record in medical care and in supporting community-based health care activities. They have important qualities such as low staff turn over, freedom from rigid bureaucracy, experience in cost-recovery system, proximity and adaptation to the needs of target populations, preference to support and serve the underserved, and high-staff motivation (Contact, Geneva, 1995). NGOs with such qualities are capable of developing

and testing new solutions such as in the fields of building (M. King), financing (Moens 1990, Criel 1997), appropriate technology and community involvement.

Most NGOs' health institutions operate adequately at first referral level. However, they suffer from lack of coordination with the government health services. WHO advises to foster close co-operation between governmental and non-governmental health institutions and establishments of an integrated district health system (WHO, 1987). The effective use of non-governmental resources is recommended as one policy reform agenda.

The advantages of the participation of NGOs/CSOs in the health sector are both instrumental and value based. It is instrumental because NGOs potentially contribute flexibility, responsiveness, adaptability, and efficient and effective performance to the health sector. Its value is related to the contribution of participation in health sector program to democratization and improved governance by creating opportunities for dialogue, accountability and transparency that advance societal transformation towards more democratic governance (Brinkerhoff, 2000). The argument is that creating and strengthening NGOs/CSOs increases opportunities for citizens to participate in decision-making and action related to policy formulation and implementation. Thus, "NGOs/CSOs are critical to developing new patterns and practices of governance."

Ethiopia, like most developing countries, is struggling with limited resources to meet the basic health needs of its rapidly increasing and predominantly young population, in the face of severe poverty, cycle of natural disasters, the AIDS epidemic, and chronic conflicts. The government of Ethiopia is the major modern health care provider in the country. Owing to past political ideology and socio-economic situations of the country, there is limited participation of NGOs and the private sector in service delivery even if, voluntary, church- based, and missionary organizations were pioneers in the introduction of modern medical services to Ethiopia.

The first health institution [a hospital] in Ethiopia was established and managed by the Russian Red Cross Medical Team- during the time of Emperor Menilik II. In the first quarter of the 20th century, church-based groups and missionaries were major health service providers in the country. Marginalized health issues such as leprosy, physical/mental disability, birth related fistula, post-abortion care, family planning services and HIV/AIDS are some of the concerns championed by

NGOs in Ethiopia. Over the last half a century, the involvement of non-governmental and voluntary groups in the health sector has increased progressively. An assessment conducted in 1997 indicates that 146 health facilities are managed by this sector. The mid-term HSDP review reports that 10% of the health -care is provided by the Non-Governmental sector.

The 2000 national welfare monitoring survey indicates that only 41% of those who had ill health consulted modern medical services, and the majority of the respondents (45.5%) do so from government health institutions. Pharmacies (most are privately owned) were consulted by 16% of the respondents who seek modern medical care. Other private facilities, health personnel privately, and NGOs provided care to 15, 12, and 3 percent, respectively. This survey, however, does not incorporate preventive services such as immunization, family planning and home-based cares. Significant number of NGOs are involved in disease prevention and health promotion activities at community level, and extend service delivery through community-based programs such as CBDs of family planning services, home based care for AIDS patients, community based rehabilitation, etc.

NGOs employ diverse program strategies to improve access to health services in their operation areas. Wesley and colleagues categorized such strategies into five groups, each with its own merits and demerits.

1. **Direct management approach**: The NGO builds, or renovates, and then manages a health facility. Missionary groups, Faith Based Organizations, or churches commonly adopt this. Their managers and senior staff have long-term commitment and retain direct control over funds and staff, maintaining "high standard" curative services. The CSA and NHA surveys most probably assessed these groups of health institutions/NGOs.
2. **The "clinic adoption" approach**: The NGO 'adopts' one or more government clinics and provides material support by refurbishing the building and supplying equipment and drugs. In such approach, it is usual for an expatriate health professional to work in the clinic, giving the staff in-service training in curative, rehabilitation and MCH work.
3. **The "impact area" approach:** The NGO concentrates its effort in a small-defined geographic area; this usually involves health facility expansion, support and health workers'

trainings, when combined with inter-sectoral activities the approach is termed 'community-based integrated rural development.'

4. **The "air-drop of resources" approach**: A visit by a consultant is followed by channeling of resources directly into public health system, which is responsible for implementation.
5. **The "health system" or "institution building" approach:** The use of NGOs' technical and material support to help analyze and then develop and implement systems and processes of district health management and care. The emphasis of this group is improving general health management system: for "decentralized process of implementation, stressing district-based training and supervision."

4. THE HEALTH SECTOR DEVELOPMENT PROGRAM OF ETHIOPIA

Ethiopia has ratified a health sector policy and subsequently launched a Health Sector Development Program (HSDP) for implementation over a period of twenty years. The HSDP responds to a number of problems identified in the coverage and quality of health services. It is broken down into four successive five-year plans and the first and second phase cover the period of 1997– 2002, and 2002-2005. The objectives for these periods are: A) Increase access and coverage to health care, along with utilization; B) Improve service quality through training and an improved supply of necessary inputs; and C) Strengthen management of health services at Federal and Regional levels. One of the strategies employed to achieve these objectives is to encourage the participation of the private sector and NGOs, by creating conducive environment.

As stipulated in the HSDP, the health care delivery system of Ethiopia has undergone tremendous restructuring within the last few years alone. As part of the national health care reform, a four-tier system has replaced the previous six-tier system. According to the health sector strategy of Ethiopia, a Primary Health Care Unit (PHCU) with one health center and five satellite health posts is the first level care provider in the health service delivery of the country. The PHCU would focus on preventive, promotive and basic curative health services. District hospitals are the first referral levels for PHCU. Equipped with the capacity of 50 beds, District hospitals are planned to serve 250,000 populations and support PHCU through human resource development among other things, and provide curative, preventive and rehabilitative services. The third level health care delivery unit, the

zonal hospital, has the capacity of 100 beds and serves as referral for District hospitals that are located in its geographic catchments area. Zonal hospitals are expected to provide curative and rehabilitative services, and operate as training and research institutions. Regional specialized hospitals are situated at the apex of the health service delivery system, and provide all specialized clinical services, have a capacity of 250 beds, and each serves a population of 1 million.

The adoption of federal state has created regions with significant autonomy in the health sector, with great opportunity for local planning based on local situations and health needs. The health system comprises of a) Federal Minister, at Federal level; b) Regional Bureaus, at Regional level; and c) Wereda offices, at the basic level. Regional Bureaus are the highest executive level in the health system, with a trend to increasingly decentralize decision making to Wereda level.

Realizing the goals of the Health Sector Development Program is not, however, without challenges. The leading challenges are related to a) the high level of poverty that poses a threat to the health and well-being of millions in the country, b) the low socio-economic status of women that endangers their health and the health of their offspring, c) the rapid population increase that the country is experiencing, d) the HIV/AIDS epidemic that presents additional challenge to the health sector, and d) the human resource deficiency of the health sector, both in terms of quality and quantity. The health care delivery system of Ethiopia is more professionally organized on paper than on the ground. Additionally, the limited institutional capacity and human resource are challenges for effective decentralization of decision-making. The growing participation of the private sector in health service delivery further accentuates the existing human resource shortage of the health sector.

5. STUDY BACKGROUND

5.1 General Background

This study is commissioned by Christian Relief and Development Association (CRDA) and examines the participation of NGOs/CSOs in the Health Sector Development Program of Ethiopia. CRDA is a non-governmental, membership, independent, and voluntary organization that was established more than 30 years back in response to the famine in Ethiopia. More than 200 international and national organizations are members of CRDA. The major strategies and activities

of CRDA are related to capacity building, project funding and lobbying on behalf of member organizations to create an enabling environment for their participation in the socio-economic development of Ethiopia. This study is undertaken to generate information about the participation of NGOs/CSOs in the health sector, identify factors and conditions affecting the success and/or shortcomings of the participation of NGOs in the health sector and strengthen collaboration between Government and NGOs/CSOs in order to realize the goals of the HSDP. Moreover, the study is expected to generate information for further detailed study in themes that are essential in strengthening the role of NGOs/CSOs in the health sector.

5.2 Purpose of the study

- To assess the participation of NGOs/CSOs in the HSDP of Ethiopia: both at policy formulation and program implementations level;
- To generate information on distribution and types of health services managed by NGOs/CSOs;
- To identify and assess existing policies and guidelines related to the participation of NGOs/CSOs in HSDP;
- To identify comparative advantages and major gaps of NGOs/CSOs, from programming responses, capacity, and partnership perspective in their participation in the HSDP of Ethiopia;
- To identify constraints and challenges faced by NGOs/CSOs in their participation in HSDP;
- To recommend policy, program, and institutional support focus that enhances the participation of NGOs/CSOs in the HSDP;
- To recommend ways to realize CRDA's contribution to strengthen NGOs/CSOs initiatives in the health sector.

5.3 Study methodology

This is a cross-sectional study, exploratory and descriptive in nature, and primarily employed qualitative methodologies of key informants interview and review of relevant documents. Guideline

questionnaires were developed to direct the interview and discussion process. The questionnaires were open -ended and broad in order to incorporate the views of respondents. Data gathered through interviews are complemented by analysis of documents and reports, as well as review of the relevant published literature.

The key informants were individuals from NGOs, faith-based organizations, MoH, selected RHBs, DPPC and networking and coordinating organizations. Discussion was held with Amhara, Oromiya, Addis Ababa and SNNP Regional Health Bureaus officials. List of NGOs was made based on data obtained from DPPC and CRDA membership database.

5.4 Limitations of the study

The major limitation of this study is related to the absence of comprehensive data on NGOs/CSOs that are operational in health sector in Ethiopia. Available information is often fragmented, dated, and suffers from lack of regular compilation and reporting. As CRDA is a membership organization, its database and directory are limited to those of members. There are, on the other hand, NGOs that are not members of CRDA with major investment in the health sector. Attempts are made to contact such organizations based on a list created through key informant interview and DPPC documents.

5.5 Operational definitions

The term NGO can refer to any Non-Governmental Organization, and different literatures provide differing definitions of Non-Governmental Organizations. Worldwide, the list of NGOs also includes Faith -Based Organizations, religious establishments and political activist groups. The Code of Conduct for NGOs in Ethiopia articulates a broad distinctiveness of NGOs as a *"voluntary, not-for-profit, non-self-serving, non-governmental, non-partisan, and independent organizations or associations"* involved in the promotion of social justice and development. There is also a lack of clarity and consistency in the definition of Civil Society Organizations (CSOs). They are broadly defined as voluntary and independent organizations from the state and the market, and are often located somewhere in the social arena between state and citizens. In countries where the state and its

agencies are the major and often the sole determinant of the political, social, economical and cultural life of society; it is not easy to clearly demarcate the arena for CSOs. For all practical reasons, professional associations, CBOs, and religious institutions fall in the category of CSOs. In some countries, the media and trade unions are also part of civil society establishments. In this study, NGOs and CSOs are used interchangeable.

There are diverse trends of role of NGOs in different parts of the world, and different organizational niches are suggested on literatures. In some developed countries, NGOs are viewed as transitory- serving a limited purpose for a limited time; some donors view NGOs as inexpensive service-delivery mechanisms for diverting resources away from "wasteful", "bureaucratic", and "expensive" government agencies. The Code of Conduct for NGOs in Ethiopia states that "*NGOs operating in Ethiopia are committed to the advancement of the people, including improvements in their quality of life, and the promotion of social justice, particularly for those disadvantaged and marginalized.*[2]*"* The document further classifies NGOs as national or international, secular as well as faith-based, membership or non-membership. In general, international NGOs are those whose head quarters, ownerships and funding are found in developed countries. National/indigenous/local NGOs are those whose head quarters, ownership and funding is located within their country of origin.

There is tremendous diversity in NGOs in terms of their ownership, mission, client base, strategic direction, and theme of program interventions. All NGOs might not reach those of greatest poverty, have direct relationships with the poor, be locally innovative, and have highly committed staff. The list of NGOs ranges from "self-serving" to noble attempts to help underserved populations.

6. MAJOR FINDINGS

6.1 NGOs/CSOs in the health sector

Within the last decade, Ethiopia has experienced an increase in the number of NGOs, for quite a number of reasons. Many of these organizations manage projects at micro-level, are service-

[2] Code of Conduct for NGOs. March, 1999. Addis Ababa, Ethiopia.

oriented, and mostly supplement the state program for development. They work on education, health, HIV/AIDS, street children, community development, legal reform and others.

Table 6.1 classifies NGOs involved in the health sector, based on their international link, ownership, profile of target population, types of services provided, etc. As shown in the table, the target population of NGOs could be national, local, or a specific segment of population. For instance, the Ethiopian Red Cross Association manages blood bank services in most parts of the country and Cheshire Foundation medical rehabilitation program benefits children from all over the country. Some organizations target a specific program theme, issue, or population: such as family planning services, malaria, trachoma, water, sanitation, etc; while others implement integrated Primary Health Care.

Table 6.1: Types of NGOs/CSOs involved in the health sector based on some selected criteria

International links	Indigenous	Indigenous with international links	International		
Ownership	Religious (churches, congregations,)	Private individuals	International Private Organizations		
Orientation to client	Public service contract	Grassroots organization	Membership organization		
Major activities	Technical innovations	Service delivery	Resource mobilization	Human resource development	Public education and mobilization
Links with grassroots	Intermediary funding organization	Umbrella or organizational membership	Direct grassroots/ Implementing organizations		
Links with GoE	Capacity building	Capacity building with service delivery	Service delivery alone		
Sources of fund	Regional governments	Private pay, fees	Community financing	Religious charity	Donors, project based
Types of services	Single program (FP, malaria, trachoma,)	Comprehensive primary health care services	Strengthening public health institutions	Training of nurses	
Scope of coverage	Multinational	National	Regional	Wereda	Sub-Wereda
Beneficiaries profile	Urban	Peri-urban	Rural	Special population (women, children, adolescents, etc)	
The framework for classifying NGOs is adopted from PHR."*A short list of topics for prioritizing and defining future work related to health sector NGOs."*					

About 400 local and international NGOs implement health or health -related projects. In Addis Ababa alone, 43 NGOs manage health projects; and two health centers, two hospitals, and eight health posts are managed by NGOs (ARHB, 2004). In Oromiya, 77 NGOs are implementing 132 health projects and they also manage four hospitals, two health centers, 85 clinics, and four health posts. Their contribution to health service coverage of the region is about 4 %. Furthermore, two nursing schools are owned by NGOs (ORHB, 2004). In Amhara Region, 33 NGOs are implementing 59 health projects (ARHB, 2004). In SNNPR, 48 health projects are managed by NGOs. In this Region, 31 clinics, 2 health centers, 4 hospitals and 1 nursing school are owned by NGOs.

6.2 Roles and functions of NGOs/CSOs in health service delivery

The health sector policy of Ethiopia has different and diverse stakeholders, both within and outside of the health sector. Though the health sector plays a lead role, the population, economic, education, agriculture policies, etc have direct effect on public health. Table 6.2 outlines the national stakeholders of the health sector and their different functions in implementing the sector program. The assigning of the different functions to stakeholders is not well demarcated in some cases, due to role overlap. As shown in the table, NGOs finance curative and preventive services. They also deliver curative, preventive and drug supply related services.

Table 6.2: Roles and functions of national stakeholders of the health sector development program

Stakeholder	**Roles and responsibilities**						
	Policy formulation	Regulation and supervision	**Financing**		**Service delivery**		
			Curative	Preventive	Curative	Preventive	Drug supply
MoH	**X**	**X**	**X**	**X**			
R/ZHB		**X**	**X**	**X**	**X**	**X**	**X**
NGOs			**X**	**X**	**X**	**X**	**X**
Private sector					**X**		**X**
Other Government sectors*	**X**	**X**	**X**		**X**		
Parastatals**			**X**		**X**		

** Includes ministry of defense, finance, and others.*
***Includes insurance companies*

Discussion with selected NGOs and MOH/RHB officials has indicated that NGOs have limited participation in health policy formulation, though there are some indications for a trend for improvement. An informant from one NGO said, "Most of us [in NGO sector] were not even aware of the health policy and HSDP until years after their ratification." Only few NGOs participate in the formulation of specific disease control strategies such as that of malaria and HIV/AIDS. However, even in such situations, participation is often limited to "attending a workshop to discuss on a document that has been drafted and almost finalized by GoE in collaboration with international funding agencies." Owing to this, the Health Sector Program by and large focuses on "how to improve the government health care delivery system" and not about "the health care delivery system of Ethiopia, which includes the household, NGOs/CSOs and the private sector."

However, all interviewees agree that there is an improvement in the relation between NGOs and the Government within the last few years, though it still needs to be strengthened. There was no forum for NGOs to express concern related to policy and national strategies in the past. This seems to improve gradually, and NGOs are increasingly invited to take part in the various committees and technical working groups of MOH/RHBs. They participate in HPN-donors group, Joint Steering Committee, annual joint reviews and meetings, and CCM of global fund. Some NGOs are also members of technical working groups such as for blindness control, polio surveillance, nutrition, HIV/AIDS, so on at national and/or regional levels. There seems to be an increased openness of government to input from NGOs, and most respondents expect that there will be an increased trust and confidence to work together, and relation will eventually be strengthened. Discussion with MoH/RHBs officials pointed out that the participation of NGOs/CSOs has contributed to improved health service coverage, and NGOs bring additional resources to the health sector.

Though several literatures describe that sectoral policy/program participation contributes to democratization process through participation of citizens, most respondents from NGOs are not sure of this in the Ethiopian context. The "limited" participation of the target community in the Health Sector Program in general and the reluctance of NGOs to advocate on behalf of their target communities are expressed as key reasons for missed opportunity for an added value to be brought by the sector.

"Even for most of us community participation is a means to achieve project objective and one more strategy to sustain project benefits. Most NGOs do not perceive participation as one of the rights of individuals and communities. Hence, we do not routinely invest to establish mechanisms for sustained participation of people in policy and program formulation, and local governance." (An informant from an NGO)

6.3 Policies and guidelines for NGOs in the health sector

Generally, the Federal Ministry of Justice is responsible for the registration of NGOs in Ethiopia. In some Regions, the Regional Bureau of Justice is responsible to register local NGOs whose operation is limited in the respective Region. The registration at MoJ provides legal entity to an organization to operate in Ethiopia. Once legally registered, an NGO is referred to DPPC where the former is required to submit an operational plan. DPPC is responsible for the national coordination of NGOs, and NGOs in the health sector are also subjected to the guideline formulated by the DPPC.

At regional level, the DPPB/BoPED and RHBs are responsible to sign a tri-partite project agreement with the respective NGO. Such project agreements lay the foundation for future collaboration by outlining the responsibilities of each signatory. DPPB/BoPED and RHBs have the responsibility to appraise project documents before approval, and monitor on-going projects. During project implementation stage, an NGO is required to report quarterly to DPPB/BoPED, and also to Zonal and Wereda health offices at project level. A team that consists of representatives from the respective NGO, DPPB, and RHBs undertake mid term and end of project evaluations. Such evaluation reports are used as springboard to decide on the future of the project.

Due to the limited human resource at RHBs, it is not unusual to observe inability to undertake NGOs' project evaluation timely. Additionally, evaluation or provision of support to NGOs health projects is not part of the routine staff performance review and work plan at Regional Bureaus; hence, there are frequent incidents of delay in evaluation of NGOs' projects. Such delays often lead to deferral of renewal of agreements, and subsequent interruption of project activities. There is also limited capacity for program evaluation at local level. Hence, evaluation often focuses on controlling irregularities, with limited initiatives to build on positive achievements and mutual support.

Health institutions managed by NGOs are registered and licensed by MoH or RHBs. Health institutions are also required to obtain drug license. Licensing for health institutions are renewed on yearly basis per institution. The national standard is used as a framework for health institution licensing. Organizations that manage multiple health institutions in different parts of the country find the licensing process a cumbersome procedure that leads to additional costs. The nationwide shortages of skilled human resources, particularly pharmacists, pharmacy, x-ray and laboratory technicians are expressed as main challenges for NGOs' health institutions. This is particularly more acute to health institutions located in rural areas.

Ethiopia lacks strategy or guideline that articulates the comparative advantage of NGOs in the health sector, and their role and functions in the implementation of the HSDP. The second HSDP mentions NGOs to contribute in the formulation of health extension package.

6.4 Ownership and distribution of health facilities

The Ethiopian government, who is the major health service provider in the country, manages close to 70% of health facilities in the country. Table 6.3 shows the distribution of health facilities by ownership. As shown in the table, the GoE, followed by the private sector, manages most of the health institutions.

Table 6.3: Number of health facilities by category and ownership

Type of facilities	Ownership		
	MOH	NGOs	Private (for-profit- sector)
Health center/clinics/health posts/health stations	3200	322	1119
District/zonal/general hospitals	77	8	12
Specialty hospitals	5	0	0
Total	**3282**	**330**	**1131**

Source: *MoH and Regional health Bureaus.*

Table 6.4 illustrates the distribution of pharmaceutical retail outlets by ownership. As shown in the table, private providers own most drug retail outlets. Only a small proportion of the drug retail outlets are managed by the NGO sector.

Table 6.4: Ownership and distribution of pharmaceutical retail outlets

Ownership type of facilities	Type of facilities		
	Pharmacy	Drug shops	Rural drug vendors
Government	44	61	0
NGO	19	5	0
Private	248	248	1876
Total	**311**	**314**	**1876**

Source: *MoH and Regional health Bureaus.*

Though health stations/clinics are not part of the current health sector strategy of the country, several NGOs provide services at clinic/health stations level. Discussions with ECC-SADCO, EECMY, and Kalehiwot Church health departments indicate concern about the future of their health stations. Down grading clinics to a health post requires different cadre of staff from that of clinics, and health posts do not provide clinical services. On the other hand, clinical services such as related to management of malaria, STIs, TB, diarrheal diseases, and family planning are yet inaccessible to most Ethiopians. Interviewed organizations feel that upgrading a clinic to a health center is costly. A feasibility study commissioned by Propride shows that the organization requires five million ETB to upgrade its clinic [located at the heart of Merkato] to a health center. For organizations that manage more than one clinic /health station, upgrading might imply much more funds. Additionally, interviewed organizations expressed that it is increasingly difficult for NGOs to secure fund for expansion of infrastructures due to change in international funding patterns and priorities. There is a "global trend to leave infrastructure establishments as the responsibility of governments." Hence, a few of the organizations expressed handing over such clinics/health stations to the government as the only option. On the contrary, NGOs are increasingly involved in the provision of Voluntary Counseling and Testing (VCT) services.

Government pharmaceutical outlets are the main drug suppliers for NGOs health institutions. The private sector is often a choice in the absence of essential drugs from government outlets.

6.5 Expenditure for health services in Ethiopia

The National Health accounts of (NHA) for 1988 (EFY) was close to 1.5 million Birr, which represents 4% of the GDP. A significant percentage of the expenditure is from out of pocket payment of households, 37% is government subsidy, 10% by the private sector, and 9% was that of NGOs' investment.

In 1992 EFY, the health expenditure of Ethiopia amounted to 355.5 million USD and was grossly equivalent to 5.6 USD per person and year. Table 6.5 shows the per capita health expenditure of Ethiopia by source in 1992 EFY. As shown in the table, the household is the major source of health care financing in Ethiopia and it accounts to 36% of the total per capita health expenditure. The GoE contributes 33% of the health expenditure, followed by donor agencies. Ten percent of the national health care expenditure is covered by the NGO sector.

Table 6.5: Per capita health expenditure of Ethiopia by source of funding

Source	Amount USD	Per capita USD	Percent
Households	128,297,219	2.02	36%
Government	118,731,993	1.87	33%
"Rest of the world"	57,178,404	0.90	16%
NGOs (local + intl.)	35,182,285	0.55	10%
Private	16,112,499	0.25	5%
Total	**355,502,340**	**5.60**	**100%**

Source: MoH. 2003. Ethiopia's second health accounts [draft] report.

6.6 Comparative advantage of NGOs/CSOs involvement in the health sector

NGOs/CSOs have complementary role with other actors in the health sector. According to interviewed organizations NGOs have comparative advantage:

- In provision of community -based health care services, including home based care for the terminally ill;
- In community mobilization and public advocacy;
- In international advocacy and resource mobilization for the health sector;
- In establishing and/or maintaining user-friendly reproductive health services;

- In building partnership between the health care system and communities to improve access to health services;
- To bring field experiences as policy and program input, particularly in "gender and health", social determinants of health, accessing health services to special segment of population such as pastoralist communities, women, street children and youth, etc;
- To ensure the participation on individuals and communities in local health sector programs and policy formulation; and
- To introduce flexibility/innovation, need-based, fast, and timely responses to the health care delivery system of the country in general.

6.7 Strength, Limitations, Opportunities and Threat analysis of NGOs health projects

Box 1 shows the strength, limitations, opportunities and threats of health projects and programs managed by NGOs, from the study respondents' point of view. As shown in the box, most respondents mentioned being community-based, targeting marginalized issues and populations, the not-for profit principle as the strength of health projects implemented by NGOs. The major threat to NGOs' health projects is related to sustainability, community "dependency" and obtaining fund to address community priorities.

Box 1: SLOT of the participation of NGOs in the health sector

Strengths	Limitations
• Operate beyond health institutions at community level • Target marginalized groups and health issues • Not-for- profit principle that is essential to benefit the poor • Major investment in disease prevention and health promotion programs • Invests in programs that directly improves public health [water and sanitation, agriculture, household income, etc] • Multi-sectoral, community development approach that potentially contributes in improving the health status of the poor. • Client perception of better quality of health care • Flexible and quick to respond to local needs • Better financial management at service delivery level	• A few operate as island with limited relation with other health programs • Limited role to represent the civil society, • Limited effort and role to influence policy, funding trend and pattern, and program strategies. • No pooling of experiences and issues to be translated into national policy and program. • Limited scale of interventions. • Dependent on outside resources; challenges of financial sustainability. • Some emphasize on IEC even though services are not available. • Emphasis is shifting from health in its totality, to HIV/AIDS programs. • Limited technical capacity of several NGOs managing HIV/AIDS projects. • There is lack of coordination and collaboration with other stakeholders; resulting duplication of activities, • Limited creativity, potential for replicability and sustainability • Resource altered by international funding pattern and priorities
Opportunities	**Threats**
• Increasing government openness to work with NGOs • There is huge need and gaps in realizing the goals of	• Benefits are not sustained beyond the life of the project, • Killing community initiatives and creativity, and bring about dependency on

the HSDP • NGOs recognitions of the importance of large scale intervention and political commitment to improve public health. • NGOs recognition of the importance of integrated health care system	outside interventions. • Increasing difficulty to obtain fund for other traditional health problems, health infrastructure and service expansion by NGOs

NGOs' health projects reach defined target population, and are often with limited scale of intervention when compared to the demand for health services in Ethiopia. Hence, it is imperative for NGOs to work in partnership with the public sector in order to bring meaningful and sustained change in the health of Ethiopians. NGOs' health projects also have the potential to test new health strategies at community level. However, replicability of small projects, where resources are often concentrated, is not always easy. Service expansion might not also be within the goal and mission of a particular NGO.

7. CONCLUSIONS AND RECOMMENDATIONS

So far, Ethiopia has not been able to extend health services to its entire population and service quality is suffering from the absence of adequate resources to meet the need. NGOs and the private sector are major partners in improving the health status of Ethiopians. There is also an increasing interest by the Ethiopian government to work with Non-Governmental Organizations, and NGOs are also emerging as new institutional actors in the socio-economic development of Ethiopia. So far, different activities/strategies and mechanisms are employed to strengthen GO-NGO collaboration in the health sector at regional level. There is, however, lack of a national strategy or plan that sets out clear and complementary roles for NGOs in the health sector, and their comparative advantages are not identified and/or recognized.

NGOs participate in the HSDP of Ethiopia through health infrastructure development, health service delivery, human resource development, health facility capacity building, communicable disease prevention, essential drug supply, and emergency nutritional supplementation and therapeutic feeding intervention in food crisis situations. NGOs manage 330 (7%) health establishments in the country out of the existing 4743, and most such health institutions are first level health care delivery establishments. Additionally, three nursing schools are managed by NGOs. Besides, direct provision of health services, NGOs finance curative, preventive, and rehabilitative health services; upgrade and

rehabilitate government health institutions; provide technical assistance; and manage integrated community development projects that potentially improve public health. In 1988 EFY, 9% of the health expenditure of Ethiopia was contributed by the NGO sector. This increased to 10% in 1992 EFY.

NGOs have limited participation in policy formulation and national program evaluation/reviews, though increasingly invited to participate in annual health sector reviews, and in formulating national strategic frameworks. Because of the diversity of NGOs, it is difficult to establish satisfactory mechanisms for their full participation in the formulation and implementation of health sector policies and program. The contribution of CSOs and local NGOs [often small] to the formulation and implementation of the HSDP is limited. Hence, the establishment of coalition and networking forum by groups mainly concerned with health issues and programs are essential for experience sharing, exchange of information, policy participation, and advocacy. Such a forum has a potential to facilitate an effective participation of NGOs/CSOs in policy and program formulation and relevant decision-making processes and forums. So far, CRDA is the largest membership NGO operating in Ethiopia. However, linkages between CRDA and its members focus on information provision, technical support and training, and facilitation of grants and funding. An effort to organize CRDA members for input to the health policy process or to develop advocacy positions and strategies on particular health issues is limited. The increased openness of the GoE to work with NGOs/CSOs presents opportunity to strengthen cooperation and partnership. Hence, establishing focus group or mechanisms that will assist NGOs/CSOs in developing position papers on the various issues related to accessing health services, health promotion, and disease prevention is essential.

In some of the interview with RHB officials, there is concern that NGOs lack the necessary technical and managerial capacity, commitment, and consistency with the national priority and health sector goal. However, such profiling of NGOs does not serve justice, as there is a huge diversity among organizations.

There is a need to strengthen GO-NGO partnership in the health sector at all levels, though their working relationship is improving. Ethiopia also lacks policy/program guideline for NGOs in the health sector.

GO-NGO partnerships might incorporate:

- Integration of NGOs' health projects and services in the local health care system;
- Sharing of staff between public sector agencies and NGOs, where applicable;
- Strengthening involvement of NGOs in the health sector policy, and national and regional program formulation; and
- Contracting with NGOs for delivery of services in program areas that the government does not have the mechanism to implement: includes home-based care for chronic/terminally ill patients including AIDS cases, community-based health programs, community mobilization, etc.

Gender is one of the main determinants of health status, life expectancy, access to health care, nutritional status, and outcome of illness and treatment. However, the integration of gender variables in health program planning and monitoring/evaluation remains inadequate due largely to limited understanding of the concepts and programming aspects of gender and health. Additionally, there is inadequate data as well as other socio-economic indicators needed for the formulation, review, implementation as well as monitoring and evaluation of gender mainstreaming in the health sector. The grassroots experiences of NGOs in gender mainstreaming can assist to enhance the understanding of gender as one of the determinants of health.

There is lack of comprehensive data on NGOs operating in the health sector. CRDA would assist in establishing database at RHB/FMoH level that provides basic information on all NGOs involved in the health sector. One might also assist in establishing a web site.

Advocate for service contracting out of the government to NGOs in health programs that the latter have a comparative advantage to implement. Furthermore, advocate for government assistance in the training of health professionals working with local NGOs - particularly in public health discipline. This can strengthen the human resources base of local NGOs to manage public health programs.

Advocate for the integration of NGOs health institutions in the health care delivery system at regional and Wereda level, where periodical routine reports incorporate health programs managed by NGOs/CSOs. With the current trend of decentralization in the public sector, it is reasonable to work for the establishment of GO-NGO forum at the basic level.

Within the last decades, several NGOs shifted their focus from emergency responses to long-term development. However, the mandate to coordinate and supervise NGOs is primarily the responsibility of DPPC/B. In the health sector, an NGO signs operational agreement with DPPC once licensed by MoJ at Federal level. A tripartite project agreement is signed between the respective NGO, DPPB/BoPED, and RHB. An NGO is also required to report to DPPC/B on quarterly basis. If MoH and its Regional and Wereda Health Offices have the major responsibility to coordinate, appraise, liaise with NGOs working in the health sector; the process will offer an opportunity to strengthen working relationship, and reduces bureaucratic processes and unnecessary reporting. It is more logical and significant if NGOs working in the health sector have direct link with the MoH than with DPPC. Hence, negotiate for the establishment of NGOs liaising office or desk at the FMoH.

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