PROCEEDINGS OF THE XVITH ANNUAL CONFERENCE OF THE ETHIOPIAN PUBLIC HEALTH ASSOCIATION

Main Theme: The Health Service Extension Program in Ethiopia*: Experiences and Prospects*

Sub-Theme: *Health Sector Millennium Development Goals (MDGs)*

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ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ANRS	Amhara National Regional State
ARI	Acute Respiratory Infection
AU	Alemaya University
BCC	Behavioral Change Communication
BMI	Body Mass Index
CBD	Community Based Distributors
CBRH	Community Based Reproductive Health
CBS	Community Based Service
CD	Compact Disk
CDC	Communicable Diseases Control
CED	Chronic Energy Deficiency
CHA	Community Health Agents
CORHA	Consortium of Reproductive Health Association
CP	Community Participation
CRDA	Christian Relief and Development Association
CRISP	Computer Retrieval of Information on Scientific Projects
CSR	Center for Scientific Review
DHHS	Department of Health and Human Service
DOTS	Direct Observation Treatment Strategy
EC	Ethiopian Calendar
EJHD	Ethiopian Journal of Health Development
EPHA	Ethiopian Public Health Association
EPI	Expanded Program on Immunization
ESOT	Ethiopian Society of Orthopedics and Traumatology
ESTC	Ethiopian Science and Technology Commission
FAO	Food and Agriculture Organization
FHI	Family Health International
FMOH	Federal Ministry of Health
FP	Family Planning
GNP	Gross National Product
HAART	HIV/AIDS Anti Retroviral Therapy
HAPCO	HIV/AIDS Prevention and Control Organization
HBV	Hepatitis B Virus
HCs	Health Centers
HCW	Health Center Workers
HEP	Health Extension Program
HEPP	Health Extension Package Program
HIV	Human Immune Virus
HIV MTCT	Human Immune Virus Mother To Child Transmission
HOs	Health Officers
HP	Health Post
HQ	Head Quarter

HRDH	Human Resource Development for Health
HS	Health Station
HSC	Health Service Coverage
HSDP	Health Service Development Program
HSEP	Health Service Extension Package
HSEPW	Health Service Extension Package Worker
IEC	Information, Education and Communication
ILRI	International Livestock Research Institute
IMF	International Monitory Fund
IOM	International Organization for Migration
IRB	Institutional Review Board
IRG	Initial Review Group
IT	Information Technology
JSI	John Snow Incorporation
JU	Jimma University
LMIS	Logistics Management Information System
MD	Medical Doctor
MD	Millennium Declaration
MDGs	Millennium Development Goals
M & E	Monitoring and Evaluation
MMISP	Making Medical Injection Safety Project
MMR	Maternal Mortality Rate
MOJ	Ministry of Justice
MSc	Master of Science
NGOs	Non-Government Organizations
NIH	National Institutes of Health
NISTF	National Injection Safety Task Force
OHRP	Office of Human subjects Research Protection
OLAW	Office of Laboratory Animal Welfare
OPRR	Office of Protection from Research Risks
OR	Operational Research
ORACTA	Operations Research on AIDS Care and Treatment in Africa
ORT	Oral Rehydration Therapy
PA	Program Announcement
PAs	Peasant Associations
PEPFAR	Presidential Emergency Plan For AIDS Relief
PH	Public Health
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PLWHA	People Living With HIV/AIDS
RATN	Regional AIDS Training Networks
RFA	Request For Application
RFP	Request For Proposals
RHB	Regional Health Bureau
RNA	Ribose Nucleic Acid
SNNPR	Southern Nations, Nationalists and Peoples Region

SPA	Single Project Assurance
SRA	Scientific Review Administrator
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendants
TT	Tetanus Toxoid
TVET	Technical and Vocational Education Training
U5MR	Under Five Mortality Rate
UOG	University of Gondar
US	United States
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WFPHA	World Federation of Public Health Association
WHA	World Health Assembly
WHO	World Health Organization

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CONFERENCE PROGRAM AT A GLANCE

DAY 1: WEDNESDAY, OCTOBER 26/2005

Morning Session:

7:30-8:30	Registration
8:30-10:00	Opening Ceremony - Master of the Ceremony – Dr. Getnet Mitike, Executive Secretary, EPHA - Welcoming Address – Dr. Damen Hailemariam, President, EPHA - Opening Address – Guest of Honor Dr. Kebede Tadesse, Minister of Health - Keynote Address – US Ambassador to Ethiopia - EPHA Award Ceremony – President of EPHA
10:00-10:30	**Coffee Break**
10:30-11:30	Plenary Session Presentation on - **"The Health Service Extension Program: Experiences and Prospects."** Moderator**:** H.Excellency Dr. Tedros Adahanom Panelists: 1. Dr. Yayehyirad Kitaw 2. Ato Yehuwalashet Bekele 3. Dr. Hailu Yeneneh 4. Dr. Mengistu Asnake 5. Dr. Shiferaw T/Mariam 6. Dr. Tibebu Alemayehu
11:30-12:30	Discussion
12:30-14:00	**Lunch Break**

Afternoon Session:

14:00-15:00	Plenary Session Presentation on: - **Health Sector Millennium Development Goals (MDGs)**

Moderator**:** Dr. Damen H/Mariam

Panelists:

1. Dr. Tefera Wondie
2. Dr. Girma Azene
3. Dr. Damen H/Mariam
4. Ato Hailegnaw Eshete

15:00-15:30 Discussion

15:30-16:00 Coffee Break

16:00-17:00 **Evolution of Public Health in Ethiopia**

17:00-17:30 Discussion

Moderator: Prof. Mekonnen Asefa

Panelists:

1. Dr. Yayehyirad Kitaw
2. Ato Gebre-Emanuel Teka
3. Ato Hailu Meche

DAY 2: THURSDAY, OCTOBER 27/2005

Morning Session:

8:30-10:00 Plenary Session
Panel Discussion on

- **Injection Safety – Building Formulation for Sustainability.**

Moderator: Prof. Yemane Berhane

Panelists:

1. Dr. Jules Millogo
2. Ato Yohannes Berhane
3. Prof. Yemane Berhane
4. Dr. Michael Dejene
5. Dr. Solomon Worku

10:00-10:30 Coffee Break

10:30-12:30 Panel Discussion on

- **HIV/AIDS-Food Security & Nutrition Interface, Rapid**

	Assessment of the State of Nutritional Care and Support Service for PLWHA.
	Moderator: W/o Abeba Gobezie
	Panelists:
	1. W/o Abeba Gobezie
	2. Ato Shewandagne Belete
	3. Ato Teferra Azage
12:30-14:00	**Lunch Break**
Afternoon Session:	
14:00-15:00	Business Meeting
15:00-15:30	**Coffee Break**
15:30-17:30	Continuation of Business Meeting
18:30-21:00	Social Evening

DAY 3: FRIDAY, OCTOBER 28/2005

Morning Session:

8:30-10:00	Grant Writing Workshop
10:30-10:30	**Coffee Break**
10:00-12:30	Concurrent Sessions (Papers)
	Room A: HIV/AIDS and TB
	Room B: HIV/AIDS and TB
12:30-14:00	**Lunch Break**
14:00-15:00	Concurrent Session
	Room A: HIV/AIDS and TB
	Room B: Reproductive Health
	Room C: Grant Writing Workshop
15:00-15:30	**Coffee Break**
16:00-17:30	**Concurrent Sessions**
	Room A: Health Service + Mental Health
	Room B: Communicable & Non-Communicable Diseases
	Room C: Malaria and Other Vector-born Diseases + Child Health

DAY 4: SATURDAY, OCTOBER 29/2005

8:30-10:00	Grant Writing Workshop
10:00-10:30	**Coffee Break**
10:30-12:30	Grant Writing Workshop
12:30-14:00	**Lunch Break**
14:00-15:00	Grant Writing Workshop
15:00-15:30	**Coffee Break**
15:30-17:30	Grant Writing workshop

PART I: INTRODUCTION, WELCOMING & OTHER REMARKS

1.1 INTRODUCTION

The 16th Annual Conference of EPHA was conducted from October 26 to 28, 2005, in Addis Ababa- Hilton. This year's conference was followed by Continuing Education on Grant Writing.

The conference was attended by the Honorable Minister of Health of Ethiopia, US Ambassador to Ethiopia, distinguished and invited guests and EPHA members from the different parts of the country and the world.

Following the opening of the conference, welcoming and keynote addresses, were made the event was also made significant by recognizing and awarding individual a person who had long years of public health service, a young public health researcher and an institution for public health service.

The selected Main and Sub-Themes and other issues for panel discussions were very important, relevant and timely. The Main Theme for the year was entitled as "The Health Service Extension Program in Ethiopia: Experience and Prospects". The Sub-Theme was "Health Sector Millennium Development Goals (MDGs)". Other issues for panel discussion were "Injection Safety-Building Formulation for Sustainability" and "HIV/AIDS – Food Security and Nutrition Interfaces, Rapid Assessment of the State of Nutritional Care and Support Services for PLWHA". The last, which was not presented, was "Evolution of Public Health in Ethiopia". CD developed by the panelists was distributed to the participants.

The other very important event was the Business Meeting where all EPHA members discussed on different issues to strengthen the Association. As scheduled, EPHA's Annual Activity Report by the Executive Secretary, EPHA's Audit Report by the Internal Auditor, Regional Chapters' Reports by the Focal Persons and discussion on the amended constitutions were made and recommendations passed. This was followed by an election process to extend/replace four executive members. Finally, the second day was closed after an open air social evening and dinner at Elsa Second Restaurant.

The third day was devoted for Continuing Education on Grant Writing and presentation of research papers. There were three concurrent sessions of oral and poster presentations.

The fourth and last day was totally devoted for Continuing Education. A Group from the Faculty of Emory University had given lectures on Grant Writing supported by power point presentations, hard and software. Many members and interested guests had attained this educative and very relevant topic to widen the scope of their knowledge on Grant Writing.

1.2 PROGRAM INTRODUCTION

The program was introduced by Dr. Getnet Mitikie, Executive Secretary of EPHA and Master of the Ceremony (MOC). He introduced the program of the conference and made the following remarks:

"I request the audience to stand up and pay a one minute silence to our members who passed away in the last one year:

1. Dr Seid Mohammed (was an active member of the Executive Committee)
2. Dr Wondimu Teka, and
3. Ato Mengesha Yadeta

Your Excellency, Dr Tedros Adahanom, Minister of Health,
Honorable Guests,
Dear Members of EPHA, Presenters and Participants,

Ladies and Gentlemen,
First of all, on behalf of EPHA I would like to welcome you all to the 16th Annual Public Health Conference.

EPHA has continued to be an icon in public health promotion, research, dissemination and advocacy in Ethiopia. For the last several years EPHA has succeeded in organizing and conducting panel discussions on major and timely public health issues. Moreover, the scientific paper presentations contribute to the growth of knowledge, best practices and evidence-based implementation of programs.

This year's conference is full of variety of activities. We have given ample time to panel discussions on outstanding public health issues. This alone will take us one-and-half day (Wednesday and Thursday); On Friday we will have the scientific paper presentations and on Saturday a grant writing seminar will continue.

I am deeply honored to say that this year marks the transformation of EPHA into a stronger public health organization structurally as well as functionally. Membership is increasing, our regional chapters have become responsive, collaborations and project management skills have increased, and our financial management system is getting better, and yet we still believe there is much remaining for us to do.

Lastly, I would like to thank our partners, collaborators, regional chapter representatives and members who are contributing to our strength. May I take this opportunity to thank all who worked very hard to materialize the Conference, particularly the EPHA secretariat, Executive Committee, EPHA members, and CDC-Ethiopia.

Now I cordially call upon Dr Damen H/Mariam, President of EPHA to give a welcoming address."
Thank you

1.3 WELCOMING ADDRESS

Dr. Damen Hailemariam, President of EPHA

"Your Excellency Dr Tedros Adhanom,
Minister of Health of the Federal Democratic Republic of Ethiopia,
Distinguished and Honorable Guests,
Esteemed Members of the EPHA, and
Dear Participants:

Once more, it gives me the greatest of honor and pleasure to deliver this welcoming address on the occasion of EPHA's 16th Annual Conference and scientific meeting.

As mentioned in a similar occasion two years ago, EPHA has recently embarked in its new chapter in terms of the extent of activities and the levels of engagement it undertakes in discharging its civic responsibilities. However, one would rarely expect the trajectory of a new path to be immediately smooth. This is especially true of one attempt to confront new, extensive and sophisticated duties with old structural and legal frameworks designed to fit very limited functions.

As the EPHA General Assembly clearly foresaw at its 15th annual conference, the constitutional and organizational framework at the disposal of the Association were constraining it from properly and effectively performing the increasingly expanded roles and responsibilities within the new chapter. Therefore, it was for this reason that mandate was given for the Executive Committee for reforming the structure of the Association and revising the constitution to fit the new structures and functions. Accordingly, the EC has come up with a new organizational set up as well as a revised constitution for final endorsement by the General Assembly. Incidentally, some of the features of the new set up are those that are put as requirements by the Ministry of Justice, the agency that regulates and licenses civic organizations such as EPHA.

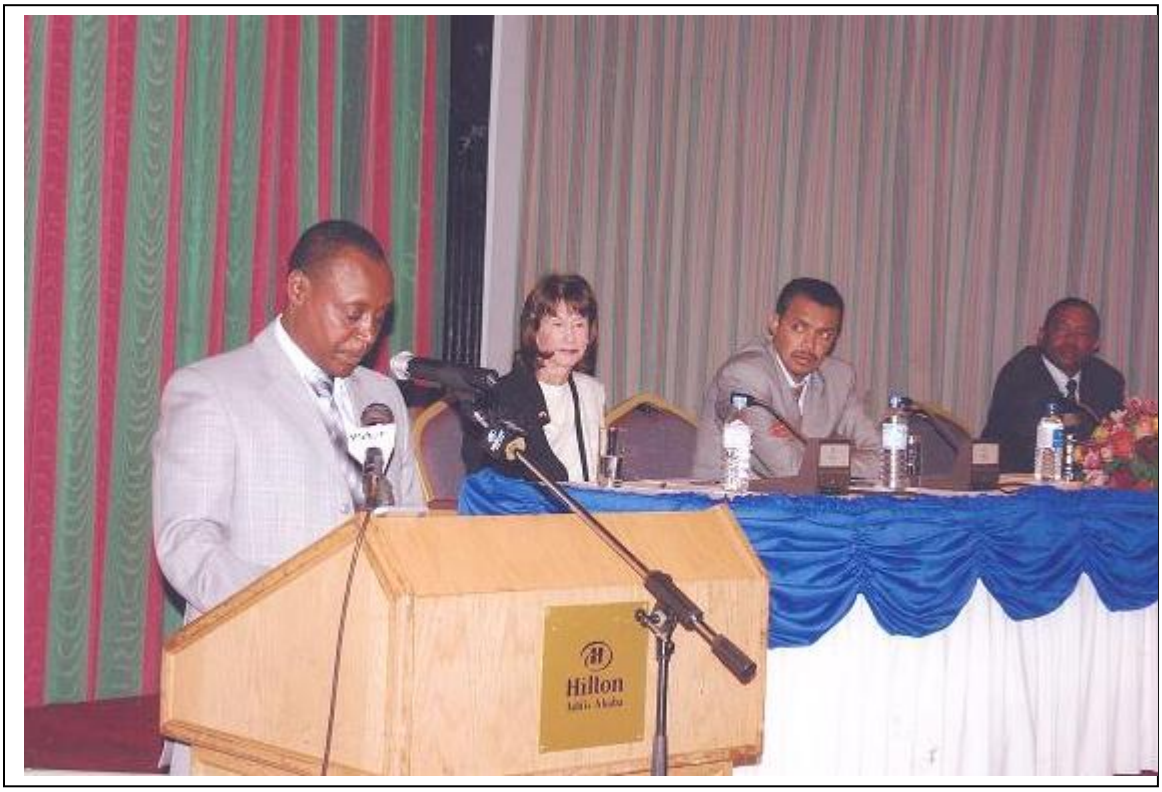
As an organization operating within increasingly uncertain external environment and as non-governmental one that cannot rely on a specifically assigned budget source, the development of a strategic plan is an indispensable activity of EPHA. Therefore, it has finalized the preparation of its second five-years strategic plan (2005-2009) through the establishing a Strategic Plan Sub-Committee, the contracting of technical assistance as well as circulation of an earlier draft to the EPHA General Assembly for comments. Among other things, the unique feature of the second EPHA strategic plan is the fact that its implementation starts by fundamentally changing the Association's organizational structure. It is our belief that the current Strategic Plan, coupled with the ongoing restructuring of its organizational structure will be instrumental in uplifting the Association to a yet new chapter with enhanced visibility and impact within the health sector of our country.

Your Excellency Dr Tedros,
Honorable Guests, and
Dear EPHA Members

EPHA has selected the topics for the panel discussions of the year's conference on the basis of their being linked to the priority public health problems and in their importance to the health activities. These topics are:

1. Health Services Extension Program;
2. Health Sector Millennium Development Goals;
3. History of Public Health in Ethiopia;
4. Injection Safety;
5. HIV-AIDS, Nutrition and Food Security; as well as
6. A continuing education in the form of a Grant Writing Workshop.

We know that there have been a number of forums in which most of these subjects and initiatives were discussed. However, EPHA considers the dissemination of such important issues as one of its responsibilities so that they can be internalized by its membership as well as by other professionals that are critical in their actual implementations.



Welcoming Address by Dr. Damen Hailemariam, President of EPHA

The Health Services Extension Program is something that EPHA views as an innovative strategy by the health sector that would serve as a critical instrument in achieving the MDGs, in addition to being a manifestation of the clear policy commitment for addressing the real health problems of the country's population.

Ethiopia being signatory to the Millennium Declaration, has made needs assessment exercise for the MDGs in all the relevant sectors including health. Achieving the MDGs seems a challenging task. However, we think the enthusiasm of confronting these challenges should be practically shared among all public health professionals and stakeholders who are eager to see dramatic changes in the health status indicators of our country within the coming decade. In this regard, it is very encouraging to hear that health was one of two sectors that were appreciated and considered promising at the commemoration of the UN's 60th Anniversary here in Addis Ababa the day before yesterday in terms of the groundwork for MDGs related activities.

Considering the fact that we are currently at the turn of the Millennium with almost a century old experience with conventional health services, the EPHA has taken the opportunity of using the expertise of some of the most senior practitioners and leaders in the field for reviewing the history of Public Health in Ethiopia. The result of this review "The Evolution of Public Health", which has been CD-packaged and distributed is a chronological review of the development of health services from the initial period of the introduction of health services in the form of the medical care model, through the basic health services and the primary health care approaches of the sixties and seventies, to the more recent eras of health sector reform and the sector wide approach. We at the EPHA think that this review document would be instrumental in helping all professionals in the field reflect back on achievements and challenges of public health in the last century for getting lessons that would serve them as momentum in their strive for making their contributions to the effective implementation health activities in the new millennium.

Currently there has been attention as well as empirical evidence of the iatrogenic risks of blood-borne microbes, to the extent that un-sterile procedures in routine medical care might represent a possibly major route of HIV transmission in countries. Research reviews show that the average person in the developing world receives about 1.5 injections per year (more than 50% of these being unsafe). Considering the experience of Africa in getting massive increase in medical injections associated with mass vaccination campaigns as well as the introduction and spread of parentheral therapies to treat other diseases, there is a need for interventions to minimize risk from iatrogenic transmission of HIV, even though promotion of safe sexual practices remains a priority in this regard.

Therefore, the issue of injection safety is an important and timely one especially at this moment when the expansion of health services facilities at the peripheral levels is being accelerated.

Currently, there are also promising activities in terms of making Anti-Retroviral Therapy freely available within increasing number of health facilities in the country. Yet one cannot over emphasize the equally important issue of the food security and nutritional status of PLWHA. This calls for the extension of the coverage and the integration of the Essential Nutrition Actions Program of the Ministry of Health with HIV/AIDS related activities, among others.

The General Assembly, EPHA's 17th Annual Conference

With regard to the Grant Writing Workshop, I would like to express our gratefulness to the Faculty from Emory University in Atlanta, Georgia who made the preparation and came to deliver this very important resource through the Collaborative AIDS Research and Training Program between Emory and Addis Ababa Universities.

Your Excellency Dr Tedros,
Distinguished Guests and Participants

Again and again, the EPHA wants to highlight the critical nature of the issue of human resources for health, particularly at this time when the health sector is accelerating the expansion of health services as well as training activities. It is obvious that the accelerated training, coupled with the involvement of the private sector, has started to alleviate the problems that emanate from quantitative shortages. However, the provision of health services would not be optimal by merely having a quantity of providers. The public good nature of health services also requires that the providers of these services be equipped with basic ethical and professional values. Ensuring such qualities among the health services workforce is mainly the responsibility of government and professional bodies through the creation of strong regulatory institution. The recent introduction of the human resources for health draft strategy is one step towards this. However, more energetic steps need to be taken in its realization in order to curb the possibility of gradual deterioration of professional values among the accelerated magnitude of health trainees be it from private as well as public training institutions.

Through the support of its partners, the EPHA reaffirms its commitment to activities related to human resources for health, specifically in effective health systems research that would provide critical information relevant for addressing the problematic issues.

Your Excellency,
Distinguished Guests, and
Dear Participants

Even though I would not be dwelling on the specifics, the routine as well as project related activities of EPHA are being implemented as planned. Of course, the EPHA is still short of accomplishing some of the important tasks assigned to it during the previous year. Among these is the issue of its being involved in really grass-root community wide activities. It would not be considered as a lame excuse if I again attribute this to organizational constraints. On the other hand, I am hopeful as well as confident that we can accomplish more on this front within the framework of the new Strategic Plan and organizational direction. In this regard, it would also be unfair if I fail to mention that there are several members of the Association that are operating at peripheral and community levels without pretension of any claim to their efforts.

Finally, on behalf of the Executive Committee and myself, I want to take this opportunity to deeply thank those who continue to stand beside EPHA in all its efforts of discharging its civic responsibilities. Among these are (but not limited to):

1. MOH along several of its Departments
2. Regional Health Bureaus
3. The EPHA Regional Chapters and focal persons
4. Ethiopian Science and Technology Commission
5. The US CDC
6. WHO and the other UN agencies
7. Addis Ababa, Jimma, Gondar, Emory, Tulane and Johns Hopkins Universities
8. The USAID
9. ESHE, Pathfinder and FHI
10. The World Bank
11. The Canadian Public Health Association
12. Christian Relief Development Association”

After thanking and welcoming all, he invited His Excellency Dr. Tedros Adhanom, Minister of FMOH to open the conference officially.

1.4 OPENING ADDRESS

DR TEDROS ADHANOM, MINISTER OF FMOH

“የተከበሩ አምባሳደር ቪኪ ሐደልስተን፣
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በመጀመሪያ ደረጃ እንኳን ለ16ኛው የማኅበራችን ዓመታዊ ኮንፈረንስ በሠላም አደረሣችሁ፡፡ በዚህ ኮንፈረንስ ለመሣተፍ እድሉን በማግኘቴ የተሰማኝን ደስታ ለመግለጽ እወዳለሁ፡፡

የዚህ ዓመት ኮንፈረንስ ዐቢይ ትኩረት ያደረገው በጤና ኤክስቴንሽን ላይ በመሆኑ ይህ የጤና ሥርዓታችንን መሠረታዊ በሆነ መልኩ ይቀይራል ብለን በምናምንበት ፕሮግራም ላይ የምንሰጠውን ትኩረት ስለሚያሣይ ከፍተኛ የሆነ ልባዊ ምስጋናዬን ለማቅረብ እወዳለሁ፡፡ እንደምታውቁት የጤና ሥርዓታችን መርህ “ሁሉም መንገዶች ወደ ጤና ኤክስቴንሽን ፕሮግራም ያመራሉ“ የሚል ሲሆን ማህበራችን በዚህ ላይ ትኩረት ማድረጉ መርሁን ለማሣካት ትልቅ ጠቀሜታ ይኖረዋል የሚል እምነት አለኝ፡፡

እንደምታውቁት በቅርብ ጊዜ የፓዝ ፋይንደር (PathFinder) **ፕሬዚዳንት እዚህ በነበሩ ጊዜ ስለፕሮግራሞች አንስተን የእኛን አሠራርና አካሄድ ተወያይተን ነበር፡፡ ከእርሳቸው ገለፃ የተረዳነው በትልቅና ለውጥ በሚያመጡ** (Big Rolling and Impact) **ፕሮግራሞች ላይ ከፍ ያለ** (Scale up) **ሥራ ማካሄድ እንዳለብን ነው፡፡ በእነዚህ ፕሮግራሞች ላይ ያለው እምነት አናሣ ነው ነበር ያሉት፡፡ ስለዚህ በተጠቀሱት ትልቅና ለውጥ በሚያመጡ ፕሮግራሞች ላይ ትኩረት ሰጥተን መንቀሳቀስ አለብን፡፡**

መሠረታዊ ጤና አገልግሎት (Primary Health Care) **ሲነሣ ሁለት መስመሮች በዋነኛነት ይነሳሉ፡፡ የመጀመሪያው ዋናውና ትልቁ የጤና ኤክስቴንሽን ፓኬጅ** (Health Extension Package) **ሲሆን ሁለተኛው እና የጀርባ አጥንቱ** (Backup) **የተፋጠነ የጤና ጣቢያ ተነሣሽነት** (Accelerated Health Center Initiative) **የሚባለው ነው፡፡**

የጤና ኤክስቴንሽንን በተመለከተ እንደምታውቁት በ2008 **ዓ\ም እያንዳንዱ ቀበሌ የራሱ ጤና ኬላ ሊኖረው ይገባል ነው፡፡ ይህም ማለት ከታች አንስተን ስናየው ቢያንስ** 25,000 **\ሃያ አምስት ሺ\የጤና ኬላ ሠራተኞች መሰልጠን አለባቸው፡፡ እስከዚህ ድረስ አብሮ ተያይዞ የሚሄደው ቁሳቁስ ፣መሣሪያ ፣ ወዘተ... ለእንዳንዱ ቀበሌ ሊሟላ ይገባል፡፡ ስለዚህ ደረጃውን ከፍ** (Scale up) **በማድረግና ፍጥነት** (Speed) **ጨምረንበት ከምንፈልገው ደረጃ ለመድረስ እንችላለን፡፡**

የጤና ኤክስቴንሽን ፕሮግራም አሁን የደረስንበትን ሁኔታ ማንሳቱ አግባብ ያለው ነው፡፡ በመሆኑም 2,800 **ተመርቀው ሥራ ላይ ተመድበው በአማካይ** 1,400 **ቀበሌዎችን ሸፍነዋል፡፡ በዚህ ዓመት ማለት በያዝነውና በሚቀጥለው ወራቶች ተጨማሪ** 7,100 **ይመረቃሉ፡፡ ስለዚህ በአጠቃላይ ከሚፈለገው ውሰጥ** 1\3**ኛውን ሸፈን ማለት ነው፡፡ ይህ አበረታች ነው ምክንያቱም በአቀድነው መሠረት በ**2008 **ግባችንን ለመምታት ተስፋ የሰጠ ነው፡፡ ግን በዚህ ብቻ ተወስነን መቆየት የለብንም ትልቁ ሌላው አስፈላጊ ሁኔታ ጤና ኬላዎችን በሚያስፈልጉ ቁሳቁሶች ማሟላት ነው፡፡**
ስለዚህ እነዚህን ጤና ኬላዎች በየቦታው ስናዳርስ ዋናው ቁም ነገር የእናቶችንና ሕፃናት ሞት መቀነስና ኤች. አይ. ቪ. ኤድስን ትኩረት ሰጥቶ መንቀሳቀስ የጤና ኤክስቴንሽን ሠራተኛው ማዕከላዊ ሥራ ይሆናል ማለት ነው፡፡

ይህ ማለት ደግሞ እያንዳንዱ ቤተሰብ በጤና ኤክስቴንሽን በኩል ኤች. አይ. ቪ. ኤድስን በመከላከልና በመቆጣጠር ላይ ኃላፊነቱን ወሰዶ እንዲሰራ በሚያደርግ መልኩ እንቅስቃሴ ተጀምሯል ማለት ነው፡፡ ይህ ማለት ደግሞ እያንዳንዱ ቤተሰብ ኃላፊነቱን በመውሰድ የራሱ ጤና አምራች ይሆናል ማለት ነው፡፡

H.E. Dr. Tedros Adhanom, Minister of FMOH

በወባ በሽታ በኩል የምንከተለው አካሄድም ተመሳሳይ ነው፡፡ ከጤና ኤክስቴንሽን አንፃር የተያዘው 3 ሚሊዮን የአልጋ አጎበር ማዳረስ ሲሆን 2 ሚሊዮን ገብቷል ፣ 1 ሚሊዮን በሂደት (pipeline) ላይ ነው፡፡ የ1998 እቅድ (Target) 7 ሚሊዮን ነው፡፡ ይህ ታሳቢ የተደረገው በእያንዳንዱ ወባማ ቀበሌ የሚኖር ቤተሰብ ቢያንስ ሁለት የአልጋ አጎበር ቢያገኝ ፣ ይህም እናቶችና ሕፃናት ተጠቃሚ እንዲሆኑ በማለት የሚገመተው 10 ሚሊዮን ቤተሰብ በእነዚህ ቀበሌዎች ይኖራል፡፡ ስለዚህ ቢያንስ 20 ሚሊዮን የአልጋ አጎበር ያስፈልጋል፡፡

አሁን እንዴት ከፍ ለማድረግ (Scale up) እና ትልቅ ሥራ ለመስራት እንደሚቻል እንየው፡፡ 3 ሚሊዮን በእጃችን አለ ፡ በ1998 ዓ\ም 7 ሚሊዮን እናስገባለን፡ በ1999 ዓ\ም 10 ሚሊዮን ብንጨምር ፡ ከአሁን በኋላ ከዘጠኝና ከአስር ወራት በኋላ ምን ይሆናል ማለን ነው ? 100% ግባችን መታመን ማለት ይቻላል፡፡

ከሐይጅንና ማኒቴሽን አኳያ በእያንዳንዱ ቀበሌ ውሰጥ ተግባራዊ ሲሆን ከ80% በላይ ተግባራዊ መሆን አለባቸው፡፡ ይህም ከመፀዳጃ ቤት አሰራር ፣ የግልና የአካባቢ ንጽህና ፣ ከወባ በሽታ ቁጥጥር ፣ ወዘተ... አንፃር ሊታይ ይቻላል፡፡

ከሥነ-ተዋልዶ ጤና አኳያ ዋናው የወሊድ መቆጣጠሪያ የሚወስዱ (Contraceptive Prevalence Rate) ቢያንስ 75% መሆን አለበት በማለት ተነስተናል፡፡ በመሆኑም አሁን የጤና ኤክስቴንሽን በተዘረጋባቸው አካባቢዎች ተስፋ የሚሰጥ ሁኔታ ታይቷል፡፡

ስለዚህ አሠራራችንን ከፍ በማድረግ ለውጥ በሚያመጣ መልኩ በፍጥነት መንቀሣቀስ ያስፈልጋል፡፡

ኤች. አይ .ቪ .ኤድስን በተመለከተ ፀረ-ቫይረስ ሕክምና እና በፈቃደኝነት ላይ የተመረኮዘ የደም ምርመራ (ART and VCT services) አገልግሎቶችን ማየት ይቻላል፡፡ ሕክምናውን (ART) በተመለከተ በአሁን ሰዓት 11,000 በሕክምና ላይ የሚገኙ ሲሆን በ2006 ወደ

100,000 ከፍ ለማድረግ ታስቧል፡፡ ግን ዋናው መሠረቱ እያንዳንዱን ቤተሰብ ማንኳኳት ስንችል ነው፡፡

በፈቃድ ላይ የተመረኮዘ የደም ምርመራን (VCT) በተመለከተ በዓመት 300,000 ሽ በላይ አካሂደን አናውቅም አሁን 100,000 ወደ ሕክምና ለማስገባት 5.1 ሚሊዩን መመርመር (Screen) አለብን፡፡ ይህንን ከፍ ለማድረግ መመሪያውን እየቀየርን ነው፡፡ ከቤተሰብ ጀምሮ የጤና ኤክስቴንሽን እስከ ሆስፒታል ድረስ ተከታታይነት ባለው መንገድ ብናያይዘው 5.1 ሚሊዩን በአንድ ዓመት ከሁለት ወራት ተግባራዊ ማድረግ ይቻላል፡፡ ጤና ጣቢያዎችንም በዚሁ አሠራር ውስጥ ማስገባት ያስፈልጋል፡፡

ሁለተኛው መሥመር ጤና ጣቢያን በሰው ኃይል ፣ በቁሣቁስና በመሣሪያዎች ማጠናከር የሚለው ነው፡፡ የሰው ኃይልን በተመለከተ በተነደፈው አፋጣኝ የጤና መኮንኖች ሥልጠና (Accelerated Health Officer Training) በብዙ ሽ የሚቆጠሩ ጤና መኮንኖች ማፍራት ነው፡፡ አዲስ የመጣው ሃሣብ ያሉንን ዩኒቨርሲቲዎች እና የተመረጡ ሆስፒታሎች በመጨመር ይህንን ሥልጠና መጀመር ነው፡፡ በዚህ መንገድ እስከ ሕዳር 1/1998 ዓ.ም 2000 ለጤና መኮንንነት ሥልጠና እንዲገቡ እናደርጋለን፡፡ ከ2 ዓመት ተኩል በኋላ ሲመረቁ እያንዳንዱ ጤና ጣቢያ በጤና መኮንን ሊመራ የሚችለውን አካሄድ ሊያስይዘን ይችላል፡፡ በመሆኑም በ2008 ዓ.ም አንድ ጤና ጣቢያ ለ 25,000 ሕዝብ ማዳረስ እንችላለን፡፡

የሰው ኃይል ሁኔታ እርስ በራሱ መጐራረስ አለበት፡፡ በዚህ ዓመት 1200 ነርሶች ወደ ሚቀጥለው ደረጃ (Upgrading) ይገባሉ፡፡ ይህ ቁጥር 89% በአሁን ጊዜ በሥራ ላይ ያሉትን ነርሶች ቁጥር እንደሚሆን ይገመታል፡፡

ስለዚህ ነርሶች ወደ ጤና መኰንንነት ማደግ ይችላሉ ፡፡ ከዚያም ከጤና መኮንንነት ወደ ሐኪምነት ማደግ ይቻላል፣ የተዘጋ መንገድ የለም፡፡ ከመከላከያ ዩኒቨርሲቲ ጋር የጀመርነው ደግሞ በሶስት ዓመት ተኩል ዶክትሬት ሊያገኙ ይችላሉ ወይም ማስትሬት ዲግሪ (M.PH) ማግኘት ይችላሉ፡፡

ከሥነ - ተዋልዶ ጤና አገልግሎት አኳያ ትልቁ ቁልፍ የእናቶችን ሞት (Maternal Mortality Rate) መቀነስ ነው፡፡ ለዚህም እነዚህን ካድሬዎች ወይም ጤና መኮንኖችን በስፋት ማሠልጠንና ማሣደጉ (Scale-up) አስፈላጊ ነው፡፡ ሕይወት አድን (Life Saving) የሆነውን በቀዶ ጥገና ማዋለድና (Cesarean Section) አስቸኳይ/አጣዳፊ የሆድ ዕቃ ሕመም (Acute Abdomen) የጤና መኮንኖችን በተጨማሪ ለስድስት ወራት በማሠልጠን መሥራት ይቻላል፡፡ የቀዶ ጥገና ሐኪም (Surgeon) ለማሠልጠን የሚወስድብን ጊዜ ቀላል አይደለም፡፡ ስለዚህ አቋራጩን መንገድ በመጠቀም ብዙ ሕይወት ማትረፍና አመርቂ ሥራ መሥራት ይቻላል፡፡

በድንገተኛ ቀዶ ጥገና (Emergency Surgery) የሠለጠነ/ች አንድ ባለሙያ ለ 100,000 ወይም ለአንድ ወረዳ ብናዳርስ 600 ባለሙያዎች ብናሠለጥን ከዚሁ ጎን ለጤና መኮንን ሥልጠና እስከ 2008 ብናፋጥን ብዙ ሕይወት ማትረፍ ይቻላል፡፡ ይህ ደግሞ የሚኖረንን የሚሊንየም ግብ (Millennium Goals) እናቶችን ሞት መቀነስ አካባቢ ቁልፍ ይሆናል የሚል ግምት አለን፡፡

በዚህ በኩል ኢ.ጤ.አ.ማ. እንደነዚህ አቋራጭ ሃሣቦችን ከማምጣት አኳያ የበለጠ አስተዋጽኦ ቢያደርግ ጥቅም ይኖረዋል የሚል እምነት አለኝ፡፡ ስለዚህ በአጠቃላይ ጠቃሚ ሃሣቦችን ማምጣቱ ለጤና ሥርዓት መጠናከር የጐላ ድርሻ አለው፡፡

እንደ መሸጋገሪያ የሚያገለግል ከዩኒሴፍ ጋር በመቀናጀት የተጠናከረ በመስክ የሚሠራ እስትራቴጂ (Enhanced Outreach Strategy) ተነድፎ በተግባር ላይ ይገኛል፡፡ በተመረጡ 325 ወረዳዎች በዚህ (EOS) አሠራር በመንቀሣቀስ ላይ እንገኛለን፡፡ በዚሁ አሠራር መሠረት ለምሣሌ በአለፈው ዓመት 6 ሚሊዬን ሕጻናት የቫይታሚን " ኤ " ጠብታ ተሠጥቷቸዋል፡፡ 2.9 ሚሊዩን ሕጻናት ለአንጀት ትላትሎች ሕክምና (Deworming) ተደርጐላቸዋል፡፡ 6 ሚሊዩን ሕጻናት የኩፍኝ መከላከያ ክትባት ተሰጥቷቸዋል፡፡ 9.2 ሚሊዩን ሕጻናት እና 2 ሚሊዩን እናቶች በምግብ እጥረት እንደተጎዱ ተለይተዋል፡፡ ይህ አሠራር ከጤና ኤክስቴንሽን ጋር ሙሉ በሙሉ እንደሚሠራ እያሣየ ነው፡፡

ዋናው ከባዱ ፈተና (Challenging Issue) ሐይጅንና ሣንቴሽን ሲሆኑ እየሄድንበት ያለ ሁኔታ ነው፡፡ አንዳንድ ላይ የአጠቃቀም ችግሮች ቢኖሩም ሌሎቹን እያየን እያጠናከርን መሄድ አለብን፡፡ ግን ስፋቱ ምን ያህል ሊሄድ እንደሚችል የእያንዳንዱን ቤተሰብ ብናንኳኳ የምንሠራውን ብናሰፋ ወይም ርቀቱን ብናሣጥር ምን ያህል ሽፋን ሊኖረው እንደሚችል የሚያሣይና ተስፋ የሚሰጥ ነው፡፡

ቀደም ሲል እንደገለጽኩት በዚህ ዓመት የገባው የአልጋ አጎበር እንደ መሸጋገሪያ የምንጠቀምበት የ EOS አካል ነው፡፡

በፍጥነት ወደ ቀበሌ እንዲገባ እያስቻለ ያለው ይህም የወደፊት የጤና ኤክስቴንሽን እና የተፋጠነ የጤና ጣቢያው መስፋፋት ምን ያህል የአብዛኛውን ቀበሌ በጤና ሥርዓት ሽፋን ላይ የጤናውን እስትራቴጂ በማሣደግ ሊጠቅም እንደሚችል ያሣያል፡፡ ስለዚህ ትልቁን ኘሮግራም ከፍጥነትና ከማሣደግ ጋር ከአየነው ትልቅ ጠቀሜታ ይኖረዋል፡፡

አሠራራችን ቀደም ሲል ለመግለጽ እንደሞከርኩት የትኩረት አቅጣጫ ኖሮት መያያዝ መቻል አለበት፡፡ የእኛ ትኩረት ኤች . አይ .ቪ . ኤድስ ነው ፣ ትኩረታችን ወባ ነው ፣ ትኩረታችን የሕጻናት ጤና እንክብካቤ ነው ፡ ትኩረታችን የወሊድ ቁጥጥር ተጠቃሚን ማሣደግ ናቸው፡፡ በእነዚህ በአራቱ ላይ ብንረባረብና ከዚህ ተጨማሪ የሰው ኃይል ልማትና አስፈላጊውን ቁሣቁስ ብናሟላ የሚፈለገው ትኩረት ግቡን ይመታል፡፡

ሌላው የትኩረት አቅጣጫ ደግሞ የጤና መረጃ (Health Information) እና የሎጅስቲክ ማኔጅሜንት ሲሆን ይህም ተጀምሯል፡፡ ከፋይናንስ አሠራር ጋር ቢጐራረሱ የበለጠ ጠቀሜታ ይኖራቸዋል፡፡

በዚህ ዓመት ከአጋሮቻችን (Stakeholders) መንግሥታዊ ያልሆኑ ድርጅቶች፣ ከሲቪል ሕ/ሰቡ ፣ ከእርዳታ ሠጭዎች ጋር አብረን የምንሠራበት ሁኔታ እየተፈጠረ ነው፡፡

በተቻለ መጠን አሠራራችን ቀለል ባለ መልኩና ባናከብዳቸው መልካም ነው፡፡ የሁሉም መፍትሄዎች በእጃችን ናቸው፡፡ በተደጋጋሚ እንደገለጽኩት ቅድሚያ በሚሰጣቸው ላይ ፍጥነት በመጨመር ማሣደግ (Scale up, Big Rolling programms with a sense of Urgency) እኛ በወጣው የአምስት ዓመት መርሃ-ግብር መሠረት ማሻሻል ያስፈልጋል፡፡ ለዚህ ሁላችን ታጥቀን እንድንነሣና ትልቅ አስተዋጽኦ እንድናደርግ ጥያቄየን በአክብሮት አቀርባለሁ፡፡

ሁሉም መንገዶች ወደ ጤና ኤክስቴንሽን ያመራሉ
በድጋሚ አመሠግናለሁ፡፡"

At the end of the opening speech, Master of the Ceremony invited Ambassador Vicki Huddleston, US Ambassador for Ethiopia to give her Keynote address.

1.5 KEYNOTE ADDRESS

AMBASSADOR VICKI HUDDLESTON, CHARGE D'AFFAIRES US AMBASSADOR TO ETHIOPIA

- "Good Morning. It is a pleasure to join this morning for the beginning of your annual meeting. I am happy to have the opportunity to learn about your work and to tell you a little about how my government is involved in promoting better health in Ethiopia.
- The United States is one of the largest bilateral donors in Ethiopia. In the health sector, it is the largest, because of the scale of our programs to fight HIV/AIDS. President Bush's Emergency Plan for AIDS Relief-a $15 Billion, five year program that has already taken unprecedented steps to reduce the global impact of HIV/AIDS around the world.
- Through active engagement in the health sector development program, we focus on improved child survival and reproductive health/family planning to reduce HIV prevalence and the mitigation of the impact of the epidemic.
- We view the provision of HIV prevention, care and treatment, made possible through the Emergency Plan funding as integrally linked to poverty reduction, economic development, food security, reproductive health and family planning, and infrastructure-improvement activities in Ethiopia.

Ambassador Vicki Huddleston, Keynote Address

- The U.S. is committed to support the efforts of the Ethiopian Government in achieving specific HIV/AIDS treatment, care and prevention targets over the next four years of providing.
    - Antiretroviral treatment to 210,000 eligible patients;
    - Enabling care and support services to over a million people including 500,000 orphans; and
    - Preventing 552,000 new HIV infections.
- The United States, through the U.S. Centers for Disease Control and Prevention-CDC- has been partnering with the Ethiopian Public Health Association.

- Much has been accomplished under the collaboration, including:
    - The development of a national HIV/AIDS research agenda and national HIV advocacy framework and guidelines;
    - A comprehensive training needs assessment was carried out and various trainings conducted;
    - We have supported EPHA publications, including the Ethiopian Journal of Health Development;
    - Conducted various symposia and workshops on major public health issues;
    - A collaboration among Tulane University in the U.S., Jimma University here, and CDC in the development of diploma and masters level monitoring and evaluation in health to start in January 2006. I'm proud to say that this program will be the first of its kind in Africa;
    - The establishment of the national public health laboratory association; and
    - Currently, we are working on the establishment of the strategic information consortium in the country.
- The United States, through the U.S. Agency for International Development (USAID) has supported community based reproductive health agents, and community health promoters are working closely with deployed health extension workers.
- To date, USAID has provided over $400,000 (almost 3.5 million birr) for the construction of 61 community-built health posts in SNNPR and for the procurement of medical equipment, including kerosene refrigerators for 86 health posts in the region. Similar assistance to the health sector extension program is being provided to Amhara and Oromia regions, with special attention to equipment required for childhood immunizations.
- USAID/Ethiopia is supporting successful community-based programs in maternal and child health, water and sanitation, and the prevention and control of infectious diseases such as malaria.
- These collaborative ventures have already shown very real results in a rather short period of time. As a result of community health initiatives, routine health management information data show an increase in immunization coverage from 54% in 2002 to 74% in 2004, while pit-latrine coverage increased from 20% in 2002 to 74% in 2004 in Southern Nations Nationalists and Peoples Region (SNNPR).
- None of the accomplishments in the health or other spheres would have been possible without the support and participation of the dedicated professionals- many of whom are sitting right here-of the Ethiopian health-care sector and the government institutions that support it. So I salute you and your dedication!
- The US government is honored to be your partner, and I wish to express to you our continuing commitment to this partnership in the effort to eradicate poverty, control HIV/AIDS, and improve the overall public health practice in Ethiopia.
- As this year's annual meeting gets under way, I want to congratulate the Ethiopian Public Health Association and all of you who will continue to play a leading role in charting the future course for a healthier Ethiopia in years to come."

The keynote address was followed by the Award Ceremony.

PART II: EPHA AWARD CEREMONY

Dr Damen H/Mariam, President of EPHA, made some remarks on the selection of this year's guidelines and criteria used to select the awardees. After highlighting the criteria, he disclosed the names of the awardees and the roles played for the development of public health in the country. His full presentation was as follows.

"EPHA awards to recognize individuals and institutions in five categories on competitive bases. The five award categories:

1. Public Health Service Award;
2. Senior Public Health Researchers Award;
3. Young Public Health Researchers Award;
4. Institutions for Public Health Service Award; and
5. Certificate of Recognition for Non-Health professional Award.

But this year EPHA has awarded three categories as follow:

2.1. PUBLIC HEALTH SERVICE AWARD

The winner of this category is identified on the basis of:

A. Success in Health Program;
B. Innovative Strategies;
C. Community Participation;
D. Human Resource Development;
E. Leadership; and
F. Publications.

The Winner, Your Honor, Dear Guests, Participants is **Dr. Tesfaye Bulto.**

2.2. YOUNG PUBLIC HEALTH RESEARCHERS AWARD

The winner of this category is identified based on:

A. Number of Eligible Publications;
B. Authorship; and
C. Relevance of Publications.

The winner, You Honor, Dear Guests, Participants-is **Ato Afework Kassu**

2.3. INSTITUTIONS FOR PUBLIC HEALTH SERVICE AWARD

The winner of this category is known for its:

A. Efforts made since 1983 to address the critical shortage of health professionals in the country under difficult situations and immense institutional challenges;
B. Innovative community oriented educational philosophy and its emphasis on public health development;
C. Horizontal and vertical diversifications in human resource development and growth to a level of university; and
D. In addition to its immense contributions, its professional society to the development of the EPHA is so high.

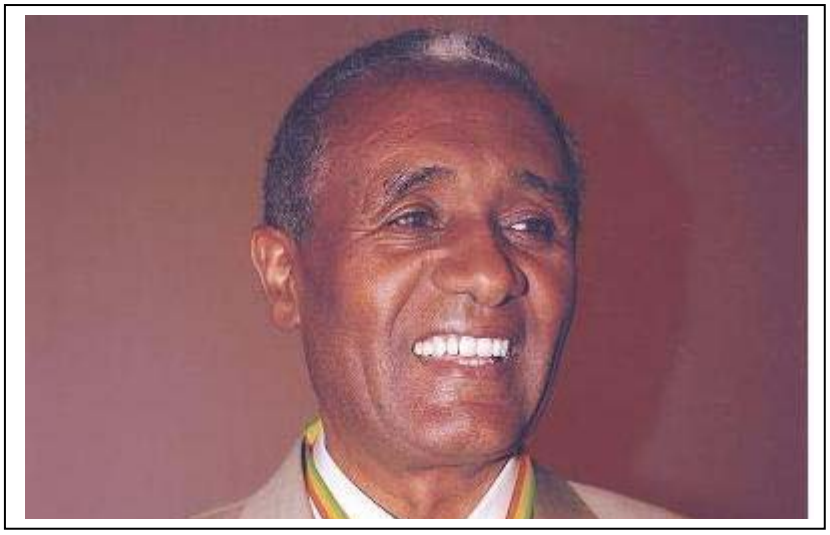
The winner, You Honor, Dear Guests, Participants- is **Jimma University**.
For Year-2005 EPHA awards, candidates' evaluation for the category of "Senior Public Health Researchers Award" was inconclusive and candidates were not nominated for the category of Certificate of Recognition for Non-Health Professional Award."
After the release of the names of the winners for this year, the President invited the Honorable Minister of FMOH to hand over the prepared awards. The Minster handed over the prizes with warm congratulation and the participants also paid honor and showed their happiness by applauding.

Finally the Awardees made the following speeches.

1. DR. TESFAYE BULTO
PUBLIC HEALTH SERVICE AWARD WINNER

"Your Excellency,
Dear EPHA Members,
Colleagues,
Ladies and Gentlemen,

I felt honored to receive this year's Public Health Service Award. There is nothing more satisfying than being recognized by fellow country professionals and an eminent Association such as EPHA. I am extremely grateful.



Dr. Tesfaye Bulto, Public Health Service Award Winner

Looking back to the past, I now can confidently say that I made the right decision when I joined the former Gondar Public Health College, now University of Gondar. I got the most appropriate knowledge and skill to provide both curative and preventive services to my people. Most of all I learned how to work in a Team. Health service delivery is a Team work.

The second important decision I made was to stay in my own country and serve my people. Otherwise I would have not been chosen for this award.

I always accepted challenges, for I kept in mind that I got free education and I should pay back by providing service to the neediest people in the un-reached locations. Accordingly, most of the places where I rendered services during my young age were remote and difficult by any standard. At that many were reluctant to serve in Gidami, Assosa and Humera. These were hardship areas. I am now pleased to tell you that I had the most peaceful time with a lot of gratifying results at the end of my service in those areas.

If I may be permitted to give advice to the young professionals of my country, I would say to them accept challenges when you are young, and serve your people. You will then have no reason to regret as you will have achievements to be proud of for the rest of your life.

As one of this year's EPHA conference focus is Health Service Extension Program (HSEP), I like to use this opportunity to reflect few of my views: One is to mention that we have enough experience that both curative and preventive activities should go hand in hand. The decision made right from the beginning to emphasis preventive activities in the health service extension program was correct and the recent addition to the program that HEWs shall treat Malaria and Diarrhea, to start with, has been very important. Many of us were sad when the initial plan was to make it drug free. With stronger logistics system established, it is the wish of many of us particularly working in child survival that we shall be able to add pneumonia treatment; as pneumonia is one of the major killers of children in the under-five years of age. It is also clear that we need to strengthen the referral system and in my opinion Health Centers should be provided with a vehicle and the necessary budget. During my service years as a Health Officer 'The Land Rover' was a symbol of the Health Centers. We were able to transport mothers with difficult labor to hospitals for better care and saved many lives.

In any case, I must say I am happy to have lived long to witness the institutionalization of the community-based health services through the health service extension program. Surveys show that more than 50% of Ethiopian children are stunted and malnutrition is the underlying cause in more than 50% of the under five deaths. Key interventions for this major health problem and maternal and child health promotion activities in general needs to be implemented at community and house hold level. I believe we are on the right track. But we really should be ready to invest on the community-based health programs. These are some of the crucial actions we need to undertake to achieve the Millennium Development Goals (MDGs) in health.

We all realize that poverty is our number one enemy and that the major public health concern at present; HIV has taken advantage of our being poor. It is, therefore, very important that gradually there is a common agreement that health is a prerequisite for development and health is part of the poverty reduction strategy document. We need to take advantage of this positive development and work hard to show results wherever we are.

I like to stop here and once again thank EPHA for this prestigious award! Finally, I like to mention that I share this award with my family, My Wife Sister Etalemahu Fikre and

my four children who gave me love and support. Particularly for their understanding when I had to be in the field very often.
Thank you!"

2. DR. MESERET YAZACHEW, REPRESENTATIVE OF JIMMA UNIVERSITY, INSTITUTION FOR PUBLIC HEALTH SERVICE WINNER

"His Excellency Dr Tedros Adhanom, Minister of Health,
Her Excellency us the Ambassador to Ethiopia,
Dear Dr Damen Hailemariam, President of EPHA,
Distinguished EPHA Members,
Ladies and Gentlemen!

It is indeed the greatest honor and pleasure for me to receive institutional award given to Jimma University for the contribution it has made to the advancement of public health and overall development of the country.

First of all, I would like to thank Ethiopian Public Health Association for electing Jimma University for the award.

Jimma University, Institution for Public Health Service Award Winner

Since its establishment Jimma University has committed itself to the attainment of public health through its unique philosophy of Community-based Education as a means of achieving educational relevance to community needs, creating a center of academic excellence, integrating training, research and service in order to produce high caliber professionals responsive to societal needs and promoting holistic and sustainable development in the country.

The rapid expansion of the university is aimed in addressing the human resource needs of the country by training professionals in diverse fields of studies through vertical and horizontal integration of its programmes.

As the university strives to meet the human resources need of the country for over all development, it considers educational relevance, high quality training, applied research, HIV/AIDS, gender and partnership and linkage with national and international universities as the core strategic issues.

Jimma University exercises Community-based, Student Centered, Team Based and Research based modalities of teaching to fully equip students with skill of problem solving.

One of the main social targets of Jimma University in the coming decades is fulfilling health human resource need of the country to promote the health of our nation and strengthen public health. To this effect we have opened post-graduate studies in eight disciplines last year five of which are in discipline of public health namely:

- Epidemiology
- Health Services management
- Health Education/Promotion
- Reproductive Health, and
- General Public Health

This academic year the University is ready to open post-graduate studies in five disciplines two of which is again in public health namely:

- Monitoring and Evaluation
- Environmental Sciences and Technology

Production of human resources in these specialty areas has positive contribution in strengthening public health services in the country.

In addition to the post-graduate programs, the University committed itself to train Health Education/Promotion professionals at B.Sc. level. The first batch will graduate this year. These professionals are the first of their kind in Africa and are believed to address public health problems related to life styles of people.

To create conducive learning and research environment for post-graduate studies, Gilgel Gibie Field Laboratory is established to enhance field based training and multidisciplinary research undertakings.

Ato Amsalu Feleke Representing Ato Afework Kassu for Junior Public Health Researcher Award

Jimma University supports the growth and development of professional associations for contribution to professional development and multidisciplinary research to address societal problems. Among these associations EPHA is one that plays a leading role in contributing to public health development in the country.

Award Winners with H.E. Dr. Tedros Adhanom, Minister of FMOH &US Ambassador, Vicki Huddleston

With this brief remark, I thank you once again for considering and electing Jimma University for the immeasurable award.

Thank you!"

PART III: MAIN AND SUB-THEMES AND OTHER PESENTATIONS

3.1 MAIN THEME: "**THE HEALTH SERVICE EXTENSION PROGRAM: EXPERIENCES AND PROSPECTS"**

MODERATOR: **His Excellency Dr Tedros Adahnom, Minister of FMOH**

PANALISTS AND TOPICS PRESENTED:

3.1.1 Dr Mengistu Asnake , "The HSEP Program: The NGO Experience and Prospects".

3.1.2 Ato Refissa Bekele , "Oromia Region Experience and Future prospects on HSEP".

3.1.3 Sr. Sossena Belayneh, "HSEP Program".

3.1.4 W/t Alemitu Setegne, "HSEP Activities Report", (presented in Amharic).

3.1.1. "THE HEALTH SERVICE EXTENSION PROGRAM: THE NGO EXPERIENCE AND PROSPECTS", Dr. Mengistu Asnake

Why Community-based Health Programs?

- Low health service coverage
- Distance from health facilities
- Provision of services by community members
- Early identification of health issues and problems

CBS Experience of NGOs in Ethiopia

- Direct care (disabled, destitute, displaced)
- Direct service delivery (CHA, TBA, CBD/CBRH, CP, Malaria Agents, etc)
- Capacity building (training, manuals)
- Innovative schemes
- Lobbying/advocacy
- Information generation (OR, Surveys)
- Networking and coordination

Current experiences in HEP

- Support to training institutions
  - Training materials
  - Training of tutors
  - Orientation training for HEP students
- Support apprenticeship programs
  - Provision of supervisory support
- Support to Health Extension Workers
  - Linkage with existing CBS

- HP construction
- Supply of HP materials

CHALLENGES IN HEP IMPLEMENTATION AND LESSONS FROM NGOs EXPERIENCE:

Challenge	Proposed Solution
Little involvement of beneficiary community in HEWs selection	Use existing experiences for other community workers
Limited practical session in major program areas (delivery services)	Use more community based practical session (home deliveries)
Shortage of training materials, teaching aids and operational budget	Mobilize resources at all levels
The need for attitudinal change of Health workers towards HEWs	Proper orientation for all providers at different levels
Lack of established coordination mechanism with existing community level workers	Establish a clear coordination mechanism and structure
Shortage of commodities and supplies in relation to the huge demand creation	Mobilize resources at all levels

THE WAY FORWARD

- Support training institutions (training aids, training of tutors).
- Support apprenticeship programs (Use existing community-based programs, operational budget support)
- Support implementation during deployment (in-service training, commodity support, linkage with existing programs).

CONCLUSIONS

- Documented successes from community programs.
- Two HEWs in a Kebele are not enough to serve the community on all the required activities.
- A need for establishing a clear linkage and relationship with existing service providers at all levels.
- HEP is at an infantile stage which requires concerted support of all stakeholders involved in improving the health status of Ethiopians.

He concluded his presentation by putting these points: “Let us work together through partnership in building a healthy future generation” and “Potential benefit of partnership is synergy, 1+1=3; If we work together may be even 4.

3.1.2. "OROMIA REGION EXPERIENCE AND FUTURE PROSPECTS ON HEALTH SERVICE EXTENSION PACKAGE"

Ato Refissa Bekele(MSc)

Outline of the presentation

- Background
- Health Service Extension Package
- Objectives
- Strategies applied in the region
- Development of HSEP in Oromia.
- Activities performed to strengthen the program.
- Performance of HEPW
- Lessons learned
- Challenges/problems
- The way forward/future prospects

Oromia:

Background:

- Located- in the central part of the country and shares internal borders with all regions except Tigray.
- Size of the region- 1/3 of the country
- Administratively divided into 14 zones,
  5 city administrations, 198 woredas, 564 urban kebeles and 6,500 PAs.
- Population size =25,817,132

Health facilities:

- 784 HPs,
- 883 HS,
- 166 HCs, and
- 29 hospitals
- Potential HSC is about 62 %.
- Health workers: 739 HEPW,
- 216 pharmacist/technicians, 432 lab technicians, 2,769 nurses of all specialties, 141 HOs and 183 physicians.

HEALTH SERVICE EXTENSION PACKAGE

It is promotive, preventive, with minimum prevention related curative and rehabilitative services targeting households particularly women/mothers/ and children at the kebele level.

It addresses:

1. **Disease prevention and control**
   - HIV/AIDS prevention and control
   - TB prevention and control
   - Malaria prevention and control
   - First Aid
2. **Family health service**
   - Maternal and child health
   - Family planning
   - Immunization

- Adolescent reproductive health
- Nutrition

3. **Hygiene and environmental sanitation**
   - Proper and safe excreta disposal system
   - Proper solid and liquid waste disposal system
   - Water supply and safety measures
   - Healthy home environment
   - Arthropods and rodent control
   - Personal hygiene

Objectives:

- To increase awareness, knowledge, and life skill among community members of the population and bring about sustainable behavioral changes,
- To improve access and equity to preventive essential health interventions close to the family and the community,
- To increase people's participation mainly on promotion of health, prevention and control of communicable diseases

Strategies applied in the Region:

- Enhancing political will and commitment at all levels.
- Reorienting the health service delivery system.
- Strengthening multi-sectoral collaboration and cooperation,
- Developing and strengthening referral system,
- Enhancing resource mobilization and utilization
- Utilizing relevant and appropriate technologies that are acceptable, cost effective and affordable.
- Enhancing team development and motivation of staff
- Enhancing community involvement
- Redefining roles of stakeholders
- Strengthening monitoring and evaluation.

Development of HSEP in Oromia:

I. **Implementation has started in EFY 1995 as pilot using 50 existing health workers**.

The pilot program was in 23 kebeles of Oromia

The training program then shifted to regional education Bureau TVET centers (5-18)

- 5 in 1996 EC (2003/04)
- 8 in 1997EC (2004/05)
- 18 in 1998 (2005/06

II. Selection of Health Service Extension Trainers (25-81)

- 25 in 1996EC
- 15 new trainers in 1997EC
- 41 new for 1998EC
- Totally 81 Trainers assigned (Professionally 37 Public Health Nurse, 36 Environmental Health Experts and 8 Home Science professionals)

III. Training progress and plan of HEPW

In 1995EC(2002/03) as a pilot 50 trained

- In 1996 EC(2003/04) 747
- In 1997 EC (2004/05)enrolment was 1296 and will graduate soon

- In 1998 EC (2005/06) the plan is 4000
- 1999(2006/07) 4337
- By the end of 2007 the region expect 10,380 HEPW

Progress and Plan of Health Post

- 550 HP in 2004
- 1383 HP under construction in 2005

The plan for:

- 2006=1383
- 2007 =1382
- Total 4697

Activities performed to strengthen the program

I. Formation of regional task force with the following members

- Regional Capacity Building and Education Bureau
- Oromia health Bureau with its relevant sections
- Partners

II. Conduct refresher Training for

- HSEP Trainers
- Health Service Extension Workers

III. Supplies were provided to strengthen health extension package training

- Demonstration Materials
- Lecture notes and textbooks
- Audiovisual Materials
- Teaching aids

IV. Apprenticeship Support

- Health Center Capacity Assessment
- Orientation of Health Center Staffs
- Dormitory Preparation and Free treatment facilitation

V. Document Translation

- Health Service Extension Implementation guideline
- 16 Health Service Extension Package documents
- Baseline Survey and Health Service formats
- Health Extension Package activity report forms were translated from Amharic or English into Afan Oromo

VI. Supervisions at all levels

VII. Budget support

- For HSEP trainers Top up 300 Birr/trainer monthly
- For Trainees pocket money from 135 to 175 Birr/ trainees monthly
- Running cost for apprenticeship in 1997

VIII. Review meetings

IX. Advocacy at all levels

HSEP:

Implementation of the Service

- Health Service Extension Package has been started in all14 Zones, 193 Woredas and in 491 Kebeles/HP
- Most of Health Service Extension Kebeles completed Data collection, Analyzing, Interpreting and Planning the activity.

- Start routine immunization, FP, ANC, and house to house delivery service
- Hygiene Education
- Home Visit
- Sanitation activity like Latrine constriction, Compound sanitation, Food and Water handling
- Birth and Death Registration
- Organizing Community for health activities
- Malaria Control

Lessons Learned

- High commitment and awareness of leaders on the program at all level can enhance HSEPW acceptance in the community.
- Close follow up, monitoring and evaluation is crucial for strengthening the program
- Having regular meeting with stakeholders has facilitated in solving the problems related to HSEP in time
- Recruiting as per the set criteria in particular from rural community is very helpful in deployment.

Presentation on HSEP

- Community sensitization on functions of HP and duties and responsibilities of HSEPW before the program commencement improves the acceptance and involvement of the community in the program.
- The presence of living house with the health post is vital

Challenges/Problems:

- In appropriate selection of trainees which created improper assignment.
- The training process suffers from the lack or inadequate practical/ demonstration facilities
- The operational budget for training was inadequate
- Community demands for clinical services

- In adequate support from kebele & woreda administration
- Most WHOs do not have adequate staff and budget to ensure proper supervision and support.
- Community mobilization in support of HEP has hardly started.

The Way Forward

- Organize adequate demonstration rooms with sufficient teaching aids
- Strict adherence to selection criteria set with full participation of relevant bodies.
- Improve the quality of apprenticeship program.
- Strengthen relationship with stakeholders and mobilize local resources to support the training program.

Future Prospect: By improving

- The quality and intake number of HSEPW;
- Accelerating the construction of health post;
- Supplying basic things;
- Improving referral linkage by accelerating health centre expansion;
- Allocating adequate budget to run the service;
- Improving participatory monitoring and evaluation.

The health service extension package coverage and service will be dramatically improved and the program attains the set objective**.**
Thank You

3.1.3.. "**HEALTH SERVICE EXTENSION PACKAGE PROGRAMME"**
Sr. Sossena Belayneh, Health Service Extension Coordinating Office, Ministry Of Health

By improving:

- The quality and intake number of HSEPW,
- Accelerating the construction of health post,
- Supplying basic things,
- Improving referral linkage by accelerating health centre expansion,
- Allocating adequate budget to run the service,
- Improving participatory monitoring and evaluation,

The health service extension package coverage and service will be dramatically improved and the program attains the set objectives.

1. Situation Analysis

- Existing imbalance between preventive and curative health measures,
- Weak health delivery system to reach the people at the grass-root levels as envisaged,
- The allocation of time & resources are still heavily biased towards curative services.
- The MTR/ARM 2001 of the HSDP raised the need to introduce an innovative community-based health care delivery system through the implementation of health extension package

2. Definition

It is a Program aiming to extend essential health services to rural communities with the cost that the community and the Government can afford and able to sustain.

3. Delivery of the Service

- Health Extension package is a service provided as a package,
- Focusing on preventive, promotive & minimum curative services,
- Targeting households particularly women/mothers and children at the kebele level,
- Referral services for problems that cannot be dealt with in the community level.

4. Objectives

- To increase awareness , knowledge and bring about sustainable behavioral changes
- To improve access & equity for preventive health interventions & essential health care deliveries
- To increase health service coverage

5. Strategies

- Ensure full community involvement & participation
- Promote & coordinate intersectoral collaboration
- Enhance supervision, monitoring and evaluation
- Strengthen referral system
- Strengthen logistic supplies.

6. Components

6.1 Family Health Service

- Maternal and child health
- Family Planning

6.2 Disease Prevention and Control

- HIV/AIDS and TB prevention and control
- Malaria prevention and control
- First Aid & emergency measures
- Immunization
- Adolescent Reproductive Health
- Nutrition

6.3 Hygiene and Environmental Sanitation

- Excreta Disposal
- Solid and liquid waste disposal
- Water supply & safety measures
- Food hygiene and safety measures
- Proper housing
- Control of insects, rodents & other stinging animals
- Personal hygiene

6.4 Health Education and Communication

7. Contents of the HEP documents

- Introduction
- Objectives
- Strategies
- Specific activities/tasks
- Expected outcomes
- Methods of communication and tools
- Monitoring and evaluation

8. Key Intervention Areas

8.1 Family Health

A. *To reduce maternal mortality through*:

- Prevention of early marriage, early age pregnancy like before 18 years, unwanted pregnancy, harmful traditional practices & etc.
- Family planning
- Antenatal care accordingly
- Care during delivery
- Immunization of TT2 to pregnant mothers/females 15-49 years old

B. R*educe child mortality through*:

- Exclusive breast feeding & on time complementary feedings,
- Immunization,
- ORT for diarrheal diseases management at home

C. *Nutrition can be attained through:*

- Nutrition education and demonstration
- Vitamin A & Iodine supplementations
- Promotion of breast feedings and on time complementary feedings
- Promotion of horticulture
- Growth monitoring.

8.2 Disease Prevention

A. Tuberculosis

- Detection of infectious cases
- Follow up of TB patients
- Expanding the DOTS for curing the sick and detecting the defaulters
- Information Education and Communication

B. Malaria

- Strengthening RBM strategies for their proven efficacy
- Rapid diagnosis and effective treatment of persons with malaria
- Promote wide spread use of insecticide treated nets and other appropriate methods to limit human mosquito contact
- Prompt recognition and control of outbreaks
- Conduct surveillance
- Facilitate indoor residual insecticide spraying

C. HIV/AIDS

- Care, follow-up of treatment and support to people living with HIV/AIDS and children orphaned
- Promotion of voluntary counseling and testing

- Condom promotion and distribution
- Sensitization of HIV positive women to receive antiretroviral treatment during pregnancy to prevent mother to child HIV transmission

8.3 Hygiene and Environmental Sanitation

A. Proper and safe excreta disposal

- Provision of hygiene education
- Promotion of proper use of latrine

B. Water supply & safety measures

- Promotion of sanitary construction & protection of simple wells, springs and harvesting of rain water
- Prevention and control of water-borne diseases
- Prevention of water contamination at water source, during collection, transportation, storage and use.

C. Promotion of:

- Personal hygiene,
- Food hygiene and safety measures,
- Healthy home environment,
- Solid & liquid waste management,
- Control of insects, rodents & other stinging animals

9. HEW Profile

- Trainees -100% new cadre of female health extension workers
- Recruitment:- students who completed grade 10
- Duration of training:-1 year
- Venue of training:- Technical and vocational training Centres in different regions
- Methodology of training:- modular training
- Employment:- :- government employees
- Deployment:-up to two health extension workers to each kebele
- Accountability:-they will be accountable to the Woreda health office of their areas,
- Supervision:- they are supervised by the Woreda health office/Health Centres
- Logistic supplies:- will be provided by the Woreda health office and the RHB

10. Duties and Responsibilities of HEWs

- Carry out all health extension package services**
- Make survey on the health, social, economic and physical facilities,
- Keep record of the number of population of the kebele
- Register daily activities in the registration book,
- Collection of vital statistics
- Carry out house to house visits
- Promotion and distribution of condoms,
- Disease Surveillance,
- Promotion of voluntary counseling and testing,
- Promotion of school health services.
- Referral services.
- Manage resources (materials, vaccines, medicines, equipment).
- Periodic reporting

11. Monitoring and Evaluation

Health Center - Technical support

- Woreda Health Office - Supervision, Monitoring and Evaluation
- Regional Health Bureau.
- Federal Ministry of Health

12. Achievements (2003, 2004 & 2005)

- Development of curriculum
- Development of 16 Packages both in Amharic & English
- Development of Health Extension Implementation Guideline
- Development of 22 kinds of lecture notes with technical & financial support from Universities & Donor Agencies like USAID & TCC
- Teaching Methodology was given for 199 Health Extension Teachers & 72 are being trained now (including for pastoralist Regions)
- 23 TVETS were selected for the training of HEWs
- Additional 12 TVETs will be opened in the present academic year (10 in Oromia & 2 in SNNRP)
- 2737 HEWs have graduated and deployed
- Currently 7090 HEWs are on training
- Piloting of HSEPP in five regions using the existing PH Workers

13. Challenges

- Teaching materials for demonstration
- Sustainable financial resources
- Shortage of health facilities for practical training
- capacity of health facilities is not well addressed
- Conducting the Training out of the conventional health professionals training schools demands more time & continuous follow-up which again demands all of us big commitment and accountability
- Resistance to 100% female trainees
- Lack of Woreda HEWs supervisors & assigned but not delegated Focal persons

14. The Way Forward

- Conduct Training of HEWs according to the need of the Regions
- Conduct Training on Supervisory skills for Woreda supervisors & Focal persons
- Consultative meetings for the directors of TVETs, HSE department heads of the TVETs & RHB to facilitate the Programme
- Strengthening the supply of teaching materials
- Reorientation of the health professionals and other management staffs,
- Follow up and support of the training of HEWs,
- Strengthening collaboration among stakeholders

15. National Call to the health professionals working with the community

- “Go with the people,
- Live with them,
- Learn from them,
- Accept & Love them,
- Start with what they know,
- Build on what they have,
- But of the best leaders,
- When the job is done & the task accomplished,
- The people will say,
- ‘We have done this by our selves”.

Taken from Chinese literature

16. Conclusion

- Health Extension package is an appropriate but a challenging intervention
- If we get ready to pay the Pain what the Programme demands, no matter what energy and time it takes, we will be able to bring the change in the health status of the community in this Country
- We are confident we can make a difference in improving the health status of our people within the coming near future
- To shorten or to lengthen the time, about when to see the change, depends upon our commitment as a whole
- Then & only then we can also say we have contributed our share to our Country

Thank you so much & may God bless you

3.1.4. “**የጤና አጠባበቅ ኤክስቴንሽን የሥራ ሪፖርት** (ጥቅምት/1998)”
ለኢ.ጤ.አ.ማ. ዓመታዊ ጉባኤ የቀረበ፣
በአለሚቱ ሰጠኝ፣ የጎምባት ቀበሌ የጤና አጠባበቅ ኤክስቴንሽን ሠራተኛ፣
ባሕርዳር ዙሪያ ወረዳ ምዕራብ ጎጃም ዞን

የጤና ኤክስቴንሽን ሠራተኛ ተልዕኮ

- **መሠረታዊ የቤተሰብ የጤና አገልግሎት በብቃትና በጥራት መስጠት፣**
- **የሐይጅንና የአካባቢ ጤና አገልግሎትን ማስፋፋት፣**
- **በሽታዎችን ለመከላከልና ለመቆጣጠር የሚያስችሉ ስራዎችን መስራት፣**
- **መሠረታዊ የጤና መረጃዎችን ማጠናከር እና ከአቅም በላይ የሆኑትን በአስቸኳይ ሪፈር ማድረግ ተልዕኮአችን ነው።።**

መርሆዎች

1. **በሥነ-ምግባር የታነፀ፣**
2. **እየሰሩ መማር፣**
3. **ባለቤትነትን ማስፈን፣**
4. **ተሳትፎ፣**
5. **ክህሎትን ፣ ችሎታንና ዘዴን ማባዛት፣**
6. **ውጤት ላይ ማተኮር፣**

7. የሕብረተሰቡን እውቀትና ብልሃትን መጠቀም፣

የጎምባት ቀበሌ ነባራዊ ሁኔታዎች

የጎምባት አባ ገሪማ ቀበሌ በባህርዳር ዙሪያ ወረዳ በጤና ኤክስቴንሽን ባለሙያዎች ከአሉት 8 ቀበሌዎች ውስጥ አንዱ ነው፡፡ የአየር ንብረቱም ወይና ደጋ ሲሆን በስሩ ያሉ ጎጦችም በተራራ እና በወጣ ገባ የተከበበ ነው፡፡

የሕዝብ ስርጭት

በ1977 ዓ/ም በቀበሌው ውስጥ የአባ ወራ ብዛት 1106

- ወንድ - 2204 ሴት - 2431
- ከአንድ ዓመት በታች ሕፃናት 151
- ከአምስት ዓመት በታች ሕፃናት 957
- ከ15-49 ዓመት የአሉ እናቶች 1023
- በጠቅላላው 4635 ሕዝብ እንደሚኖር ታውቋል፡፡

የፖለቲካና የአስተዳደር ሁኔታ

የጎ/ቀ/ጎ/ማ የሚተዳደሩት ዲሴንትራላይዜሽን በሆነ መስተዳድር የሚተዳደሩ ሲሆን በአጠቃላይ 19 ጎጥ ያቀፈ ነው፡፡

የኑሮ ሁኔታ

በዚህ ቀበሌ የሚገኙ ነዋሪዎች አብዛኛዎቹ የሚተዳደሩት በግብርና ሙያ ሲሆን የኑር ደረጃቸውም መካከለኛ ነው፡፡

የትምህርት ሁኔታ

1ኛ ደረጃ ት/ቤት 1 የአማራጭ ት/ቤት ይገኛል፡፡

ሐይማኖትና የዘር ሀረግ

ሁሉም ኦርቶዶክስ ሲሆኑ የዘር ሐረጋቸውም አማራ ናቸው፡፡

የመጓጓዣ አገልግሎት

የጎ/ቀበሌ ከባሕርዳር በ20 ኪ/ሜ ርቀት ላይ የምትገኝ ቀበሌ ናት፡፡

የጤና ፖሊሲ ሁኔታ

ከአሁን በፊት የጤና ድርጅት የሌለ ቢሆንም በአሁኑ ስዓት ግን 2 የጤና ኤክስቴንሽን ባለሙያ ተመድበው በመስራት ላይ ይገኛሉ፡፡

የአሰራር ሁኔታ

በተመደብንበት ቀበሌ በመሄድ ከቀበሌ አመራሩ፣ ከሐይማኖት አባቶች፣ ከመንግሥታዊ ቡድኖች ፣ ከመምህራን፣ ከግብርና ባለሙዎች፣ ተሰሚነት ከአላቸው የሀገር ሽማግሌዎች ጋር ራሳችንን በማስተዋወቅ፣

- ቀበሌውን የሚያመለክት ካርታ ተሰርቶ በግድግዳ ላይ ተለጥፏል፡፡
- ቤት ለቤት በመሄድ መሠረታዊ የጤና መረጃዎች ተጠናክረው ተሰርተዋል፡፡
- መረጃዎች ወደ ቋሚ መዝገብ ተመዝግበዋል፡፡
- በቀበሌው ጎልተው የታዩ ችግሮች ተለይተው ትኩረት ተሰጥቶባቸው እየተሰራባቸው ይገኛል፡፡
- መረጃዎች ለወ.ጤ.ጽ/ቤት ተልኳል፡፡
- ከመረጃው በመነሳት እቅዱ ተዘጋጅቷል፡፡
- በቤተሰብ ፖኬጅ የታቀፉ ቤቶችን በመለየት ለእያንዳንዳችን ሃምሣ /50/ በድምሩ 100 ቤተሰብ ፖኬጅ ላይ እየተሰራባቸው ነው፡፡ ተጨማሪም ቼክሊስት በማዘጋጀት ክትትል እና ድጋፍ እየተደረገላቸው ይገኛል፡፡

- እንዲሁም በማኅበረሰብ ፓኬጅ ለይተን እገዛ እየተደረገላቸው ይገኛል፡፡
- የክትባት ሞኒተሪንግ ቻርት ተሰርቶ ተለጥፏል፡፡
- የተሰሩ ስራዎች በሠንጠረዥና በግራፍ በቻርት ተሰርተው ግድግዳ ላይ ተለጥፏዋል፡፡
- የሞትና የልደት መረጃዎችን እናሰባስባለን፡፡ ከሐምሌ ጀምሮ የተለወዱ ሕፃናት 19 የሞቱ 7
- የቅብብሎሽ /የሪፈራል ሲስተም/ ሥራ እንሰራለን፡፡
- የቤቶች ጉብኝት በአማካይ 8 ቤቶችን በቀን የሚጎበኙ ሲሆን ከሰኞ እስከ ሐሙስ የመስክ ሥራ (Outreach) አርብ ደግሞ ቢሮ ውሰጥ መረጃዎችን ማጠናከርና የሪፖርት ሥራ ይሰራል፡፡

ተ.ቁ	ዝርዝር ስራዎች/የተሰሩ/	ከአሁን በፊት የተሰራ		አሁን የተሰራ	%
1	ነፍሰ ጡር የሆኑ እናቶች TT_2 + ክትባት	-	-	92	-
2	ነፍሰ ጡር ያልሆኑ እናቶች TT_2 + ክትባት	3.5%	36	405	39.6
3	ቢ.ሲ.ጂ	33.8%	51	188	124.5
4	ዲ.ፒ.ቲ. 1	-	-	180	-
5	ዲ.ፒ.ቲ. 3	29.8	45	144	95.4
6	ሚዚልስ	3.3	5	159	105.3
7	ክትባት ያጠናቀቁ	3.3	5	100	66.2
8	ቅድመ ወሊድ አገልግሎት	-	-	15	-
9	ድኅረ ወሊድ አገልግሎት	-	-	28	-
10	የመጀመሪያ ሕክምና እርዳታ መስጠት	-	-	41	-
11	የቤተሰብ ምጣኔ አገልግሎት • ፒልስ አዲስ ድጋሚ • በመርፌ የሚሰጥ /ዲፖ ኘሮቬራ/	- 0.2% 0.2%	- 2 2	26 4 15	- - 1.5
12	የተለየ ኩሽና ማሰራት	18%	201	11	1
13	ጭስ አልባ ምድጃ ማሰራት	0.2%	2	13	2.8
14	የመፀዳጃ ቤት ማሰራት	-	1	201	-
15	የፍሳሽ ቆሻሻ ማስወገጃ ጉድጓድ ማሰራት	-	-	8	-
16	ምግብ አዘገጃጀት ማሳየትና ትምህርት መስጠት	-	-	56	-
17	ለተማሪዎች ስለመጀመሪያ ሕክምና እርዳታ ስልጠና መሰጠት	-	-	23	-
18	ሴቶችን የሚገርዙ ሰዎችን እንዲተው ማስቻል	-	-	3	-
19	የቤተሰብ ፓኬጅ ጉብኝት	-	-	100	-
20	የማኅበረሰብ ፓኬጅ ጉብኝት	-	-	838	-
21	በተለያዩ ርዕሶች የባህሪ ለውጥ አምጭ ትምህርት መስጠት በአዲስና ድጋሚ	-	-	5282	-
22	በፈቃደኝነት ላይ የተመሰረተ የኤች. አይ. ቪ. ኤድስ ምርመራ እንዲያደርጉ መላክ	-	-	5	-
23	የደረቅ ቆሻሻ ማስወገጃ ጉድጓድ ማሰራት	-	-	8	-
24	ሽታ አልባ የመፀዳጃ ቤት ማሰራት	-	-	3	-
25	የወባ ቁጥጥር በጊዜ መስጠት	-	-	18	-
26	የአልጋ አጎበር ማሰራጨት	0.2	2	1900	171.8
27	የወባ ሕክምና አገልግሎት መስጠት	-	-	195	-
28	ለልምድ አዋላጆች ሥልጠና መስጠት	-	-	7	4
29	ከጤና ሃይላት ጋር ስብሰባ ማካሄድ	-	-	10	-

30	ከጤና መ/ቡድን ጋር ስብሰባ ማካሄድ	-	-	3	-
31	ከቀበሌ አመራር ጋር ስብሰባ ማካሄድ	-	-	6	-

ትኩረት የሚያስፈልጋቸው ነገሮች

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- **ለባለሙያዎች የትምህርት እድል ቢሰጥ ፡**
- **የወሊድ መከላከያ አቅርቦት ቢስተካከል /ዲፖ ኘሮቬራ/**

DISCUSSION ON HEALTH SERVICE EXTENSION PACKAGE

At the end of the presentations discussions carried out, questions raised and answers were given by the presenters.

COMMENTS

1. Public health is an important health service and a priority health program in this country. But it seems that people working in NGOs and many sectors, nowadays, fail to understand curative services are as equally important in preventing diseases and promoting health. This is raised because an officer had presented that one of the biggest challenge in the Health Service Extension Program was the community's demand on clinical services. The clinical part of public health that is trying to decrease the burden of diseases through the curative services have to be given due consideration at the community level.

2. The health services that have to be offered at the community level need to depend on their felt needs. They have to get prevention and curative services together. So the Health Service Extension Package need to have curative services as a package but this has to depend on the affordability and level of education of the workers.

3. Most of the participants had appreciated the report made by W/T Alemitu Setegne, a Health Service Extension Worker from Gombat village around Bahir Dar town in the ANRS. Based on this, a participant had requested this HEW to be member of the EPHA and this was unanimously supported by all participants.

4. Health Service Extension Program is an important entry to the family which needs to be accepted and continue in the future.

5. The report made by the Health Service Extension Worker was an encouraging one. Many achievements had been done. Collecting and analyzing data which is followed by intervention works have to be encouraged and strongly recommended.

6. The population and related problems are increasing tremendously in this country. We have been advising families to use family planning. Trainees/youths in the Health Service Extension Package need to be thought on F/P and they have to go

the houses and teach mothers. They need to develop this skill and transfer to mothers because this would be one of the mechanisms to decrease MMR.

7. The four areas of public health, i.e. prevention, promotion, curative and rehabilitation services have to go together and could not be separated. Everybody should work closely in an integrated manner for the implementation of these services in the community.

8. All extension workers be it agriculture, health or education must work together in an integrated manner at the household level to save time. We need to equip or train them how to develop skill on integration works.

9. If candidates are selected from the nearby towns, the probability of working and staying as extension worker in the rural areas is questionable. Therefore, to sustain this program selection of candidates need to be from the rural people.

QUESTIONS

1. The experience of NGOs' input is fine. Would you shade light on the financial resource? This is the problem across the presentations. What is the cost that NGOs put for the interventions?

2. Do you have any evidence or any study done at the community level on the issue of acceptability and ownership of the program by the household?

3. On the presentations, there were Conclusions, Recommendations and Ways Forward. You need to have evidences and justifications as bases. What did you consider as bases for the Ways Forward?

4. The question may be policy related. One is related to candidates, all have to be 100% females. The other issue is on selection, how do we solve the problems with selection? Is it because we started as 10+2 grade completed to be candidates? Does it bring any problem if we lower the class?

5. In line with prevention and control of HIV/AIDS, are VCT, ART, etc. being done at the Health Service Extension level? Could you share us your experiences in your area?

6. What were the major problems health service extension workers faced and what lessons do we learn from this?

7. So far we are cooperating with external donors but when do we cooperate among ourselves?

8. How much orientation on health service extension works had been given to other health workers and to those at the pre-service areas?

9. What is the future career of HEWs?

10. What were the main problems faced so far in lines with resources?

RESPONSES

1. Most of the NGOs incurred costs after the program started. They supported on-going programs in the form of additional support, but that is not huge expense. In the future, we have to think of, for instance, on supplying teaching aids until the first graduates. Then in-service training, refresher courses, etc. have to be thought of. In the future specific cost analysis has to be made.

2. The "Way Forward" had been raised several times because it is an important issue. During monitoring visit is funding well documented or problems existed need to be seen. Any problems during the implementation of the program, such as selection, training, etc. would also help us to put down Ways Forward. Routine activities are also other areas where we could monitor and the findings can help for putting down the Way Forward.

3. Curative service could not be separated from prevention, promotion and rehabilitation services. When HEP was started, we had been saying no drugs need to be handled by HSEWs. Now this concept is already changed, they give immunization, Depo-injection, and some selected drugs. The focus has to be on the level of curative service that has to be rendered by the Health Service Extension Worker.

4. The other issue is how to strengthen the referral system. Strong referral system between the health post and the health center has to be established. If we do this we have bright future in the service and the program.

5. The Health Service Extension Workers are also users of the developed career structure. They are thought 10% on curative and 90% on public health aspects. The choice is left for them, either to continue on clinical or environmental health field. If they want to continue on the clinical part, they are expected to start from scratch. Because they have less exposure (10%) but on the environmental part every thing is ready and favorable for them.

6. It is clear that the Health Service Extension Program is new and expected to face many challenges and problems. This can be due to lack of any system of passing information to the community when we launch new programs like the HSEP.

7. Because we didn't inform the community about the main purpose of establishment of the Health Post, they ask for injection. But according to the Health Policy of Ethiopia, at the community level we have PHCU consisting of a health center with 5 satellite Health Posts. So if the H.C. is accessible, the community can use it for curative and any other health problems beyond the capacity of the HPs. The H.C and the H.P need to work closely.

8. The district health office and the health center have clearly defined roles and responsibilities. Though structurally the health center and the health post are under the DHO, the health center can monitor and supervise the health post technically. This linkage has to be clearly resolved.

9. There are problems on resources, especially during training and when the Health Service Extension Workers go out for practices. We have planned many activities to be performed at once, but there are many problems which were not recognized. Everybody has to participate and assist the Health Service Extension Program as our external partners did.

10. The main problems existing in the Health Service Extension Program is the availability of contraceptives. Even though the referral system is related to the Health Center, it would be very hard for mothers to walk 3 or 4 hours to reach it and receive contraceptives. This needs due consideration by higher officials to make avail of contraceptives at the health post level.

11. The Health Service Extension Program is also working on the prevention and control of HIV/AIDS. So far 5 people had VCT at Gombat village. But the institutions performing VCT service in the towns need to give priority to referred cases especially from the Heath Service Extension Workers.

12. There is no problem with the policy on selection of candidates but the main problem is at the implementation site especially at the district level. Those who are corrupted and have low consciousness misuse the selection criteria and give opportunities for their relatives. Everybody wants to select his/her unemployed relatives. Through our follow up even we have found girls residing in the towns who went to the rural areas to be selected for the training.

13. The Health Service Extension Program was started free of handling drugs. But now it is modified and even they practice at the hospitals and health centers. This is a new development and has to go with time.

14. Health institutions, nowadays, are oriented on how to follow the Health Service Extension Workers and the areas that need demonstrations. Close follow up and monitoring are being conducted at this level and trying to solve problems faced.

15. Training centers for HSEWs need to be under the MOH rather than MOE.

CONCLUSION MADE BY THE MODERATOR

1. Based on our request and the policy of the government TVET (Technical and Vocational Education Training) institutions are under the MOE. The MOH could not handle this because of lack of materials and space for the training schools. The MOH can not close nursing schools and take over this training because both professionals are important for the country. Rather we need to support the training schools by deploying the necessary resources or establish new training schools.

2. The basic principle is to use the available assets to the maximum and we need to use the shortest path. For instance, the Defense Health Science College had proposed to train a health officer within $3^1/_2$ years to perform Emergency

Obstetric, Acute Abdomen and the like. But when we implement the shortest ways, quality should not be compromised. The motto is "Don't follow the crowd", and need to find new ways to alleviate the shortage of manpower.

3. The career structure of the Health Service Extension Workers is available and it is part of the civil reform. To retain these people we need to show their career structure. Accountability and those who performed best have to be recognized and go up on the ladder.

4. The curative service should not be separated from the prevention, promotion and rehabilitative services. But we have to focus on important diseases that bring impact. It would be dangerous to put everything on the Health Service Extension Workers and we shouldn't forget the back up from the health center. The health center is, nowadays, being equipped with the necessary manpower, supply and materials. We should not always depend on foreign assistance, self-reliance is important.

5. Another issue is the health insurance scheme. It may be complicated but we need to start it now. It is the first program and intervention for this year (1998 E.C).

6. Continuous discussion with the community about the health extension is vitally important.

7. All extension workers, i.e. health, agriculture, education, etc. need to work in an integrated manner.

8. The potential or political leadership is at the district level and then it goes down to the kebeles. But technically the health center has to work closely with the Health Post.

3.2. SUB-THEME: **"HEALTH SECTOR MILLENNIUM DEVELOPMENT GOALS (MDGs)"**

MODERATOR: Dr. Damen H/Mariam

The moderator of this panel discussion made the following introductory statement before inviting the three panelists.

The panel discussions that we have organized today are forms of dissemination of new initiatives and programs at the national and at the global levels. So that you will discuss it, when it is accepted you will internalize it for proper implementation. This is because at the end of the day, it is we the members and other professionals that would be implementing this initiative. As you know, the MDGs are talks of this day. They had come to the picture as a result of the Millennium Declaration in September 2000. They set the global development agenda and reflect a renewed commitment of the world development establishments to the poverty as well as the problems of developing countries.

The MDGs focus on 8 major areas. Health is the center of the MDGs, because it accounts 3 of the 8 goals. In addition, there are lots of synergies that would come from the MDGs of education, MDGs of gender and empowerment of women as well as MDGs to environmental sustainability. Therefore, health is being considered as a crucial source of sector in the overall development of the society. After making these introductory remarks, the moderator invited the distinguished panelists to present their preparations.

PANELISTS AND TOPICS PRESENTED

1. Dr Tefera Wondie, "Global Overview of MDGs"

2. Dr Girma Azene, "Prospects and Challenges for Achieving Health MDGs in Ethiopia"

3. Ato Hailegnaw Eshete, "Goal and Targets"

3.2.1 "GLOBAL OVERVIEW OF MDGs" Dr Tefera Wondie

Dr Tefera started his presentation by thanking for getting such a chance to learn and sort of outlet. He also congratulated those who were awarded by the EPHA and particularly Jimma University. He went back to history and recalled how this University was established. It was established as a Health Sciences Institute and there had been many comments on the naming. So he expressed his happiness on the changes he has seen in the University.

After putting these remarks, he mentioned that Millennium Declaration is the mother of MDGs. Before the Millennium Declaration came into being there were many discussions, workshops, social sciences, economics and exchange of ideas. Based on these, the Millennium Declaration was developed and signed by the UN in the year 2000.
Extending his presentation, he explained that the MDGs are time-bound, and targeted. It has 18 targets and 48 indicators. Out of these targets, 17 are purely health indicators. If we include calorie intake, it will be 18 but the responsibility is left for FAO not for WHO. The Millennium Declaration is development, peace, collective security, governance and human rights. Therefore, the MDGs are human rights based.
The full presentations are presented below.

Global Perspective of MDGs

- The Millennium Declaration (MD) was adopted by the UN General Assembly, which was attended by 191 member states and 189 countries in 2000.
- The MD mainly focuses on: Development, peace and collective security, human rights and the Rule of Law, and strengthening the United Nations (the reform of the UN System).
- The Millennium Development Goals (MDGs) derived from the Millennium Declaration.

- The MDGs are eight and time bound Goals which are interdependent and very much synergistic which cannot be seen in isolation. The MDGs have 18 targets and 48 indicators of which 17 are health indicators.
- The baseline year for MDGs is 1990 and they have to be attained by the year 2015.

Panel Discussion on MDGs

- In 2002 in Monterrey, Mexico, there was a meeting of development partners where by they expressed their commitment to support the developing world financial to attain the MDGs.
- There is a UN Millennium Project, which monitors the implementation of MDGs, headed by Prof. Jeffrey Sachs from Columbia University. Prof. Sachs is the MDG Advisor to the UN Secretary General, Mr. Kofi Annan.
- The 58th World Health Assembly's resolution: "Accelerating the achievement of the internationally agreed health related goals including those contained in the MD" and commitment between rich and poor nations.
- The UN Secretary General reports briefly on the MDGs Status to the UN General Assembly on annual basis, while he gives comprehensive report every five years, i.e. 2005 is a decisive year.
- Health being central to the achievement of all international goals, not only the health related goals.
- The WHA urged rich countries to scale-up development to 0.7% of GNP. African countries are also urged to commit 15% of their national budgets to health.
- Other recommendations include: Strengthening public health systems, making health a priority in national development plans or poverty reduction strategies.
- Need for closer coordination between WHO and other members of the United Nations and the international financial institutions such as WB, IMF, etc.
- Need for addressing the crisis in human resources for health; improving, monitoring mechanisms and ensuring health of the poorest people in countries, particularly those emerging from conflict and crisis.

UN SYSTEM IN ETHIOPIA

- There are meetings of UN MDGs Focal points which are involved in the MDGs sector.
- Needs Assessments out of which the synthesis in a macro framework is prepared.
- HSDP III and SDPRP II are MDG-based.
- WHO/HQ, Geneva has established a department of MDGs and Development Policy for guidance and follow-up of MDGs.
- WHO Country Office, Ethiopia also has MDG Task Force, which follows up the MDGs status and implementation.
- WHO Country Office, Ethiopia also has MDG Task Force, which follows up the MDGs status and implementation
- On the one hand MDGs are said to be ambitious goals, and on the other hand, the MDGs are understood as the least development goals, what is to be done to achieve them in the African context in general and in that of our country in particular???

Thank you

3.2.2. "PROSPECTS AND CHALLENGES FOR ACHIEVING HEALTH MDGs IN ETHIOPIA"

Dr Girma Azene, Program and Planning Bureau, MOH

Historic international commitment

- MDGs are historic commitments by the global community to:
  - Eradicate extreme poverty and
  - Improve the health and welfare of the world's poorest people within 15 years
- They provide an overarching framework for development efforts, and benchmarks against which to judge success

The eight Millennium Development Goals

1. Eradication of extreme poverty and hunger
2. Achievement of universal primary education
3. Promotion of gender equality and empowerment of women
4. Reduction of child mortality
5. Improvement in maternal health
6. Combating HIV/AIDS, malaria and other diseases
7. Ensuring environmental sustainability
8. Developing a global partnership for development

Importance of health MDGs

MDGs provide a common set of priorities for addressing poverty:

- Since the UN Millennium summit in September 2000 that adopted the millennium declaration, there is now unprecedented level of commitment amongst national governments, international agencies, and UN system that brought both political momentum and a focus to economic and social development efforts.

Health is at the heart of MDGs - a re-affirmation that it is now at the heart of the global agenda for reducing poverty as well as an important measure for human welfare:

- health is represented in three of the eight MDGs, and
- the health goals also focus on problems which disproportionately affect the poor

Health MDGs

Goal 4: Child Health

2/3 reduction of U5MR between 1990 and 2015

Goal 5: Maternal Health

¾ reduction in MMR between 1990 and 2015

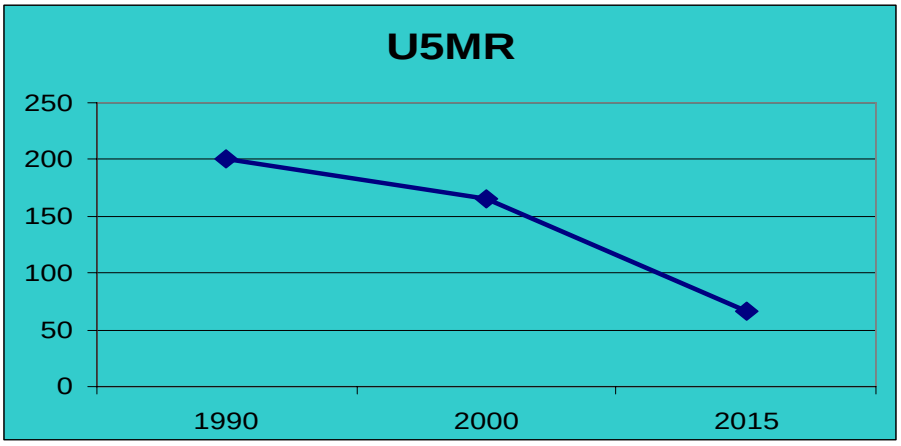
Goal 6: Infectious Disease

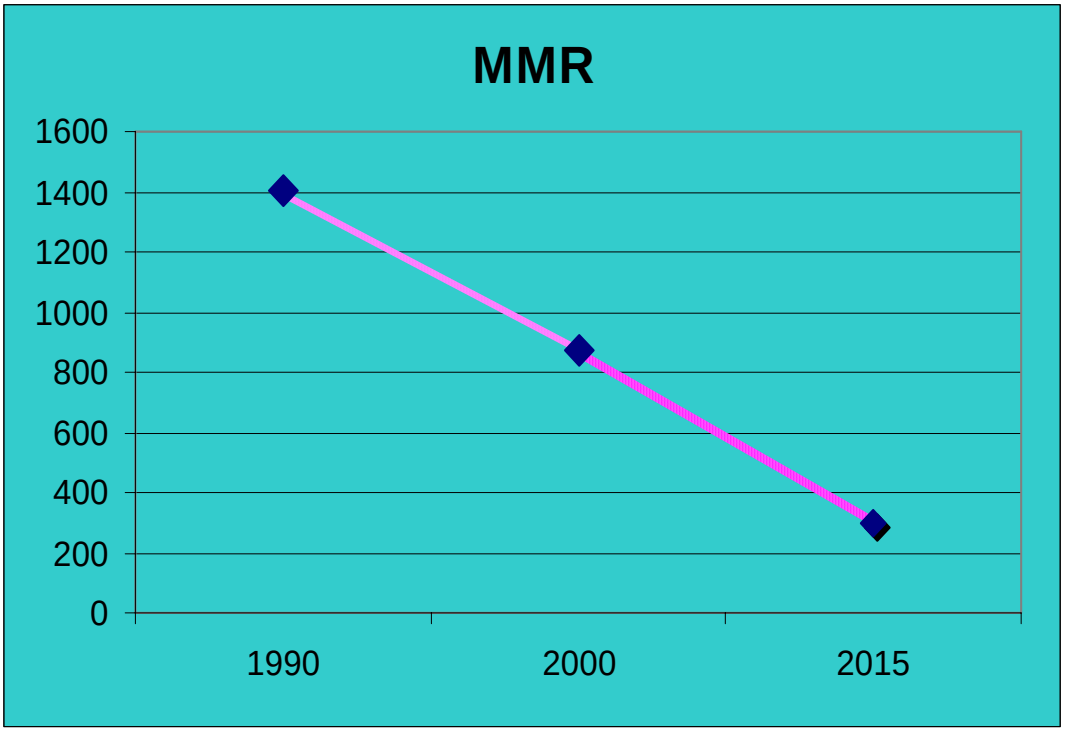
- Have halted and begun to reverse the spread of HIV/AIDS by 2015;
- Have halted and begun to reverse the incidence of malaria and other major communicable diseases by 2015.

Requirement and current national status of the three MDGs

• **U5 Child Mortality** 2/3 reduction of U5MR between 1990 and 2015	**- Under 5 MR 140/1000 live births** (in 2000) only 15% of children with ARI receive treatment
• **Maternal Mortality Ratio** ¾ reduction in MMR between 1990. and 2015	**- MMR 871/100,000 (in 2000)** . Only 9.2% deliveries are assisted By skilled health workers . 0.6% of pregnant women receive C-sections
• **Combating major Killer Diseases**	
- halt and begin to reverse the spread of HIV/AIDS by 2015	- Current prevalence rate of HIV/AIDS is 4.4%.
- halt and begin to reverse the spread of HIV/AIDS by 215	- TB incidence 196/100000 in 2003
- halt and begin to reverse the incidence of malaria and other major diseases by 2015	- 4-5 million malaria cases per year

Health MDGs …





Health sector preparation towards achieving MDGs

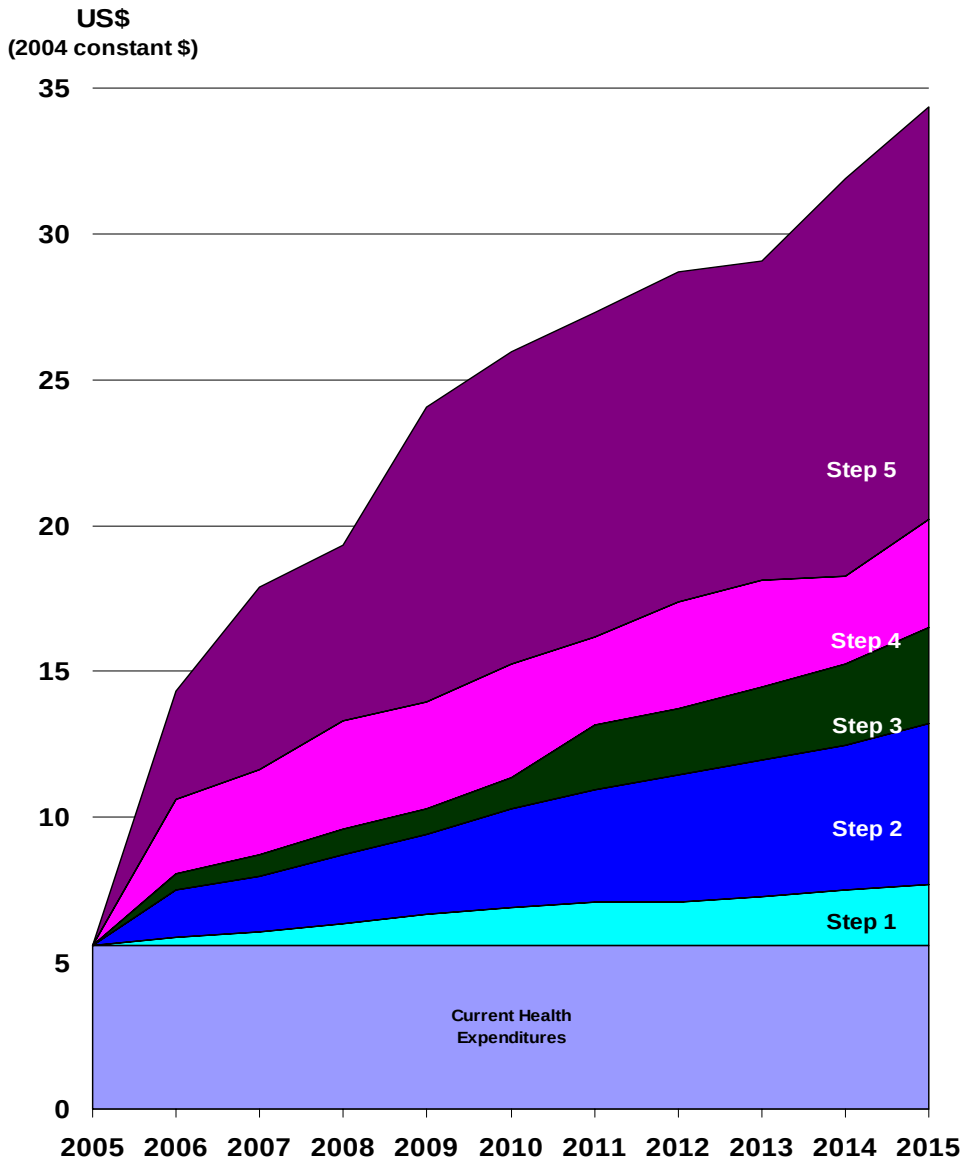
- **Completed a full range of MDG Need assessment that clearly:**
  - Identifies a combination of scaled up inputs needed to meet MDGs
  - Illustrate the application of MMB costing model
  - Provide estimation of physical, HRH and financial requirement
  - Show the linkages amongst HSDP III, SDPRPII, and Health MDGs.

Health sector preparation towards achieving MDGs

Development, publication and dissemination of:

- Child Survival Strategic document
- Institutionalization of the village health delivery system through the
- implementation of HSEP.
- AEPHC with the aim of reaching universal PHC coverage by the year 2009.
- MDG-based HSDP III
- Development of Strategic framework for Human Resource for Health (accelerated training of HEW, HOs and others).
- Development of MHSP

Cost of scaling up health services incremental cost per capita 2005-2015 for reaching the MDGs



Scale Up Strategy	Health Outcomes	MDGs reached
Step 5 : Expansion and Upgrade of Referral Care	Further decrease of : child mortality, maternal mortality, HIV MTC transmission Provision of HAART , multi-drug resistant TB and severe malaria treatment	

Step 4: Expansion and Upgrade of Emergency Obstetrical care	Further decrease of : child mortality maternal mortality HIV MTC transmission	Reduced MM by 75%
Step 3: First level clinical upgrade	Further decrease of: Child mortality Maternal Mortality Malaria, morbidity & mortality TB	Reduced malaria mortality by 50% Increase TB DOTS coverage
Step 2: Health Services Extension Program	Decrease in child mortality Reduction in HIV Mother To Child Transmission Reduction of deaths due to pregnancy by 40%Reduce malaria mortality morbidity Reduce Child malnutrition	Reduced child mortality by two third
Step 1: Information and Social Mobilization for Behavior change	Decrease in child mortality due to HIV, malaria, diarrhea diseases Reduced HIV transmission Reduced malaria morbidity and mortality	Reversed trend in HIV incidence and stabilized trend in HIV prevalence

Reasons for being optimistic

1. Policy environment
   - SDPRPII
   - Population policy
   - Women's policy, etc
   - Conducive Health policy and very high government commitment

2. Decentralization
3. HSEP and institutionalization of the village health care delivery system
4. AEPHC aimed at universal coverage
5. Global commitment to MDGs
6. Public-private partnership including community and civil society

Major Challenges for achieving MDGs in Ethiopia

1. The expected fast sliding gradient of the MDGs indicators.
2. Removing bottlenecks in the implementation and resource absorptive capacity in the public sector
3. Scaling up HRDH
4. Massive resource mobilization
5. Partnership amongst public, private, NGO and the general public.

Thank You

3.2.3. "GOAL AND TARGETS"
Ato Hailengaw Eshete

- Goal: Combat HIV/AIDS
- Target: By 2015 have halted and begun to reverse the spread of HIV/AIDS

CURRENT STATUS

Magnitude of the epidemic (2003):

- HIV/AIDS Adult prevalence 4.4%
- Total living with HIV/AIDS 1.5 million
- Women 770,000; Children 120,000
- Death during 2003 =120,000
- AIDS Orphans 560,000

(Source: UNAIDS 2004 Report)

PURPOSE

AIMS by 2015:

- Reverse HIV incidence from 0.66 % to 0.55%
- Stabilize HIV prevalence at 4.4%

SELECTED INTERVENTIONS

- BCC
- Human rights and legal issues
- Vulnerable groups
- Blood safety
- Harmful practices
- VCT, PMTCT, ART, OIs, HIV/TB, STDs,
- Palliative care (HBC)
- Research and surveillance
- Orphan support

MDG COMPLIMENTARITY

- HIV/AIDS Goal is closely linked to other MDGs
- All sectors will address HIV/AIDS
- HIV/AIDS costing is done in one center
- HIV/AIDS costs should be spread across all sector plans and budgets

NEXT STEPS

Additional attention to mainstreaming HIV/AIDS issues in - other sector and cross-cutting assessments

ESTIMATED COSTS ASSUMPTION

- HIV/AIDS costing is complex
- No vaccine in the near future
- ARV Cost will remain as it is
- Health interventions are interrelated

ESTIMATED COSTS

Information and Social Mobilization for BCC

- Increase Media coverage on HIV/AIDS
- Social marketing and Condom Promotion
- Social Mobilization
- Workplace intervention
- Youth programming

COSTING ASSUMPTION

- General Prevention (e.g. BCC, Condom)
- PMTCT (Proportion accessing <1 to 40 %)
- VCT (Proportion accessing < 20-100%)
- HAART From 1.5% treated now (10,000) to 95% (600,000)
- Orphan support (20% benefiting social support = 1,000,000)

COSTING COMPONENTS FOR SCALING UP MDG PROGRAM

- Information and social mobilization for behavior change (US$1.25)
- Health service extension program (US$3.54)
- First level clinical upgrade (US$1.72)
- Expansion and upgrade EOC (US$3.50)
- Expansion and upgrade of referral care (US$9.79)
- Expand social service (US $15)

Table: Summary of costs (USD per capita) for social mobilization

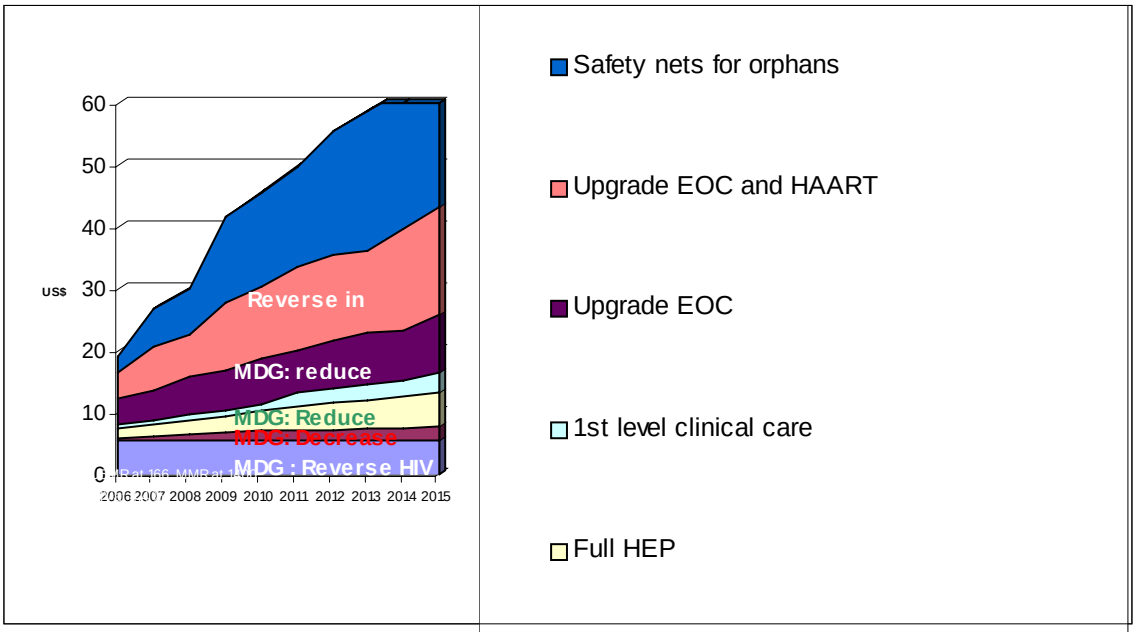
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Investment	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13
Recurrent	0.59	0.79	1.19	1.28	1.38	1.48	1.58	1.68	1.78	1.98
Total	0.72	0.92	1.32	1.42	1.52	1.48	1.71	1.81	1.91	2.11

		Per Capita (USD)	USD (Million)
2006	74,957,752	3	251
2007	76,921,645	4	348
2008	78,936,992	6	468
2009	81,005,141	8	648
2010	83,483,000	9	747
2011	85,519,985	11	935
2012	87,606,672	12	1044
2013	89,744,274	13	1157
2014	91,934,034	13	1183
2015	94,526,000	14	1316
		TOTAL COST	**8.1 BILLION**

DRAFT CONSOLIDATED COST ESTIMATE (.000 US$)

	Total Health & HIV/AIDS	Health Sector	HIV/AIDS Sector	Safety nets (20% OVC)
2006	753000	502000	251000	370000
2007	1045000	697000	348000	532000
2008	1159000	691000	468000	711000
2009	1445933	797933	648000	891000
2010	1499000	752000	747000	1245000
2011	1697000	762000	935000	1275000
2012	1876879	832879	1044000	1392000

2013	2036000	879000	1157000	1513000
2014	2178999	995999	1183000	1638000
2015	2524000	1208000	1316000	1786000
TOTAL	16214811	8117811	809700	11353000



CONCLUSIONS AND RECOMMENDATIONS

- Design resource mobilization strategy
- TA to bridge gaps in human resource capacity
- Expand M&E plans
- Strengthen the coordination/partnership mechanisms
- Review or development of new policies
- International and National TA at all levels
- Mainstreaming HIV/AIDS issues
- Establish Global MDG facility, UN theme, AU ECA

		Per Capita (USD)	**USD (Million)**
2006	74,957,752	3	251
2007	71,971,145	4	348
2008	78,931,992	5	418
2009	81,005,141	8	148
2010	83,483,000	9	747
2011	85,519,985	11	935
2012	87,101,172	12	1044
2013	89,744,274	13	1157

2014	91,934,034	13	1183
2015	94,521,000	14	1311
		TOTAL COST	**81 BILLION**

DISCUSSIONS ON HEALTH SECTOR MDGs

COMMENT

The goals seem ambitious and time is running for changing commitment to action. It needs assessment and commitment to action by stakeholders is very important.

QUESTIONS

- How far have you gone to achieve MDGs both at the National and International levels?
- The population issue is the main problem in the country. According to the Population Policy of Ethiopia, CPR is expected to reach 44% at the end of the targeted time. Then why did we excluded FP from the programs? Why not we expand FP to solve the population problem?
- In the presentation the target is shown as 0.66 – 055%. Could you share us how did you come up with such figure?
- Because of the increased absorbing capacity by the private sector, what is the status of private-public relationship?
- Is there any mechanism devised to familiarize MDGs to the health professionals?
- What should be our steps to mainstreaming HIV/AIDS in all developing activities?
- Are all MDGs policies? When are we going to develop out home-based goals?
- During counseling there are issues against the human right. We are taking care for HIV positive person only while forgetting the negative one, e.g. the husband may be positive while the wife is negative. So how are we going to minimize such problems in relation to the human right?

RESPONSES

- To achieve the MDGs by 2015, we need 120 Billion USD. There are many competing actions in the world. Much had not been done but money is not a problem as long as developing countries take actions. Some are absorbing this money but not used properly.
- HSDP is based on MDGs. In the last 5 to 6 years the health programs are accelerated. The prerequisites to MDGs are strengthening the health system and need to be our priorities. Harmonization, documentation, human resource development and health service extension program are means of achieving MDGs.
- We have our own policies based on the MDGs. MDGs have to be owned by each country and that is why we organized a Task Force at the National level.
- Population and gender issues are important parts of MDGs. They are well addressed and are cross-cutting issues. We are taking actions in relation to

population problems. We are making some progress in line with CPR to reach the MDGs.

- In line with the incidence from 0.66 – 0.55, there are different approaches and models for calculation. For our use we had utilized the Goals Model developed by the UN.
- Sensitization and advocacy works have to be made to internalize MDGs. Continuous forums have to be devised to sensitize health workers at the lower levels. Based on this MDGs have been translated into local languages.
- Closely collaborative works with the private and other associations is mandatory to achieve MDGs.
- Mass resource mobilization for the health sector is being done to achieve MDGs.
- One of the strategies by HAPCO is mainstreaming of HIV/AIDS to all sectors. Mainstreaming is one of the major areas of interventions/strategies for the coming 15 years. HAPCO has outlined, published and distributed National Guidelines to the Regions and Districts.
- Many controversial issues are present in HIV/AIDS. Human Rights and other legal issues are not well developed.

Finally the moderator closed this session by emphasizing that population is one of the cross-cutting issues and MDGs 3 is focusing on gender. The Health Sector Program for the coming 10 years needs to involve these issues and the main stakeholders also need to internalize it.

3.3. OTHER PRESENTATIONS

3.3.1. "INJECTION SAFETY-BUILDING FORMULATION FOR SUSTAINABILITY"
MODERATOR: Dr. Chandrakant Rupareha, Country Representative Jhpiego, Ethiopia

PANELISTS and TOPICS PRESENTED

3.3.1.1. Professor Yemane Berhane, "Impact of Injection Safety: Epidemiological Evidences".

3.3.1.2. Dr Solomon Worku, "Injection Safety in Ethiopia".

3.3.1.3. Ato Yohannes Tadesse, "Building Foundation for the Sustainability of Injection Safety in Ethiopia, Ministry of Health".

3.3.1.4. Mr. Ousmane Dia, "Making Medical Injection Safer".

3.3.1.1. IMPACT OF INJECTION SAFETY: EPIDEMIOLOGICAL EVIDENCES
Professor Yemane Berhane

What is unsafe injection?

- Too many injections
- Dangerous injections: contaminated needles and syringes

Panel Discussion on Injection Safety

Injection Providers in Developing Countries

Injection treatment has wide spread popularity, it is given by:

- Formal and informal medical practitioners
- Traditional healers
- Lay people

Reason for wide injection practice: common misunderstandings

- **Patient side**
  - Believe injections to be stronger and faster medications.
  - Believe that doctors regard injections to be the best treatment
- **Health worker side**
  - Believe that injections best satisfies patients
  - Prescription of an injection sometimes allows the charging of a higher fee for service.

Injection Practices in Developing Countries

- Each year 16 billion injections are administered, 95% in curative care.
- 9 out of 10 patients presenting to a primary healthcare provider receive an injection, over 70% are unnecessary
- 70% injections are given with syringes or needles reused without sterilization
- Unsafe disposal can lead to re-sale on the black market of used equipment.

Burden of disease associated with unsafe injection practices
Unsafe Injection account for:

- **Hepatitis B virus**:
  - 33% of new HBV infections in developing and transitional countries
  - A total of 21.7 million people infected each year.
- **Hepatitis C virus**:
  - 42% of cases, the most common cause of HCV infection in developing and transitional countries
  - two million new infections each year
- Human immunodeficiency virus (HIV)
  - 2% of all new HIV infections
  - A total of 96 000 people infected annually.
- Among health care associated sources unsafe injections are accounting for an estimated 3.9% to 7.0% of new infections worldwide.

Cost of Unsafe Injection

- Unsafe injections cause 1.3 million early deaths each year a loss of 26 million years of life
- Annual financial burden is US$ 535 million in direct medical costs.

Findings from Injection Survey 2000
Risk to Recipient

- 71% of health facilities had no dedicated area for injections
- 28% of therapeutic injections and 16% of vaccinations were given with non-sterile equipment

Risk to Provider

- Safety boxes not used for collection of sharps even when available
- 62% injection provider had at least one needle stick in the last 12 months

Risk to Community

- Waste disposal very poorly done: dumping in unsupervised area or open burning
- 37% of health facilities visited had evidence of sharps around the health facility

Potential medical transmission of HIV in Ethiopia

- Evaluation done in 16 rural health institutions in Ethiopia.
- Most institutions reported re-using disposable needle/syringes.
- 12% of observed injections were given with used, disposable syringes prepared for re-use.
- Analysis of used needle flushes showed no HIV RNA; but the method used did not have good sensitivity.

Conclusion

Medical injection practices are not likely to contribute significantly to HIV transmission.

3.3.1.2. "INJECTION SAFETY IN ETHIOPIA"

Dr. Solomon Worku, Project Director, Making Medical Injection Safer

Why Injection Safety is a concern for developing countries?

- 16 billion health care injections are administered each year – an average of 3 – 4 injections per person, per year in developing countries.
- Excessive uses of injections have been recorded to administer medications.
- Injections are not only overused, but are unsafe because of shortage of single use injection equipment and other factors.

Why injection safety?

- "UNAIDS estimates that, worldwide there will be 45 million new HIV infections by 2010 if efforts to fight the pandemic are not stepped up"
- It is also estimated that up to 4 million of these infections will result from:
  1. Unsafe blood transfusions
  2. Unsafe medical injections and
  3. Unsafe procedures performed in the absence of universal precautions.

In Ethiopia:

- Injection and related medical practices are unsafe, exposing patients, health workers and the community to transmission of blood-borne pathogens.
- Very limited studies were conducted
- Very little concern regarding injection safety.
- The issue was highlighted first by the EPI program.

OVERVIEW OF FINDINGS 2004

Description of study site

- Regions and Woredas

  Oromia

  1. ADAMI-TULU
  2. ADA'A

  SNNPR

  1. Dale
  2. Wolaita Soddo

- Number of health facilities visited: 49
  - Hospitals :7
  - Health centers :10
  - Health stations :27
  - Health posts :5

Steps in injection provision:

- Use of a dedicated working table or tray: 172 (63.5%)
- Type of swab used for skin cleaning:
  1. Disinfectant swab :66.5%
  2. Water swab : 15.7%
  3. Non skin cleaning :14%
- Type of syringe used: disposable or auto-disposable, nearly all health facilities
- Use of sterile needle/syringe: all facilities (at time of observation!)
- Use of sterile syringe/needle for reconstitution of injection: 98.5%
- Use of diluents from a new single-dose diluents vial for reconstitution of powdered substance: 55.9% (about 44% unsafe)
- Reconstituted vaccines and other perishable medications left over from previous day: 16.0%
- Reconstitution of lyophilized vaccines (BCG, Measles) with correct diluents: 68.9%
- Two-handles re-capping of needle after injection: 35.4%
- Use of puncture proof safety container (sharps box): 44.3%

Observation of health care waste disposal facilities and practices

- Facilities with dirty, blood-stained or wet swabs used for skin cleaning: 58.3%
- Facilities with punctured-proof, safety containers (sharps boxes) in stock: 61.7%
- Facilities with sharp boxes in areas where injection is given: 45.8%
- Facilities where sharps are left in an open container exposing to needles-stick injuries: 61.2%
- Facilities with evidence of used sharps not properly disposed: 63.3%
- Type of waste disposal facilities used for disposal of majority of sharps:
  1. Open burning in a hole or enclosure: 45%
  2. Incineration: 43%
  3. Dumping in unsupervised area: 22.4%
  4. Dumping in pit latrine or other secure pit: 14.2%
  5. Open burning on ground: 10.2%
  6. Burial: 4.0%

Review of prescriptions

- Total prescriptions reviewed=6200
- 1274 (20.5%) had at least one injection
- Average number of daily prescriptions:
  Hospital=75 - Health Center=38 Health Station=11
  Sada Dist.=18.6 - Ada'a Dist.=24.9%

OVER VIEW OF FINDINGS 2005

Description of study site (Expansion)

- Amhara (Bahir Dar and Dessie)
- Tigray (Axum &Mekele)
- Harari (All health facilities)
- Dire Dawa (All health facilities)

In this study 65 health facilities were included

- 16 hospitals
- 12 health centers
- 32 health stations
- 5 health posts

Inventory of injection supplies

- Stock card for safety boxes 13.5%
- Stock card for disposable syringes 46.25
- Updated stock cards 47.2%
- Stock outs in the last six months 14.8%
- Balance corresponds with the physical inventory 24.3%
- Stock of one safety box for 100 syringes 20.2%
- Health facilities with one stock of oral formulation 78.3%

Observation of facilities

- HF with sharp containers in each injection area 71.6%
- HF that only uses safety boxes 40.5%
- HF safety boxes are stored in a closed place inaccessible to the public 14.9%
- HF with used sharps exposing providers to accidental needle stick injury 59.5%
- HF segregate their waste into different containers 25.7%

Observation of injection administration providers WHO:

- Prepared on a clean table or tray 66.7%
- Washed their hands before injection 3.5%
- Took needle and syringe from a sterile pack 97.6%
- Did not recap used needles 68.7%
- Used sharp containers immediately after injection provision 68.7%

After this the presenter had displayed different photographs that were taken at the different areas on Injection Practices. The topics of the pictures were:

1. A table where injection is provided in a clinic.
2. Multi-dose injections, even the left over analgesics (a covered ampoule), unclean table
3. Multi-purpose table in a health station
4. Reuse of syringes at a hospital and health station
5. Use and storage of supply: storage of syringes and safety box at a corridor
6. Misuse of safety boxes, storage of safety box at a corridor
7. Misuse of safety boxes for filling patient cards
8. Site of safety box

9. Segregation of waste (Best practice)
10. Collection of syringes and needles: at a health center, clinic, and a hospital
11. Collection of syringes and needles: Best practices (Soda hospital)
12. Collection of syringes and needles: Use of cartoon as a safety box (in a laboratory), unsupervised disposal
13. Collection of syringes and needles: Inappropriate use of safety box
14. Final disposal of sharps at a health station: improper incinerator, open field, shallow pits
15. Final disposal of sharps: incinerators that are not maintained, inappropriate use of an incinerator, disposal of needles and syringes in incinerator, incinerator at a hospital/needles exposed near incinerator, Best practice (Sodo hospital), ideal condition/good potential (a health center)

3.3.1.3. "BUILDING FOUNDATION FOR SUSTAINABILITY OF INJECTION SAFETY IN ETHIOPIA, MINISTRY OF HEALTH"
ATO YOHANNES TADESSE, HEAD, HEALTH SERVICE AND TRAINING DEPARTMENT, MOH

JSI **MOH** **MMIS**

BACKGROUND

- 1.12sq.km area with 73 Million population
- National HIV prevalence 4.4% (2.6-12.6%)
- 1.5 million PLWHA
- Estimated 123,000 AIDS cases
- Health service coverage 64%
- Health service utilization 0.36
- EPI coverage 60.8%
- Antenatal coverage 40.8%

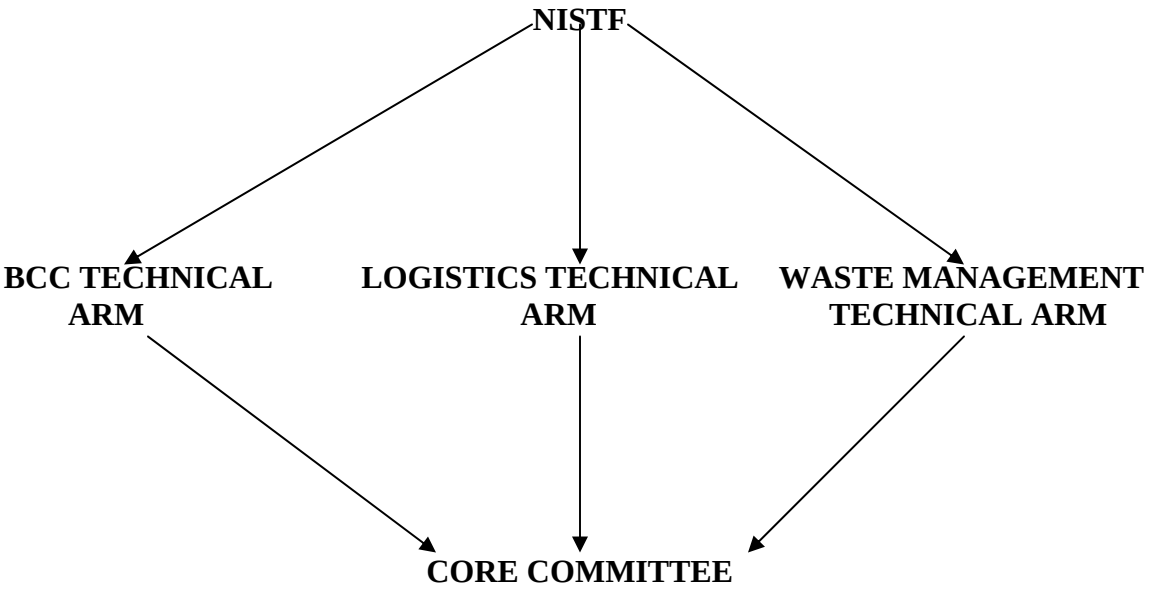
Injection safety situation in Ethiopia

- Assessment on injection safety was conducted in the year 2000 focused on EPI
- MMISP (Making Medical Injection Safer Project) started in March 2004 since then assessments were conducted in 6 regions and 10 woredas.
- Sites for assessment and project implementation were selected jointly by (MOH&MMISP)
- Agreement was reached among stakeholders to expand the National injection safety committee established primarily only for EPI purpose
- MMISP is part of PEPFAR/ETAEP program to address HIV/AIDS.
- MMIS started activities in two regions, four woredas and 53 health institutions in 2004
- The project expanded in 2005 to additional four regions, six woredas and 89 health facilities.
- Currently 142 health institutions were included.
- Training was conducted for 609 HW and > 200 auxiliary staffs.
- Around 1.6 Million syringes, 25,000 safety boxes, 260 needle cutters and > 10,000 units of heavy duty and Latex gloves were distributed

National Injection Safety Task Force

- Composed of international, bilateral, government and NGO's.
- MOH & JSI/MMIS play the leading role
- Core committee was established
- Technical arms were formulated
  A. Technical arm BCC.
  B. Technical arm Waste management
  C. Technical arm Logistics
- Have regular meetings every two months.

ORGANOGRAM OF THE NATIONAL INJECTION SAFETY TASK FORCE



MAJOR ACHIEVEMENTS BCC, LOGISTICS AND WASTE MANAGEMENT

- Five year country strategic framework was designed and endorsed
- Donors round table meeting initiated
- National advocacy strategy was designed
- Job aids, posters, leaflets, pocket reference books and documentary films were produced and disseminated.
- Advocacy was launched using newspapers and various forums to the public.
- Quarterly newsletter was produced and disseminated.
- In service training modules prepared
- Injection safety devices supplied.
- Principles of forecasting injection safety supplies provided.
- Waste management committees were established at each health facility level
- Waste disposal plan designed at district level
- Malfunctioning incinerators maintained
- In-country safety box production initiated
- MOH included requirement of incinerators in new health facility construction.

PLAN TO ENSURE SUSTAINABILITY OF ACTIVITIES

A. SUPPLY

Revolving drug fund mechanism was adopted to ensure sustainability, thus it

1. Ensures availability of injection safety devices all year round
2. The margin profit 15 - 20% generated will be used for
    - Maintenance of Incinerator
    - Purchase of PEP in case of needle stick injury
    - Purchase of protective gears
    - Bridging supply gap shortage

B. CURRICULEM DEVELOPMENT

- Adaptation of facilitators guide developed by JSI/WHO Afro in the country context.
- Inclusion Injection Safety topic in the pre-service training curricula for all category of health professionals
- All universities participating in the adaptation and curricula development in collaboration with Carter center.
- Orientation to Lecturers, instructors on injection safety for nursing schools and Technical vocational Education Training institutes (TVET) was planned

C. SUPERVISION, MONITORING and EVALUATION

- WHO surveillance officers were trained and planned to include Injection Safety in their supervisory checklists
- All US affiliated organizations jointly developing supervisory checklists
- Regions promised to include Injection Safety activities in the five year Health Sector Development Program (HSDP)

D. IMPORTANT EVENTS

- Injection Safety is included in the National infection prevention control guideline as one chapter

- Health care waste management policy and guideline development is in process
- MMIS is working on strengthening Logistics Management Information system (LMIS)
- Panel session on Injection safety was organized in collaboration with EPHA.
- In-country production of safety boxes and injection equipments initiated.

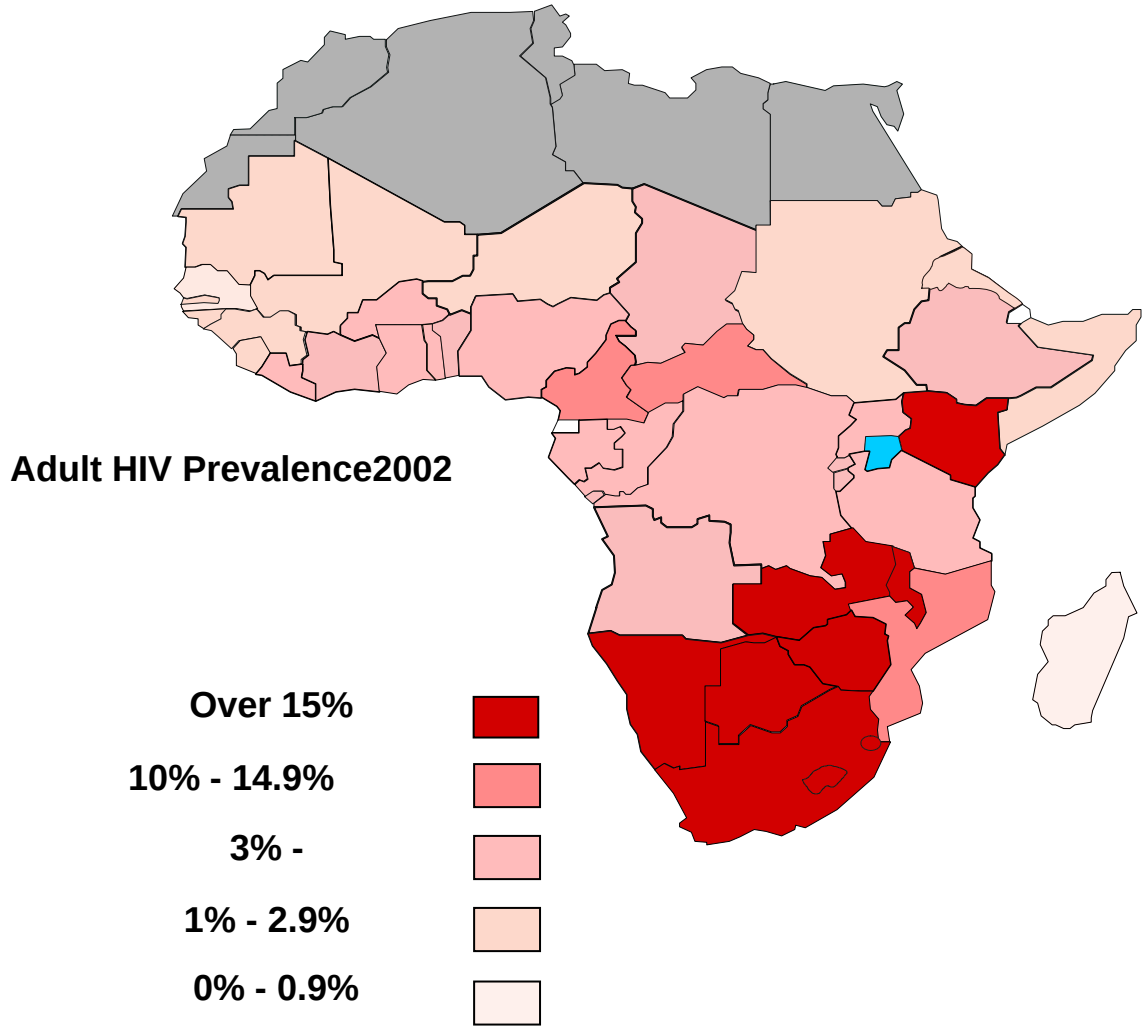
Thanks a lot

3.3.1.4. "MAKING MEDICAL INJECTIONS SAFER",

Mr. Ousmane Dia, Senior Logistics Advisor, Presented the paper on Behalf of Dr Jules Millogo, Project Director

Overview and future plans

Adult HIV Prevalence in Africa



The Emergency Plan's Five Year Goals

- $15 Billion five-year program
- Focus on 15 countries in Africa, Asia & Caribbean

- **To TREAT**
  2 million HIV-infected persons with combination ART
- **To PREVENT**
  7 million HIV infections
- **To CARE**
  for 10 million individuals infected with or affected by HIV including orphans

Safer Medical Injections Primary Implementing Partners

CDC

John Snow, Inc. (JSI): Botswana, Cote d'Ivoire, Haiti, Kenya, Rwanda, South Africa, Tanzania

USAID

- JSI: Ethiopia, Mozambique, Nigeria, Uganda
- Chemonics International Inc.: Zambia
- University Research Corp: Namibia
- Initiatives Inc: Guyana

STATUS

- Phase 1:
  - Baselines & pilot activities completed
- Phase 2:
  - Nationwide scale-up

Baseline Assessments

Countries with finalized reports

- Ethiopia (2004)
- Kenya (2003)
- Mozambique (2004)
- Nigeria (2004)
- Rwanda (2004)
- Tanzania (2004)
- Uganda (2003)

- **Countries with draft reports**
  - Botswana (2003)
  - Haiti (2004)
  - South Africa (2004)
- **Baseline planned**
  - Cote d'Ivoire (prior report on waste management report 2000)

Findings from both the final and draft reports have been disseminated.

MMIS Phase II

- Five Year Cooperative Agreement (CDC) through September 2009
- Five Year Cost Extension (USAID) through September 2009
- Staff changes at HQ and field levels

The way we work

- Partnership building
- Reinforcement of ownership by MOH
- Working through National injection safety Task Force
- Technical Assistance
- South to South collaboration

Technical Approach

- Training and capacity building
- Commodity and supply procurement and management
- Advocacy and Behavior Change to reduce un-necessary injections
- Sharp waste management
- Monitoring and Evaluation

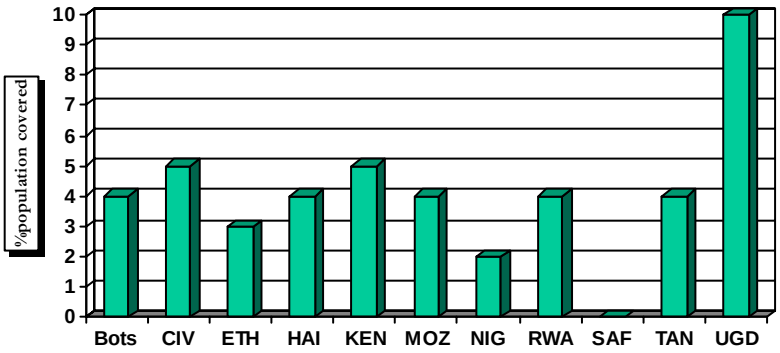
Capacity building

- Training activities conducted in countries
- Final draft of Facilitator's Guide
- Participants handbook and other job-aides to be developed shortly
- Scaling up of training and capacity building activities

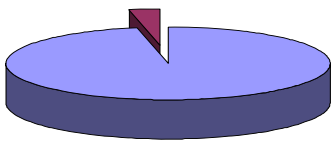
Supplies and commodity management (1): status

- Selection of injection devices made by countries with guidance from MMIS and partners
- Pooled procurement of 16 millions syringes (standard or safety syringes)
- National medical store used in most places for reception and distribution

Population covered with Phase I (supplies)



Overall population covered with pooled procurement supplies during Phase I



Monitoring and Evaluation

- Baseline assessments conducted where needed
- Monitoring tools developed (supervision, health facility assessment tool)
- Hospital assessment tool to be finalized

Advocacy and BC

- Strategy development workshops organized by AED
- TA visits to several countries
- Strategies drafted in all countries
- BCC materials developed in all countries
- South-to-South collaboration opportunities

Waste Management

- Health care waste management plans at district and facility level
- Local procurement of supplies for waste handlers
- Meeting with WHO/Geneva to discuss some of the inconsistencies in guidelines
- "Africa meeting" in Addis in October 05

Healthcare workers safety

- Procurement of syringes with safety feature
- Training sessions emphasize on avoidance of recapping
- Protective gear procured locally for waste handlers
- Encourage governments to include healthcare workers protection measures in national policy and guidelines (PEP, Hepatitis B vaccination, protective gear)

Sustainability plan: current status

- Part of JSI approach to move through MOH structure and encourage ownership
- 98% of country staff are nationals

Enabling environment

- Ministries of Health commitment
- HQ and Country staffs
- Collaboration with WHO
- Sub-contractors: PATH, AED, Manoff
- Collaboration with other contractors
- Support from CDC and USAID

Lessons learned

Partnership and Synergy

DISCUSSIONS ON INJECTIONS SAFETY

COMMENT

From the presentations, we have seen hand washing before giving injection by the health workers is 3.5%, a physician did not even know where the incinerator is, etc. If the health service extension workers could bring behavioral change, we the health workers have to be good examples before we go out into the community,. We have also seen pictures how wastes are collected in the health institutions. Therefore, we need to internalize it and work more on this line.

QUESTIONS

1. Seventy percent of the injections are unnecessary and it is an African problem. To change the attitude of injection is there any effort done globally in dealing with pharmaceutical companies to reduce injectable medicines, if possible for those which can be replaced by oral?
2. For the national implementers/FMOH, we had seen the different strategies devised such as incorporating in the curriculum, working with the health workers, etc. But if we see most of the private service deliveries/agents/clinics are situated at the center/nearby the villages. Most of the injections are prescribed from the private sectors. Is there any steps taken to reduce the problem in collaboration with the private clinics?

RESPONSES

1. The issue is not reduction in terms of numbers. But the issue is how we health workers do we need to prescribe injections when we have equal effect of oral drugs. So we need to change our attitude first.

The global situation in production of oily injectables is decreasing because the demand is low. The producing companies are producing less even they are planning to close. So the global market will go out by itself.

2. In most of the urban settings, almost 50% of the prescriptions are from the private sectors. But in order to say about the private sector, first we need to clean our house and then we need to initiate the private practitioners to use the safety boxes. For every 100 injections one safety box is needed and we need to provide them. More safety boxes are needed through different aids and the production of safety boxes in-country is being initiated.

3.3.2. "HIV/AIDS – FOOD SECURITY and NUTRITION INTERFACE, RAPID ASSESSMENT OF THE STATE OF NUTRITIONAL CARE AND SUPPORT SERVICES FOR PLWHA", MODERATOR: W/O Abeba Gobezie

PANALISTS and TOPICS PRESENTED

Part I – W/O Abeba Gobezie, "Food Security"

Part II - Ato Shewandagne Belete, "Food Security – Nutrition and HIV/AIDS Interface"

Part III – Ato Teferra Azage, "Development of the Training Manual on Nutritional Care and Support for PLWHA".

PART I: "FOOD SECURITY"
W /o Abeba Gobezie

BACKGROUND

Food security exists when all people, at all times, have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life (World Food Summit 1996).

FOOD SECURITY AND NUTRITIONAL SITUATION IN ETHIOPIA

- Annual minimum required production 225 KG/person
- Annual food production 145.5 KG/person
- Deficit: 80 KG/person
- Average daily Calorie Intake 1840/2200 kcl (FAO estimate)
- 52% of under-five stunted (highest in SSA)
- 30% of women (15-49) BMI less than 18.5 (chronic energy deficiency CED)

Panel Discussion on Food Security

MICRONUTRIENT DEFICIENCY

- Iron deficiency anemia in 85% of under-five and 58% of 15-49 women
- Iodine deficiency in one in five of every new born (685,000)
- 30% of under-five suffer from Vitamin A deficiency
- 60% under-five mortality related to malnutrition

ONGOING FOOD SECURITY PROJECTS

There are several ongoing Food Security interventions based on the GO Policy.
FAO is undertaking certain Food Security Programs in Ethiopia out of which the major one is the BSF/FAO Project.

BSF/FAO/MOARD JOINT PROJECT ON IMPROVING NUTRITION AND HOUSEHOLD FOOD SECURITY

The Project is:

- Supported by the Belgian Survival Fund
- Attached and implemented jointly with FAO and MOARD through the implementation mechanism of MOARD (at Federal, Regional and Woreda level)
- LOCATION: environmentally degraded and food insecure of Northern Shoa and Southern Tigrai)
- Project life 4 years (2001-2005)

DEVELOPMENTAL OBJECTIVES

Nutritional status and household food security improved in selected communities in the four woredas of Lalomama and Gera-Keya in Northern Shoa and Enderta Hintalo Wajerta in Southern Tigray.

PROJECT COMPONENTS

- Natural Resource management and/agriculture
- Nutrition and health
- IGA through skill training, off-farm alternative enterprises, etc.

PROJECT CATCHMENTS AREA

Covers about 80000 people in 40 selected sites/Gottes or Kushets (ten from each target woreda).

THE DIRECT BENEFICIARIES include:

- Women Headed Households
- Oxen less
- Landless

MAJOR ACHIEVEMENTS

- Baseline data systematically established
- More than 2180 micro-projects received financial and technical support through 2003-2005
- Covering 8000 families and about 45,000 family members
- Community participation enhanced
- Food production including backyard vegetables and fruits increased
- Household income from IGA and sale of ruminants/chicken and surplus increased

- Household consumption, Nutrition and HH food security improved
- Water supply and environmental sanitation improved
- Environmental rehabilitation expanding
- End term evaluation showed success and indicated for scaled-up intervention with appropriate exit strategy for sustainability.

Water harvesting and horticulture (picture was presented).

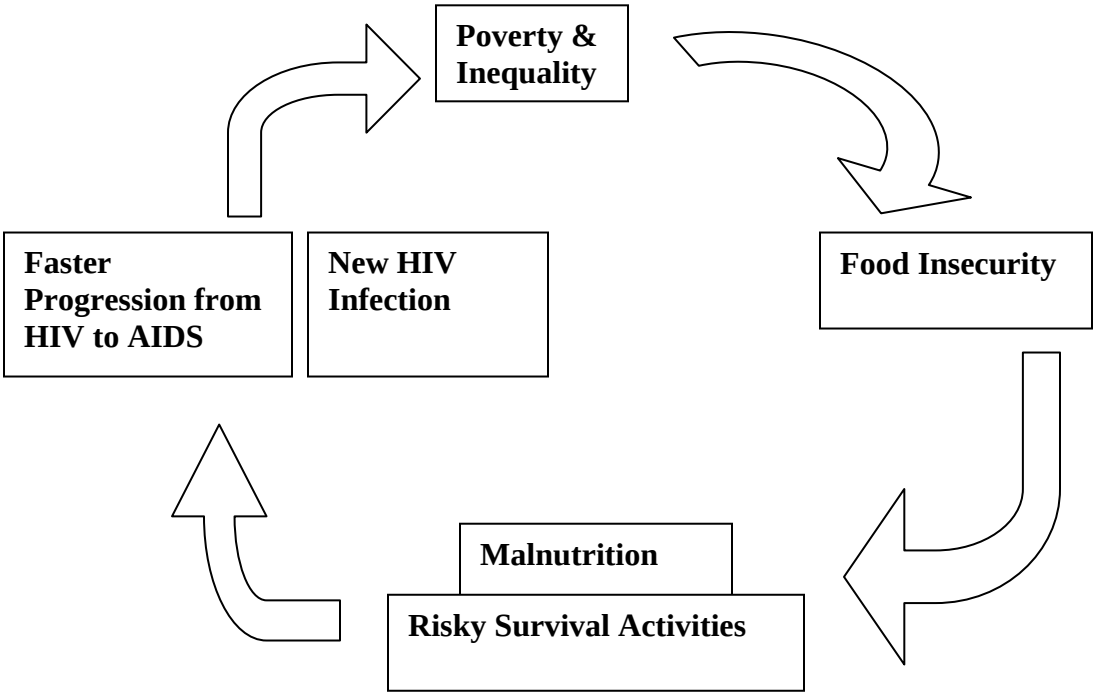
- The HIV/AIDS pandemic is perceived by FAO as a "problem of critical importance for development and not only as a health problem".
- The recognition of the bi-directional linkages between HIV/AIDS and food security led to the initiation of the baby project on HIV/AIDS which is attached to the BSF/FAO food security project.
- The project is focused on the development of the Training Courses on Nutritional Care for PLWHA and is supported by Norwegian fund.

PART II: "FOOD SECURITY – NUTRITION and HIV/AIDS INTERFACE"
Ato Shewandagne Belete

OVERVIEW

- The HIV/AIDS pandemic is still spreading worldwide including Ethiopia.
- The steady increase in the rural areas has caused a national alarm and concern.
- HIV/AIDS increasingly associated with malnutrition and household food insecurity.
- Life-prolonging medication for HIV/AIDS more and more available.
- Access is beyond the reach of most of the needy people, (less than 10% in Ethiopia)

BI-DIRECTIONAL LINKAGE OF HIV-FOOD SECURITY



IMPACT OF HIV/AIDS ON FOOD SECURITY

- Depletes agriculture labor force and other livelihood activities
- Reduces agriculture produce and productivity, reduction in cultivated land,
- Erodes household asset base
- Affects household demography
- Increases household expenses
- Affects transfer of agriculture skill

IMPACT OF FOOD INSECURITY ON HIV/AIDS

- Causes rural disintegration
- Increases adoption of risky coping mechanism (behavior) like labor migration, unprotected sex including sex for money
- Increased vulnerability
- Reduces resistance to OIs and rapid progression to AIDS, affects ART

HIV/AIDS is now.

A cause for a new variant of Famine/ as opposed to the traditional drought induced famine (South Africa)

Superimposed on chronic food insecurity and widespread state of malnutrition including in Ethiopia.

Unmet.

HIV/AIDS contributes to malnutrition by

- Reducing appetite
- Interfering with nutrient absorption, utilization and
- Making additional nutrient demands
- Malnutrition in turn WEAKENS THE IMMUNE SYSTEM
- Reduces resistance increases vulnerability to Ols,
- Affects drug utilization and
- Speeds up the progression to AIDS and early death.

Rapid Assessment on the State of Ongoing Nutritional Care and Support Services for PLWHA

PROCESS

Purposefully selected ongoing Nutritional Care and Support Services

- PLWHA and OVC
- IGA facilities of PLWHA identified, visited and assessed.
- Relevant stakeholders (Government, Academic Institutions, NGOs Multilateral and bilateral agencies and partners) contacted and consulted.

Pictures presented

1. Milk cow for OVC (D.B.)
2. Urban horticulture by PLWHA

CONCERNS/TRENDS

- HIV/AIDS is creeping and spreading deep into the countryside and affecting development gains
- The number of PLWHA deserving comprehensive care and support services is continually growing and
- The demand for care and support services is yet

ON THE LINKAGE BETWEEN NUTRITION AND HIV/AIDS

- The linkage between Nutrition and HIV/AIDS is not yet properly recognized
- Nutrition is not integrated/mainstreamed into the ongoing care and support services
- No uniformed and standard training manual and guideline on Nutritional Care and Support for PLWHA.
- Available training manual for health workers including for HEWs, Agricultural Extension Agents, Home Agents, and care providers are deficient on basic nutritional component.

ONGOING SERVICES FOR PLWHA ARE:

- Uncoordinated, inadequate
- More focused on irregular handout of food, finance, and clothing
- Not directed at sustainable building the household livelihood capacity
- Stigma is still widespread, most of the PLWHA have not yet out public
- The household food availability of PLWHA is very low and
- Their demand for food aid is vivid.

CARE/SERVICE PROVIDERS

- Are not sufficiently trained
- Lack manuals and guidelines
- Confronted with diverse challenges
- But their dedication has to be acclaimed
- Training manuals and guidelines on nutritional care and support for PLWHA is highly desired and awaited for
- Managers, trainers, service providers and all of the contacted stakeholders agreed on the existing gap and expressed their appreciation of and readiness to join hands on the development of the manual.

PART III: "DEVELOPMENT OF THE TRAINING MANUAL ON NUTRITIONAL CARE AND SUPPORT FOR PLWHA", Ato Teferra Azage

TARGETS

Care Service providers such as:

- Health care givers
- Agriculture Extension Workers
- NGOs
- Volunteers

- PLWHA and other beneficiaries
- Training Institutions
- Trainees (health, home agents/AEWs, etc.)

PROCESS

- Base Reference: FAO/WHO joint generic training course manual
- Actual drafting by 2 National Consultants
- Zero Draft circulated among stakeholders for comments
  Draft presented to a pre-testing workshop reviewed by participant/facilitators/panelists and constructive comments generated

THE MANUAL

The updated draft prepared in two sets:

- Text/Handout for participants and other users
- Facilitators Guide
- Other than the introductory parts each has nine sections focusing on:
  (Pictures of the Two sets of the Manual were presented)
- ***Session One***. Food and Nutrition: deals with basic concepts of food and its functions, nutrients and their roles, balanced diet, food choice, etc.
- ***Session Two***. The relationship between Nutrition and HIV/AIDS: Treats
  The Effects of HIV/AIDS on Nutrition and the Effects of Nutrition on HIV/AIDS
- ***Session Three*. Special Eating Needs for PLWHA: Treats**
  Importance of good nutrition, PLWHA taking care of themselves, nutritional concerns of PLWHA, Nutritional Assessment, Targeted Nutrition Supplements and How to care for PLWHA, etc.
- ***Session Four*. Nutritional Management of HIV related Complications:**
  Deals with major types of difficulties related to eating like sore mouth, throat, vomiting, diarrhea, fever, etc. and strategies and techniques to improve food intake.
- ***Session Five*. Nutritional Care and Support for Pregnant and Lactating Women with HIV/AIDS. Deals with:** concerns during pregnancy and lactation, recommended nutritional requirements, purpose of nutritional care and support and issues and challenges.
- ***Session Six*. Nutrition in Infant and Child feeding during HIV/AIDS.** Deals with risks of PMTCT, Infant Feeding Options, Feeding a Child with HIV/AIDS and How to feed children.
- ***Session Seven*. Protect the Quality and Safety of your food: Treats**
  How to protect the quality and safety of foods, Food safety and hygiene practices, etc.
- ***Session Eight.* Improve Access to Food.** Deals with food security and HIV/AIDS interface, HHFS, Community Support for nutrition, etc.
- ***Session Nine.* Course Review**

ANNEX: Recipes on community available foods.

WAY FORWARD

- Finalize the Training Course Manual on Nutrition Care for PLWHA.
- Updating and editing with pedagogical touch, translation into local languages, printing and dissemination
- Launching workshop
- The manual will be operational jointly through MOARD, MOH, HAPCO, FAO other key partners.

MAJOR ISSUES TO BE ADDRESSED

- Policy advocacy to incorporate HIV/AIDS considerations and objectives into Food Security polices and programs and vice-versa.
- Ensure nutritional care for PLWHA (enhancing access to adequate and nutritious diet, IGA, food assistance, nutrition education, etc.)
- Ensure that the state of needy PLWHA is included in the eligibility criteria of safety net schemes.
- Strengthen and promote community-based initiatives to better care for AIDS affected households by focusing on the family.
- Protect and support Food Security and Livelihood among vulnerable Households. (IGA, labor and time saving technologies)
- Undertake periodic and systemic assessment and operational research on the issue.
- Assessing the reciprocal impact of HIV/AIDS and food security
- Mainstreaming HIV/AIDS into the agriculture sector and strengthening its HIV/AIDS response.
- Scale-up prevention and programs in the rural areas.

3.3.3 EVOLUTION OF PUBLIC HEALTH

The panel discussion on Evolution of Public Health in Ethiopia was not conducted. But the prepared CD on this subject distributed to the participants.

DISCUSSION ON FOOD SECURITY AND NUTRITION INTERFACE, RAPID ASSESSMENT OF THE STATE OF NUTRITIONAL CARE AND SUPPORT SERVICES FOR PLWHA

COMMENTS:

1. The study is the base for intervention as presented on part III. Most of the studies, researches and consultancies had been done but what follows? In most of the cases it is unknown. But in this case, the study is done and the intervention is in the process. This is a recommendable approach.

2. The very definition of food security, as has been indicated, I am afraid whether it is fully considered. From the very document, I think you have taken the definition. “It indicates food security itself whether to get enough or not enough food and in developed countries food security question whether it is

safe or unsafe. Both must be balanced and equally considered. In our case, the availability of food may outweigh safety and quality.

3. From PLWHA point of view, I am sure this aspect of the definition is very important. For instance, people who are cultivating vegetables, what if they are cultivating in night-soil, when that vegetable is collected and consumed will result in severe consequences of health? Let alone immuno-compromised people, nowadays, we see this problem as a serious case in semi-urban agricultural practices.

4. My concern is of course from HIV/AIDS point of view; I think the manual may contain and will address adequately. I am not sure, if locally available, what are simple things that should not complicate what nutrient means? What do we have in Ethiopia high protein content foods, high vitamin content? I think if these are addressed very well, it would be very nice.

5. How do the prepared manuals will reach to the majority? It would be advisable if leaflets and the likes could be developed and distributed.

6. The gap between MOH, MOA and Rural Development is my concern. Yesterday from one speaker I heard that the Chinese are now in such a position too seriously address the food safety and quality. I don't know, I am not sure, are we in such a position first to fight other aspects and later on come to find quality and safety or should we see proactively just right now? Moreover, the gap I am saying is MOH always sees some aspects of nutrition and health. MOA and Rural Development the production and maximizing of the pro-harvest aspect. We know food and nutrition are big disciplines which deserve serious from the very processing, safety and quality points of view and I would like to emphasize the need for serious concern for this blank pot between the two Ministries, which I am sure it is very much over looked.

QUESTIONS:

1. It would have been very much if the methodology of the study is presented. Because recommendations, and outcomes were presented but what was the methodology? Because it is a professional society where scientific studies are discussed. The science depends on the methodology. So could you enlighten us on the methodology? How were the two inter-phase studies conducted? How sensitive the methodology had been?

2. The manual is very important but I have one concern. How conceptualized is it? After all this is nutrition. If we are going to list the types of foods that are not available in these communities we are talking about, then it becomes a textbook. How carefully conceptualized to the Northern Shoa people, the type of food they can eat and if they are served? The people of Southern Tigray and other parts of the country?

How people can use of it and bring an impact at the end of the day?
Have you checked manuals that were developed by other organizations?

3. From the presentation, I have seen 30% of the women BMI is <18.5%. How

were you working to improve the nutritional status of the community?
In the area where I lived once I went to the market to buy food oil. I saw 4 liters of oil in a tin at the shop, where all of them have written papers saying "Not for sales, free donation by UNICEF". All the shopkeepers are telling that they will sell it with reduced price.

Second, I told my security guard to use mosquito nets because he frequently is attacked by malaria. Mosquito nets are freely supplied by UNICEF but they are being sold. If they are not utilizing them properly they will sell them. Without proper education, we cannot change attitude and behavior. How were you working in this village?

RESPONSES:

1. Breast feeding as a policy is encouraged both by the WHO and by MOH. Breast feeding is sufficient and easily available. Therefore, when it comes into HIV/AIDS cases, the matter is very much complicated. As we all know, the risks of transmission mother to delivery and pregnancy itself and the risk have to be reduced to nil. In the prevailing condition of the country, the state of food security and level of poverty complicate the whole issue again. Whatever the recommendations are, the options will be either exclusive breast-feeding and never mixed feeding to decrease the risk. The food availability, accessibility, feasibility and sustainability are to ensure complete replacement. The issue is not policy, not individual and not household issue. The policy is dependant basically on encouraging breast feeding and to HIV on condition available exclusive beast-feeding and management and/or never mixed feeding. We have consulted the Ministry. The MOH is aware of the development of the manual and we are also focusing on the recommendations and policy issues made by the WHO.

2. The Breast-feeding by PLWHA; so far we are lacking guidance in this area. We do not have any advice at all. Something is being done. The guidelines developed will be implemented through the MOH and some others. I am wondering whether the MOH is involved in the discussion. Because the issue of Breast-feeding is not simple thing. If we advise bottle-feeding and so on, we go into more difficult problems, infection and so on. We are now emphasizing that mothers have to put children on exclusive breast feeding. If we raise the issue of the risk involved particularly in Breast-feeding by PLWHA then the discussion will be more complicated and we might totally discourage mothers from exclusive Breast-feeding. Because it is not easy to find out whether they are free from infection. If you could indicate how we should advise at the moment with regard to Breast-feeding in particular with regard to PLWHA is important.

3. The manual before publication was sent to 40 individuals and institutions for comments. After incorporating the comments, the manual was presented to a workshop where key people and stakeholders had participated.

4. Structured questionnaires were prepared and sent for officials, PLWHA, families and health workers. In addition focus group discussions, documentary review were utilized as methods of getting more information. Assessing the current service providers, on-going attempts in developing guidelines focusing on ART and nutrition relationships, and organize different types of extracts from different sources were used. Culture, believes, etc. were also incorporated during the study.

5. Different organizations have their own definitions on food security, but it is the same throughout.

6. Affordability and accessibility of foods are our concerns. Cheap foods, and culturally accepted foods are presented to them. We made food accessible and available and other care services too. Holistic approaches are very important for HIV/AIDS and ART services.

7. We built latrines, fuel saving stoves, give them chickens/cows and help them on gardening. The foods grown are safe and the gardens are fenced. We select vegetables that are relevant to them such as carrots, potatoes, etc. We also advise them to grow oil seeds rather than buying oil which is expensive and not accessible to purchase.

8. In addition to the manual development, coordination, increasing the capacity, availability and acceptability of foods, good networking, coordination of the community and the working areas are also made. Directory at all levels is available and training health provider by NGOs, private and all health workers were conducted.

PART IV: BUSINESS MEETING

This session was moderated by Dr Damen H/M, President of EPHA. After welcoming and thanking the participants, he put down the agenda for approval and requested if any additional agendas from the house. With the approval of the agenda, the meeting started. The main agendas were

- Annual Activity Report
- Annual Internal Audit Report
- Annual Regional Chapters Reports
- Election
- Amendments of the EPHA constitution

Based on the agreement, the moderator invited Dr Getnet Mitikie, EPHA Executive Secretary, to present the annual activities report of the Association.

4.1. EPHA ANNUAL ACTIVITY REPORT (From October 14/2004-October/2005

Presented By: Dr. Getnet Mitikie, EPHA Executive Secretary

The Ethiopian Public Health Association (EPHA) has carried out several activities in one year, between the 15th Annual Conference in October 2004 and the 16th Annual Conference. The following is only a summary of the most important activities accomplished by EPHA in 2005.

Business Meeting – Annual Activity Report

MAIN ACTIVITIES ACCOMPLISHED

1. ORGANIZATIONAL AND MEMBERSHIP AFFAIRS

1.1 Prepared all report including Minutes of the Ministry of Justice (MOJ)
1.2 Accomplished and published EPHA Strategic Plan (2005-2009)
1.3 EPHA's financial procedure and personnel manuals in process for finalization
1.4 Accomplishment of EPHA membership Database
1.5 Distribution of membership payment receipts for Focal persons of Regional Chapters

1.6. Recruitment and hiring of EPHA Executive Director and Senior Accountant
1.7. Restructuring of EPHA's secretariat based on strategic plan and government requirements – document presented to General Assembly for endorsement.
1.8. Revision of EPHA constitution – Document presented to the General Assembly for endorsement.

2. EPHA-CDC PROJECT

Separately reported, see leaflet, EPHA-CDC Project Addis Ababa, Ethiopia, Sep. 2005

3. PROJECTS

3.1 Agreement on the National HIV/AIDS/STIs Behavioral Surveillance Survey Round 2, MOH/HAPCO
3.2 Agreement on the national Blindness and Low Vision Survey Fund Administration: Orbis, Carter Center, CVM, ITI, Light for the world
3.3 Agreement between the Ethiopian Public Health Association and Principal Investigators and UNICEF for the Assessment of Health Service Extension Program Project.
3.4 Administratively managed Monitoring and Evaluation training- Measure Evaluation for Anglophone countries coordinated and conducted by the Department of Community Health.

4. NATIONAL INVOLVEMENTS

4.1 EPHA is an active member of the National Review Board in HAPCO.
4.2 Chair, Health Professionals Licensing Committee; members of the Health Professionals' Council.
4.3 Committee member of CCM.

5. PUBLICATIONS

5.1 Accomplishment of the draft report of the Evolution of Public Health in Ethiopia, distributed on CD.
5.2 Publishing of the book "Epidemiology and Ecology of Health and Disease in Ethiopia, in printing press.

Produced and distributed the following publications:

- The Ethiopian Journal of Health Development (EJHD),
- FelegeTena Newsletter,
- Proceedings of the 15th EPHA Annual Conference, Abstracts of 2004, Posters and Conference Programme.

6. SEMINARS, CONFERENCES and TRAININGS ATTENDED

Attended over 25 major conferences and training of national and international capacity

6.1 Workshop organized by Consortium of Reproductive Health Association (CORHA) on "Facility Based Training Curriculum", February 24 – 25, 2005 at Desalegne Hotel.
6.2. Workshop organized by CDC-Ethiopia, "Guidelines validation workshop" March 4-5, 2005 in Nazareth, Adama Mekonnen.

6.3. World Federation of Public Health Association (WFPHA) Executive Committee meeting from May 18-22, 2005 in Bonn, Germany.

6.4 CDC-Ethiopia conducted a refresher training entitled "Managing and Monitoring Cooperative Agreements", July 29, 2005, Hilton Hotel.

6.5 CDC-Ethiopia conducted "Financial Management Training" August 1, 2005, Hilton Hotel.

6.6 Workshop organized by Medecins Sans Frontieres "Lessons Learnt" and Challenges faced", September 16, 2005 at Ghion Hotel.

6.7 Workshop organized by VLP "Leadership Forum on Population and Development" 29 September 2005, Ghion Hotel.

6.8 Workshop organized by HIV/AIDS Prevention and Control Office "National HIV/AIDS Monitoring and Evaluation Framework", Hidar 7-10, 1997, CRDA Hall.

6.9 Annual Conference of Ethiopia Nurse Association "Nurse working with the society against HIV/AIDS" and "HIV Care Model: A Multidisciplinary Team Approach" Hidar 17, 1997.

6.10 Tenth Annual Conference of Radiological Society of Ethiopia "Telemedicine Teleradiology" December 4th 2004, Ghion Hotel.

6.11 Semi-Annual grantees and Lucile Packard Foundation, February 8, 2005 at International Livestock Research Institute (ILRI).

6.12 Conference of Ethiopian Society of Orthopedics and Traumatology (ESOT), March 29, 2005, Ghion Hotel.

6.13 World Health Day 2005 conducted by Ministry of Health for the theme 'healthy mothers and children and the slogan chosen is "Make Every Mother and Child Count", April 7, 2005, Federal Ministry of Health Conference Hall.

6.14 Meeting conducted by Regional AIDS Training Network (RATN) "Discussing emerging regional training needs with a specific focus on Behavior Change Communication (BCC), April 18, 2005 at Sheraton Addis.

6.15 Meeting organized by Ministry of Health on Polio, Ginbot 11, 1997, Ghion Hotel.

6.17 Annual Conference of Ethiopian Pediatric Society "Child Survival: A National Challenge" May 23, 2005 at UN Conference Hall.

6.18 Annual General Meeting of Ethiopian Medical Association "Emerging Non-Communicable Diseases in Ethiopia", May 25-27, 2005 at UN Conference Center.

6.19 Annual International Day of Ethiopian Nurse Midwives Association with the theme "Midwifery Pathways to Healthy Nations" June 6, 2005.

6.20 Graduation Ceremony of Victims of Trafficking by International Organization for Migration (IOM), June 21, 2005 at Ministry of Health Conference Hall.

One month training in London, England, EPHA-CDC staff, Ato Berhanu.

6.21 One month training at The Johns Hopkins University, from June 7- July 2, 2005- EPHA-CDC staff, Dr Frehiwot.

6.22 Training on Tuberculosis "Johns Hopkins University" July 26-August 6, 2004, provided support-Dr Kibrebeal Melaku.

6.23 Training on Leadership "Santa Cruz" November 22, - December 10, 2004, provided support.

6.24 CPHA 96th Annual Conference from September 18-23, 2005 at Ottawa, Canada, Dr Abeba Bekele.

7. OTHER ACTIVITIES

7.1. Established a committee and selected the 2005 EPHA Award winners for different categories.

7.2. EPHA'S Annual Internal Audit Report
Ato Teshome Gebre, EPHA, Auditor

General Accounting Policies

- EPHA follows a modified cash basis accounting
- Fixed assets are charged as expenses at the time of purchases against a nominal value of 1.00 Birr.
- Donations in foreign currencies are stated in the accounts in birr at the prevailing exchange rate on the date the bank account of EPHA is credited.

External Audit

- The EPHA book of accounts was inspected by a certified public audit firm known as Aweke Gebre Selassie and Co.
- The external audit covered a period of one year that ended 31st December 2004.

Independent Auditor's Note

- Fixed Assets – Birr 167.00
  - No insurance cover for fixed assets. *It is recommended that all fixed assets must have insurance cover against any and all risks*.
- Cash and Bank – Birr 2,691,222.84
  - No insurance cover for cash in safe and in transit including fidelity risks. *It is recommended that insurance cover be arranged to cover all anticipated risks.*
- Revenue – Birr 3,222,522.08
  - Only 520 individual members and 10 institutions paid their annual membership fee, while 1065 individuals and 5 institutions didn't pay.

  Efforts required to collect more membership fees.
- Expenditures – Birr 2,224,636.30
  - Some items purchased were not received against goods receiving notes. ***Goods receiving notes must be raised to confirm that the items are delivered to the association***.
- Purchase of 400 bags with a sum of Birr 23,200.00 was done without an official and pre-numbered receipt. ***For the validity of the transaction, proper receipts must be collected.***

4.2 EPHA ANNUAL INTERNAL AUDIT REPORT, 2005

General: Per the recommendations given last year, three major steps have been taken by the EPHA management:

- A new senior accountant has been hired
- The Financial Manual has been revised to cope up with recent developments

- Cash receipts have been issued to some regional EPHA chapters

EPHA Balance Sheet as of Sept 30, 2005

ASSET

Fixed Asset	167.00	
Total Fixed Asset		***167.00***
Current Asset		
Petty Cash	4,000.00	
Cash at Bank (C/A)	2,255,150.00	
Cash at Bank (S/A)	1,896,976.52	
Debtors (House Rental)	106,753.35	
TOTAL CURRENT ASSET		***4,262,879.87***
TOTAL ASSET		***4,263,046.87***

CURRENT LIABILITY

Visionary Leadership	145,464.29	
NCPB	889,786.52	
Mekele Univ.	40,180.00	
Mental Health	39,177.67	
Health Professionals	563,937.16	
Payables	14,222.70	
TOTAL CURRENT LIABILITIES		***1,692,768.34***

EPHA Fund Balance	2,125,662.20	
Fund Balance (CDC Proj.)	15,181.01	
Net Income	429,435.32	
Total Fund Balance		**2,570,278.53**

TOTAL LIABILITY AND CAPITAL ***4,263,046.87***

EPHA INCOME STATEMENT AS OF SEPT 30, 2005

Revenue

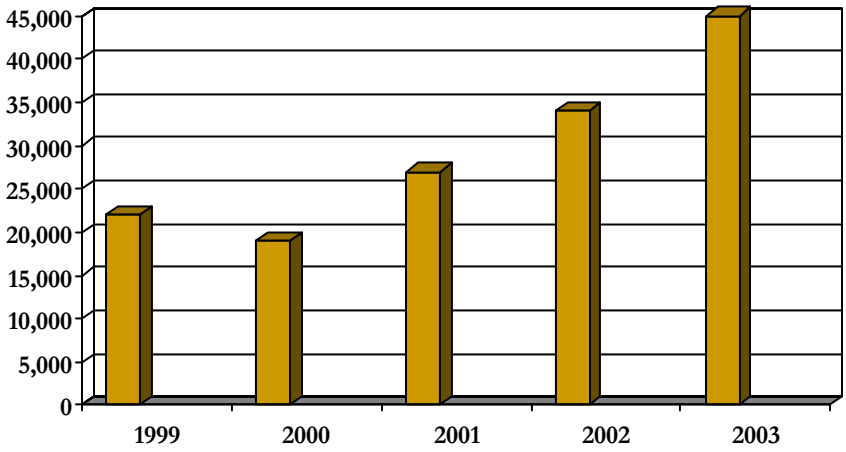
Project Income	3,306,126.79	
Other Income	16,092.82	
Membership Fee	15,612.00	
Total Revenue		**3,337,831.61**
Expenditure		**2,908,396.29**
EXCESS OF INCOME/EXPENDITURE		***429,435.32***

MEMBERSHIP STATUS AS OF SEPT 30, 2005

Description	Members	Membership Fee (Birr)	Total Birr
Registered Members	1700	50.00	85,000.00
Members who paid their dues until Sept. 30/2005	235	50.00	11,750.00
Outstanding balance (Registered members)	1465	50.00	73,250.00
Active Members*	980	50.00	49,000.00
Outstanding balance (active members)	745	50.00	37,250.00

Active members are those who paid their annual membership dues during the last three years at least for one year.

Trend of Membership Fee Payment by Year, 1999 - 2003



- Although membership growth shows and increasing trend, income from membership fee constitutes only about 3% of EPHA revenue.
- Regional chapters could be very instrumental in addressing this issue

EPHA IS GROWING WELL BOTH IN WEALTH AND PROFESSIONAL INFLUENCE!
Every single member has a role to play and a share to contribute!

Thank you for listening!

4.3. EPHA's REGIONAL CHAPTER REPORTS

4.3.1. ANNUAL REPORT OF CHAPTER FOR THE UNIVERSITY OF GONDAR Amsalu Feleke, Focal Person

INTRODUCTION

EPHA is one of the oldest Associations and aiming the achievement of public health in the country at large. It is also the base and advocate of other sister organizations. The different roles played by the Association since its birth is beyond imagination. Participation at national and international forums as an advocate of public health, developing policies and guidelines with the responsible bodies, etc. are some of the main ones.

EPHA after considering the importance and relevance of Ethics in the professionals recently developed and submitted "Public Health Code of Ethics for Ethiopia". At this time I would like to mention that the University of Gondar has adapted this Code of

Ethics as a base for developing ethics in research and other issues. This is what is expected from such magnificent and exemplary Association but still we are expecting more.

The opening of Chapters at the Regions and Universities is one step of developing the Association. By doing this the Association can expand its Mission through out the country.

Before last year EPHA had released some amount of money as petty cash and this year the Association released/distributed receipts for collecting fees. I think these are signs of progress to develop the Chapters. Therefore, EPHA has to find means of developing the Chapters to facilitate its works.

The Chapter at the University of Gondar has four members. The Chapter might have not performed as expected but some of the activities are presented below. This annual report covers from October 15, 2004 – October 25, 2005.

A. ACTIVITIES REPORT

1. By putting different notices we had tried to sensitize and create awareness among the University staff and students.
2. This year we received one voucher/receipt for collecting annual fees and other donations. Using this receipt we have collected annual membership fees both from new and old members.

   - New members = 1 (student)
   - Old members= 16

   I had collected Birr 880.00 (Birr eight hundred eighty) from the above mentioned members and submitted to the EPHA Office.

3. Some information, that were passed from EPHA, had been channeled to the members, such as
   - General Guide for the EPHA Research Award Proposal Development
   - Invitation for the XVIth Annual EPHA Conference
4. I had received invitation to attend a workshop to review a document on different disciplines of HIV/AIDS prevention and control. But I could not attend because of overlap of programs.
5. With the invitation of the EPHA, I have participated in the XVIth annual conference.

B. FINANCIAL REPORT

The remaining money from the previous year was Birr 320.00 (Birr three hundred twenty). Out of this, Birr 260.00 (Birr two hundred sixty) was utilized for stationary and communicating purposes.

- Received in 2004 = Birr 500.00
- Utilized in 2004 = Birr 180.00

- Utilized in 2005 = Birr 260.00

BALANCE:
- Received =500.00
- Utilized =440.00
- Balance =60.00

C. PROBLEMS ENCOUNTERED (minor)

- Some members are complaining of not receiving journals and other documents from the Association.
- Some are requesting to put stamp on the ID after paying their fees.

D. SOLUTIONS

EPHA

a. Has to update the list of members at each Chapter and release for follow up.
b. Needs to find a means of notifying the Chapters at least the list of members for whom the documents are distributed.
c. Has to think of producing stamps and distribute to the Chapters, if possible.

Finally, on behalf of the members of the Chapter, the University of Gondar and myself; I would like to thank EPHA for conducting its XVth Annual Conference at Gondar.

4.3.2. የጅማ ዩኒቨርሲቲ ቻፕተር ሪፖርት

በኘሮፌሰር መኰንን አሰፋ

- የጅማ ዩኒቨርሲቲ ቻፕተር 120 አባላት አሉት።
- በዚህ ዓመት 20 አዲስ አባላት ተመልምለዋል።
- ከኮንፈረንሱ በፊት ከ40 አባላት ዓመታዊ ክፍያ ተሰብስቧል ከአሉ በኋላ በቻርተሩ በኩል አጀንዳ እንዲያዝላቸው ጠይቀው በመፈቀዱ የሚከተሉትን ሁለት አጀንዳዎች ፣
  1. በጤና አጠባበቅ ጉዳዬች ላይ በመንግሥት ተወስኖ ከመገለጹ በፊት በቅድሚያ የማሕበሩ አባላት ብቻ የራሳቸውን አቋም ይዘው መገኘት አለባቸው። ምሳሌ የጤና አጠባበቅ ባለሙያዎች ማሰልጠኛ ካሪክለም ለሕብረተሰቡ የጤና ፍላጐት መልስ (Need Respond) የሚሰጥ አይደለም። ስለዚህ ማሕበሩ በዚህና በሌሎች ተመሳሳይ ሁኔታዎች ላይ አንድ አቋም መያዝ ይኖርበታል ብለን እናስባለን፤

  2. የሕብረተሰብ ጤና አጠባበቅ (Public Health) ከላይ እስከ ታች መኖር ሲገባው አሁን ከሆስፒታል ብሎም ከጤና ጣቢያ እየወጣ በመንደር (Village) ደረጃ ብቻ ይገኛል።
     ስለዚህ የሕብረተሰብ ጤና አጠባበቅ በምን ደረጃ ላይ ይገኛል? የሚለውን ከዚህ ማሕበር አባላት ውጭ ሊያስረዳ የሚችል ስለማይኖር በዚህም አቋም መያዝ ያስፈልጋል የሚሉትን ለውይይት አቅርበዋል።

4.3.3. ANNUAL REPORT OF CHAPTER FOR ALEMAYA UNIVERSITY NEGGA BARAKI, FOCAL PERSON

This is in response to your letter Ref. No. 7943/05 dated 10/10/2005 calling for participation to the EPHA 16th Annual conference and reminding to prepare an annual activity report of the chapter. With great appreciation to your call the following is narrative of the chapter's activities in 2005.

- On receiving the paper (poster) calling for abstracts to the 2005 annual conference, it has been photo-copied and distributed to all the departments in the Faculty of Health Sciences at the Alemaya University and ensured display of it to be seen by all the staff in the Faculty. Moreover, this was also posted in different notice boards in the Faculty campus to be viewed by the Faculty community including students.

- Posters advertising the 16th Annual Conference and its main theme has been distributed and posted in all the departments and notice boards in the Faculty, East Hararghe Zonal Health Department, Harari Regional Health Bureau and all 5 governmental hospitals in Harar city.

- Prepare a notice/reminder in a form of a fly-paper and distributed it to all the academic staff at the Faculty. The fly-paper contains information on how to apply for a membership and the advantages a member will be entitled.

- In the same manner a similar notice was posted for students advertising the benefits in becoming a manner to this professional association.

- Moreover, academic staffs have been contacted for sensitizing individually.

- A profile of all academic staff in the Faculty is being prepared based on interview of each staff to know list of current members, who would like to be members, status of membership payment and their professional category.

- On the bases of the information communicated to the Faculty academic staff, 3 instructors have submitted their research abstracts and are invited to present their papers in this conference.

- Seven graduating Public Health Officer students have filled for membership registration and have paid their fees through the Commercial Bank of Ethiopia, Harar Branch to the Association's account number.

- Distributed reading materials to departments and also availed for reference personal copies of Journal of Health Development for students to help enhance their research (thesis work) capability.

PROBLEMS FACED BY THE CHAPTER

- High staff turnover and difficulty to conduct long-term track.

- Few members, even though most reflect they would like to be, but actually they fail to apply for membership with the standard format.

- Lack of immediate receipt and stamp for members who wish to pay in cash to the chapter focal person (feeling of distrust observed).

- Unstable faculty station/location: still on move to a new location.
  - Lacking of enough offices for academic staff to work in.
  - Lack of space for gathering and discussions.
    The above reasons have created difficulty to meet/catch the staff whenever wanted.

- Difficulty of communication with the main office (postal, telephone, fax) because of the instability in the Faculty's location.

- As a result of the above difficulties the 500.00 Birr mailed for small activities of the chapter is not yet utilized.

FUTURE PLANS

1. Complete all the membership profile of the academic staff in the Faculty.
2. Create links with professionals and professionals in the health service delivery area in close contact with the Faculty (around Harar).
3. Organize a core-group at the Faculty to actively initiate membership activities.
4. Initiate the Faculty to subscribe the EJHD.
5. Continued effort to sensitize for increasing membership.
6. Disseminate information and channel messages to and from the main office as usual.

With regards

4.3.4. ANNUAL REPORT OF CHAPTER FOR AMHARA REGIONAL BUREAU ATO AYENEW MESSELE, DELEGATE

INTRODUCTION

- There are more than 5000 HCW providing public health and clinical services at 15 hospitals,115 health centers, more than 1250health posts, 5 health colleges,7 extension health workers training schools and in > 400 private health facilities
- Many of the HCW are assumed to be inaccessible to scientific journals that help them to update information and to provide evidence based services.
- Regional focal persons (regional chapters) of the EPHA have been assigned since the last 4 years.
- The regional chapters have been provided some support in the coordination of the two EPHA Annual Conferences held at Gondar.

ACTIVITIES

- The 2005 activity annual plan had been developed
- Committee of the regional EPHA chapter had been formed, committee members elected and action plan developed.
- Sensitizations and orientations about EPHA given, during trainings, review meetings and workshops

- Membership formats duplicated and distributed to zones and hospitals
- Notice prepared and viewed on notice boards
- Annual membership fee from existing and new members being collected
- Most send their membership forms to the EPHA head office
- Notice prepared and viewed on notice boards
- Annual membership fee from existing and new members being collected
- Most send their membership forms to the EPHA head office

CHALLENGES

- Frequent turn over of regional chapters and members
- Activities not performed as per the annual plan (poor performance).
  - Worked as additional task
  - Poor attention and coordination
  - Frequent members transfer
  - Other factors (e.g. membership fee collection)
- Directory of EPHA members in the region not known at the regional level as most of the members send their membership forms directly to head office.

WHAT TO DO NEXT?

- Strengthening the regional chapter by full-filling on the missing members
- Will be worked extensively on the remaining time to accomplish the proposed annual plans
- Directory of EPHA members in the region will be prepared and updated regularly
- Strengthening the regional chapter by full-filling on the missing members
- Will be worked extensively on the remaining time to accomplish the proposed annual plans
- Directory of EPHA members in the region will be prepared and updated regularly
- Advocacy on EPHA activities
- Memberships will be increased extensively.
- Accomplish tasks given form EPHA head office
- Advocacy on EPHA activities
- Memberships will be increased extensively.
- Accomplish tasks given form EPHA head office
- Request and involve EPHA members to participate on national and regional public health activities that the Head office of EPHA runs and coordinates.
- Request and involve EPHA members to participate on national and regional public health activities that the Head office of EPHA runs and coordinates.

Thank you

4.3.5. ANNUAL REPORT OF CHAPTER FOR SNNPR

Ato Asrat Woldeyes, Focal Person

ከደቡብ ክልል የአዋሳ ቻፕተር ለአስራ ስድስተኛው የኢትዩጵያ ጤና አጠባበቅ ዓመታዊ ኮንፈረንስ የቀረበ አጭር ዘገባ

ይህ ዘገባ የሚካተተው በ1997 ዓ\ም በአስራ ምስተኛው የኢትዩጵያ ጤና አ/ማህበር ዓመታዊ ጉባኤ ላይ ከቀረበው ሪፖርት ወዲህ የተከናወኑ ተግባራት ላይ ይሆናል፡፡

ክንውን

52 ሰዎችን ለአዲሰ አባልነት መዝግበናል ክፍያ አቋርጠው የነበሩ አራት አባላት አባልነታቸውን ንነዲያድሱ ተደርጓል፡፡ በሆነነ አጋጣሚ የተዋወኩትን የሱማሊያ ክልል ጤና ባለሙያ ስለማህበሩ ዓላማ አስረድቼ የአባልነት ማመልከቻ ቅጽ ሞልቶ ከነመታወቂያው ደብተር 55.00 ብር ከፍሎ መደበኛ አባል ሆኗል፡፡
ይህንን ሪፖርት የሰራሁት መስክ ላይ ሆኜ ስለሆነ የሂሣብ ዝርዝር ሪፖርት ማቅረብ አልቻልኩም ከተላከው ገንዘብ ውሰጥ ባለፈው ዓመት ሪፖርት ሳደርግ የቀረው በ1997 ዓ\ም ተሰርቶበት እንዳለቀ ለማወቅ ይቻላል፡፡

ገንዘቡ ሲውል የነበረው

1. ለጽሕፈት መሳሪያ
2. ለፎቶ ኮፒ
3. ለሐዋላ በየወሩ የተሰበሰበውን ገንዘብ ወደ ማእከል በባንክ ለመክተት
4. ለታክሲና ለጋሪ ወዘተ ነው፡፡

ያጋጠሙ አዲስ ክስተቶች

በምልመላ ወቅት ሴቶች ብዙ ግዜ እንደሚወሰዱ በኋላም ለመግባት መወሰን እንደሚችገሩ አባል መሆን ምን ጥቅም እንዳለው ምን ለአባላት እንደሚሰጥ ጥያቄ ያቀርባሉ፡፡ ከዲኘሎማው ወደ ዲግሪ የተሸጋገሩ ጤና ባለሙያዎችም እንደዚሁ ብዙ ማብራሪያ መጠየቅና ለመወሰን ብዙ ጊዜ እንደሚፈጅባቸው የአባልነት ማመልከቻ ፎርም ከሞሉ በኋላ ገንዘብ ሲጠየቁ አመጣለሁ ብለው ጠፍተዋል፡፡

ያጋጠሙ ችግሮች

1. ቅስቀሳ ቢደረግም ብዙ ሰዎች አባል ለመሆን እንደማይፈልጉ
2. የራስ የሆነ የሥራ ቦታና ስልክ አለመኖር
3. ለቻኘተር አባል የሚሆኑ ሰዎች ማጣት

አስተያየት

1. ለቻኘተር ተጠሪዎች መጠነኛ ወርሃዊ አበል ቢኖር
2. በክልል ደረጃ ለአባላትና ላልሆኑትም ባለሙዎች ከ1- 2 ቀን የዓላማ አንድነትን የሚገልጽ ጉባኤ ቢካሄድ

After the presentations, the moderator requested the house for discussion. The following were comments, questions and responses during the panel discussion.

COMMENTS and QUESTIONS:

1. In relation to Health Extension Workers: Whom are they expected to serve? What would be the curriculum? Who is going to devise the curriculum for them? Is it the higher bodies or other professionals? Is it fair what we are doing?

   Who is living at the village level? We know most of them are mothers and children. So we have to devise the minimum comprehensive (curative and preventive) health services they should get. The people need to air out their needs. The curriculums have to be based on facts and should serve the people.

The professionals that we develop/produce should be skilled enough to answer/give solutions for the main health problems of the community.

Now, even we hear that the health center cadres are delivering only curative aspects and forgetting the public health part. Is public health left only for the village level alone?

What is the main purpose of the establishment of the Association? EPHA is established for the benefit of the Ethiopians and need to discuss how should be the health services in this country. It needs to have its own position after the discussion.

2. The Association has to be proactive, innovative of new ideas and give suggestions for the future. Based on the developed ideas, we need to challenge and influence the policy makers. But our comments/challenges have to be based on researches and experiences of other countries. The issue of health insurance scheme had been raised, so the Association has to take this opportunity, discuss and give important ideas or comments to the government. The Association has to create forums, round table discussions on challenging and urgent issues and come up with constructive ideas on time rather than waiting for the annual conference.

3. EPHA is expected to undertake scientific works and scientific researches. For the purpose of researches it is advisable to have Research Advisory Board. The Association is responsible to control unscientific information that are being disseminated to the public.

4. The ABC strategy is not working for controlling/preventing HIV/AIDS. It didn't work in Uganda, Kenya, and South Africa. So the Association should not sit quietly, it has to control unscientific strategies that are not able to control/prevent such a killing disease.

5. It is a common practice that whenever any workshop is conducted EPHA will be invited and somebody will be delegated to attend. However, the question is how much is the delegate summarizes the issue of discussion and present to the Executive Committee. So the Association has to delegate the right person, the issue has to be discussed by the Executive Committee and an immediate action has to be taken.

6. Recently a document on Essential Health Service Package has been developed and it is under printing. So the Association has to discuss and give comments before implementation.

7. In general, during the business meetings we discuss administrative issues of the Association. But we had no experience of discussing and passing position statements on the points/themes discussed during the panel discussions. To facilitate this a Task Force has to be organized to prepare points for discussions.

Then a General Assembly would discuss and pass the position statement on that particular issue. Based on the outcome, the Association has to disseminate the information to the concerned bodies and the public using the different medias.

8. It would be advisable to create a Council during structuring of the Association. This Council will meet 3 or 4 times during the year, discuss on relevant issues, and present to the General Assembly for discussion and passing position statements. Otherwise it would be very hard to pass position statements with a three hours meeting.

9. We need to discuss on issues how to improve the health status of the Ethiopians and what to introduce as new initiatives for the development of health in this country.

RESPONSES:

1. The Association, after consulting with the chapters, had decided Health Service Extension Program to be one of the major themes of this conference. It is a burning issue and that is why panel discussion was conducted.
   Based on the comments, it is very hard at this moment in time to take position statement on this issue. But what could be done by the Association in the future is probably to organize a symposium and come up with a position statement.
   So far the Association had not simply accepted issues that challenge public health. We had tried to take the necessary actions like organizing symposium and the like.

2. Excellent comments are forwarded by the participants. But does the Association have the capacity to undertake these comments? It is in doubt. The first issue at the moment is to undertake capacity building of the Association, modify/change the structure/organization and the constitutions. Accommodation or entertaining of the above comments can take place after taking action on the above issues. That is why we are more concerned on the organization and structure of the Association. If these are settled, every thing would be easy to implement.

4.4. ELECTION

Dr Damen H/Mariam, president of the Association and moderator of this session, gave some introductory remarks before the election. According to his remarks, the need of the election was to extend/replace four Executive Committee members; Ato Tiruneh Sinshaw competed one term and the rest Dr Damen Hailemariam, Dr Seid and Ato Teshome Gebrie completed two terms.
After releasing the names, some comments and suggestions were made by the members before the nomination.

Comments:

The election need to be from all organizations/institutions so as to get good mix of experts for the Executive Committee.

Question:

- Is it the right procedure to conduct election prior to the approval of the constitution?
- The Executive Secretary had requested to be released from the secretarial work because he was running many projects. The committee delayed his request until this conference. Is it possible to decide on this issue now?

Response

- There is no harm in running the election. Amending the constitution was the mandate that had been given to the Executive Committee a year ago.
- It is inappropriate to reject someone from being elected even though he/she is running a project. Based on this, the Executive Secretary is allowed to complete the remaining one year.

After the response, the moderator requested the General Assembly to forward seven names and to elect four people. Using parliamentary procedure the following names were forwarded:

1. Ato Yohannes Tadesse
2. Dr Mengistu Asnake
3. Ato Kebede Faris
4. Dr Yared Mekonnen
5. Ato Tiruneh Sinshaw
6. Ato Mirgessa Kabba
7. Ato Mequannent Tesfu

The moderator gave short briefing about the above nominees and the election was caste votes on secret ballot.

Proposed candidates and the results of the votes were

1. Ato Yohannes Tadesse = 39
2. Dr Mengistu Asnake = 76
3. Ato Kebede Faris = 61
4 Dr Yared Mekonnen = 67
5. Ato Tiruneh Sinshaw = 43
6. Ato Mirgessa Kabba = 58
7. Ato Mequannent Tesfu = 32

Based on the above results, the following people nominated to replace those who had completed their terms:

1. Dr Mengistu Asnake = 76
2. Dr Yared Mekonnen = 67
3. Ato Kebede Faris = 61
4. Ato Mirgessa Kabba = 58

Before closing this session, some suggestions were forwarded

- We had taken time for the election. The procedure has to be revised. It can be done by raising hands rather than using computer.
- Advisory Council is expected to give advice on regular basis. The involvement of the chapters in such areas would create problems because of the distance.

- The election was fine and democratic. From the experience point of view, the Administrator of the Association is by-passed in most of the cases. By-passing may create problems and may harm the Association. The new selected people have to consider this issue seriously. The new elected people have to give us directives on how to continue our works.

4.5. DISCUSSION ON THE AMENDED CONSTITUTION

The President requested the Assembly to discuss and finalize the amended constitution. The mandate was given to the Executive Committee last year and it was also requested by the Ministry of Justice. Having said this, he requested the Executive Secretary to present the prepared document.

Dr Getnet Mitikie, Executive Secretary, put the following introductory remarks and explanation about the amendment: According to his explanation, the strategic planning focused on two areas: The Secretariat and the Executive Board that is covered through election. Before presenting the amended constitution, he made some comments about the Association.

- Public health problems could not be influenced/solved by conducting annual conference or presenting papers, or working on projects.
- The Association has to be strong enough to challenge policy issues, take active part in trainings, consider and challenge on priority diseases and prepare panel discussions.
- It has to organize and come up with standing positions on some relevant issues of public health.
- When the Association is invited to attend any workshop/seminar/meeting experts have to be selected based on the issues, discuss and attend as advocacy/influencer.
- The Executive Committee has to be exempted from routine works. It has to focus on strategic issues, be proactive, and is a decision-maker.
- The Association has to organize itself and it needs responsible bodies that would take care of EPHA affairs, membership affairs, project controller and follower.
- Advisory board that can create ideas, meet 3 or 4 times in a year and come up with important issues for discussion.
- According to the amendment of the constitution organ of the Association are
    1. The General Assembly: composed of fall members of the Association and shall be the supreme body of the Association.
    2. The Executive Board shall have seven members and composed of the President, Vice President, five other officers, and the Executive Director of the Association may be a Secretary of the Board without having a voting right.
    3. Executive Director and Secretariat, and
    4. Chapters
- The other important body according to the amended constitution is the Advisory Council. This council will provide counseling and policy support to the Association. In addition it will create a mechanism for the expression of concerns and issues at the wider membership of the Association. The council can meet at least twice a year.

- The Executive Director is responsible for the implementation of policies and programs set by the Executive Board. It has to be structured in the organization as a new development. This also requested by the MOJ. This body has to be proactive, follows and finds new projects as income generating schemes, needs to work in collaboration with others, follow up the secretariat, support the officers, and decide on routine issues to the extent of signing cheques.
- The Association shall have a Secretariat to run its day-to-day activities and led by the Executive Director.

After this introductory remark, Dr Getnet Mitkie read the main constitutions that are amended. Accordingly the amended constitution has six articles. The main areas are:

- Article One - General Provisions with 6 sub-articles,
- Article Two - Vision and Mission with 4 sub-articles,
- Article Three - Membership Eligibility with 8 sub-articles,
- Article Four - The General Assembly with 2 sub-articles,
- Article Five - The Advisory Council with 2 sub-articles,
- Article Six - The Executive Board with 2 sub-articles,
- Article Seven - Officers of the Executive Board with 4 sub-articles,
- Article Eight - Executive Director/Secretariat with 2 sub-articles,
- Article Nine - Election and Voting with 6 sub-articles,
- Article Ten - Sources and Management of Funds with 2 sub-articles,
- Article Eleven - Miscellaneous Provisions with 4 sub-article, (The detail is annexed).

Finally the President opened the floor for discussion. Comments made and questions raised during the panel discussion are presented below.

COMMENTS:

- It would be very hard to decide on the strategic planning within a short period of time. It would be better if we delegate one group to look the amendments and respond.
- What is the purpose of the Advisory Council? Increasing the number of committees would be a problem to the Association. Rather it would be better to organize an ad-hoc committee and give the mandate.
- To whom does the advisory council responsible for? It has to be clearly organized/structured.
- The General Assembly, Executive Board, Executive Director, and the Advisory Council need to have clear structure with clearly identified responsibilities.
- Because of shortage of time and other reasons, it is hard to conclude that all members have read the amendments seriously and hard to give comments. It would be important to give more time to read or assign a group to look and give comments.
- The General Assembly has to delegate the Executive Committee with some people to revise, give comments and rectify the amendments. The Association can take action based on the comments and the results can be presented to the General Assembly next year. Structures are dynamic and so based on the result of implementation we can take action if there is a need.

- The question of having legal advisor for EPHA was raised and commented to be involved in revising the amended constitution or invite other experts to check.
- It would be better if some people from the Chapters to be included in the above committee if time and distance are not problems.
- The number of females in the Executive Committee had not been more than one. The General Assembly has to pass a resolution to have 3 females and 4 males in the future.

There was a consensus on the forwarded comments by the Business Meeting, and then decided that they should be put into action. The amendments (revision) of the constitution of the Association and the 2nd Strategic Plan should be seen again, as suggested in the comments, and forwarded to the General Assembly next year (for 2006 G.C.) for final approval.

Before finalizing this session, discussion was carried out on the next conference and the General Assembly unanimously accepted it to be conducted in Harrar.

Finally, the President closed the Business Meeting by thanking all members for the full support and open discussion.

PART V: RESEARCH PAPER PRESENTATIONS

The third day of the conference was devoted for paper presentations. Out of 74 papers 25 were selected for oral and the remaining were poster presentations. The topics for the presentations were HIV/AIDS and TB, Reproductive Health, Health Services and Mental Health, Communicable and Non-communicable diseases, Malaria and other Vector-borne diseases and Child health and Grant writing. The concurrent sessions were conducted in 3 rooms and the posters were openly presented at the corridor of Hilton Addis.

5.1. ORAL PRESENTATION

Room A: HIV/AIDS and TB
Chairperson: Dr. Tadesse Wuhib

1. UPTAKE OF VOLUNTARY COUNSELING AND TESTING (VCT) AND CORRELATES AMONG WOMEN ATTENDING ANTENATAL CARE (ANC): IMPLICAION TO PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) OF HUMAN IMMUNODEFICIENCY VIRUS (HIV), SOUTHWEST ETHIOPIA. Alemayehu Amberbir (BSc Ph), Kebede Deribe (BSc Ph), Wassie Lingerh (MD), Binyam Getachew (BSc Ph), Yismaw Dejene (BSc, PH).

2. ETHIOLGIES OF GENITAL ULCERS DISEASES (GUD) IN ETHIOPIA AND IMPLICATION FOR SYNDROMIC CASE MANAGEMENT. Abera Geyid (MSc, PhD) Asaminew Girma (MD), Tesfaye Kebede, Abebe Shume (MSc), Almaz Abebe (MSc, PhD)

3. UTILIZATION OF VOLUNTARY COUNSLING AND TESTING SERVICES, PERCIEVED BARRIERS AND PERFERENCES OF ADOLESCENTS OF 15 TO 24 YEARS OF AGE IN HARAR TOWN, EASTERN ETHIOPIA. Lemessa Oljira (BSc, MPH)

Room B: HIV/AIDS and TB
Chairperson: Dr. Yared Mekonnen

4. PREVENTION OF MOTHER-TO CHILD TRANSMISSION OF HIV/AIDS: KAP SURVEY IN SELECTED URBAN AREAS**.** Kassahun Deneke

5. ETIOLOGIC PATTERNS OF COMMON STI SYNDROMS IN ETHIOPIA**.** Asaminew Girma, Aberra Geyid, Zewdeneh Mekonen, Tesfaye Kebede, Almaz Abebe, Girum Taye, Woldemariam Girma, Hailu Melesse, Abebe Shumie, Jelaludine Ahmed, Abeba Bekele, Tadesse Wuhib, Hailu Negassa, Mathias Aklilu, Enias Baganizi.

6. VALIDATION OF THE SYNDROMIC ALGORITHM APPROACH FOR THE MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS IN ETHIOPIA. Asaminew Girma, Abera Geyid, Zewdeneh Mekonen, Tesfaye Kebede, Almaz Abebe, Girum Taye, Woldemariam Girma, Hailu Meles, Abebe Shumie, Jelaludine Ahmed, Abebe Bekele, Tadesse Wuhib, Hailu Negassa, Mathias Aklilu, Enias Baganizi.

7. CHARACTERIZATION OF MYCOBACTERIAL ISOLATES FROM LYMPH NODES OF PATIENTS WITH TUBERCULOUS LYPMHADENITIS IN DERRA WOREDA, NORTH SHOWA, ETHIOPIA**.** Berhanu Seyoum, Dawit Asmamaw, Rahel Iwnetu, Lawrence K Yamuah, Yimtubezinash WoldeAmanuel, Abraham Aseffa.

Room A: HIV/AIDS and TB
Chairperson: Dr. Shabbir Ismail

8. ANTIRETROVIRAL TREATMENT ADHERENCE AND ITS CORRELATES AMONG PEOPLE LIVING WITH HIV/AIDS ON HIGHLY ACTIVE ANTIRETROVIRAL THERAPY IN ADDIS ABEBA, ETHIOPIA. Yonas Tadios (MD, MPH Candidate)

9. ASSESSEMENT OF HIV RISK PERCEPTION AND CONDOM USE AMONG YOUTH IN DEBRE BIRHAN TOWN, AMHARA REGION. Zebideru Zewdie (BSc, MPH), Ahimed Ali (PhD)

10. INTESTINAL PARASITISM AND RELATED RISK FACTORS AMONG THE STUDENTS OF SHEBE ELEMENTARY AND JUNIOR SECONDARY SCHOOL, SOUTH WEST ETHIOPIA**.** Shimelis Assefa, Gebru Mulugeta, Andargachew Mulu.

11. AN OVERVIEW OF HIV/AIDS – FOOD SECURITY & NUTRITION INTERFACE, AND RAPID ASSESSMENT OF THE STATE OF NUTRITIONAL CARE AND SUPPORT SERVICE FOR PLWHA**.** Abeba Gobeze, Shewandagne Belete, Teferra Azage.

Room B: Reproductive Health
Chairperson: Dr. Hailu Yeneneh

12. KNOWLEDGE, ATTTUDE & PRACTICE IN FANILY PLANNING IN AMHARA, OROMIA, SNNPR AND TIGRAY**.** Mengistu Asnake, Kassahun Deneke.

13. QUALITY OF FAMILY PLANNING SERVICE; PERSPECTIVE OF HEALTH CARE PROVIDERS IN AWI ZONE, AMHARA NATIONAL REGIONAL STATE, 2004. Yared Abera (MD, MPH)

14. ASSESSMENT OF FACTORS AFFECTING UTILIZATION OF MATERNAL HEALTH CARE SERVICE IN ASSAYITA AND DUBTI TOWNS, AFAR REGIONAL STATE, NORTH EAST ETHIOPIA**.** Melkamu Fenta (BSc, MPH), Fikru Tesfaye (MD, MPH)

Room A: Health Service + Mental Health
Chairperson: Dr. Asfaw Desta

15. EVOLUTION OF PUBLIC HEALTH IN ETHIOPIA. I. GENERAL OVERVIEW. Yayehyirad Kitaw (MD, MPH, CNHD-E), GebreAmanuel Teka (MSc), Hailu Meche (MPH)

16. ETHNOPHARMACOLOGICAL AND PHARMACEUTICAL STUDIES OF MEDICINAL PLANTS IN DABAT DISTRICT, NORTHWESTERN ETHIOPIA. Berhanemeske Weldegerima, Gebremariam, Tsige; Gedif, Teferi.

17. BUILDING FORMULATION FOR SUSTAINABILTY**.** Mary Carnell (Dr.), Yohannes Tadesse, Yemane Berhane (Prof.), Fikru Tesfaye (Dr.), Solomon Worku (Dr.)

18. EXPLORATORY STUDY ON THE CONTEXTS OF DOMESTIC VIOLENCE IN GONDAR TOWN, NORTH WEST ETHIOPIA**.** Tegbar Yigzaw (MD), Nigussie Deyassa (MD) and Mergissa Kaba.

19. GRANT WRITING PRESENTATION OUTLINE. Laurie Ferrell, Dr. Richard Rothenberg, Dr. Carlos del Rio

Room B: Communicable & Non-Communicable Diseases
Chairperson: Dr. Tesfaye Bulto

20. ASSESSMENT OF PREVALENCE OF WORK RELATED INJURIES AMONG SMALL AND MEDIUM SCALE INDUSTRIAL WORKERS IN NORTH GONDAR ZONE, AMHARA REGIONAL STATE**.** Takele Tadesse (BSc, MPH) And Abera Kumie (MD, MSc)

21. HIGH HERITABILITY OF PODOCONIOSIS (NON-FILARIAL ELEPHANTIASIS): PILOT PEDIAGREE STUDY IN SODO, WOLAITTA.

22. PREVALENCE AND CAUSES OF ELEPHANTIASIS IN ARBAMINCH ZURIA WOREDA, ARBAMINCH, ETHIOPIA**.** Frehywot Eshetu (MD), Aschalew Endale (MD), Hanna Tujuba (MD)

Room C: Malaria & Other Vector-borne Diseases + Child Health
Chairperson: Ato Hailu Meche

23. RESPONSES TO MALATRIA AMONG UNDER-FIVE CHILDREN IN RURAL ETHIOPIA**.** Wakgari Deressa (BSc, MPH), Ahmed Ali (PhD).Damen Haile Mariam (PhD), Yemane Berhane (PhD)

24. GENETIC DIVERSITY OF PLASMODIUM FACILPARUM AND PLASMODIUM VIVAX ISOLATES IN DIFFERENT ENDEMIC ZONES OF ETHIOPIA**.** Netsanet Gizaw, Beyene Petros, Howard Engers, Fekade Balcha, Lawrence Yamuah and Abraham Aseffa.

25. UNDER-FIVE MORTALITY IN TIGRAY REGION IN 2003: A COMMUNITY-BASED SURVEY**.** Tedros Adhanom Ghebreyesus, Teklay Kidane (PHD, MD, MPH), Mamaye Tadesse (BSc), Abrham Kasisay (BS Candidate), Bereket Amare (MD, MPH), Abay Hagos (MD, MPH), Mengistie Mesfin (MD, MPH), Karen Hanna Witten (MD, MSPH)

5.2. POSTER PRESENTATIONS

1. Factors affecting the initiation of Antiretroviral Treatment for HIV/AIDS patients in Jimma Town, Southwest Ethiopia. Selomie Mequanent MD, Ayalew Tegegn MD, MCoomH, Yoseph Mamo, MD.
2. Determinants of Condom use and remaining faithful among Gondar College of Medicine and Health Science Students, University of Gondar in North West Ethiopia Modular Approach. Yohannis Fitaw MD, MPH.
3. Role of Dendritic cells in the initiation of immunity to Mycobacterium tuberculosis infection. Adane Mihret, Gezahagne Mamo, Mesfin Tafesse, Asrat hailu, and Shreemanta K. Parida.
4. Drug Susceptibility Patterns of M. tuberculosis Isolates in Addis Ababa. Dawit Asmamaw, Birhanu Seyoum, Hanibal Atsabiha, Dawit W/Meskel, Hamza Addus, Lawerence K. Yamuah, Eyasu Mekonnen, Abrham Assefa.
5. Human Immune responses to Antigens of Mycobacterium tuberculosis relevant to Non-replicating persistent (NRP) TB in an endemic population of Ethiopia. Gezahegne Mamo, Adane Mihret, Girmai Gebru, Mekbebe Afework, Abebech Demissie, Lawerence K. Yamuah, NRP-TB team and Shreemanta K. Parida.
6. Seroepidemic survey of viral STDs in rural Ethiopia: A population-based comparative study on the prevalence of HIV, HSV – 2 and HBV in Gundomeskel and Shebe, Ethiopia. Hannibal Atsbeha, Abrham Aseffa, Alemayehu Worku, Dawit Asmamaw, Rahel Ewnetu, Lawerence K. Yamuah, Yetubzenash W/Amanuel.
7. BCC campaign to reduce stigma and discrimination in Addis Ababa, Ethiopia. Abayneh Biru BA, Aida Girma MD, MPH, Francesca Stuer RN, MSc, Tsige Teferi BSc, MSc, Tamirat Assefa BScN, MPH.

8. Home and Community-Based care scale up in Ethiopia. Worknesh Kereta RN, BSc, Francesa Stuer RN, MSc, Tsige Teferi BSc, MSc, Tamirat Assefa BScN, MPH.
9. Cryptosporidium parvum and Isospora belli infections among diarrhea patients infected with HIV-1 in Addis Ababa, Ethiopia. Tekola Endesaw MSc, PhD, Ayele Zewdie MD, Kebede Tsige MD, Amha Kebed MSc, PhD, Dereje A.S. MD, Ermias Hailu SMLT, Dawit Wolday MD, MSc, PhD, Tsehaynesh Messele MSc, PhD, A.M. Polderman MSc, PhD, Beyene Petros MSc, PhD.
10. Outreach Voluntary Counseling and Testing (VCT) of HIV acceptability and client satisfaction: Experience of Menschen Fur Menschen (MFM) Foundation, Illubabor Zone, South west Ethiopia. Kebede Deribe BSc, PH, Alemayehu Amberbir BSc, PH.
11. Determinant of VCT utilization among youth in Jijiga town, Ethiopia. Zenebu Yimam, ane Yemane Berhane.
12. Factors affecting acceptance of VCT among different professional groups in north and south Gondar administrative zones. Mengesha Admassu RS, MD, MPH, Yohanis Fitaw MD, MPH.
13. Assessment of HIV/AIDS related knowledge among Window of Hope population in Kombolcha town, south Wello zone, Amhara Regional State. Mahteme Haile B.Sc, MPH, Wakgari Deressa B.Sc, MPH, Yemane Berhane MD, PHD.
14. Youth Friendliness of sexual reproductive health SRH and HIV/AIDS services for young people: Study in eight selected regions of Ethiopia. Ambaye Gedfa MA, Yared Mekonnen MSc, PhD, Gugsa Yimer MSc.
15. Association of Entamoeba dispar infection with disease progression among HIV/AIDS patients with complaints of diarrhea from three hospitals in Addis Ababa. Amha Kebede, Tekola Endeshaw, Jaco Verwei, Tshaynesh Messele, Tilahun Woldemichael, Yared Mekonnen, Ton Polderman, Beyene Petros.
16. Aerobic and Facultative bacterial isolates from blood cultures and their antibiotic susceptibility patterns in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia. Alemayehu Negatu BSc, MSc.
17. Improving community participation through community feedback system. Yeshewamebet Ejigsemahu MSc, BSc, Sofnias Nega MHS, BA.
18. External quality assessment of plasma glucose determination in health institution laboratories at different level in Addis Ababa. Samuel Kinde BSc, Tesfaye Bekele MSc, Belete Tegbaru MSc, and Gonfa Ayana MSc.
19. Screening of E. histolytica/E. dispar by direct microscopy and Specific Antigen Detection Assay. Assefa Marsie, Estifanos Kebede BSc, M.Med.SC, Mohammed Adel El Kadi MD, Professor.
20. Significance of Blastocystis homins in patients referred for bacteriological stool culture. Tekola Endeshaw MSc, PhD, Gemechu Tadesse Dip. MLT, Beyene Petros, MSc, DSc.
21. Health service Extension Program (HSEP): Beyond creating demand in Amhara Region, North-west Ethiopia. Amsalu Shiferaw, Solomon Abebe, Tilahun Yemaldu, Tadele Bogale.

22. In vitro assessment of the antibacterial effect of garlic (Allium sativum) on bacterial isolates from wound. Bealy Tessema, Andargachew Mulu.
23. Knowledge, Attitude, and Practice on modern contraception among female beggars of reproductive age groups in Addis Ababa. Tsion Assefa, Ayalew tegegn.
24. Sexual Behavior of married military personnel: Does duty location matter? Wozam Tesfay and Yemane Berhane.
25. Addressing socio-cultural and legal factors to promote women's reproductive health and rights. Bogalech Alemu MSc.
26. KAP of family planning and reproductive health in resettlement sites: East Wollega and West Shewa Zones. Yeshewamebrat Ejigsemahu MSc, BSc, Mengistu Asnake MD, MPH.
27. The effect of community based reproductive health program on knowledge and utilization of family planning and other reproductive health services in east Wollega Zone. Gultineh Kebede, Yeshewamebrat Ejigsemahu, an Yeshewamebrat Ejigsemahud Mengistu Asnake.
28. Maternal Mortality in Tigray region in 2003: A community-based survey. Teklay Kidane MD, MPH, Tedros Adhanom Ghebreyesus PHD, Mamaye Tadesse BSc, Abrham Kahisay BSc candidate, Bereket Amare MD, MPH, Abay Hagos MD, MPH, Mengistie Mesfin MD, MPH, Karen Hanna Witten MD, MSPH.
29. Effectiveness of antenatal care services in identifying and preventing labor related complications in Hadya zone, Southern Ethiopia. Adamu Addissie MD, MPH.
30. Barriers to use contraceptive among adolescents in the city of Addis Ababa. Tsigereda Gadisa MD, MPH.
31. Assessment of level of knowledge of reproductive health and sexual behavior among adolescents in Nekemte town. Gudina Egata BSc.
32. Sexual violence among female students in Jimma town Jiren Senior Secondary and Prepartory School. Rahel Tesfaye, Yohannes Dibaba, Ayalew Tegegn.
33. Assessment of prevalence, determinants and effects of mental distress among Alemaya University students. Alemayehu Galmessa, BSc. MPH, Neguisse Dayessa MD, MPH, Atalay Alem MD, PhD, Minilik Desta MD.
34. Development of appropriate defluoridation technologies for Ethiopian communities. Argaw Ambelu BSc. MSc.
35. The effect of organic waste discharge on diurnal varations of dissolved oxygen (DO): The case of Boye pond, Southwestern Ethiopia. Teferi Abegaz, Worku Legesse, Seid Tiku.
36. Assessment of malaria prevalence and knowledge, attitude and practices towards malaria prevention and control in Gondar town, North Ethiopia. Tesfaye Tilaye B.Sc. MPH, Wakgari Deressa BSc, MPH.
37. Assessment of effectiveness of insecticide treated nets for malaria prevention in under five children in Altawondo woreda, Southern Ethiopia. Eshetu Wassie MD, Ahmed Ali PhD.

38. Expression of NM23, MMP-2, TIMP-2 in breast neoplasm and the relationship in invasion and metastasis. Shen Peihong, Zhang Yunhan, and Gexianghong.
39. Determination of prevalence of intestinal parasites and its predisposing factors. Beker Feto BSc, Ahmed Zeynudin BSc, Mohammed Alqaide BSc, PhD, Professor.
40. Evaluation of antibody response to oncoproteins of human Papillom virus type 16 and 18 as potential seromekers for cervical cancer screening in Ethiopian cervical cancer patients. Liku Bekele, Wude Mihret, Lukman Yusuf, Michael Pawlita, Peter Sehr, Lawerence K. Yamuam, Yohannes Mengistu, Abraham Aseffa.
41. Determinants of dental caries in Ethiopian military personnel. Senait Mantagaftot MSc, Nigussie Deyessa MD, MSc.
42. Hepatitis C virus and Human Immunodeficiency Virus coinfection among attendants of Voluntary Counseling and Testing Center and HIV follow up clinics at Tikur Anbessa Hospital, Addis Ababa, Ethiopia. Gebre Kibru MSc candidate, D.P. Monga Professor, Daniel Fekade MD, MSc, Amare Mengistu MD, MSc.
43. Determination of Iodine excretion to assess Iodine deficiency level and Iodine intake in Primary School Children, Bahir Dar, Northwest Ethiopia. Belay Bezabih, Yihun Assefa,Andargachew Mulu.
44. Epidemiological assessment of the determinants of under five mortality. Belaineh Girma, Yemane Berhane.
45. The prevalence of intestinal helminthic infections and associated risk factors among school children in Babile town, Eastern Ethiopia. Girum Tadesse.
46. Patterns of intestinal helminth infection among children with and without BCG vaccination scar. Desalegne Admassu BSc, and Gebru Mulugeta BSc.
47. Collection and isolation of the common Gram positive bacteria causing upper respiratory tract infection in children. Abayneh Unasho, Aberra Geyid, Abebe Melaku, Asfaw Debela, Amha Mekasha, Samson Girma, Tesfaye Kebede, Surafael Fantaw, Nega Asaminew and Kidanemariam Mamo.
48. Causes of death among under-five children in Jimma town. Belaineh Girma, Yemane Berhane.
49. Strategies to reduce infant and child mortality for Ethiopia: Lessons from other countries. S. Sandhya PhD, Associate Professor.

PART VI: CONTINUING EDUCATION
GRANT WRITING

6.1. BASICS OF GRANT WRITING OR HOW TO SUPPORT YOURSELF IN ACADEMIC JOB

THE PLAYERS

- Funding Agency
- Reviewers
- Proposal Writers

THE PROCESS

- Announcement
- Submission
- Review
- Notification

GENERAL ADVICE

- Search thoroughly to find the **best match** between what you want to do and a funding source. Otherwise all other efforts are wasted. E.g. NIH Guide, CRISP
- Find out everything you can about the **funding source**
  - Number of applications in a typical cycle
  - % of applications funded
  - % of requested budget funded
  - Reviewers' interests and credentials
- Talk to/contact people at the funding agency to **review/clarify details** of the announcement
  Details are important!!
- Talk to previous **successful applicants** to the funding agency
  Review successful proposals
- **Study the announcement** thoroughly and frequently
  Get in the head of the agency
  Understand their mission
- **Review the literature** to identify the gaps and needs in your area
  You must propose good science and/or fill an important need.
- Once you decide to apply, give it **100%** of you effort.
  No one can do it for you
  Be Enthusiastic!!
- Allow at least **twice the time** you think it will take to write the proposal
  Especially time to refine the final version.
- Choose more experienced/senior **collaborators** as co-investigators, if possible
  - Seek mentoring
  - Get help
  - Test your ideas on colleagues

- **Multi-disciplinary and inter-institutional groups** often have a better chance with many funding agencies
  Especially related to Public Health and/or international projects
- Act like a **salesperson**
  Convince the reviewers the proposed work is **very valuable** and you are the **most qualified** to do it.
  You **know more than anyone** about your project. Tell them.
- Write clearly
  - Explain preliminary data
  - **Don't assume** the reviewers know your field
  - **Proofread** and have someone else proofread
  - **NO MISTAKES** are acceptable.
- As much as possible, use the **exact words** from the announcement in your proposals.
  You might use the announcement the initial draft of your proposal.
- Don't give reviewers a **reason to eliminate** your proposal
  Over warded and under paid reviewers have very many other very good proposals to consider in a short time period.
- **Help the reviewers** write their review
  Make their job as easy as possible.
  Feed them the right words
  Take control
- If at all possible, get reactions from **outside reviewers** who will be critical.
  Ask them to be tougher than the reviewers will be.
- Be creative, but honest, about **cost-sharing**
  All agencies like to see their money multiplied by in-kind and other contribution from applicant
- **Keep focused on the end result!**
  Important work requires good funding.

The NIH Intramural/Extramural Program

- *FY **2001** Actual Current Law* **$20,469 mil**
- *FY **2002** Estimate Current Law* **$23,536 mil**
- *FY **2003** President's Budget (prop.)* **$27,244 mil**

80% of NIH money = extramural program

EVERY DOLLAR IS SPENT EACH YEAR AND IS HARD TO GET

Some Sources of Information on NIH Grant Writing
http://www.niaid.nih.gov/ncn/grants/default.htm
http://www.nigms.nih.gov/funding/tips.html
http://www.niddk.nih.gov/fund/grants_process/grantwriting.htm
http://deainfo.nci.nih.gov/EXTRA/EXTDOCS/gntapp.htm
http://www.drugabuse.gov/Funding/Grantapps.html
http://www.nigms.nih.gov/funding/tips.html
http://grants.nih.gov/grants/guide/notice-files/not97-010.html

NIH Grants System

- **RFA** = **R**equest for **A**pplication (one time)
- **PA** = **P**rogram **A**nnouncement (recurring)
- **Cooperative Agreement** (NIH staff has a prominent and on-going role in all aspects of the work throughout the life of the grant.)

Solicited vs. Unsolicited Grants

- Solicited = 25% (in response to RFA or PA)
- Unsolicited =75% (sent in by the applicant but not in response to an RFA or PA)

CRISP

Computer **R**etrieval of **I**nformation on **S**cientific **P**rojects

- database of federally-funded biomedical research
- http://crisp.cit.nih.gov
  - National Institutes of Health (NIH),
  - Substance Abuse and Mental Health Services (SAMHSA),
  - Health Resources and Services Administration (HRSA),
  - Food and Drug Administration (FDA),
  - Centers for Disease Control and Prevention (CDCP),
  - Agency for Health Care Research and Quality (AHRQ),
  - Office of Assistant Secretary of Health (OASH).

USE CRISP TO

- Search for scientific concepts, emerging trends and techniques
- Search for funded grant abstracts
- Find NIH institutes interested in your area
- Find the NIH study section that reviews applications in your research area http://crisp.cit.nih.gov

SOME AGENCIES MAY WANT A LETTER OF INTENT

- Helps the agency to understand the proposed work
- Helps the agency office to find reviewers
- Program Officer may ask questions and give advice

BEFORE WRITING AN APPLICATION

- Test your ideas on colleagues
- Review the literature to find the gaps and needs in the research area
- Understand the mission of the funding agency and their guidelines
- Call the contact person listed in any solicitation or program announcement or request for applications
- Review the review panelists interests and credentials
- NIH.gov --> Institutes and Centers --> CSR --> Study Sections and rosters

WHAT ARE SOME REASONS FOR FAILURE?

- Idea not well-developed
- Didn’t convince the reviewers there was a need

- Didn't convince the reviewers there was background
- Lack of coherent argument in the application
- Lack of basic information on the application (signatures, letters)
- Late application

NIH REVIEW SYSTEM

- Review Panel determines **Scientific Merit**
- There are 20 Initial Review Groups (IRG) of the Center for Scientific Review (CSR) at the NIH
- Institute: **Funding**
- What do the reviewers want to determine?
  - SCIENTIFIC CREDIBILITY
- What does the IC want to determine?
  - WILL THE WORK HAVE IMPACT AND BE SUCCESSFUL IF FUNDED
- Who reviews?
  - Center for Scientific Review
  - Institutes' own review panels
  - Special Emphasis Panel

How Does the Application Flow Through the System?

- Comes into CSR
  > 65,000 applications per year
  > 500,000,000 pieces of paper

Center for Scientific Review (continued)

- Initial Review Group (IRG) assignment
- Assignment to an Institute or Center (IC)

PANEL MAKE-UP

- Scientific Review Administrator (SRA)
- Chairperson
- Panel Members
- First, second and third reviewers

SENDING IN THE APLICATION

- Write a cover letter: helps determine where the unsolicited application goes
  – Briefly explain the hypothesis and the aims
  – Any special expertise needed?

APPLICATION FORM 398

http://grants.nih.gov/grants/funding/phs398/phs398.html

LET'S TALK ABOUT SPECIFIC CONCERNS

- Face sheet (animal/human subjects?; RFA/PA?)
- Abstract (capture essence of proposal and clear to the non-assigned study section members?)
- Components (guidelines followed?)
- Biosketch (expertise required for aims shown?)
- Preliminary data (strong, convincing data?)
- Specific Aims (independent but related?; overambitious?)

WHAT ARE THE PARTS OF AN NHI APLLICATION?

- Face Page
- Abstract
  - Budgets
  - Biographical sketches
    - Preliminary data
    - Specific aims
    - Scientific presentation of methods and expected work

TYPES OF APPLICATIONS: 1-3

New Application

A request for financial assistance for a project or activity that is not currently receiving NIH support and must compete for support

Competing Continuation

A request for funding review, a project that would otherwise expire.

Completing Supplemental

A request for an increase in support in a current budget period for expansion of the project's approved scope or research protocol.

TYPES OF APPLICATION: 4,5

Revised (Amended)

An unfunded application that the applicant has modified following initial review and resubmitted for consideration.

Noncompeting Continuation

A request for funding for the second or subsequent budget period within an approved project period.

- ➔ **Program Announcement (PA):** announces increased priority and/or emphasizes particular funding mechanisms for a specific area of science; applications accepted on standard receipt dates on an on-going basis. (A PAR is a PA for which special referral guidelines apply, described in the PAR.)
- ➔ **Request for Applications (RFA):** identifies a more narrowly defined area for which one or more NIH institutes have set aside funds for awarding grants; one receipt date, specified in RFA.
- ➔ **Request for Proposals (RFP):** solicits proposals for a contract; one receipt date, specified in RFP.

REQUESTS FOR APPLICATIONS

- Stand-alone solicitations
- Provides information to allow prospective applicants to determine whether or not to apply
  - amount of funding available
  - number of awards anticipated
  - deadline date for receipt of applications
  - information describing the nature of the effort desired
  - obligations of recipients
  - date for receipt of applications

TYPES OF AWARDS:

Research Project

The **R** series of grants. They support individual research projects under the direction of a single PI.

Program Project and Centers

The **P** series. Support organized efforts of collaborating groups of investigators who conduct integrated research projects.

Training Programs

The **T** series. Provide funds for research training programs, primarily at the graduate and postdoctoral levels.

Fellowship

The **F** series. Support the training of individual awardees at the pre and post-doctoral levels

Research Career Program Awards

The K series. Support the development of outstanding scientists.

BEFORE YOU BEGIN

Before you begin writing your grant application, read the PHS 398 instructions carefully and become familiar with all the requirements and certifications necessary.

APPLICATION SUBMISSION

Applicant Must:

- ➔ Be an eligible entity
- ➔ Submit a complete and compliant application
- ➔ Meet established deadline dates with copies

GENERAL INSTRUCTIONS

- Prepare the application single-sided and single-spaced.
  - (A) The height of the letters, type density, and number of lines in a vertical inch are ALL specified.
  - (B) Try to use 12 fonts with paragraph spacing to make the page appealing and well organized
  - (C) English language only

PAGE LIMITATIONS

Observe the page number limitations or the application will be returned without review (or will be truncated at 25 pages without distribution of those >25)

- ➢ Introduction: Revised applications----------3 pages
  - ➢ Supplemental applications------1 page
  - ➢ New applications----------None
- ➢ Research Plan: Sections a-d----------25 pages
- ➢ Biographical Sketches: Per Person----------2 pages

REVIEW PROCESS

- The review and selection process for applications takes 8 to 10 months (< 6 months for AIDS-related)
- Submit your very best application because reviewers expect you to have taken the time needed to think it through before submitting. You are the world's expert……

OBJECTIVE EXPERTS

- Have objective experts (e.g., successful grantees, members of key institutional panels) review your proposal.
- Friends or close collaborators are rarely as critical as the reviewers on an NIH study section.

CAREER DEVELOPMENT APPLICANTS

- **Letters of reference and institutional commitment** are critical, including specific wording or phrasing
  - The institutional commitment letter, in particular, should clearly state that the applicant has independent lab space and adequate equipment
  - Any other tangible expression of institutional commitment that might exist (start-up funds, support for a technician, etc.) should be mentioned for these "K" series awards

ABSTRACT

- Describe **succinctly** every major aspect of the proposed project except the budget.
  - It is used in the grant referral process to determine what study section is appropriate to review the application and to what institute at NIH it should be assigned
  - It goes into the CRISP data base if awarded

THE ABSTRACT SHOULD INCLUDE

1. a brief background of the project
2. specific aims or hypotheses
3. the unique features of the project
4. the methodology (action steps) to be used
5. expected results
6. evaluation methods
7. description of how your results will effect other research areas
8. the significance of the proposed research

ALL IN ONE-TWO PARAGRAPHS!!!!!

SPECIFIC INSTRUCTIONS
Follow the instructions!

SPECIFIC INSTRUCTIONS: RESEARCH PLAN

- The Research Plan should include the information needed for evaluation of the project, independent of any other document incl. the appendices
- Be specific and informative; avoid redundancies.

Organize Items a-d, to answer these questions:

(1) What do you intend to do? (a.)
(2) Why is the work important? (b.)
(3) What has already been done? (c.)
(4) How are you going to do the work? (d.)

- The research plan should answer these questions:

- What do you intend to do?
- Why is this worth doing? How is it innovative?
- What has already been done in general, and what have other researchers done in this field (use appropriate references)? What will this new work add to the field of knowledge?
- What have you (and your collaborators) done to establish the feasibility of what you are proposing to do?
- How will the research be accomplished? Who? What? When? Where? Why?

Do not exceed 25 pages for Items a-d. The PHS recommends the following format and page distribution. All tables, graphs, figures, diagrams, and charts must be included within the 25 page limit. The 25 page limit will be strictly enforced. Applications that exceed this limit or do not conform to the type size limitations will be returned without review or truncated!

RESEARCH PLAN SUGGESTIONS

1. Make sure that all sections (A, B, C, and D--the ***what***, ***why***, and ***how*** of the proposal) are internally consistent (i.e., they dovetail with each other). Use a numbering system to make sections easy to find. Lead the reviewers through your research plan. One person should revise and edit the final draft.
2. Using the recent literature, explain how the proposed research will further what is known.
3. Emphasize how some combination of a novel hypothesis, important preliminary data, a new experimental system and/or a new experimental approach will enable important progress to be made.
4. Establish credibility of the proposed principal investigator and the collaborating researchers.

SPECIFIC INSTRUCTIONS

Format & Page Distribution

The PHS recommends the following format and page distribution:

a. **Specific Aims**: List the broad, long-term objectives and what the specific research proposed in this application is intended to accomplish. State the hypotheses to be tested. One page recommended.

RESEARCH PLAN PART A

SPECIFIC AIMS

- Purpose: The purpose of the specific aims is to describe concisely and realistically what the proposed research is intended to accomplish.
- Content: The specific aims should cover:
  - broad, long-term goals;
  - the hypothesis or hypotheses to be tested, and
  - specific time-phased research objectives.

- Suggestions:
  - Generally, the Specific Aims section should begin with a brief narrative describing the long-term goals of the project and the hypothesis guiding the research. This is followed by a numbered list of the Aims.
  - State the hypothesis clearly. Make sure it is understandable, testable and adequately supported by citations in the Background and by data in the Preliminary Results Sections. Be sure to explain how the results to be obtained will be used to test the hypothesis.
  - Show that the objectives are attainable within the stated time frame.
  - *Be as brief and specific as possible*. For clarity. each aim should consist of only one sentence. Use a brief paragraph under each aim if detail is needed. Most successful applications have 2-4 specific aims.
  - Don't bite off more than you can chew. A small, focused project is generally better received than a diffuse, multifaceted project.
  - Be certain that all aims are related. Have someone read them for clarity and cohesiveness.
  - Focus on aims where you have good supporting preliminary data and scientific expertise.

SPECIFIC INSTRUCTIONS

Format and Page Distribution

The PHS recommends the following format and page distribution:

Background and Significance: Briefly sketch the background leading to the present application, critically evaluate existing knowledge, and specifically identify the gaps which the project is intended to fill. State concisely the importance and health relevance of the research described in this application by relating the specific aims to the broad, long-term objectives. **2-3 pages recommended**.

RESEARCH PLAN PART B

BACKGROUND AND SIGNIFICANCE

- Purpose: The purpose of the background and significance section is to state the problem to be investigated, the rationale for the proposed research, the current state of knowledge relevant to the proposal and the potential contribution of this research to the problem(s) addressed.
- A fancy term paper of publishable review caliber
- Content: The background and significance section should cover:
  - the rationale for the proposed project;
  - the state of existing knowledge, including literature citations and highlights of relevant data;
  - gaps that the project is intended to fill

- Suggestions
  - Make a compelling case for your proposed research project. Why is the topic important? Why are the specific research questions important? How are the researchers qualified to address these?
  - Establish familiarity with recent research findings. Avoid outdated research. Use citations not only as support for specific statements but also to establish

familiarity with all of the relevant publications and points of view. Make sure the citations are specifically related to the proposed research. Cite and paraphrase correctly and constructively.
- Highlight why research findings are important beyond the confines of a specific project i.e., how can the results be applied to further research in this field or related areas.
- Stress any innovations in-,experimental methods (e.g., new strategies,-research methods used, interventions proposed).

SPECIFIC INSTRUCTIONS
Format & Page Distribution
Format and Page Distribution
The PHS recommends the following format and page distribution:
Preliminary Studies/Progress Report: For new applications, use this section to provide an account of the principal investigator/program director's preliminary studies pertinent to the application information that will help to establish the experience and competence of the investigator to pursue the proposed project. **6-8 pages recommended.**

RESEARCH PLAN C
- **Content:**
  - a description of recent studies by the applicant investigators that establish the feasibility and importance of the proposed project;
  - a description of older published studies by the applicant that provide background information relevant to the proposed project;
  - results of previous studies by the applicant not directly relevant to the proposed project if they are needed to establish the applicant's competence and experience with the experimental techniques to be used.
- **Suggestions**
  - All Tables and Figures necessary for the presentation of preliminary results must be included in this section of application.
  - Full-size glossy photographs of materials may be included in the appendix, but only if a photocopy (reduced in size, as appropriate) is included in the Research Plan.
  - Figures and Figure legends must be legible. Follow font size rules, but the critical factor is whether the data are legible and convincing to the reviewers.
  - Do not dwell on results already published. Summarize the critical findings in the text and include reprints of the full article in the appendix. Up to 10 publications can be included with the appendix material of an R01.

SPECIFIC INSTRUCTIONS
Format & Page Distribution
Format and Page Distribution
The PHS recommends the following format and page distribution:
D. Research Design and Methods:
- Describe the research design and the procedures to be used to accomplish the specific aims of the project. Include how the data will be collected, analyzed, and

interpreted. Describe any new methodology and its advantage over existing methodologies. …….

- Discuss the potential difficulties and limitations of the proposed procedures and alternative approaches to achieve the aims. As part of this section, provide a tentative sequence or timetable for the project. Point out any procedures, situations, or materials that may be hazardous to personnel and the precautions to be exercised. **20 pages maximum.**

Research Plan Part D

RESEARCH DESIGN AND METHODS - I

- **CONTENT**
  - an overview of the experimental design
  - a detailed description of specific methods to be employed to accomplish the specific aims
  - a detailed discussion of the way in which the results will be collected, analyzed, and interpreted
  - a projected sequence or timetable (work plan)

RESEARCH DESIGN AND METHODS - II

- a description of any new methodology used and why it represents an improvement over the existing ones;
- a discussion of potential difficulties and limitations and how these will be overcome or mitigated;
- expected results, and alternative approaches that will be used if unexpected results are found;
- precautions to be exercised with respect to any procedures, situations, or materials that may be hazardous to personnel or human subjects.

- **Suggestions - I**
  - Number the sections in this part of the application to correspond to the numbers of the Specific Aims.
  - Give sufficient detail. Do not assume that the reviewers will know how you intend to proceed.
  - Avoid excessive experimental detail by referring to publications that describe the methods to be employed with key methods citations.
  - If relevant, explain why one approach or method will be used in preference to others. This establishes that the alternatives were not simply overlooked. Give not only the "how" but the "why."

- **Suggestions - II**
  - If employing a complex technology for the first time, take extra care to demonstrate familiarity with the experimental details and potential pitfalls. Add a co-investigator or consultant experienced with the technology, if necessary.
  - Document proposed collaborations and offers of materials or reagents of restricted availability with letters from the individuals involved.

APPENDIX

For new, revised, and competing applications, the following materials may be included in the appendix:

1. Up to 10 publications, manuscripts (submitted or accepted for publication), abstracts, patents, or other printed materials directly relevant to this project. These may be stapled as sets.
2. Surveys, questionnaires, data collection instruments, and clinical protocols. These may be stapled as sets.
3. Original glossy photographs or color images of gels, micrographs, etc., provided that a photocopy (may be reduced in size) is also included within the 25 page limit of items a-d of the research plan. No photographs or color images may be included in the appendixes that are not also represented within the Research Plan.

BUDGET AND JUSTIFICATION - I

- Purpose: The purpose of the budget and justification is to present and justify all expenses required to achieve project aims and objectives. For multi-institutional applications, there must be a separate budget for each subcontractor or consortium member.
- Recommended Length: Special forms are provided for the budget and justification. Read the instructions carefully. If there is a co-investigator at another institution, for whom funds are requested, be sure to include their budget.

BUDGET AND JUSTIFICATION II

Content: The budget and justification should cover the following:

- personnel;
- consultants;
- equipment;
- supplies;
- travel; and
- other **expenses**, e.g., patient costs, incentives, animal maintenance.

BUDGET AND JUSTIFICATION III

Suggestions:

- Be realistic. Both "padding" and deliberate under-budgeting reflect naïveté, that will be recognized by reviewers.
- Provide brief descriptions of duties for all positions listed in the budget, with the percentage of effort requested each year and any anticipated fluctuations. Special skills or accomplishments of a designated person may be included.
- If possible, try to identify specific individuals for each position requested. "To be named" personnel are very often deleted by reviewers.

BUDGET AND JUSTIFICATION IV

- Justify all equipment purchases. The proposed acquisition of major pieces of equipment is likely to be scrutinized very carefully. Details are important, especially for non-project specific equipment e.g., FAX machine and computers.

- Break out supply costs into major categories (reagents, disposables, etc.). Provide special justification for any unusual expenses requested.
- Detail and justify travel costs. Make sure they reflect current fares and lodging costs and that proposed travel is project related.

BUDGET AND JUSTIFICATION V

- Explain any year-to-year fluctuations in the budget, including the level of effort of personnel, especially if they can not be attributed to routine salary increases.
- Check indirect costs. Many institutions have on-campus and off-campus rates.
- Be complete but concise. There are no page limits in this section so more detail on the talents of investigators may be presented.
- Provide adequate justification for the need to use outside consultants, if applicable.

BUDGET AND JUSTIFICATION VI

- The budget must be approved by the grantee institution business office by signing the application front sheet.
- Prorate service contracts to percentage of time equipment is used for this project.

ASSURANCES I

- Purpose: The purpose of the assurances section is to ensure that the applicant organization will comply with all relevant Federal laws and guidelines.
- Recommended Length: A special form must be completed for the assurances section. See page B of the PHS 398 application.

ASSURANCES II

Content:

- human subjects
- vertebrate animals
- inventions and patents
- debarment and suspension
- drug-free workplace
- lobbying
- delinquent Federal debt
- misconduct in science;
- civil rights
- handicapped individuals
- sex discrimination
- age discrimination

ASSURANCES III

Suggestions

- Be familiar with assurances, certifications and requirements for complying with these regulations.
- Begin to obtain assurances early, since they tend to require the cooperation of different institutions.

- Check your institution's grants management office for additional requirements. Different institutions follow different procedures and timelines.

HUMAN SUBJECTS I

- **Purpose:** The purpose of this section describing the involvement of human subjects is to ensure the protection of the rights and welfare of people who participate in research projects.
- Recommended Length: There is no specified length, but be succinct.

HUMAN SUBJECT II

Content: Provide a complete description of the proposed involvement of human subjects as it relates to the work outlined in the Research Plan section. If an exemption has been designated in item 4a on the face page, enough detail still must be provided to allow the determination of the appropriateness of the exemption. If no exemption is claimed, there are six points which must be addressed in this section. A full description of these points can be found on page 22 of the PHS 398 application package.

HUMAN SUBJECT III

All research applications involving human subjects must address the issue of inclusion of women, minorities, and children in the subject population. A justification is required if there is limited representation of these 3 populations. Peer review and NIH program staff will consider this justification in their evaluation of your application. Failure to address this issue will impose a bar, making any award until all the concerns raised by the IRG have been resolved.

HUMAN SUBJECT IV

- The assurance of compliance number from the NIH Office of Protection from Research Risks (OPRR) must be provided in item 4b of the face page, as must the IRB approval date.
- Most institutions have a multiple project assurance from OPRR. If your institution does not, contact OPRR as soon as possible to obtain a single project assurance.

HUMAN SUBJECT V

- All research involving human subjects requires a current review by your Institutional Review Board (IRB). Be sure to provide the most recent review date for your project.
- You must provide information on the inclusion of women and minorities in the study population.

GRANT FORMS ON-LINE

- In PDF for Adobe Acrobat
  - http://main.uab.edu/show.asp?durki=30279
- In Word, Excel, Word Perfect, incl. Budget pages
  - http://research.bcm.tmc.edu/Proposal-Prep/proposal-prep.html

PEER REVIEW
All research and development projects funded by NIH are legislatively required (42 USC 289) to undergo peer review.

SCIENTIFIC REVIEW GROUPS
Applications for grants and cooperative agreements are initially evaluated by Scientific Review Groups made up primarily of scientists actively engaged in research. SRG's that review grant and cooperative agreement applications are termed Initial Review Groups. SRG's that review contract proposals are termed Technical Evaluation Groups.

Initial Review Groups (IRG's)
Evaluate each application against a set of specific criteria and assigns a numeric priority score.

Review Criteria (SAIIE)
- Significance
- Approach
- Innovation
- Investigator
- Environment

Priority Score: like cholesterol…the lower the better
1.0 – 1.5: Outstanding
1.5 – 2.0: Excellent
2.0 – 2.5: Very good
2.5 – 3.5: Good
3.5 – 5.0: Acceptable

SUPPLEMENTATION INFORMATION
- Appendices
- Bibliographies
- Do not have to be read:
  - therefore all information that MUST be read needs to be in the body of the application

LETTERS
- Reference
- Collaboration
- Support (institution)

NIH Review Criteria
-- Significance
-- Approach
-- Innovation
-- Investigator
-- Environment

SIGNIFICANCE

- What is the importance of the work?
  Why should they give you money?
- What is the relevance?
  If you are successful, so what?
- What is the rationale?
  Why this work at this time?
- What is the usefulness?
  How will this work fit into future work?

PROBLEMS WITH SIGNIFICANCE

- Not significant, not exciting, not new
- Lack of compelling rationale
- Incremental and low impact research
- Lack of biomedical relevance

PROBLEMS

- Too ambitious, too much work proposed
- Unfocused aims, unclear goals
- Limited aims and uncertain future directions

APPROACH

- Is there a hypothesis?
- Is it too ambitious? Be realistic!
- Is it focused?
- Is it clear?
- Are there alternative approaches?
- Can the reader understand it?
- Are the statistical analyses appropriate?
- Detail needs to be right
- Need clear and complete preliminary data
- How does this build on the preliminary data?
- Are there alternatives?
- Are the pitfalls addressed?
- What will you do if the first part fails? Does everything else depend on it?
- What will you do if it all succeeds?
- Are you challenging what is already known?

PROBLEMS WITH APPROACH

- Too much unnecessary experimental detail
- Not enough detail on approaches, especially untested ones
- Not enough preliminary data to establish feasibility
- Feasibility of each aim not shown
- Little or no expertise with approach
- Lack of appropriate controls
- Not directly testing hypothesis

- Correlative or descriptive data
- Experiments not directed towards mechanisms
- No discussion of alternative models or hypotheses
- No discussion of potential pitfalls
- No discussion of interpretation of data

INVESTIGATORS

- Is the investigator trained and able?
- Investigator background and expertise, as indicated in publications
- Collaborators and whose project is it anyway?
- Letters from collaborators and consultants?

PROBLEMS WITH INVESTIGATOR

- No demonstration of expertise (publications)
- Low productivity, few recent papers
- No collaborators or no letters from collaborators

ENVIRONMENT

- **Institutional support: show the institution is behind you:**
  - Laboratory space
  - Personnel
  - Start up funds, if relevant
- **Basis on which to build the work:**
  - Adequate equipment and resources
  - Access to qualified personnel

PROBLEMS WITH THE ENVIRONMENT

- Little demonstration of institutional support
- Little or no start up package or necessary equipment

HUMAN SUBJECT CONCERNS

- Belmont Report (http://ohsr.od.nih.gov/mpa/belmont.php3)
- Helsinki Report (http://www.wma.net/e/policy/17-c_e.html)
- US Policy (Common Rule) 45CFR46

  http://pw1.netcom.com/~alalli/BillSite_Documents/CommonRule.html#Subpart%20A
- http://ohrp.osophs.dhhs.gov/index.html
- Federal Wide Assurance (FWA)
- The Federal Policy (Common Rule) for the protection of human subjects at Section 103(a) requires that each institution "engaged" in Federally-supported human subject research file an "Assurance" of protection for human subjects. The Assurance formalizes the institution's commitment to protect human subjects. The requirement to file an Assurance includes both "awardees" and collaborating "performance site" institutions.
- Institutional Review Board (IRB)
- Independent Ethics Committee (IEC)

What good is the Review to you if you do not get funded?

- Most do not get funded the first time: most get funded at some time
- Critique on your work
- Basis of a revision and resubmission
- Technical suggestions may be made
- RESUBMIT

6.2. Building Capacity for Global Health

Better Skills, Stronger Health Programs, Sustainable Results

Skilled human resource and financial management capacity is the backbone of accessible, high quality, sustainable health care. To meet the challenges created by the **HIV/AIDS** pandemic and its impact on the health care systems around the world, WHO, CDC and the presidential Emergency Plan for AIDS Relief (PEPFAR) urge health professionals to look for innovative approaches to training in order to retain qualified health personnel and exhibit financial accountability of their programs. BCGH was created to address the pressing need for management training of health care professionals working in national, regional and community level health programs in Africa.

Services provided:

BCGH Inc. provides **training and technical assistance** to healthcare professionals involved in the management of health care programs. Workshops are tailored to the specific needs of participants and their organizations. Detailed curriculums are designed upon needs assessment and the actual needs of our clients. Follow up trainings and continuous technical assistance are available as well.

Strengths:

The staff has over 30 years of experience in academia and international field work with focus in Anglophone and Francophone Africa. BCGH combines a unique mix of strong academic, medical and administrative backgrounds with practical knowledge of financial and human resource management plus understanding of the culture and work practices in different countries will provide the participants with specific practical skills and tools that help them design implement and manage successful health programs.

In-country Training Programs:

In-country Customized Workshops

- Strategic Planning – organizational and programmatic
- Program Management – needs assessment, program design, human/financial resource management, monitoring and evaluation
- Communication and Coordination, Conflict Management and Negotiation Skills
- Program Costing – defining financial needs
- Grant writing
- Grant administration – financial and compliance
- Financial Monitoring Systems – financial sustainability

Upon Completion of training participants will be able to:

- Conduct strategic planning for their organization/program
- Develop specific practical tools and steps that will enable them to effectively evaluate the human resources and financial resources that they have available

- Determine winning strategies for effective HIV/AIDS programs
- Know ways to make communication more effective
- Identification of discrepancies between existing human resource and financial management capabilities and the goals and objectives of the current programs
- Write successful proposals
- Manage the financial and compliance requirements of donors
- Identify indicators and set up detailed monitoring and evaluation plans

Yolanta S. Melamed, MD, MPH **Laurie A. Ferrell, MPH, BBA**

6.3. Financial Sustainability for Development Programmes:
Analyzing Costs and Preparing Grant Budgets
Presented to CRDA
By Laurie A. Ferrell, MPH, BBA, *trlaf@sph.emory.edu*

SUMMARY OF TODAY'S DISCUSSION

- CHALLENGES – for financial managers
- COSTS – measuring, using cost data
- BUDGETS – inputs, cost sharing
- GRANT PROPOSALS – budgets, budget justifications
- SUSTAINABILITY – maintaining the funding flow

Achieving Financial Health of Public Health Programs

- Knowing the cost/value of your programs is important to the program's survival
- Budgeting/monitoring costs and being accountable to your funding sources leads to future funding
- Having a financial strategic plan leads to program sustainability

Challenges for Program Managers

- Market, donor and political forces
- Limited resources – financial/human
- Cost control and reduction
- Which services to invest in order to best serve the community
- Marketability of services offered
- Health **workers becoming managers**

WHY STUDY COST ACCOUNTING?

- Need to know program costs
- Determine pricing/funding needs
- Provide insight into program activities
- Identify efficiencies/waste
- Setting priorities
- Strategic planning at the clinic, community, district or national level

HOW IS COST ACCOUNTING USED?

- Planning
  - Long and short term tools for financial & operational forecasting and budgeting
- Organizing and Implementing
  - Quantifying resources required to implement programs
- Control
  - Provides comparative measurements
- Leading and Communicating
  - Transparency and accountability

Questions Cost Accounting Can Help Answer

- How many patients can I treat with existing funding?
- Where can I cut costs that will affect the minimum number of patients?
- What is the optimum price to charge?
- What is the optimum mix of services?
- How can I keep the program/services sustainable?

WHY MEASURE COSTS?

- Define needs for fund raising efforts
- Economic evaluation to demonstrate cost effectiveness/cost benefits
- Variable in decision making when developing community/district/national health programs

WHY MONITOR COSTS?

- Managing limited resources
- Transparency/reporting
- Planning and budgeting
- Donor request or demand

INTERPRETING/USING COST INFORMATION

- Analyze Cost Data
  - Program cost by line item over time
  - Allocation of expenditures by service/activity/site ($$)
  - Percentage allocation of costs by service/activity/site
  - Comparison of cost-per-patient by service or clinic

INTERPRETING COST INFORMATION

- Interpreting Cost Data
  - Which line item/activity is most expensive? Why?
  - Which line item/activity is least expensive? Why?
  - Explain the variances between time periods, activities, sites, etc.
  - Anticipate changes in costs, health issues, population changes

THE BUDGET

WHAT IS A BUDGET?

- Financial and quantitative detail of the resources necessary for the successful conduct of the proposed research or activity
- Itemized presentation of the costs by major category and time period

- Realistic reflection of the research/program/activity goals

FACTORS THAT EFFECT THE BUDGET

- Number of patients//participants/sample size
- Allocation of staff – the "right mix"
- Availability of supplies
- Availability of space
- Location of service – rural vs. urban
- Tradeoffs between cost/quality/ effectiveness
- How does quality fit into the equation
- Macroeconomic variables – inflation, currency fluctuations, import/export issues

TYPES OF COSTS

- Fixed vs. Variable – space rent vs. materials
- Capital vs. Recurrent – vehicle vs. fuel
- Direct vs. Indirect – salary of instructors versus program administration
- Financial vs. Economic – travel/per diem vs. donated services

MAJOR CATEGORIES

- **Direct Costs**
  - Personnel
  - Consultants
  - Subcontracts
  - Communications
  - Supplies
  - Travel/per diem
  - Other
- **Indirect Costs**
  - Compliance oversight
  - Clinic/lab/office space
  - Program/research administration
  - Utilities/maintenance
  - Other shared resources

ASSESSING COSTS BY CATEGORIES

- **Personnel** – salaries, benefits, allowances % of effort, daily rate, tax/benefit rates
- **Consultants/Honoraria** – hiring experts daily rate, flat fee
- **Subcontracts** – delegating tasks elsewhere
- **Communications** – phone, postage, printing per unit, per page, monthly usage
- **Supplies** – office, lab, medical, educational unit cost, bulk rate
- **Equipment** – office, lab, vehicle (All costs!)
- **Travel** – local transport, long distance air/train/bus fare, mileage, per diem, other
- **Other** – space/equipment rental, participant incentives, meeting/training costs

BUDGET TIME LINE

Three Stages

- **Stage 1** – start-up/infrastructure costs
  Most expensive

- **Stage 2** – costs of managing/conducting research or program
- **Stage 3** – costs of evaluation/sustainability
  Least expensive

BUDGET STRATEGY

Program versus Research

- **Program Project**
  - Running a program
  - 85% service
  - 15% evaluation of service
- **Research Project**
  - Answering a question
  - 85% data collection
  - 15% evaluation of data

THE BUDGET JUSTIFCATION

The budget justification ties together the budget numbers and the proposed activities.

- Explains why and when specific items of expenditures are required
- Details how cost estimates are calculated
- Justification of normally unallowable costs

Justify everything – assume nothing

OTHER BUDGET ISSUES

- **PLANNING STAGE**
  - Restrictions – salary caps
  - Indirect cost calculation
  - In-kind contributions/cost sharing
  - Budget formats

- **PROGRAM STAGE**
  - Monitoring/projecting
  - Reallocating between line items
  - Contingencies: surplus/deficit

THE AWARD NOTICE

- Awarded as proposed
- Awarded with budget revisions
- Awarded but less than proposed
- Not awarded yet worthy of resubmission
- Not awarded – back to the drawing board

SUSTANINABILITY

- Future funding searches should start at the beginning of the current grant period to avoid funding gaps.
- Financial strategic planning should be a continuous process.
- Be aware of:

- Changing needs over time
- Workload allocation of personnel
- Trend Analysis/Competitive Analysis

MAINTAINING THE FUNDING FLOW

- ATTRACT FUNDERS/DONORS
  - Know your research/activity/program costs
  - Be able to define/predict future resource needs
- SECURE FUNDING/DONATIONS
  - Use your financial strategic plan
  - Submit convincing grant proposals
- KEEP FUNDERS/DONORS
  - Set up fiscal monitoring and reporting systems
  - Demonstrate effectiveness

WHAT IS THE MORAL OF THE STORY?

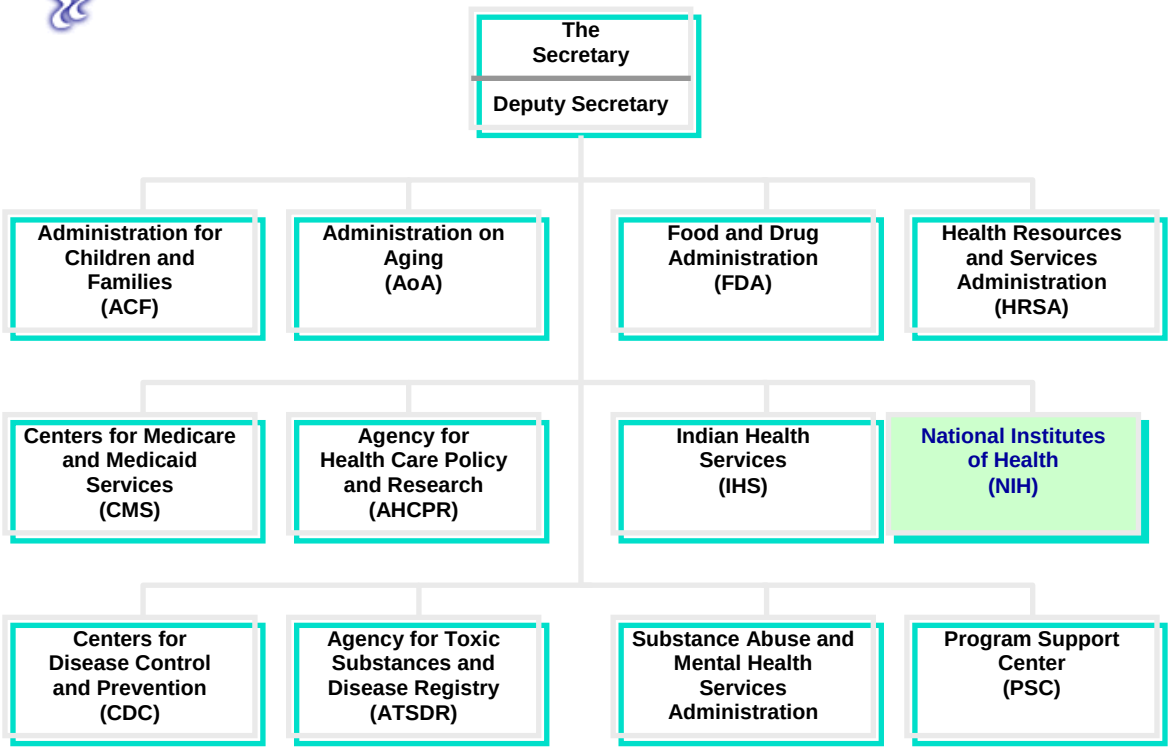
Knowledge of costs gives you the power when negotiating funding, writing convincing grant/funding proposals and establishing good relationships with your future donors or funding agencies.

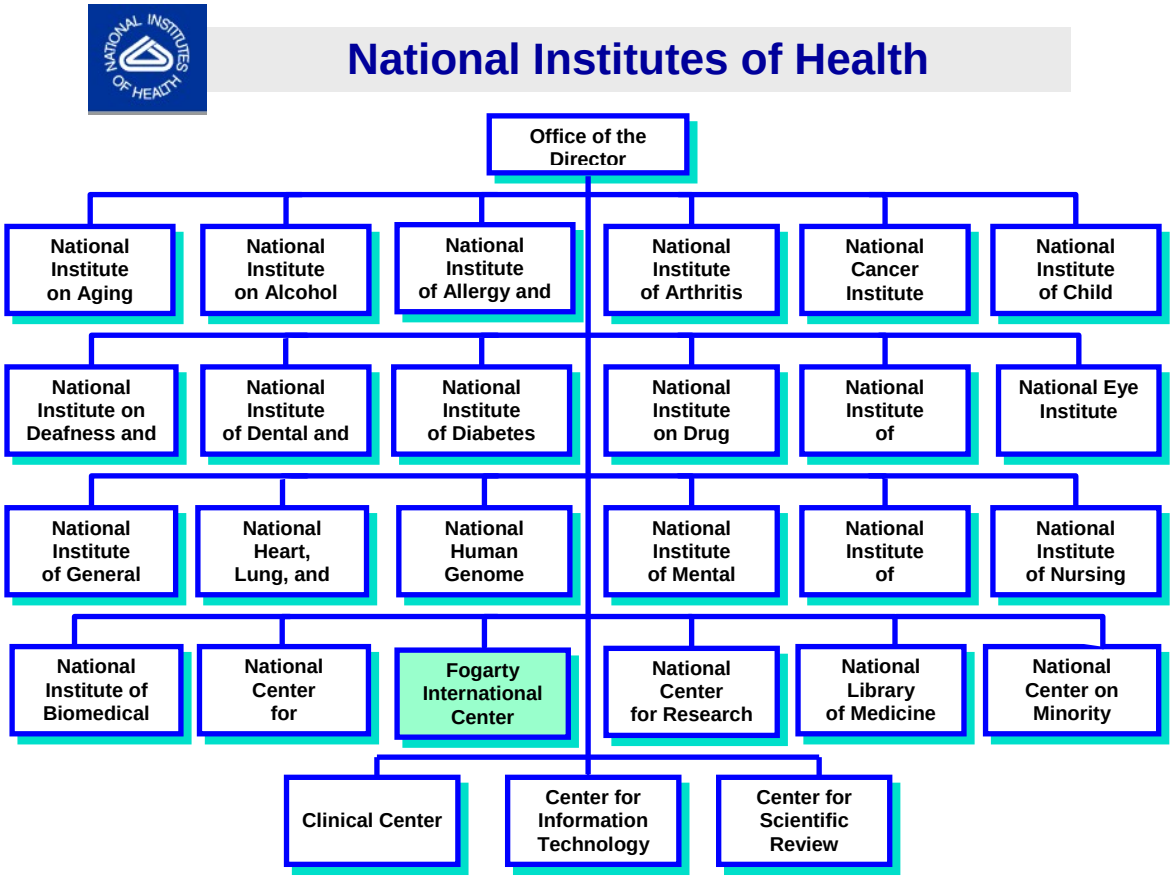
6.4. INFORMATION ABOUT THE NIH GRANTS PROCESS
Fogarty International Center (FIC)
National Institutes of Health

NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health (NIH) is the principal health research agency for the U.S. Federal Government. NIH is a component of the Department of Health and Human Services (DHHS). The next two slides show the different components of DHHS and the different Institutes and Centers at NIH.

U.S. Department of Health and Human Services





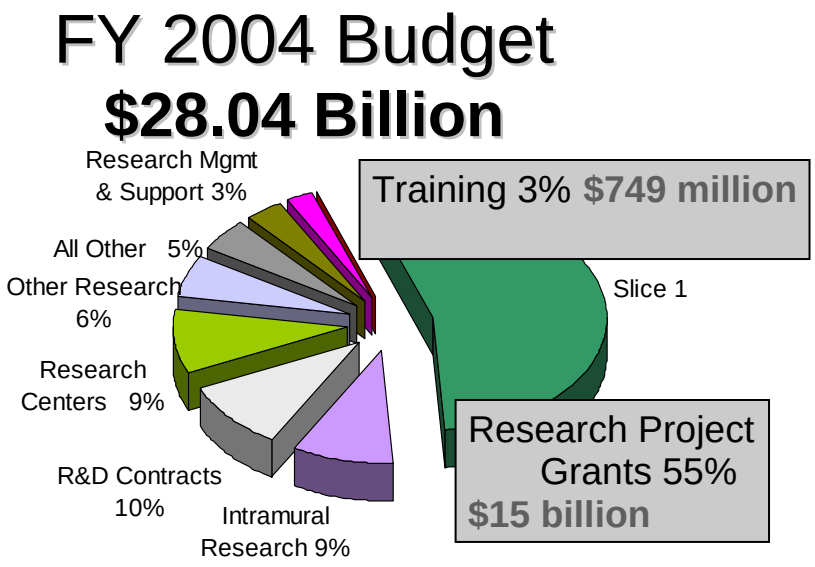
NATIONAL INSTITUTIONS OF HEALTH

Mission

NIH conducts and supports basic, applied, clinical and health services research to understand the processes underlying human health and to acquire new knowledge to help prevent, diagnose, and treat human diseases and disabilities.

How does NIH help accomplish this mission?

NIH spends 80-85 percent of its total budget in support of biomedical and behavioral research and research training by more than 50,000 scientists located at more than 1,700 universities, research institutions, and medical centers across the United States and outside the United States.



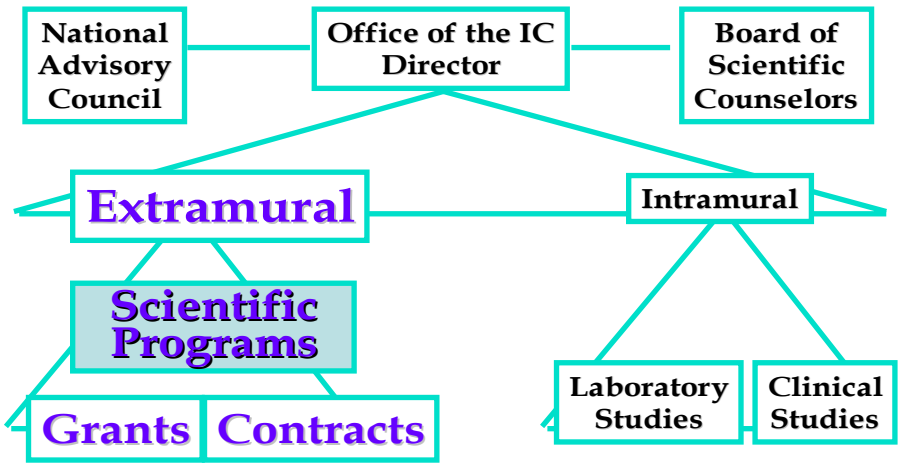
FY '05 President's Budget Request

- $28.757 billion
  - ~ 2.6% increase over FY 2004
- Approximately 10,400 competing RPG awards
  - ~ 260 increase over FY 2004
- Major initiatives
  - NIH Roadmap
  - Obesity
  - Biodefense
  - AIDS

NATIONAL INSTITUTES OF HEALTH

The NIH awarding institutes use three major instruments to provide funds to organizations outside the NIH to accomplish program goals. The three instruments are grants, cooperative agreements, and contracts.
This presentation will focus on grants and cooperative agreements.

A Typical Institute/Center



Grants and Cooperative Agreement Instruments
How are they used?
Grants

- NIH provides funds to support what was proposed in the application
- NIH provides assistance

Cooperative Agreements

- NIH is a full partner in the project
- NIH provides assistance and substantial program involvement

Applications for NIH Grants and Cooperative Agreement Instruments
Grants and Cooperative Agreements are normally submitted to NIH in three ways:

1. CSR, NIH - as an Unsolicited Grant Application
2. Program Announcement (PA) - Institute or Center is inviting grant applications in a general scientific area of research. There are generally no funds set aside for these projects.
3. A Request for Applications (RFA) - one or more NIH Institutes and Centers invite applications in a well-defined scientific research area. Specific funds are set aside for the projects.
4. Unsolicited applications are sent to the Center for Scientific Review (CSR).
5. Applications submitted to a PA or RFA should be sent to the appropriate office Referenced in the PA or RFA announcement.
6. The CSR mailing address is:
   CENTER FOR SCIENTIFIC REVIEW
   NATIONAL INSTITUTES OF HEALTH
   ROCKLEDGE II ROOM 1040 MSC-7710
   BETHESDA MD 20892-7710 USA
7. Find PHS 398 at: http://grants.nih.gov/grants/forms.htm

NIH Guide for Grants and Contracts
HOW DO I FIND OUT NIH PAs AND RFAs?
The NIH Guide Announces NIH Scientific Initiatives provide NIH Policy and A Administrative Information. See
http://www.nih.gov/grants/guide/index.html

When preparing and application an investigator:

- Read and carefully follow instructions
  (See NIH GUIDE, PHS 398 at: http://grants1.nih.gov/grants/forms.htm)
- Write a concise, reviewer-friendly application. Never assume that reviewers "will know what you mean"
- Refer to literature thoroughly
- State rationale of proposed investigation and clearly explain the methodology
- Include well-designed tables and figures
- Present an organized, lucid write-up
- If possible, have someone who has experience
  working with NIH review the completed application

Useful Web Site to Help Prepare a Grant

Please look at the resources on the NIH Grants Information CD that can be found at: http://www.fic.nih.gov/butrum/welcome.pdf

Applications Submitted to NIH are Peer Reviewed

The review of grant and cooperation agreement application involve two sequential levels of review for each application.

In this system, the scientific assessment of proposed projects is kept separate from policy decisions about the scientific areas to be supported and the level of resources to be allocated.

The first review, the evaluation of Scientific and technical merit, is conducted by one of many chartered scientific review groups, referred to as SRGs, managed by the NIH center for Scientific Review (CSR) or by the institutes.

The group or panel, established according to scientific disciplines or medical specialties, may consist of as many as 16 to 20 members who are primarily non-Federal scientists with expertise in various disciplines and areas of research.

The primary requirement for serving on an SRG is competence as an independent investigator in a scientific discipline. Other factors such as respect among peers and quality of research accomplished are also important.

The reviewers study each application individually before the meeting; and for each application, some reviewers are assigned to prepare written critiques.

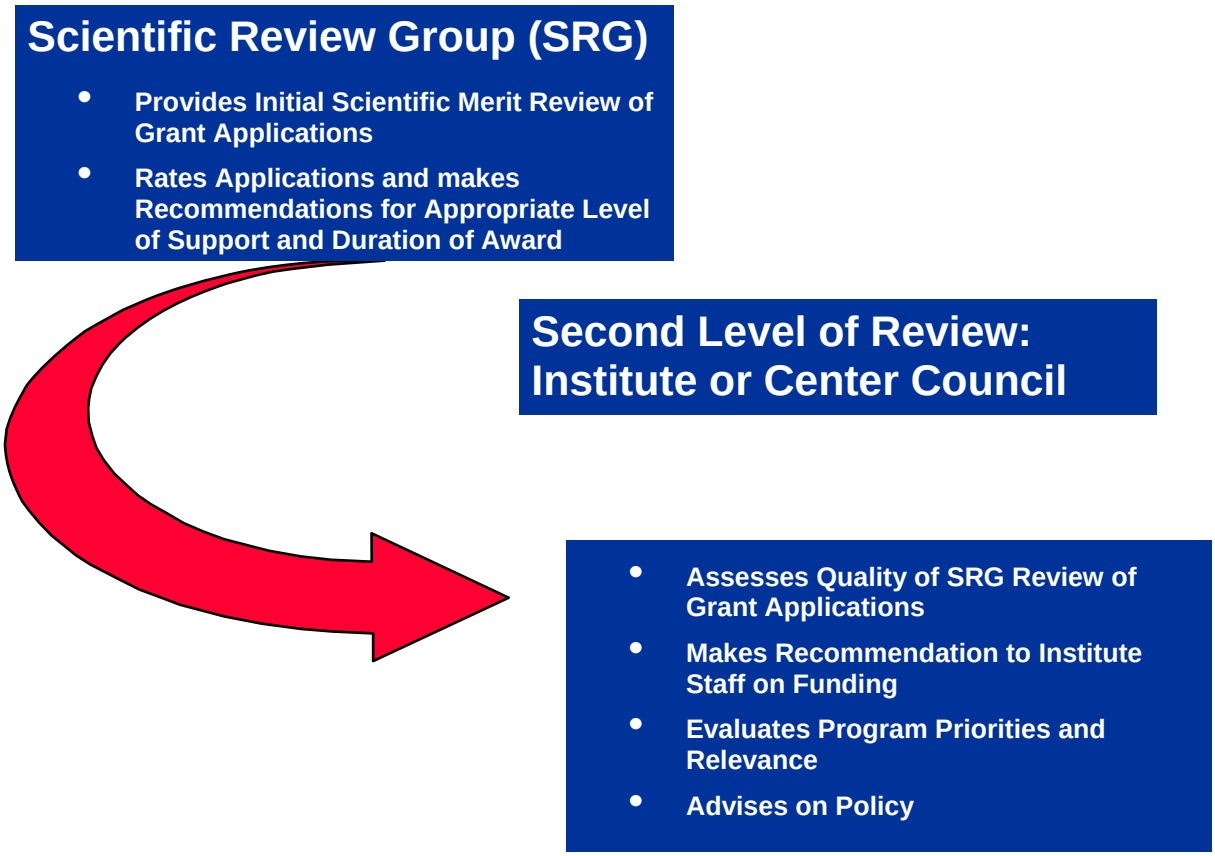
Those projects deemed most competitive, approximately the upper half, are fully discussed and given a priority score based on the scientific merits of the project.

The second review is performed by National Advisory Boards or Councils, hereafter "councils," of the NIH funding components. This panel of 12-18 members consists of scientists and laypersons chosen for their interest in matters related to health and disease.

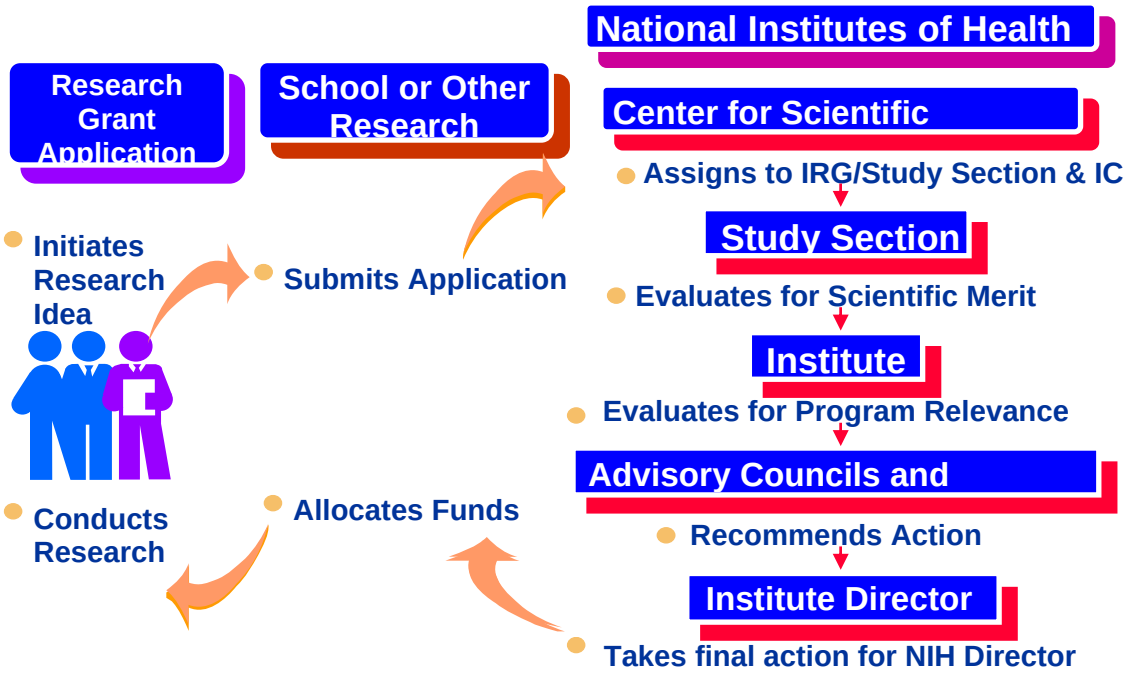
Council members review the applications against a broad background of considerations including relevance, program goals, and available funds of the institute; they also consider the appropriateness of the scientific review conducted previously by the SRG.

The Dual Peer Review System and an example of a complete grant cycle is shown on the next two slides.

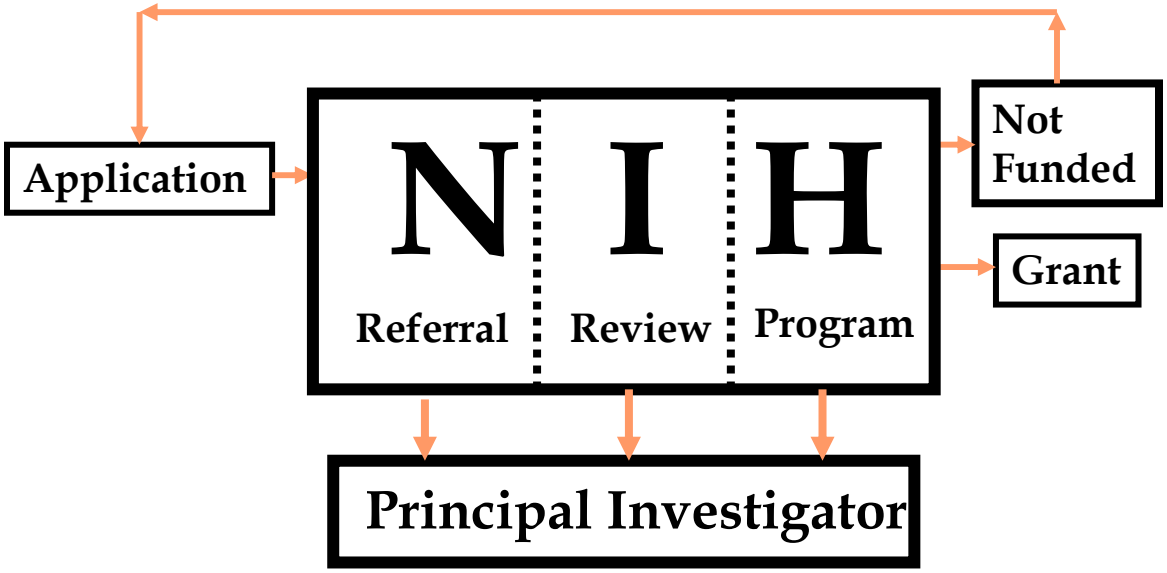
Dual Review System for NIH Grant Applications



Review Process for A Grant Application Submitted to CSR, NIH

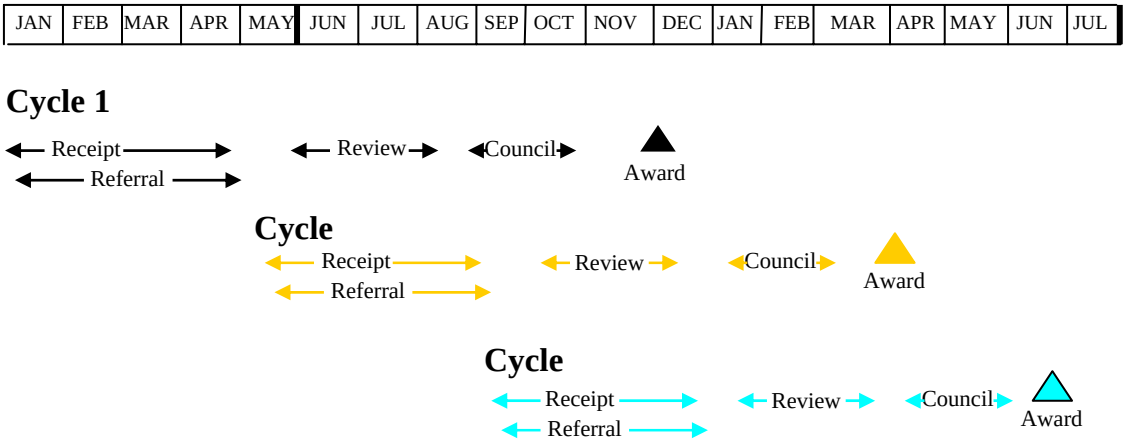


Review Process for a Research Grant



Normal Timeframe from Submission to Award for Unsolicited Grants
(PAs & RFAs may be different)

There are normally three overlapping cycles per year :



Review and Award Considerations for Grants that Involve Foreign Research

Applications from foreign institutions will be evaluated and scored during the initial review process using the standard review criteria. In addition, the following will be assessed as part of the review process and award decision:

Whether the project presents special opportunities for furthering research programs through the use of unusual talent, resources, populations, or environmental conditions in other countries that are not readily available in the U.S. or that augment existing U.S. resources. Whether the proposed project has specific relevance to the mission and objectives of the IC and has the potential for significantly advancing the health sciences in the U.S.

Research grant applications from foreign or international organizations

Potential Funding of Applications

What happens if an application receives a outstanding score and it appears that NIH may be interested in funding the application?

- You may be contacted by NIH to obtain additional "Just-In-Time" (JIT) information that will normally be needed before a potential award can be made. The next slides will provide information on what may be requested.

- IRB approvals – if applicable
- Certification of Education on Human Subjects – if human subjects are involved
- IACUC approvals – if applicable
- Complete Other Support Information

Assurances – Human Subjects

- Applicants who plan to engage in human subjects research should have a Multiple Project Assurance (MPA) on file with the Office of Human Subjects Research Protection (OHRP) or need to negotiate an FWA or Single Project Assurance (SPA) with the OHRP.

- Refer to the following website to obtain instructions on how to submit documentation to negotiate an FWA with OHRP:

http://odoerdb2.od.nih.gov/oer/policies/hs/index.htm

Human Subjects Education

NIH requires education on the protection of human research participants for all key personnel on grants involving human subjects research. Key personnel include all individuals responsible for the design and conduct of the study.

While NIH does not endorse a specific training program, there are a number of curricula readily available to investigators. For example, NIH has an on-line tutorial accessible at: http://ohsr.od.nih.gov/. While this training module was developed for NIH staff, it can be used by other institutions seeking to meet training requirements in this area.

Further information on the education requirement can be found on the internet at: **http://grants.nih.gov/grants/guide/notice-files/NOT-OD-00-039.html**

PHS Policy on Human Care and Use of Laboratory Animals

As of October 1, 2002 receipt date,
IACUC approval information
may be provided "just-in-time."

Assurances: Vertebrate Animals

The *PHS Policy on Humane Care and Use of Laboratory Animals* (the Policy) requires applicants proposing to use vertebrate animals in NIH-supported activities to file a written Animal Welfare Assurance with Office of Laboratory Animal Welfare (OLAW) http://grants.nih.gov/grants/olaw/olaw.htm

- NIH Grants Policy Satement: http://odoerdb2-1.od.nih.gov/gmac/nihgps_2003/NIHGPS_Part5.htm#_Toc54600087

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- NIH Grants Policy Satement: http://odoerdb2-1.od.nih.gov/gmac/nihgps_2003/NIHGPS_Part5.htm#_Toc54600087

Other Support

- NIH requires complete and up-to-date other support information prior to award for all key personnel. *All sources of research support* (including outside the applicant organization).

- Other support information must include the percent effort for each program, not to exceed 100% total effort for each person (0% and "as needed" are not permissible).

- Grantees must report changes as part of the annual progress report.

A format page example is provided on the next slide.
NIH Guide, February 13, 2003
http://grants.nih.gov/grants/guide/notice-files/NOT-OD-03-029.html

DO NOT SUBMIT UNLESS REQUESTED PHS 398 OTHER SUPPORT

NAME OF INDIVIDUAL **ACTIVE/PENDING**		
Project Number (Principal Investigator) Source Title of Project *(or Subproject)* The major goals of this project are…	Dates of Approved/Proposed Project Annual Direct Costs	Percent Effort
OVERLAP *(summarized for each individual)*		

Potential Funding of Applications
What are the issues that normally delay a potential award?

- Lack of or Slow Response to Inquiries
- Delays Sending JIT Info
  - IRB approvals
  - IACUC approvals
  - Certification of Education on Human Subjects
  - Other Support
- Info Sent Without Identification
- Lack of Institutional Signatures

For More Information
NIH website: www.nih.gov
NIH Office of
Extramural Research:
http://grants1.nih.gov/
grants/oer.htm
FIC website:
http://www.fic.nih.gov/

6.5. GRANT WRITING AND PROTOCOL DEVELOPMENT

Carlos del Rio, MD
Professor of Medicine. Emory University School of Medicine
Co-Director, Emory Center for AIDS Research

Special thanks to: Richard Rothenberg, MD, MPH and Laurie Ferrell, MPH

OUTLINE
…from IDEA to grant…
…from grant to study…
…from study to publication!

WHAT'S OPERATIONAL RESEARCH?
Designing a Research Protocol

It may sound silly, but the key to a successful grant is…
A GOOD IDEA
With a good idea, a lot can be forgiven…

The Research Protocol: A concise version

- **The Research Question**
  - What do you want to do ?
  - Why is it important?
- **Background**
  - What is important to know about this question?
  - What have you done before in this area?
- **Approach**
  - How will you conduct the study?
  - How will you analyze the data?
  - What do you expect the study to show?
- **Study subjects**
  - What is the risk to subjects from this study?
  - What steps will you take to minimize the risk?

This is a chance to think through what you want to do…
…without worrying about the format, the details, the references…

The Research Question:
Compose a single sentence that states the essence of the problem you are trying to solve. (*A great challenge)*
State the hypothesis(es) you have about the potential answer to this question.

Background:
Describe the issues and observations that led to your posing this question. Outline the thinking that has been invested in the problem to date.

Approach:
Summarize the general way in which you will deal with this issue.
Decide on a study design (case-control; cohort follow-up; cross-sectional; etc.)
Make an approximation of how many study subjects you will need.
Describe where and how the study will take place (clinic, field station, community site, etc.).

Methods: **Data ascertainment**
Describe the logistics of the study

- How you will select people or things for the study?
- What sort of information you will collect?
- What tools you will use for data collection?
- How you will record the information?
- What tools you will use for analysis?

Methods: **Data analysis**
The epidemiologic and statistical tools

- Descriptions
- Univariate association
- Graphic and tabular presentation
- Complex multivariable approaches

Show how you will use these measures to test your original hypothesis(es).

…from protocol to grant

Research Protocol and the Research Plan

Research Protocol (concise version) **NIH Research Plan**

The Research Question → **a. specific aims**

- What do you want to do?
  - Why is it important?

Background → **b. background and significance**

  - What is important to know about this question?
  - What have you done before in this area?

Approach → **c. preliminary studies/ progress report**

→ **d. research design and methods**

  - How will you conduct the study?
  - How will you analyze the data?
  - What do you expect the study to show?

Study subjects → **e. human subjects research**

  - What is the risk to subjects from this study
  - What steps will you take to minimize the risk

NIH Research Plan

A. SPECIFIC AIMS

Opening paragraph that states a brief rationale

a.1 Specific aims

1.0 - 3-4 aims
2.0 - One sentence each
3.0 - VERY specific

a.2 Hypotheses

H1.0
H2.0
H3.0 A one sentence statement about what the result is likely to be: what is expected, not the null hypothesis

A closing paragraph that states the significance

B. BACKGROUND AND SIGNIFICANCE

b.1 Expanded discussion of why the question is important (length appropriate to content).

Literature review: An expanded discussion of the topics for THIS proposal that require an in-depth review:

b.2 Available (population) data that are germane
b.3 Review of work that has been published on these issues
b.4 Special methods required for this proposal
b.5 Background on measuring risk or exposure
b.6 Special issues of concern for THIS proposal
b.7 …..
b.8 …..

C. PRELIMINARY STUDIES/ PROGRESS REPORT

- **c.1 – c.n**
  - Some investigators begin with a description of the team
  - This is a good strategy, but, unfortunately, the strongest qualification for being a Principal Investigator is having already been one. The absence of one might backfire.
  - A description of prior work that you and your colleagues on this grant have done that is germane to the current proposal.
  - If this is new, and you have no prior experience, list other work you have done that demonstrates your competence to perform such studies.
  - If this is a new topic for you, and you have no other relevant work, try to add a colleague who does. If you are a new investigator, it is most helpful to add a senior person whose prior experience can be presented.

D. RESEARCH DESIGN AND METHODS

d.1 Brief overview of study (with diagram if appropriate)
d.2 Study design
d.3 Target population, enrollment, informed consent
d.4 Data and specimen collection
d.5 Data management and tools
d.6 Analytic methods
(d.7 Laboratory methods [if a laboratory study])
d.8 Hypothesis testing
d.9 Sample size and power considerations
d.10 Limitations
d.11 Project tasks and timeline

d.1 Brief overview of study (optional)

- Summarize the study in one paragraph (again)
- Include diagram of study design, if appropriate.
- This should be a shorter version of the abstract, focusing primarily on the methods to be enumerated in the following sections

d.2 Study design

- Type of study (case-control, cohort, chart review, cross-sectional, etc.)
- General procedures for conducting study
- Decision rules for inclusion of subjects
- Diagram of design (optional, if complicated, and if not included in d.1)

d.3 Target population, enrollment, informed consent

- Approach (ethnographic, sampling, clinic based)
- Enrollment procedures; mechanisms for randomization
- Informed consent process: when performed, by whom, how witnessed etc.

d.4 Data and specimen collection

- Interview (include form or data items)
- Diagnostic testing (methods)
- Medical procedures and follow-up; contingencies for problems that arise
- Participant follow-up; frequency, intensity, rules for quitting

d.5 Data management and tools

- Where the data will be kept
- Physical safeguards
- Computer safeguards
- Who has access
- What programs (data base management, analysis etc.) will be used

d.6 Analytic methods

- General epidemiologic approach
  - Decriptive statistics
  - Univariate comparisons
  - Multiple variable approaches
    - Logistic regression
    - Survival analysis methods
    - Hierarchical analysis
    - Multilevel methods
    - Special statistical and epidemiologic tools

d.7 Laboratory methods

- Detailed description of laboratory approaches
- Types and source of reagents
- Required training for lab personnel
- Details of the conduct of specific experiments

d.7 Laboratory methods

- Detailed description of laboratory approaches
- Types and source of reagents
- Required training for lab personnel
- Details of the conduct of specific experiments

d.8 Hypothesis testing

- Repeat each hypothesis verbatim
  - Describe the steps to be taken to either accept or reject the null hypothesis
  - Describe the methods to be used
  - Include dummy tables, if appropriate

d.9 Sample size and power considerations

- Pick appropriate formulas for calculation, for example:
  - Difference of proportions
  - Difference of means

- Determine required sample size, variance and power
  Use a range of values, perhaps with a graph
- Demonstrate that the sample size selected will have a power of 80% to detect a difference of at least X%, using an alpha level of 0.05

d.10 Limitations

- What the study will not be able to do
- What the methods you have chosen will not be able to show
- Why superior methods, if available, were not chosen (cost, non acceptability etc.)

d.11 Project tasks and timeline

- Specify the tasks required, for example
  - Finalize design
  - Develop and test instrument
  - Hire staff
  - Pilot test field methods
  - Develop data storage and retrieval methods
  - Write interval data reports
  - Develop articles for publication
- Incorporate these items in a table that shows the timeline for each item over the life of the project

E. HUMAN SUBJECTS RESEARCH

(If this sounds repetitive…)

Opening statement

- If the study involves human subjects
- If it is exempt from IRB review or not
  (Note: Usually YES to questions 4 and 4a on face sheet)
- If it will be reviewed (just in time)
- If there are collaborating sites
- What referral will be made for medical care

e.1 Proposed involvement of human subjects

(a summary of key features of the study in lay terms)

- Study design
- Enrollment
- Sample size
- Procedures

Derived from sections d.1, d.2, and d.3

e.2 Data

- Types of information and material to be included
  Derived from section d.4

e.3 Recruitment

- How subjects will be recruited into the study

Derived from sections d.3

e.4 Risks

- Description of potential risks to subjects

Derived from sections d.1, d.2, and d.3

e.5 Risk minimization

– What you will do to minimize risk

Derived from sections d.3, d.4, and d.5

e.6 Cost/Benefit

– Not a formal CB analysis; general discussion of why the risks that this study may generate are worth it.

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– Not a formal CB analysis; general discussion of why the risks that this study may generate are worth it.

Derived from section d.1

e.1 Proposed involvement of human subjects
e.2 Data
e.3 Recruitment
e.4 Risks
e.5 Risk minimization
e.6 Cost/Benefit
d.1 Brief overview of study (with diagram if appropriate)
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d.6 Analytic methods
d.7 Laboratory methods [if a laboratory study])
d.8 Hypothesis testing
d.9 Sample size and power considerations
d.10 Limitations
d.11 Project tasks and timeline

THE ABSREACT

- It is the first thing that will be read
- It is often the only thing that will be read
  - Primary, secondary reviewer and reader read the whole grant
  - Everyone else reads the abstract…if that
- It is therefore the most important thing you will write in the grant
- Do it LAST, when you have a picture of the whole project in your mind.
- Use a structured format, but leave out the headings:
  - Background
  - Objectives
  - Methods
  - Intended results

BACKGROUND

- What to say
  – 2-3 sentences
  – Summarize the purpose of the grant
  – Provide a brief note of background

- Where to find it
  - Introduction to Section A
  - Section b.1
  - Section d.1

OBJECTIVES

- What you will do in this grant
  - Repeat one or two of the major specific aims
- What you will do in this grant
  - Repeat one or two of the major specific aims
- Where to find it
  - Sections a.1

METHODS

- How you will do it
  - Summary of approach and study design
  - Summary of logistics and venue
  - Summary of information to be sought
- Where to find it
  - Sections d.3-d.5

INTENDED RESULTS

- What you hope to find
  - Repeat one or two of the most important hypotheses
  - Add a final sentences about what will be learned if this study is done
- Where to find it
  - Section a.2
  - See also section b.1 and introduction to section A
- Where to find it
  - Section a.2
  - See also section b.1 and introduction to section A
- Where to find it
  - Section a.2
  - See also section b.1 and introduction to section A

…from Grant to Study….

T**he Conduct of a Study**

Key point:

Murphy's Law:

If anything can go wrong, it will.

Rosenstock's Rules:

- There are never as many subjects as were estimated and are needed
- Refusal rates are always greater than expected
- Nobody knows what to do with the control group
- Nobody knows what was actually *done* with the control group
- Crossover between groups will occur
- Both the experimental and the control group will improve
- The control group shows strong effects
- The intervention is never continued long enough or intensively enough to work

- Any effects of the intervention dwindle as soon as the study ends
- Every step of the design, implementation, conduct, and analysis takes longer than expected

…from Protocol to Publication…via study…

Overall Structure

I INTRODUCTION *(Why did you do it?)*
M METHODS *(How did you do it?)*
R RESULTS *(What did you learn?)*
D DISCUSSION *(Who cares?)*

Overview of Operational Research

INTRODUCTION

- OR is part of a continuum of research to practice
- Operations research is implementation oriented. It has to do with problem solving.
- Usually involves identification of service delivery problems and testing new programmatic solutions to these problems.
- Virtually all research methods can be and are employed in OR.
- Not all identified problems require research to solve them. Some just require common sense!

GOAL OF OPERATIONS RESEARCH

- To increase the efficiency, effectiveness, and quality of services delivered by providers, and the availability, accessibility, and acceptability of services desired by users.

ANOTHER DEFINITION OF OR

- May be described as the search for knowledge on interventions, tools or strategies which enhance program effectiveness
- Key ingredient to do OR – must have an 'operation'!
- Judge OR on whether and how it has affected program operation
- OR looks at problems affecting service delivery operations, focusing on the search for solutions, or in the language of research, variables that can be manipulated through administrative action.

AND YET ANOTHER DEFINITION

Operations Research (OR) is the application of systematic research techniques to program improvement with a focus on factors under the control of managers

OR and the expertise divide

- In OR, those who know the problems and can identify the solutions are those who work in the programs/projects on a day-to-day basis.
- OR technical expertise and wisdom resides in program/project managers, planners and staff. Reverse 'capacity building'.
- Funds for research often originate in U.S., Europe and often research priorities are defined there as well.
- Data and authorship proprietorship – give credit where credit is due.

Selecting solution, strategy or intervention

- Don't select a solution or strategy in search of a problem.
- Look for solutions/strategies that can be implemented without overburdening the implementing institution.
- Seek solutions/strategies that are simple to implement.
- Develop solutions/strategies where the proposed solution is under the control of program managers and acceptable to the key stakeholders.
- Select solutions/strategies that can be sustained over time.

OR METHODS

- Employs all research methods ranging from qualitative to quantitative, with study designs ranging from non-experimental to true experimental.
- No single set of methods
- Key is not the application of a set of methods or a particular design but
- What distinguishes OR from other types of research is the objective of the research – improve delivery of services

EXAMPLE I

- Goal: Efficiency, Acceptability

- *Problem*: Long waiting times in an overloaded South African health centre
- *Solution*: Block appointments introduced and evaluated
- *Methods*: Time/motion study; focus groups with providers and patients
- *Results*:
  - After introducing appointments, patients with acute and chronic illnesses and with appointments had significantly shorter waiting times than similar patients without appointments
  - Difference in median waits: 39 minutes (with appt) and 63 minutes (without appt)

EXAMPLE 2

- *Goal:* Effectiveness, quality, availability
- *Problem*: Contamination of household water supplies in a refugee camp
- *Solution*: Provision of a water vessel with a constricted opening (improved bucket)
- *Method*: Intervention study with randomization
- *Results*:
  - Mean fecal coliform values were 53.3% lower in the improved buckets than the ration buckets.
  - Improved bucket users experienced 8.4% fewer diarrhoeal episodes than the ration bucket users

Window of Opportunity for Operations Research

- GFATM and PEPFAR
- Much emphasis on health systems and health systems strengthening from international and global groups
- Opportunity to do multidisciplinary and interdisciplinary research – have to step outside comfort zone

GFATM and Health systems

- Design and implementation processes that the GFATM requires and the programmatic interventions it funds will have a direct impact on
  - The targeted diseases – HIV/AIDS, TB and malaria
  - The functioning of the broader health system
- System-wide effects may be intentional or unintentional
- Assess GFATM health system effects on stewardship, resource development, financing, and service delivery functions (WHR 2000)
- Country-driven processes
- GFATM committed to use its funds to support the three diseases “in ways that contribute to the strengthening of health systems”.
- Likely to have system-wide effects because of sheer magnitude of funds

DORIS DUKE CHARITABLE FOUNDATION

2005 Operations Research on AIDS Care and Treatment in Africa (ORACTA)

Request for Proposals

The purpose of the Doris Duke Operations Research on AIDS Care and Treatment in Africa (ORACTA) program is to support operations research related to AIDS care and treatment in Africa. It is expected that these studies will help to improve the care and treatment of AIDS patients in resource-limited settings, inform antiretroviral therapy (ART) program policy and practice, and improve the outcomes of the roll-out and scale-up of ART in Africa. The program will provide up to ten 2-year grants of up to $100,000 per year to teams of investigators to conduct health operations research on AIDS care and treatment in Africa.

OR AND ART

- OR is a key component of ART scale up and should be carried in tandem with ART service delivery.
- Priority research topics related to HIV treatment include:
  - Health systems
  - Adherence and sexual behavior
  - Equity and accessibility
  - Impact of ART on uptake of HIV testing and counseling
  - Community involvement
  - Cost and cost effectiveness
  - Human rights
  - Stigma and discrimination

Research and Service Integration

- OR should be conducted within the existing health system and in tandem with service delivery.
- Including OR from the start of program planning is critical in integrating research within program implementation.
- This helps define the research design in the context of program implementation, in mobilizing resources to conduct research and in increasing acceptability among healthcare workers, program planners and implementers.

- The quality and effectiveness of health interventions benefit from informed practice-to-research and research-to-practice initiatives.
- Ultimately, operational and applied research should make a difference in programs.
- Thus, results of OR should be incorporated into program activates.
    - The quality and effectiveness of health interventions benefit from informed practice-to-research and research-to-practice initiatives.
    - Ultimately, operational and applied research should make a difference in programs.
    - Thus, results of OR should be incorporated into program activates.

CONCLUSIONS

- OR is fun because the focus is working with programs/projects to make them 'work better'.
- OR is field research.
- OR does not proscribe any single type of research design or analytical method.
- Sometimes OR is messy.
- It must be done in partnership with program/project colleagues.

Finally, Dr. Getnet Metike made a short closing remark and on behalf of EPHA and himself thanked the Chairpersons, Paper Presenters, all the participants and organizers who tried their best to make the conference a success. The 16th Annual Conference of the Ethiopian Public Health Association was officially closed at around 5:00 PM October 28/2005.

ANNEX 1 - AMENDED CONSTITUTION

ETHIOPIAN PUBLIC HEALTH ASSOCIATION AMENDED CONSTITUTION
(October 2005)
(Draft for Comments)

PREAMBLE

The mission of public health, the promotion of optimal health, and the prevention and control of diseases in human population can best be addressed through the joint efforts of an informed public, and trained and committed health professionals, coordinated within the national health system. A public health association is instrumental in the achievement of the social goal through the dissemination of evidence-based information among professionals and the public, and through advocacy and influencing public health policy. It is within this context that the Ethiopian Public Health Association is established in Ethiopia.

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ARTICLE ONE – GENERAL PROVISION

Article 1.1. Name

The name of the association shall be "Ethiopian Public Health Association (EPHA)."

Article 1.2. Definition

Unless the context requires otherwise in this constitution,

1.2.1. "Association" means the Ethiopia Public

Health Association;

1.2.2. "Executive Board" means executive board elected by the General Assembly to execute the objective of the Association;

1.2.3. "Executive Director" means the executive director recruited and employed by the Executive Board for directing the Secretariat and running the day-to-day activities of the Association;

1.2.4. "Secretariat" means the administrative support structure that runs the day-to-day activities of the Association and directed by the Executive Director.

Article 1.3. Version

The constitution that was approved during the establishment of the Association in 1991 and that was revised in 1998 is hereby further amended. The amendment was made to accommodate for the expanded structures and functions of the association during the periods since its establishment, as well as to conform with the new guidelines that govern civil societies in the country.

Article 1.4. Address of the Association

The registered address and seat of the Association in Addis Ababa, Ethiopia.

Article 1.5. Chapters

1.5.1. EPHA has regional chapters in various Regions of Ethiopia and shall continue to establish more of these and deemed necessary;

1.5.2. When possible, EPHA shall also establish chapters in the Diaspora;

1.5.3. Chapters have the right, on behalf of the Association, to undertake such activities as will promote the objectives of the Association in the locations in which they are based.

Article 1.6. Organs of the Association

1.6.1. General assembly
1.6.2. Executive Board;
1.6.3. Executive Director and Secretarial; &
1.6.4. Chapters.

ARTICLE TWO – VISION and MISSION

Article 2.1. Vision

EPHA envisions the attainment of an optimal standard of health for the People of Ethiopia.

Article 2.2. Mission

To promote better health service to the public and professional standards through advocacy, active involvement and networking.

Article 2.3 Values

EPHA is committed to improve the health and living status of the people of Ethiopia through the dedicated and active involvement of its members and in collaboration with all stakeholders. EPHA stands for professional development of its members without prejudice as regards gender, religion or ethnic affiliation.

Article 2.4 Objectives

The objective of the Association is the advancement of public health measures for the promotion of health, prevention of diseases, timely treatment of the sick and rehabilitation of the disabled by:

2.4.1 Bringing together the persons who are trained in, working in, or interested in public health or public health related disciplines;

2.4.2 Participating in and making recommendations on health policy, planning, training, management and practice of public health;

2.4.3Promoting the professional standard and interest of the members and other public health personnel;

2.4.4 Establishing forums for promoting communications among members and the public on the matters of health;

2.4.5 Advancing research in public health; and publishing scientific journals, newsletters and bulletins for disseminating results and information for facilitating advancement of knowledge and evidence-based practice;

2.4.7 Playing active advocacy roles on important health issues, including the mobilization of expertise of its members and other relevant resources in the forecasting, prevention, analyzing and control of health epidemics and disaster situations.

ARTICLE THREE-Membership Eligibility

Article 3.1 Full Membership

Full membership shall be open to all those who are trained in and/or are working in the field of public health and who comply with the Association's rules and regulations, including the payment of required fees. Ethiopians in the Diaspora that fulfill the above also have the right to full membership.

Article 3.2 Associate Membership

Complying with EPHA's rules and regulations and upon paying the required membership fees, the following shall be eligible for associate membership:

3.2.1 Students in public health;

3.2.2 Those who have training in health related disciplines and are working in the health field;

3.2.3 Individuals with public health interest that are nominated by members and approved by the Executive Board;

3.2.4 Expatriates working in public health in Ethiopia, and

3.2.5 Institutions and Organizations interested in and contributing in public health.

Article 3.3 Honorary Membership

Individuals who have made outstanding contributions to public health in Ethiopia or to EPHA shall be granted honorary membership upon being selected by a minimum of two third votes of those attending a General Assembly;

Article 3.4 Life Membership

Ordinary members may opt to become life members by paying a lump sum fee equivalent to 10 years. Up on such remittance, the life member shall be exempted from paying subsequent annual subscriptions, but will continue to exercise her/his full membership in the Association during her/his lifetime.

Article 3.5. Membership Regulations

Membership is full-fledged upon complying with the following:

3.5.1. Filling the appropriate forms;

3.5.2. Paying the required entry fees;

3.5.3. Being confirmed by the executive Board ;

3.5.4. Not being more than two years in arrears of fees (not applicable to life and honorary members). A member who is three years or more in arrears shall lose her/his membership status.

Article 3.6. Rights and Obligations of Members

A member of the association who satisfys the requirements under article 3.5 shall have the duties and responsibilities to:

3.6.1. Vote, elect and be elected to the various organs of the Association

3.6.2. Express views and participate in all activities of the association; and

3.6.3. Get publications documents distributed by the association

Article 3.7. Loss of Membership Status

A member shall be deemed to have forfeited her/his membership status in EPHA upon the decision of the Executive Board in the event of:

3.7.1. Failure to abide by the rules and regulations on the association; and

3.7.2. Professional misconduct.

Article 3.8. Membership Fees

3.8.1. Full members and associate members shall pay a membership fee of 50 birr per year unless changed on the basis of the sub-articles below;

3.8.2. Students shall pay 50% of that stated in 3.7.1. Every year, the Executive Board can, however, grant waiver for students who cannot afford to pay membership fees.

3.8.3. National institutions and organizations shall pay 500 every year;

3.8.4. International institutions and organizations shall pay USD 500 or equivalent every year.

ARTICLE FOUR-THE GENERAL ASSEMBLY

Article 4.1. Composition of the General Assembly

The General Assembly is composed of all members of the Association.

Article 4.2. Duties and Responsibility of the General Assembly

The general Assembly shall be the supreme body of the Association with the following duties and responsibilities:

1.2.5. The regular general assembly shall be convened in conjunction/concurrently with the Annual Scientific Conference; quorum is considered to be met by the attending members;

1.2.6. The General Assembly shall bear, receive, and adopt the report from the Vice President;

1.2.7. The General Assembly shall conduct all elections of members of the Executive Board;

1.2.8. The General Assembly shall delegate to the Executive Board to discus and approve annual budget estimated and plan of action for the year;

1.2.9. The General Assembly shall approve/ disapprove and amend the constitution by a two thirds majority;

1.2.10. The General Assembly shall remove members of the executive Board when necessary;

1.2.11. The General Assembly shall endorse the resignation and removal of members of Executive Committee when it is carried out and presented by the latter.

ARTICLE FIVE- THE ADVISORY COUNCIL

The Advisory Council will provide counseling and policy support to the Association. In addition, it will create a mechanism for the expression of concerns and issues at the wider membership of the Association. The council can meet at least twice a year.

Article 5.1. Composition of the Advisory Council

The advisory council shall have members

composed of:

5.1.1. Membership of the Executive Board;
5.1.2. Focal persons of Chapters;
5.1.3. Editors of the Association's Journal
5.1.4. Members of EPHA panels;
5.1.5. Members of EPHA sections; and
5.1.6. Other persons in the profession that the EB believes to play such advisory roles

Article 5.2 Duties and Responsibilities of the Advisory council

5.2.1. Acts as a medium of communication between the membership and the executive Board;
5.2.2. Plays an advisory role on major undertaking of the Association.

ARTICLE SIX-THE EXCUTIVE BOARD

Article 6.1. Composition of the Executive Board

The Executive Board shall have seven members:

6.1.1. President ;
6.1.2. Vice President;
6.1.3. Five other Officers;
6.1.4. The Executive Director of the Association may be secretary of the Board without having a voting right.

Article 6.2. Duties and Responsibilities of the Executive Board

The Executive Board shall have the following duties and responsibilities;

6.2.1. Develops policies and directions for smooth functions of the Executive Director and the secretariat;
6.2.2. Recruits and appoints the office bearers of the Secretariat, including the Executive Director;
6.2.3. Prepares the agenda for the General Assembly;
6.2.4. Follows up the proper implementation of the decisions of the General Assembly;
6.2.5. Based on the memorandum of understanding to be renewed with AAU, approves the editorial policy of the Association and appoints members of the Editorial Board;
6.2.6. Discuss and approve budget proposals and plan of actions;
6.2.7. Plans, organizes and implements activities for the development of the Association;
6.2.8. Presents to the General Assembly proposals for new policies and programs;
6.2.9. Ensures the availability of financial and material resources;
6.2.10. Expands new Chapters;
6.2.11. Submits for decision the short, medium and long term strategic plans and budget proposals of the Association after consultation;
6.2.12. Prepares the internal regulations of the Board; and
6.2.13. Calls the extraordinary meeting of the General Assembly.

ARTICLE SEVEN-OFFICERS OF THE EXECUTIVE BOARD

Article 7.1. The President

The President shall have the following duties and responsibilities:

7.1.1. To preside over all ordinary and extraordinary meetings of the General Assembly and Executive Board;
7.1.2. To follow up and direct the Executive Director and Secretariat to implement the decision of the General Assembly and Executive Board;
7.1.3. To call the meeting of the Executive Board and the General Assembly;
7.1.4. To submit for approval to the General Assembly decisions, strategies and directive of the Executive Board; and
7.1.5. To forward agendas and matters that require decisions of the Executive Board.

Article 7.2. The Vice President

The Vice President shall have the following duties and responsibilities:

7.2.1. To keep the records and minutes of the General Assembly and the Executive Board;
7.2.2. To be responsible for the distribution of the decisions of the Board;
7.2.3. To assume the responsibilities of the President in his absence until the General assembly makes replacement through the extraordinary meeting; and
7.2.4. To prepare the agenda of the Board in consultation with the President.

Article 7.3. Other Roles of Officers

7.3.1. The Executive Board shall also assign among its members as officers in charge of coordinating the activities of the different sections of the panels;
7.3.2. The Executive Board shall also assign among its members (as necessary) a Treasurer that will be responsible for the supervision of finance and property as for upholding the advancement of EPHA's financial and property rules and regulations.

Article 7.4. Term of Office of Executive Board

A term of office for a member of the Executive Board shall be only two years. However, she/he may be re-elected for additional term.

ARTICLE EIGHT-EXECUTIVE DIRECTOR/ SECRETARIAT

Article 8.1. Duties and Responsibilities of the Executive Director (ED):

The ED who is responsible for implementation of policies and programs set by Executive Board, will have the following duties and responsibilities:

8.1.1. Responsible for overall leadership of staff in the development and implementation of short and long range plans and other activities of the Association;

8.1.2. Assist the Executive Board in setting programs and goals for, and directing the conduct of the annual conference of the Association;

8.1.3. Ensure that projects directed by the Association are properly functioning in terms of quality of works, accounting, reporting and administrative functions;

8.1.4. In close consultation with the President, responsible for liaison with other organization, such as the FMOH, Universities, Professional Associations, Foundations, and other multi and bilateral organizations;

8.1.5. Assist in providing information and advice the Executive Board in the preparation of policies, programs and strategic directions of the Association;

8.1.6. Responsible for organizing the meeting and reporting the minutes of the Executive Board;

8.1.7. Responsible for directing and administering the Secretarial and the overall operations of the Association, including: reviewing the result of the programs activities, ensuring the continuing contractual obligations are being fulfilled;

8.1.8. Identify areas requiring planning, develops and recommends goals, objective and action plans for the approval of the Executive Board;

8.1.9. Monitor and evaluate all activities provided by the Secretariat and project Staff and reports progress to the Executive Board; makes recommendations for changes as needed;

8.1.10. Oversee the human resource function to ensure optimum staffing and utilization of competent staff, recommending policy changes to benefits, compensation, employment, training and other areas as appropriate; and

8.1.11. Support and facilitate the activities of the Association's Chapters.

Article 8.2 Functions of the Secretariat

The Association shall have a secretariat to run it's day-to-day activities and led by the Executive Director that shall:

8.2.1 Have coordinators, financial officer, cashier, secretaries, and other essential support staff as may be necessary;

8.2.2 Duties and responsibilities of its staff will be specified by relevant by laws; and

8.2.3 Be equipped with essential office and communication facilities.

ARTICLE NINE-ELECTION & VOTING

Article 9.1 Election

9.1.1 All election shall be by casting votes on secret ballots;

9.1.2 During an election the nominated individual shall be present and give her/his opinion;

9.1.3 When an election is to be undertaken, the President and Vice-President shall oversee all electoral procedures (provided that they are not candidates at the time);

9.1.4 Upon the death, incapacitation or resignation of an executive organ member, the officer who has been assisting the deceased or the incapacitated officer shall take over the office. Where such is not available, the executive organ shall select one from among its members to fill the vacant position;

9.1.5 Associate and honorary members may attend general meetings but they do not vote or stand for elections.

Article 9.2 Voting

9.2.1 Voting shall be by casting vote. All elections and of contention shall be resolved by this method;

9.2.2 The President shall preside over all voting except on the occasion where he/she is standing for election or when the issue to be voted upon involves him/her in person. In such cases, the chairperson shall disqualify himself/herself and step down from the chair. The meeting shall then elect an ad hoc chairperson who shall preside over that meeting only and relinquish this temporary position after the voting exercise;

9.2.3 All members of the Executive board except the President shall have voting privileges similar to those of the general members;

9.2.4 A member has only one vote;

9.2.5 The President shall have a casting vote when there is a tie.

Article 9.3 Meeting

9.3.1 The General Assembly shall have one ordinary meeting every year;

9.3.2 Extraordinary meetings may be convened under the following conditions;

9.3.3.1 Upon the decision of the Executive Board when an extraordinary meeting is deemed necessary;

9.3.3.2 Upon petition by half of the bona fide members;

9.3.4 The Executive Board shall have one ordinary meeting every **two months;**

9.3.5 An extraordinary meeting of the Executive Board may be called at any time by the

President or four of the members of the Executive Board.

Article 9.4 Venue of Meetings

9.4.1 The Executive Board shall decide upon the venue of the General Meeting of the Association. However, suggestions for the venue and the theme may come from the General Assembly;

9.4.2 The Executive Board shall determine the venue for extraordinary meetings;

9.4.3 The venue for the ordinary meetings of the Executive Board shall be the Association's Headquarters or as determined by the Executive Board.

Article 9.5 Notice of Meetings

9.5.1 The President, through the Secretary shall issue written invitations for General Meetings, one month in advance;

9.5.2 The President may use any reasonable means of communication in calling extraordinary meetings of the General Assembly or the Executive Board.

Article 9.6 Quorum

9.6.1 The quorum for general meetings shall be 51% of the total registered conference attending members;

9.6.2 The quorum for the Executive Board shall be four of its member.

ARRTICLE TEN- SOURCES AND MANAGEMENT OF FUNDS

Article 10.1 Source of Funds

The sources of funds for the Association shall be: membership fees; donations and grants; fees from administrating projects; journal and other publications sales; consultancy fees and others.

Article 10.2 Finance & Property Management

The Association shall have its own bank account and:

10.2.1 The Executive Board may assign a person from its members to withdraw fund from the Association account with the joint signatures. The signatories would be (subject to change as necessary) the President, Vice President and /or the Executive Director;

10.2.2 The Executive Director shall administer petty cash funds;

10.2.3 The Association's accounts shall be audited by an external auditor every year;

10.2.4 Regular auditing shall be carried out every three months;

10.2.5 The Association's financial year shall begin on -----and end on----;

10.2.6 The Association shall have a legal right and duties to own and administer property;

10.2.7 The Association shall maintain simple generally accepted accounting standard, system and procedure; and

10.2.8 For the enhancement of the Association's financial management, the financial manual adopted by the General Assembly shall be strictly adhered.

ARTICLE ELEVEN-MISCELLANEOUS PROVISIONS

Article 11.1 Legal Matters

11.1.1 EPHA shall be registered according to the laws of the Government of Ethiopia;

11.1.2 EPHA shall use the services of the existing governmental or private organizations the functions of which shall be to advise the Executive Board on matters pertaining to national and international laws that have a bearing on the Association;

11.1.3 Contracts, documents or any instruments in writing requiring the signature of EPHA's officials shall be signed by its President or the Vice President; and

11.1.4 The Auditor shall have access to all financial papers and document;

Article 11.2 Amendment of the Constitution

This constitution may be amended by a two-third majority of the General Assembly.

Article 11.3 Dissolution of the Association

The Association may be dissolved by votes of a minimum of 75% of the General Assembly. This shall be preceded with a detailed explanation of the reason for its dissolution and after having received feedback from members, in writing, agreeing to dissolve it.

Upon dissolution the property of the Association shall be distributed to other Associations, government and non-government offices with similar objectives.

Article 11.4 Effective Date

This constitution shall come into force upon ratification by the General Assembly.

Conference Facilitators & Organizers

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