Proceeding of the 27th Annual Conference of the Ethiopian Public Health Association

Attaining Universal Health Service Coverage and Sustainable Development Goals Related to Health: Opportunities and Challenges.

February 22-24, 2016

UNECA, Addis Ababa

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List of Acronyms

ANC	Antenatal Care
CDC	Center for Disease Control
CRC	Caring, Respectful and Compassionate
EFMHACA	Ethiopian Food, Medicine and Health Care Administration and Control Authority
EJHD	Ethiopian Journal of Health Development
EPHA	Ethiopian Public Health Association
FDRE	Federal Democratic Republic of Ethiopia
FGM	Female Genital Mutilation
FMoH	Federal Ministry of Health
HIT	Health Information Transformation
HMIS	Health Management Information System
HRH	Human Resources for Health
HSTP	Health Sector Transformation Plan
HTP	Harmful Traditional Practices
ICT	Information Communication Technology
IMR	Infant Mortality Rate
JSI	John Snow Inc.
MC	Master of Ceremony
MNCH	Maternal, Neonatal and Child Health
NMR	Neonatal Mortality Rate
ODWaCE	Organization for the Development of Women and Children in Ethiopia
PNC	Postnatal Care
SDG	Sustainable Development Goals
UHC	Universal Health Coverage
CPD	Continuous Professional Development
SOP	Scope of Practice

Acknowledgements

On behalf of the Ethiopian Public Health Association, I would like to extend my deepest appreciation to all workshop participants for their huge dedication, active participation and effective deliberations. My special thanks also go to the organizers of the 27th EPHA conference, EPHA management and staff for showing great time and devotion in launching such colorful and successful conference.

EPHA's conference has been a success, thanks to the immense dedication of all facilitators and organizers, presenters, panelists and participants. Thank you very much indeed!

Last but not least, I would like to thank all governmental institutions, international organizations, donors and development partners (particularly, the Ministry of Health of the Federal Democratic Republic of Ethiopia FMoH, CDC Ethiopia, The Packard Foundation, JSI and IPAS Ethiopia) for making the event so fruitful by sending their representatives, sharing their experiences and firing each of us with enthusiasm.

Dr. Fikreab Kebede,
President of the Ethiopian Public Health Association.

Executive Summary

The 27thannual conference of the Ethiopian Public Health Association (EPHA) was effectively held at the UNECA Conference Hall here in Addis Ababa from February 22 to 24, 2016. The conference was officially opened right after Dr. Aster Tsegaye, Executive Board Member of EPHA, introduced the program. High level government officials and partners including H.E. Dr. Kesetebirhan Admassu, Minister of FMoH through his representative, Dr. Mahlet Kifle; Professor Afework Kassu, State Minister of the Ministry of Science and Technology of the FDRE and Dr. Jeffrey Hanson, Country Representative of CDC-Ethiopia through his delegate, Dr. Ashenafi Haile inaugurated the conference.

In addition, the 27th Annual Conference of the Ethiopian Public Health Association was attended by some 700 invited guests including scientists, researchers, celebrities, students, Non-Governmental Organizations and members of various associations. As shown throughout the conference, the participants were constructively sharing their scientific findings, ideas and experiences.

In his welcoming address, Dr *Fikreab Kebede, President of EPHA*, gave the highlights of the major undertakings performed by EPHA during the past one year. After welcoming the guest of honor and the participants, on behalf of EPHA and the Organizing Committee, Master of Ceremony and Executive Board member of EPHA, Dr Fikreab asked the audience to stand up to observe a minute of silence in memory of the untimely death of professional colleagues and EPHA members, namely: Dr. Hailu Yeneneh, Dr. Yohannes Kebede and Ato Dereje Seyoum, who had been Ex-secretary of the General Assembly, EPHA secretariat and a member respectively. The president further pointed out the valuable contributions of the EPHA in terms offering trainings for health workers at different levels. According to him, in delivering consecutive trainings due attentions were given to fields such as epidemiology, leadership strategic information (LSI), immunization, tuberculosis, RH/ FP and HIV/AIDS. And he also underlined that the involvement of universities as partnership played significant roles for the achievement of the intended objectives. Furthermore, in his speech the president addressed as to how the association trained health extension workers on long acting family planning method that equipped them with the knowledge of family planning

access and choice. He, finally, thanked the organizing committee members who put their hearts into making the conference come true.

Afterwards, Dr. Ashenafi Haile and H.E. Professor Afewerk Kassu, State Minister of the Ministry of Science and Technology of FDRE, delivered keynote speeches on behalf of Dr. Jeffrey Hanson, Country Representative of CDC-Ethiopia. Following this, Dr. Mahlet Kifle made an opening speech on behalf of H.E. Dr. Kesetebirhan Admassu, Minister of FMoH.

During the 27thAnnual Conference and General Assembly meeting, three distinguished public health professionals and two institutions were recognized for their remarkable contributions to the development of public health in Ethiopia. The following four categories were identified to issue the recognition: 1) life time public health service award, 2) senior public health researchers' award, 3) young public health researchers' award, and 4) institutional award. Accordingly, Dr. Asfaw Desta, Dr. Abera Kumie and Dr. Belay Tessema were declared winners in the first three categories respectively and received their certificates of acknowledgement. And the Organization for Women and Children Development in Ethiopia (ODaCE) and Menschen fur Menschen (People to People) each received the institutional award. All of the awardees received certificates of recognition from the guest of honor H.E. Professor Afework Kassu, State Minster of the Ministry of Science and Technology and Dr Mahlet Kifle, representative of the Minister of the Federal Ministry of Health of Ethiopia.

After tea break, wider panel discussions focusing on the "Human Resource for Health (HRH) in Ethiopia", "Challenges and Opportunities in Meeting the Sustainable Development Goals (SDG's) Targets" and "Health Service Coverage" took place. In this session, four panelists took turns to comment on different but complementary aspects of HRH in terms of national and global perspectives. During the discussion the panelists reached the consensus to focus on quality while maintaining quantity, strengthen continuous professional development, ensure inclusiveness in licensure of health professionals and strive for brain gains to draw in the diasporas to the health sector in Ethiopia.

Business meeting, concurrent sessions and visits to poster presentations were held in the afternoon in line with the conference schedule. The second and the third days were devoted to panel

discussions, concurrent sessions and poster presentations. There were a total of five (5) panels involving 18 sessions, 116 oral presentations and 73 posters at this conference. The 116 oral presentations were organized under 11 subcategories namely: Behavioral Science and Communication, Biomedical Science, Communicable Disease, Demography and Population, Environmental Health, Food and Nutrition, Health Economics/ Health Services and Human Resources, Mental Health and Substance Abuse, Neonatology – infant/ child and Adolescent Health, Non-Communicable Diseases and Pharmacology and Drug Use.

During the business meeting which was chaired by Dr. Fikreab Kebede, EPHA's annual activities report, EPHA's external audit report, election of new EPHA board members and other business issues were treated.

I. OPENING CEREMONY

(Monday, 22 February, 2016)

1.1. Program Introduction by Dr. Aster Tsegaye

The opening ceremony of the 27th Annual Conference of the Ethiopian Public Health Association, EPHA was started with program introduction made by **Dr Aster Tsegaye,** Executive Board Member of EPHA and the Master of Ceremony of the Conference. Dr. Aster welcomed the participants of the conference and introduced the program for the next three (3) days. Following this, she invited Dr. Fikreab Kebede, President of EPHA, to the floor so that he delivered the welcoming speech.

1.2. Welcoming Speech by Dr. Fikreab Kebede

Dr. Fikreab Kebede, President of EPHA, on behalf of EPHA and the Organizing Committee, welcomed the guest of honor, government officials, celebrities, representatives of partners, EPHA members and other invited guests to the 27th Annual Conference of the Ethiopian Public Health Association. He also thanked those who contributed to the success of the annual conference. On his welcome speech, he announced that over 207 scientific, oral and poster presentations would be conducted during the conference. He further expressed his belief that these presentations would have significant contributions to the development of science and technology and the strengthening of evidence based approaches in public health and medicine. Before moving to the introduction of the program, he kindly requested the participants to stand up and pay tribute to the untimely death of professional colleagues and EPHA members, namely: Dr. Hailu Yeneneh, Ex-secretary of the General Assembly, Dr. Yohannes Kebede, EPHA member, and Ato Dereje Seyoum, EPHA secretariat member, by conducting a moment of silence. (See the full text of Dr Fikreab's speech in Annex I).

Photo 1: Dr. Fikreab Kebede, president of EPHA, delivering a welcoming speech to the participants of the 27th EPHA Annual Conference.

Afterwards, Dr. Aster Tesgaye, Board Member and Master of Ceremony, invited Dr Ashenafi Haile, of CDC Ethiopia, to the floor to make an opening remark on behalf of Mr Jefrey Hanson, Country director for CDC Ethiopia.

Photo 2: Partial view of the participants of the 27th EPHA Annual Conference.

1.3. Keynote Addresses

1.3.1. Keynote Address by Dr. Ashenafi Haile, Representing Dr. Jeffery Hanson, Country Director of CDC Ethiopia.

Representative of CDC Dr. Ashenafi Haile delivered his keynote address in which he appreciated EPHA for its remarkable contributions to the development of the public health sector in Ethiopia. He further revealed as to how the meaningful partnership between CDC and EPHA has brought forth the implementation of the field epidemiology program and surveys across the country.

Dr. Ashenafi has also accentuated the role and meaningful interventions of the association in terms of capacity building program which has been geared towards improving the public health situation of the country. He finally stated that CDC would continue the partnership with the association in areas pertinent to both organizations (See Annex II for the full text of Dr. Ashenafi Haile's speech).

1.3.2. Keynote Address by H.E. Professor Afework Kassu, State Minister of the Ministry of Science and Technology

Professor Afework Kassu, State Minister of Science and Technology, also delivered his keynote speech that shows to what extent the Second Growth and Transformation Plan of Ethiopia has paid great emphasis to scientific researches. He emphasized that the significant increment of budget allocation has enhanced the magnitude and dissemination of locally based scientific researches. He further expressed the strong commitment of the ministry to support the research endeavors undertaken by institutions like EPHA and other national institutions which are engaged in conducting scientific and technological research activities.

Photo 3: H.E. Professor Afework Kassu delivering a keynote speech to the 27th EPHA Annual Conference.

(The full speech of Professor Afework Kassu is attached as Annex III)

1.3.3. Opening Speech by Dr. Mahlet Kifle, on behalf of H.E. Dr .Keseteberhan Admasu, Minister of Health of Ethiopia.

The event was officially opened by the speech delivered by His Excellency Dr. Kesetebirhan Admassu, Minister of health, through his representative Dr Mahlet Kifle. In his speech, the minister highlighted the contributions that the EPHA has made particularly towards the training of health workers at different levels on immunization, tuberculosis and HIV/AIDS in partnership with Universities. He also mentioned that the association played important role in terms of training health extension workers on long acting family planning method. According to him, this would improve access to the service and diversify the choice. In addition, the minister acknowledged that EPHA has played its part for the successful implementation of Health Sector Development Program and for the improvement of the health of Ethiopian people at large. His Excellency also recognized the momentous role that the EPHA played during the development of the Health Sector Transformation Plan which has been launched nationwide for a couple of months. He finally stressed the importance of the joint Post Graduate Training Program, which is supported by the association in partnership with the Ministries of Health and Education (See Annex IV for full text message).

Photo 4: Dr. Mahlet Kifle, representative of H.E. Dr. Keseteberhan Admasu, officially opening the 27th EPHA Annual Conference.

1.4. EPHA Award Ceremony

As in previous years, the 27th Annual Conference of EPHA also identified awardees that made significant contribution to the improvement of public health in Ethiopia. Accordingly, three distinguished public health professionals and two institutions were awarded. Professor Amsalu Feleke of Gondar University facilitated the award ceremony. Professor Amsalu declared that this year's the EPHA awards is given to five winners in four categories, namely:

1. Life Time Public Health Service Award
2. Senior Public Health Research Award
3. Young Public Health Research Award and,
4. Institutional Award

The guest of honor, H.E. Professor Afework Kassu, State Minster of the Ministry of Science and Technology and Dr. Mahlet Kifle, representative of the Minister of Health, handed the prizes to the awardees.

Photo 5: Awardees of the 27th EPHA Annual Conference.

Left to right: Dr. Asfaw Desta, W/ro Zewdie Belay (for Dr. Abera Kumie), Center (for Dr. Belay Tessema), Representative of the organization for the development of Women and Children in Ethiopia and, Dr Asnake who is representative of the Menschen fur Menschen.

1.4.1. Life Time Public Health Service Award– Dr. Asfaw Desta

Life Time Public Health Service Award goes to Dr. Asfaw Desta. He has immense contributions to the development and wellbeing of the sector. Dr. Asfaw graduated in Doctor of Public Health from John Hopkins University in 1971, and he did his MPH in California University in 1968. He earned his B. Sc. Degree from American University of Beirut in 1961. His professional career started as a science teacher and he served as a health educator in Gondar as Chief Provincial Health Educator in MoH. He also worked as a Health Administrator in both A.A.U. and Gondar.

Between 1972 and 1987, he served his country as Executive Secretary of Ethiopian Red Cross Society, Assistant Professor in Health and Administration of School of Public Health, Head and member of NHDN-E of Nucleus of National Health Development Network and Head of Department of community Health of A.A.U.

This notable and distinguished professional also served EPHA as a member, reviewer and volunteer Editor-in chief of the Ethiopian Journal of Health Development for several years. All in all, Dr. Asfaw contributed a lot in the development of public health in Ethiopia for about 43 years. He retired some years ago.

1.4.2. Senior Public Health Research Award – Dr. Abera Kumie

Dr. Abera Kumie graduated as a Medical Doctor Practitioner in public Health in 1983 from former USSR. He received Master of Science (MSc) in public Health in 1991 from Tulane University School of Public Health, Louisiana, USA. He graduated with PhD in Public Health in 15 June, 2009 from Addis Ababa University, Medical Faculty. Currently, he is working in the school of Public Health, college of Health Sciences, Addis Ababa University. He has been Post-doc student since January 2015.

Dr. Abera's professional career started in 1983. He worked in the Ministry of Health as an expert, Head of Division and Department at various capacities till 1993. From 1993 to1998 he worked in Addis Ababa Regional Health Bureau as a specialist, expert, department head in the field of Environmental Health. From January 2000 to February 2003, he was a Lecturer in Medical Faculty of Addis Ababa University.

Dr. Abera Kumie has a total of 39 publications. He has been a member and representative of EPHA for many years. Dr Abera Kumie is a Volunteer reviewer for EPHA year after year. He contributed a lot in the Development of Public Health in Ethiopia. Since May 2003, he has been working as an Assistant Professor of Public Health. He has been giving a lecture on Public Health with Special Reference to Environmental Health. Currently, he is coordinating the PhD training programs, teaching undergraduate medical students and graduate (MPH) students. He actively involves in research works independently and with students. Apart from his involvement in various public consultancy and academic committees, he advises and supervises both undergraduate and graduate students in their efforts to prepare their senior essays and theses respectively. In short, Dr. Abera has served his country for 31 years.

1.4.3. Young Public Health Research Award- Dr. Belay Tessema

Dr. Belay Tessema studied Medical Laboratory Technology from 1996 to1998 in Gondar College of Medical Sciences and earned Diploma. He also earned Bachelor of Sciences (BSc) in 2003 from Jimma University. In 2007 he earned Master of Sciences (MSc) in Tropical & Infectious Diseases from Addis Ababa University. Lastly, from 2008 to 2012 he was awarded a scholarship from University of Leipzig, Germany to attend Epidemiology of Infectious Diseases and Clinical Immunology.

His professional career started in 1998 as a Technical Assistant in the Department of Medical Laboratory Technology of University of Gondar (the former Gondar College of Medical Sciences). From 2003 to 2004 he served as Graduate Assistant Lecturer II; from 2004 to 2008 he became Assistant Lecturer and Lecturer in the University. Since September 2011, he has served as a Consultant of International Laboratory Capacity Building program of American Society for Microbiology. He also served as Assistant Professor of Medical Microbiology and Epidemiology of Infectious Diseases in the University of Gondar. Furthermore, he served as Director and Head of school Health Sciences College in University of Gondar. In 2014, he was assigned as an Executive Board member of the same place, and he became one of the founders of Ethiopian Society for Microbiology. He has more than nine (9) publications.

1.4.4. Institutional Award

Two organizations were identified as winners for the event at the 27th EPHA Annual Conference. They are:

1. **The Organization for the Women and Child Development in Ethiopia (ODWaCE)**

Launched in 1987, the Organization for the Development of Women and Children Ethiopia (ODWaCE) works to improve the physical and psychological well-being of women and children in Ethiopia by reducing harmful traditional practices (HTPs). ODWaCE is a member of the National Female Genital Mutilation (FGM) Network, partnering with faith-based organizations and NGOs to conduct national and regional surveys on HTPs and FGM. By providing economic and medical aid to women, ODWaCE, supports those affected by HTPs. It makes them physically recover, generate personal income, and contribute to the growth of the economy. ODWaCE also

endorses programs that enable children have access to higher education. The organization hopes to use its research to supplement governmental institutions such as the Ethiopian Ministry for Women, Children, and Youth Affairs. The organization was formerly known as the Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber [የኢትዮጵያ ጎጂ ልማዳዊ ድርጊቶች አስወጋጅ ማህበር] and the National Committee on Traditional Practices in Ethiopia.

2. Menschen fur Menschen (MfM)

Menschen für Menschen was brought into being by Karl Heinz Böhm. The actor, who became famous in the 1950s through his role as Emperor Franz Joseph at the side of Romy Schneider in the film trilogy 'Sissi', delivered brilliant performances in the films of famous directors such as Rainer Werner Fassbinder and on major German-language stages. Profoundly shocked by reports of the catastrophic famine in the Sahel Zone, in 1981 Karl Heinz Böhm took advantage of his popularity to help. His legendary wager in the ZDF show raised DM 1.2 million for people in Africa. In October, 1981 Böhm flew to Ethiopia for the first time. On 13 November, 1981 he set up the Menschen for Menschen Foundation, which he managed until 2011. Karl Heinz Böhm died on May 29, aged 86.

The goal of the Menschen for Menschen Foundation is to enable the people it supports to continue improving their living conditions by their own means within a reasonable time scale, until one day – thus the vision – Ethiopia no longer requires help from the outside. As laid down in its statutes, the Foundation aims to promote development aid and the health care system in Ethiopia as well as understanding among peoples. Besides this, it provides support to Ethiopians who urgently need the help of others for reasons of poverty and physical, mental or spiritual limitations. In order to achieve this, *Menschen für Menschen* provides emergency aid and funds for the improvement of water and food supplies, the preschool and school education system, general and vocational training, medical care, infrastructure, agriculture and livestock farming. In a multitude of projects the Foundation strives to protect natural resources. It also supports the abolition of harmful traditions, such as female genital mutilation and the fight against diseases and HIV/AIDS. In addition, *Menschen für Menschen* promotes awareness-raising initiatives, to bring the crisis situation of people in poor countries to the attention of the population of industrial nations and inform them about the work of the Foundation in Ethiopia. To achieve its goal *Menschen für*

Menschen organizes media work, events and high-profile campaigns. The Foundation provides details of the application of funds in its annual report.

Currently, *Menschen für Menschen* operates in nine (9) regions in Ethiopia.

Immediately after decoration, the awardees were given two minutes each to express their feeling. Accordingly, though it is given to him in recognition to his contributions to the promotion of public health in Ethiopia, Dr. Asfaw Desta was generous enough to acknowledge the contributions of his colleagues and institutions he worked for the honor he has received at this very day. He finally said, this is his special day and thanked EPHA for the acknowledgement and award. Next to him spoke W/ro Zewdie Belay, and she witnessed that Dr. Abera is so committed, polite and honest. She further describes that she is deeply impressed by the feedbacks she has got from his students, and believes that he deserves the prize.

EJHD Oonline Article Submission Website Launching Event

Demonstration of the newly developed website of the Ethiopian Journal of Health Development (EJHD) for online submission of articles was shortly presented to participants by EPHA IT expert. The online application page as displayed by the IT expert is presented on Figure 1.

Figure 1: The online application page at the website of the EJHD.

Professor Damen Hailemariam, Editor- in- Chief of the Journal, chaired this session. After hot discussion, Professor Damen Hailemariam announced the official launching of the online submission website for the EJHD which is made possible in collaboration of EPHA and Public Health Department of A.A.U. The electronic submission system is believed to simplify access to the Journal and encourage contributors to easily submit articles. The website can be visited at www.ejhd.org

II. PANEL DISCUSSIONS

A series of panel discussions focusing on various thematic areas were organized during the course of 3 days. Accordingly, day 1 had only one panel focusing on the theme "Strengthening Human Capital in Meeting Health Related SDG's Targets and Health Service Coverage." In this session, four panelists took turns to comment on different but complementary aspects of HRH in terms of national and global perspectives. During the discussion the panelists reached the consensus to focus on quality while maintaining quantity, strengthen continuous professional development, ensure inclusiveness in licensure of health professionals and strive for brain gains to draw in the Diasporas to the health sector in Ethiopia.

Photo 6: Panel discussion on progress at the 27th EPHA Annual Conference.

In day 2 and day 3, two panel sessions each were conducted.

The themes for day 2 were:

1. Ensuring equitable and quality health care in urban and rural settings.
2. The health lenses of demographic and epidemiologic transitions.

The themes for day 3 focused on:

1. The urban health concerns in Ethiopia
2. Health information: key component of the health system

2.1. Strengthening Human Capital in Meeting Health Related SDGs' Targets and Health Service Coverage

Chair: Professor Yemane Berhane, Addis Continental Institute of Public Health;

The following main topics were presented to the audience in a plenary meeting:

1. Policy and practice frameworks on HRH – Ethiopian context
   Presenter: Mr Mohammed Hussiene (On behalf of Dr. Getachew Tolera of FMoH)
2. HRH capacity development: Transforming education and training.

Presenter: Dr. Tegbar Yigzaw from JHPIEGO

3. Health professional licensing and registration.
   Presenter: Mrs Mastewal Kerebih from FMHACA –FMoH
4. Motivation and retention of health professionals
   Presenter: Dr. Helina Worku from USAID Ethiopia

2.1.1. Policy and Practice Frameworks on HRH – Ethiopian Context

Mohammed Hussien Abaseko, MPH, Ministry of Health

The following national, regional and global initiatives for HRH were presented as introduction:

1. Health workers are the cornerstones and drivers of health systems.
2. Shortage is one of the most critical constraints to the achievement of health and development goals
3. New and innovative initiatives are ultimately needed to increase the number of trained health workers and to scale up investment in education
4. The 2001 Abuja Declaration for increasing financial resources for health including HRH
5. The Kampala Declaration and Agenda for Global Action, endorsed in March 2008 at the First Global Forum on Human Resources for Health.
6. It is high time that the issue of human resource for health figures prominently on the global public health agenda

National policy framework for HRH was presented. The policy framework is thought to be practiced on the basis of the National Health Policy itself that intends to make the nation a lower middle income country by 2025, Envisioning Ethiopia's Path towards universal health coverage through strengthening Primary Health Care, and the Growth and Transformation Plan, HSTP and HRH Strategy.

Ethiopia's health tier system, distribution of health personnel and the levels of the health service program are presented on figure 1

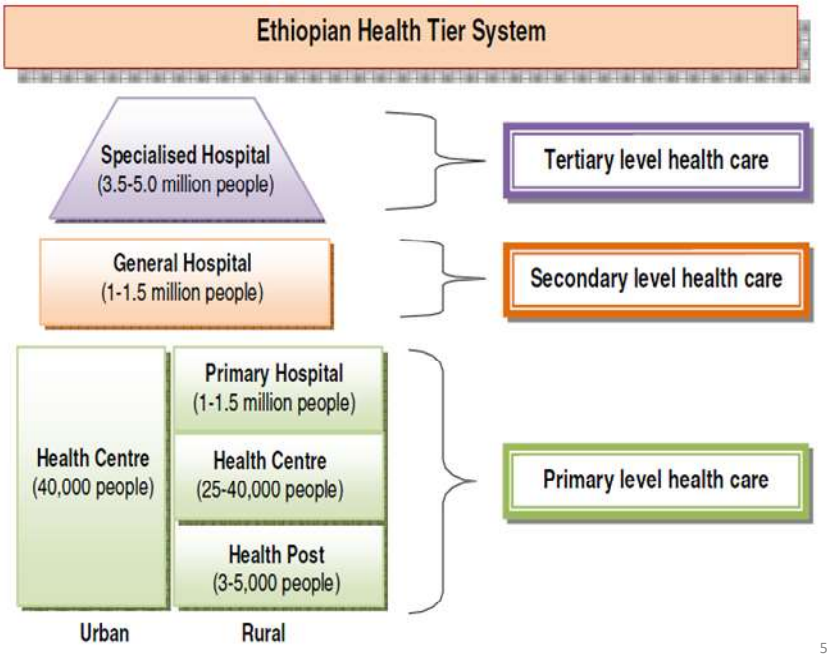


Figure 2: Human resource distribution and the levels of health care in the Ethiopian health tier system.

Shortage of HRH is identified as one of the most critical constraints to the achievement of health and development goals.

The National Health Policy, the GTP, HSTP and the draft HRH strategy are among the sound policy frameworks.

A promising achievement is that the density of health force has increased from 0.1to1.3 per 1000 population.

Poor quality of training, high attrition rate, substandard ethics and professionalism are substantiated as major challenges.

2.1.2. HRH Capacity Development: Transforming Education and Training

Dr. Tegbar Yigzaw

In his introduction, Dr. Tegbar Yigzaw discussed the concepts of SDG's, UHC and HRH in line with the Global Strategy on Human Resources for Health: Workforce 2030 initiative.

Ethiopia has one of the lowest workforce densities. This is demonstrated by the fact that total workforce per 1000 population in the world is 5.99; in Africa it is 2.22, in low middle income countries 3.91; whereas in Ethiopia it is only 1.3 (Figure 3).

Ethiopia has very low health workforce density (WHO, 2015; FMOH, 2015)

Region	Total health workforce per 1000 pop	Medical doctors per 1000 pop	Nurses/ midwives per 1000 pop
World	5.99	1.38	2.81
High income	12.91	2.92	6.48
Upper-middle income	6.12	1.61	2.74
Lower-middle income	3.91	0.77	1.75
Low	1.11	0.19	0.51
Africa	2.22	0.27	1.22
Ethiopia	1.3	0.05	0.57

Figure 3: The health workforce density in Ethiopia

The last decade has observed remarkable jump in workforce in Ethiopia. Medical schools jumped from 3 to35, and over 35 000 HEW's are operating in the country.

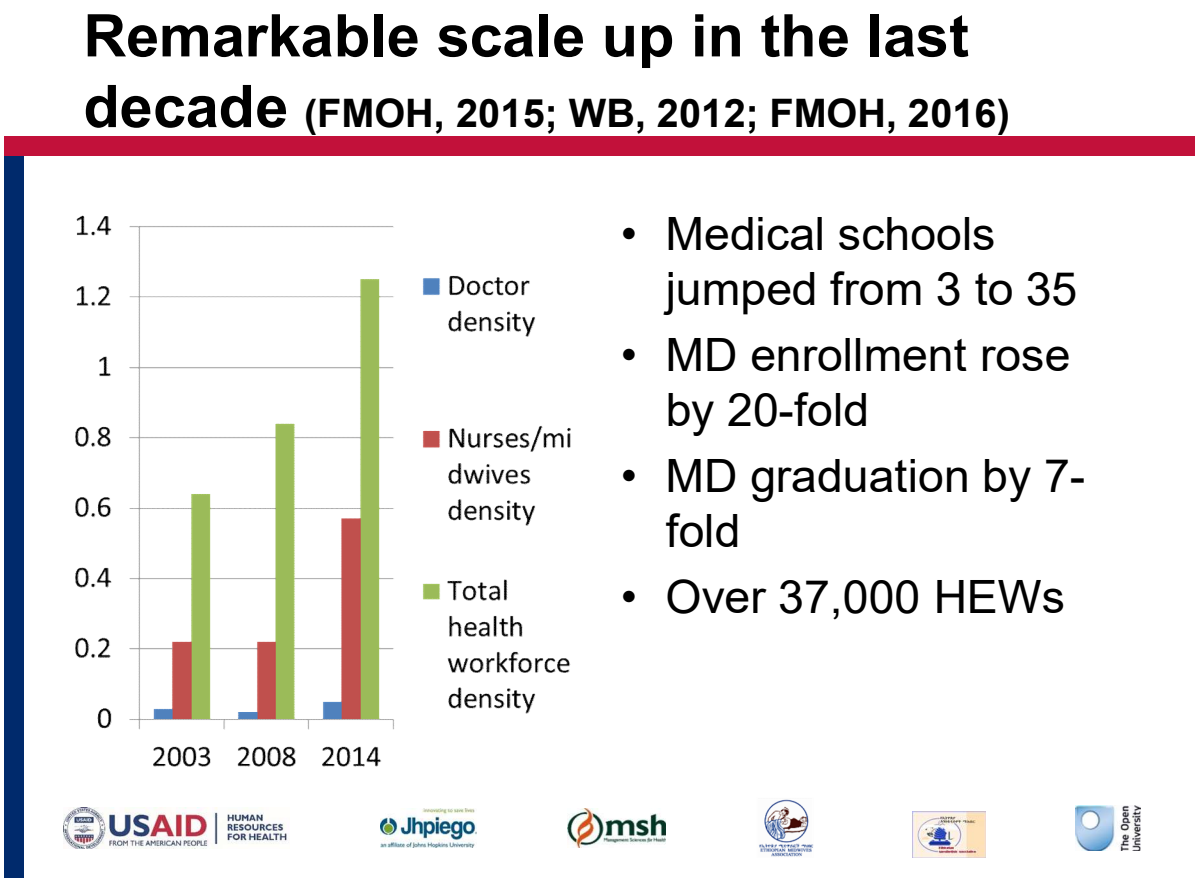


Figure 4: Changes in the number of health workforce during the last decade in Ethiopia.

Regional disparity in health workforce density, (Highest in Harari and Addis Ababa and lowest in Afar and Amhara).

Problems related to pre-service education were mentioned as: low competence level, curriculum lacks relevance and not performance oriented, shortage of able and motivated faculty, sub-optimal skills learning resources, poor coordination with clinical practice sites, weak quality management, weak accreditation systems and limited criteria of student selection.

Suggested corrective actions that would transform the problems related to HRH are mentioned as: redesigning competency based curriculum, strengthening practical education, strengthening inter-professional education, developing faculty and retention, developing culture of continuous quality improvement, having mandatory accreditation and using comprehensive student selection criteria.

2.1.3. Health Professionals Registration and Licensing

Mrs Mastewal Kerebih

Despite the fact that health professional licensing started in 1949, laws, regulations and enforcement mechanisms were vague if not absent.

The new regulation, the Food, Medicine and Health Care Administration and Control Proclamation No 661/2009 and Regulation No. 299/2013 have been introduced since 2009. Professional practice license given to any health professional shall be renewed every five years upon ethical and competence evaluation.

FMHACA in collaboration with professional associations, developmental partners and FMOH is working on the process of establishing and implementing CPD, SOP and ethical and competency review system at federal and regional level.

FMHACA is currently issuing license to new graduates, professionals in the service sector and those coming from abroad.

Standards in health professionals' registration and licensing:

- Development of enforceable directives
- Ensuring the relevance of health regulatory system and to increase the knowledge of health professionals
- Strengthening the scope of health professionals and continuous professional development program
- System to strengthening the ethical competence of health professionals
- Strengthening the involvement and commitment of professional associations
- Establishing internal audit regulatory system
- Strengthening the structure of health regulatory sector

For further information visit the website of EFMHACA, **www.fmhaca.gov.et , Free line – 8482,** and use the email address: **regulatory@fmhaca.gov.et**; these sources practically help anyone access Guidelines, Directives & Any Regulatory information.

2.1.4 . Motivation and Retention

Dr. Helina Worku

Dr.Helina started her presentation with an attractive outline followed by a diagram illustrating the glue of the health system.

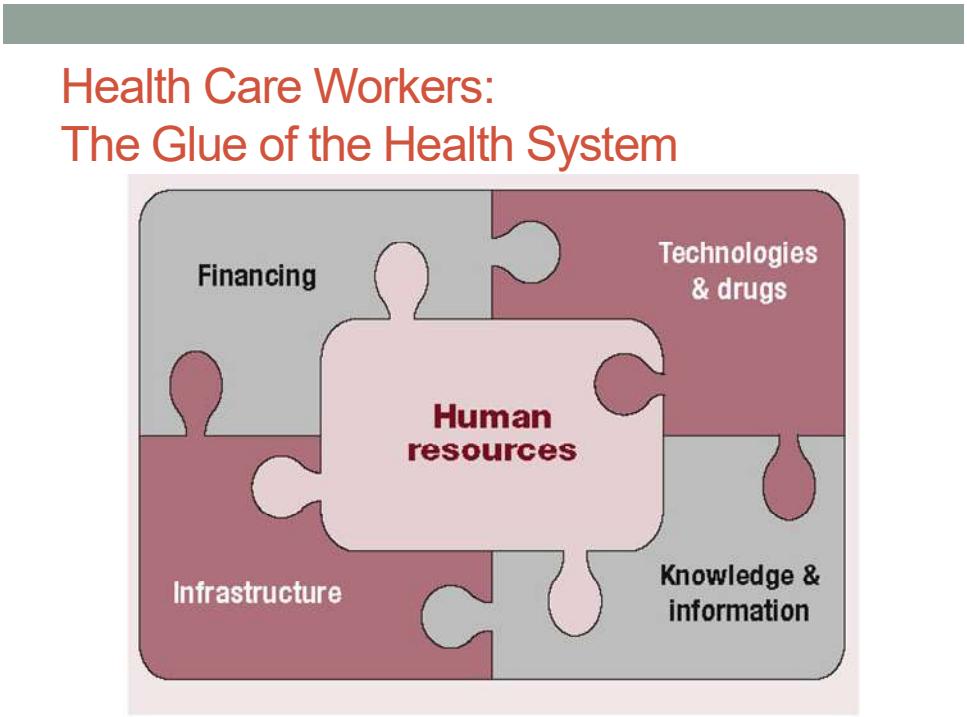


Figure 5: An illustration of the glue to the health system

During the course of the presentation conceptual definitions of retention and motivation were forwarded as follows:

- **Retention:** refers to the ability to keep employees in an organization; usually as a result of employees' job satisfaction;
- **Motivation:** indicates the tendency to initiate and sustain effort towards a goal; it is usually achieved through incentives that bring forth the improvement employees' performances.

This was followed by illustration of the relationship between retention and motivation:

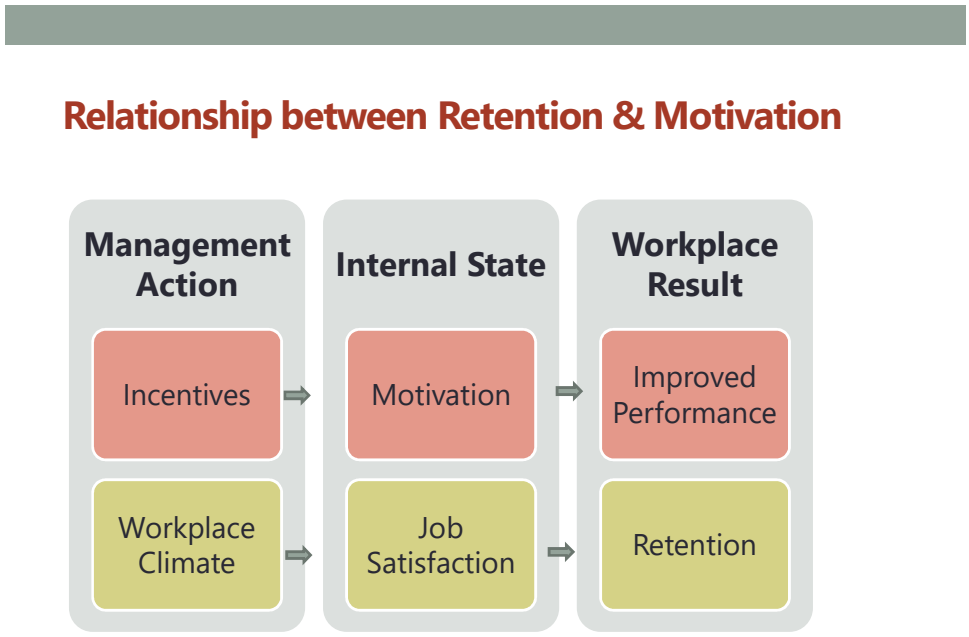


Figure 6: The link between retention and motivation

- Ethiopia is included in the list of 53 countries with critical shortage of health service providers
- Seven motivational components identified from a review of 20 articles. These are: (1) financial rewards, (2) career development, (3) continuing education, (4) health facility infrastructure, (5) resource availability, (6) health facility management and (7) recognition/appreciation.
- Survey on Job satisfaction of different health professionals is not promising. Nearly 50% of the professionals have a plan to leave within a year;
- The three main reasons that urge the professionals to leave are low pay, high cost of living and less chance to get further education;
- Dr. Helina also elaborated what is meant by Brain Drain, Brain Gain, Brain Circulation and Brain Waste;
- Most of the workforce in developed countries comes from other developing countries
- Sub-Saharan Africa is losing more than 30% of its health workforce to Europe and America;
- The two general strategies to address brain drain are increasing retention and facilitating the return of diasporas;

Photo 7: Panelists facing questions and comments

Discussion: Questions, comments and suggestions

After the presentation of the first group of panelists on four topics namely: (1) Policy and practice framework on HRH, (2) HRH capacity development: Transforming education and training, (3) Health professional licensing and registration, and (4) Motivation and retention of health professionals, the chair person opened the floor for questions and discussions. Accordingly, the following questions and comments were forwarded from the audience:

Questions directed to Ato Mohammed

Q. It was suggested that recycling of health professionals, for example, changing a health officer to a physician may not solve the problem of shortage, and it may even create critical shortage of manpower to the other end. How do you explain this?

R. It is true that recycling of professionals needs to be made based on data. However, we have a gap in that we do not have a data base for priority setting. Because of the confusion created due to lack of updated data, we have not been perfect in priority setting, and this has been reflected in the universities, too. The universities were requested to close and open programs without having tangible evidences that lie on sufficient data and study.

Q. It was commented that the flagship mentioned is not complete; it did not show what is planned for all categories of health professionals. What is your plan?

R. Flagship is planned in consideration of all health professionals. What is mentioned in the list is just to prioritize health disciplines that the ministry follows and check regularly. It should also be clear that the health and ethics issues are complex that we cannot merge together as it is not feasible to start the flagship for every discipline at once.

Questions directed to Dr.Tegbar

Q. The question about recycling was also forwarded to Dr Tegbar, and he responded it as:

R. I agree that we have shortage of manpower in all disciplines. Recycling doesn't help. Competence measurement for post graduate level health professionals is also under consideration.

Q. In your presentation, you mentioned that by 2030, 90% of the countries in the world will be having an HRH strategy. Is Ethiopia included?

R. That is the expectation.

Questions directed to Mrs Mastewal

Q. The capacity of your organization to get all professional licensed is not sufficient. Many health professionals report that they spend too much time and unable to get the license upon their request. What is the problem?

R. We acknowledge that we have gaps in serving the Health workforce in licensing. Our capacity currently is minimal and it has to be strengthened.

Questions directed to Dr. Helina

Q. May increasing age of retirement help to fill some gape in the shortage of manpower?

R. Yes, increasing the retirement age of health workers may help

General Comments and Suggestions

1. The participants emphasized that Ministry of Health has to examine and seek solutions for the instability of the health professionals in their place. What we are observing nowadays is that the health professionals are ready to leave by the very day of their graduation. We need to know what is going wrong and work towards solving this problem. We have to produce a citizen that is motivated to serve her/his nation.
2. It is also advisable to revisit our naming to health professionals. Previously we used to call them health professionals; currently, we call them health CADRES. Could this be one of the sources for dissatisfaction? The ministry has to assess this and re-consider the naming.

3. Why did the ministry fail to test the competence of public health officers? Considering the objectives of training that seek to make them public health workers who even practice minor surgery, it is critical that the ministry give priority in testing the competence of public health officers.

4. Finally, it was concluded from the podium that there is also a critical need to look into the quality of training institutions and trainers themselves. Standardization of public health training institutes must be enforced and trainers must be certified/ licensed. Double standards between public and private institutions must be avoided.

2.2. ENSURING EQUITABLE AND QUALITY HEALTH CARE IN THE URBAN AND RURAL SETTING.

Chair: Professor Damen Hailemariam

Pannelists:

1. Dr. Tatek Bogale, from FmoH
2. Dr. Tadele Bogale, from FmoH – MSH
3. Ato Kora Tushune, from Jimma University

2.2.1. Caring, Respectful and Compassionate Health Workforce (CRC)

Dr .Tatek Bogale (MD, MPH).

The goal of CRC is to achieve the HSTP's goal through the production of caring, respectful and compassionate health workforce.

Rationale: This National Movement (CRC) will play a vital role in achieving plans and goals in the HSTP.

Some of the strategies intends to:

- Provide CPD on CRC implementation
- Keep the profile and data base of the existing health workforce electronically
- Provide advice for students joining health science colleges
- Provide continuous training for higher education instructors on CRC
- Engage model instructors and reward

- Do a 360 degree evaluation among students and reward champions
- Create CRC clubs with in Student Associations
- Revise curriculum in the context of CRC
- Revisit ethics and professionalism courses and include other teaching methods

There is a need to reflect the concept of CRC in all courses given for Health Science Colleges;

There is also a need to ensure as to how continuous assessments in Health Science Colleges focus on attitude in addition to knowledge and skills;

An advocacy work needs to be established so as to implement the CRC movement in Health science colleges and Universities;

Put a lot of effort into making students love and respect their profession so that they develop sprit of public service.

Work in collaboration with students association and students medical associations

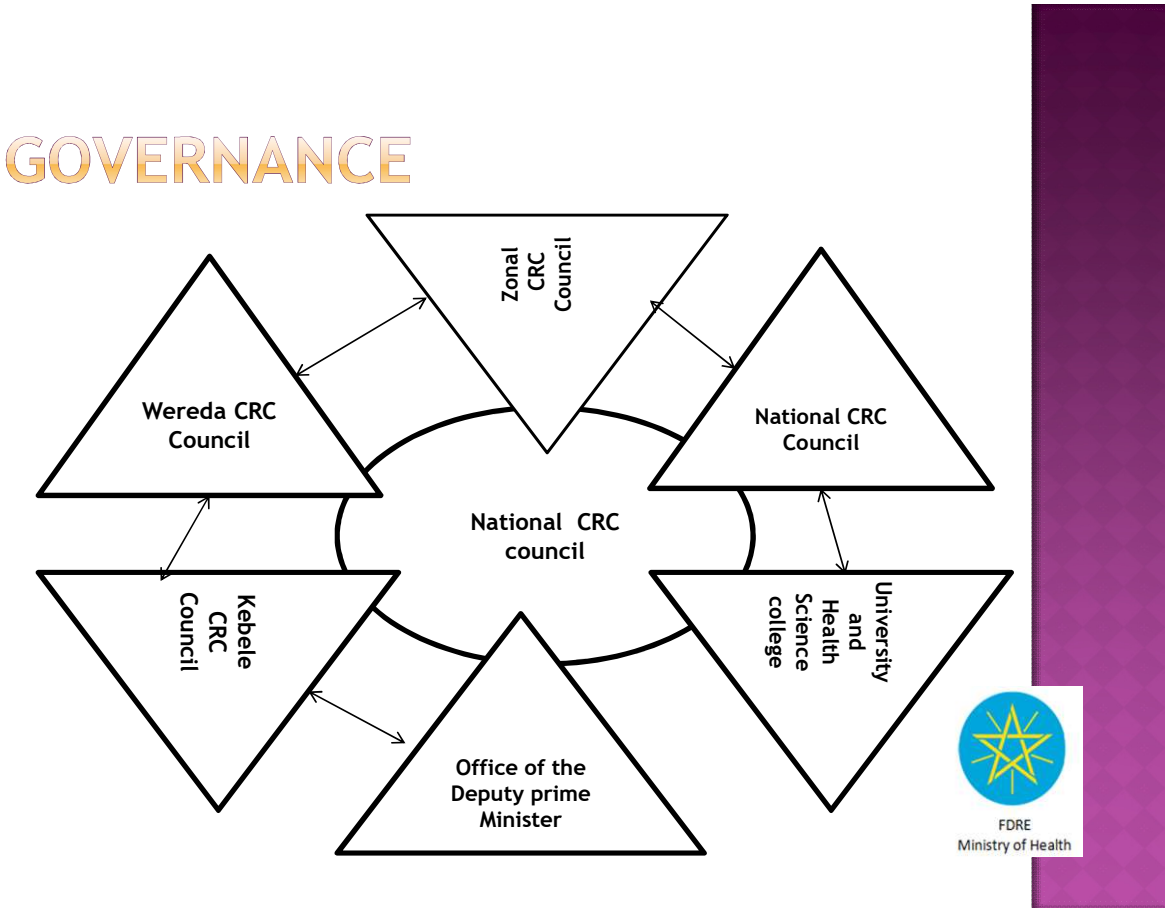


Figure 7: Governance structure for CRC in Ethiopia

2.2.2. Ensuring Equitable and Quality Health Care: Health Care Quality Parameters

Dr. Tadele Bogale

- Quality in health care is defined as, **"**the degree to which health services for individuals and populations increase their likelihood of desired health outcomes and are consistent with current professional knowledge"
- The full potential of healthcare will not be realized unless change making becomes an intrinsic part of everyone's job, every day, in all parts of the system;
- Although all improvement involves change, not all changes are improvement;
- If the system cannot consistently deliver today's science and technology, it would even be less prepared to respond to the extraordinary scientific advances that will surely emerge during the next decades;

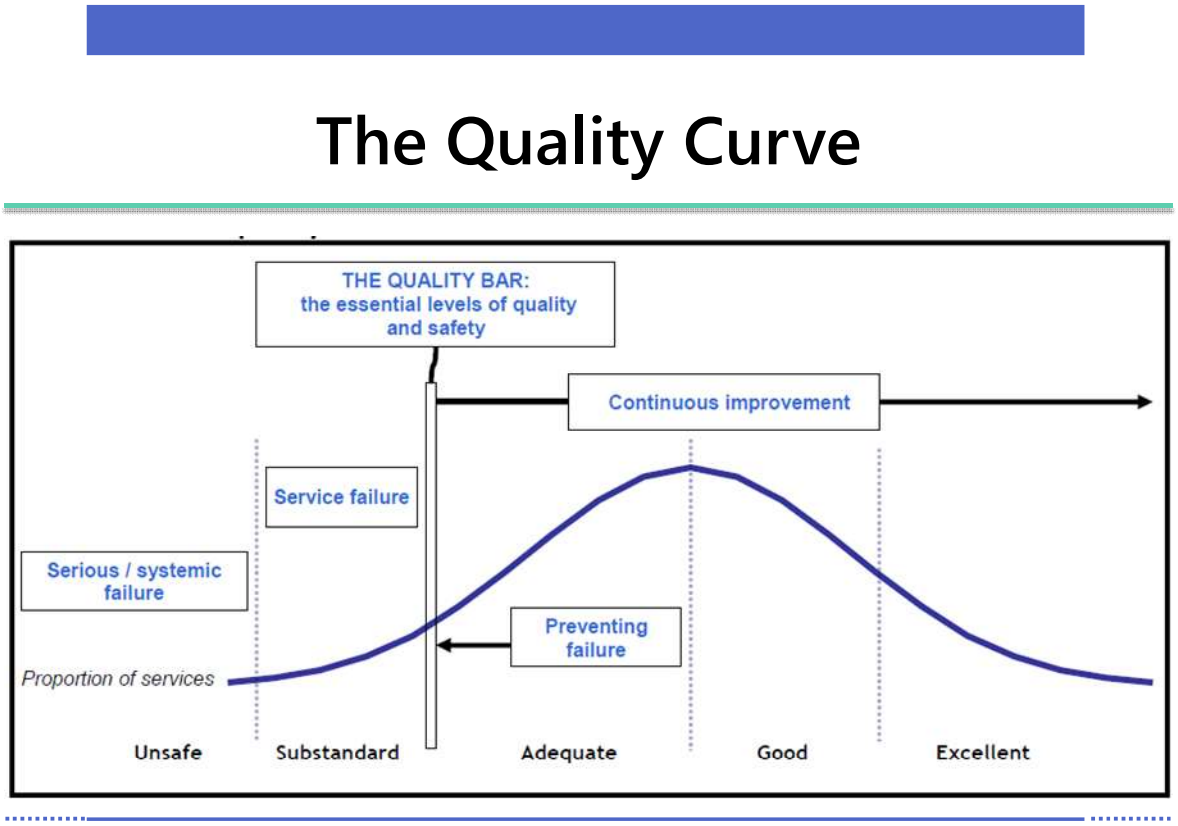


Figure 8: The quality curve

- Key components of the health care quality framework include: Clarity to quality, Measure quality, Publish quality, Reward quality, Leadership for quality and Innovate for quality;
- The key dimensions of the healthcare quality were presented as safe, effective, patient centered, timely, efficient and equitable;
- Quality in Ethiopia is defined as, "Comprehensive care that is measurably safe, effective, patient-centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently"
- Three core elements of quality are: (1) Quality planning, (2) Quality improvement and (3) Quality control;

Healthcare Quality Framework:

1. **Bring clarity to quality:** there must be clear and accepted definitions of what high quality care looks like; it can unite around patients, commissioners and providers. The quality standards of today will need to become the essential standards of tomorrow.
2. **Measure and publish quality:** the system can only hope to improve what it measures. There must be robust, relevant and timely information transparently available on the quality of care being provided at every level of the system. This information should be used to drive quality improvement at the front line, for the purposes of accountability and to support patient choice.
3. **Reward quality:** payments and incentives must be structured to encourage quality improvement. Clinical commissioning groups and others will use these payment mechanisms to contract with providers for the delivery of high quality care and to manage those contracts.
4. **Leadership for quality:** leadership nationally and locally is essential for quality improvement to be embedded, encouraged and rewarded.
5. **Innovate for quality:** continuous quality improvement requires health services to search for and apply innovative approaches to delivering healthcare, consistently and comprehensively across the system.
6. **Safeguard quality:** any system that strives for quality improvement must, at the same time, ensure that the essential standards of safety and quality are maintained. Each part of the system must fulfill their distinct roles, and responsibilities in relation to quality, as well as working together in a culture of open and honest cooperation in the best interests of patients.

Benefits of Quality:

Table 1: The benefits to providers, clients and organizations of providing quality care.

Provider	Receiver/clients	Organization
▪ **Pride in services delivered** ▪ **Job satisfaction with the final outcome** ▪ **Improved communications** ▪ **Streamlined work processes** ▪ **Happier clients** ▪ **Strong client relationships**	▪ Improved choices ▪ Improved services ▪ Accessible and affordable services ▪ Expectations met/exceeded ▪ Friendlier atmosphere ▪ Less waiting time ▪ Early cure and rerun to work ▪ Being treated with integrity, courtesy and respect	▪ Standardized care ▪ Ensure social equity ▪ Effective public resource utilization ▪ Improved/expanded services ▪ Improved client relations ▪ Improved community relations ▪ Better political relations ▪ Lower costs/cost contained ▪ Improved funding ▪ Better profit margin

Quality in Equity and Equality

Figure 9: The quality in Equity and equality

2.2.3. Health care financing for Universal Health Coverage (UHC).

Kora Tushune

Mr Kora started his presentation by defining what health care financing is. He provided a shorter and simpler definition that shows the mobilization of resources (money or in-kind) for provision of health care.

He further elaborated the building blocks of health care as recommended by WHO.

He also underlined the different models of health care financing, namely: The Bismark Model, which is insurance financed, the Beveridge Model, which is tax financed, and the DYI for developing countries.

Health care financing objective focuses on:

- Raising adequate resources
- Pooling resources in efficient, effective, equitable and sustainable way
- Paying for services in a way that ensures value for money

Attaining health system goals

Health care financing can be made possible through different modalities like:

1. Direct payment (User fees or -out -of pocket payments)
2. Prepayment methods such as general taxation, social health insurance, voluntary health insurance, community based health insurance.
3. External assistance
4. Others

The payment methods and the sources of prepayment methods are illustrated in Figure 10.

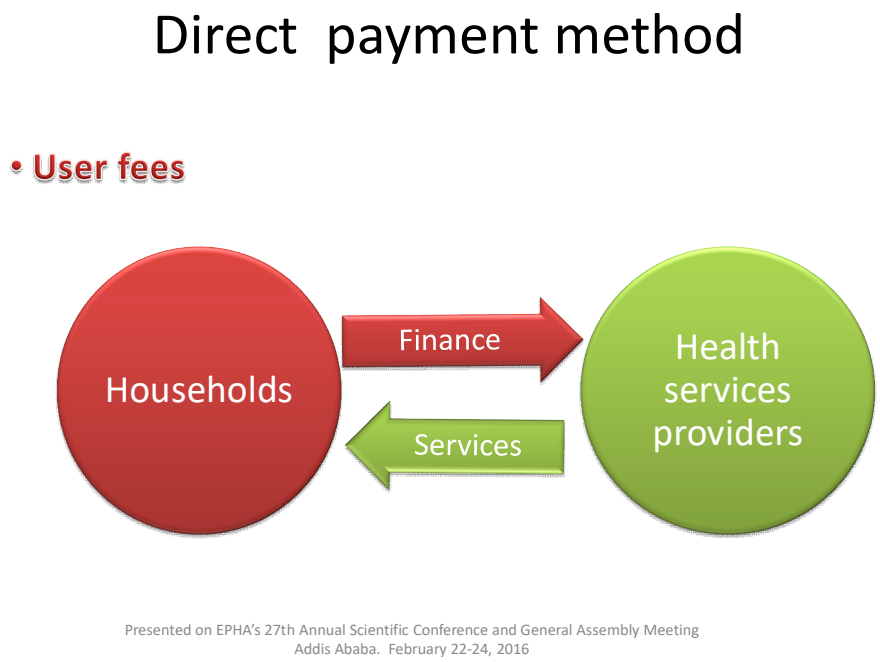


Figure 10: Direct payment methods in health care financing.

Indirect payment methods

- **Prepayment methods**

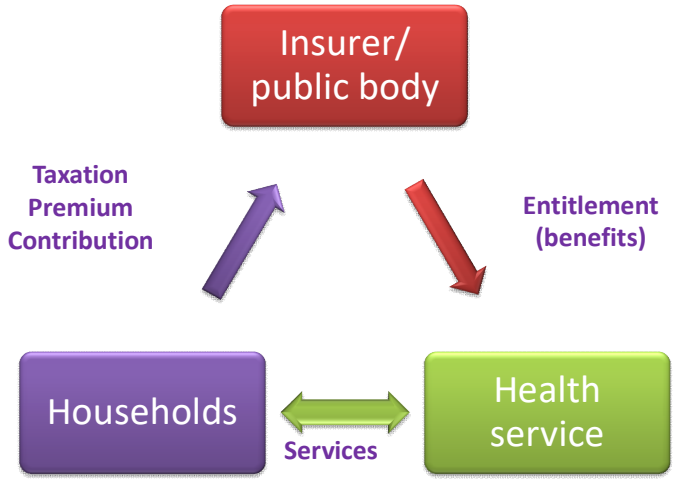


Figure 11: Indirect payment methods in Health Care Financing.

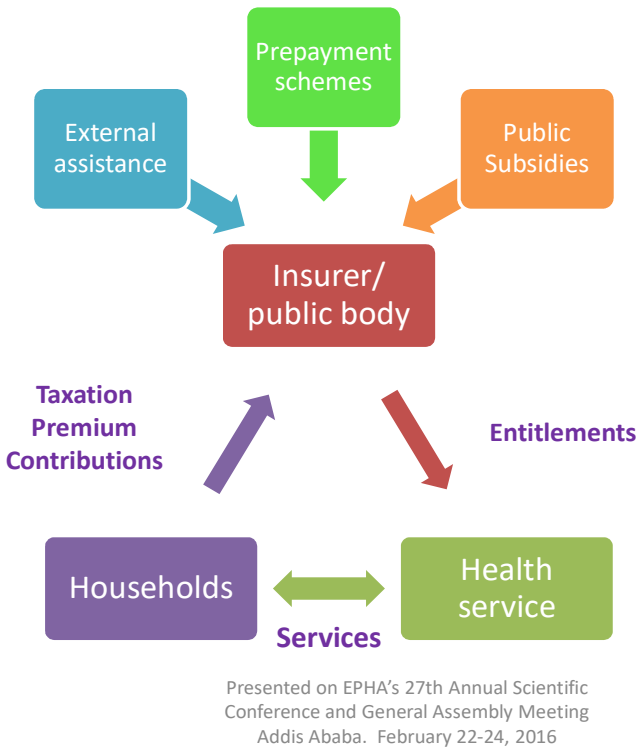


Figure 12: The sources of pre-payment methods in Health Care Financing.

In summary, Ethiopian health care financing reflects the following features:

- Highly donor financed;
- Per capita health spending is increasing, yet very low;
- Out-of-pocket payment accounts for a significant share of health expenditure;
- Development partners (50%) and households (34%) are the leading source of finance followed by the government (16%);
- Government handles half of the health care finance (48.9%), followed by households (34%);
- Health expenditure as % of total government expenditure (TGE) is increasing (to 5.6% from 5.0% in 2010/11), but it is still far from Abuja target

Finally, the presentation was concluded by showing selection criteria of the different health care financing models; it also reveals the strong and weak sides of each HCF modality.

Discussion/ Q & A

Questions directed to To Dr. Tatek:

Q. What are the specific mechanisms to ensure accountability?

R. A lot of mechanisms can be sited. Some of the most important ones include:

- Establishment of clear code of conduct
- Give clear job description to every assignment
- Clearly state the legal measures that health professional will face if failed to do ethically and,
- Avail the appropriate motivation modalities including job satisfaction.

Q. Don't you think in-service training is relevant to develop CRC workforce?

R. That is true. Currently, there are specific activities underway for in-service training. The training areas focus on:

- National laws and required conducts for health professionals
- Case scenarios and,
- Organized multi-disciplinary discussion sessions

Q. The strategies mentioned in the CRC are too much and redundant. It is very difficult to follow. They need to be revisited.

R. That is a valid comment. We will consider re-visiting them.

Q. The development of caring and respectful health professionals requires the identification of existing problems itself and the root causes for currently observed de-motivating factors. The presentation does not show the process as to how the ministry has come up with such a strategy. It is important to see where the problem is and align the solution to existing problems.

R. The ministry has already identified existing problems in CRC

Q. Many more factors than mentioned are involved in developing a CRC workforce. For example, the working environment (the physical environment) needs to be included. Please clarify on these factors.

R. It is planned to assess factors which lead to stress and lack of motivation. In the objective, the physical environment will be included as suggested.

Questions directed to Dr. Tadele

Q. Addressing gender equity and gender equality is a key to success of health service programs. I have not seen gender mainstreaming approaches in any of the presentations.

R. Gender is addressed in one of the 6 dimensions of health service quality.

Q. Where do you think we are in the quality bar? Do you think we have established essential levels of quality and safety that can prevent service failure?

R. In health quality parameters, quality bar is given to be used as a benchmark. I believe that we have established safety zones.

General comment

1. The current improvement in maternal mortality that this country is achieving should have been mentioned as an opportunity.
2. There is a need to identify role models and motivate them so that other professionals will follow.

2.3. THE HEALTH LENSES OF DEMOGRAPHIC AND EPIDEMIOLOGICAL TRANSITIONS

Moderator: Professor Tefera Belachew

Panelists:

1. Dr. Nega Assefa from Haromaya University on "Demographic Transition: an Opportunity and a Threat"
2. Professor Yigzaw Kebede from University of Gondar on "Triple Burden of Diseases: Conceptual framework"
3. Dr Kunuz Abdella from FMoH on "None Communicable Diseases"
4. Mr Biruk Kebede from FMoH on "Diseases of Poverty: Neglected Tropical Diseases"

2.3.1. Demographic Transition: an Opportunity and a Threat

Dr. Nega Assefa

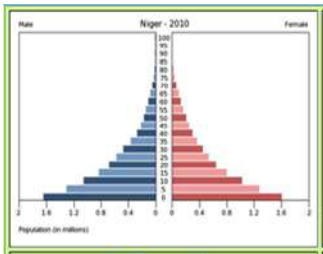
Areas of focus in this presentation were:

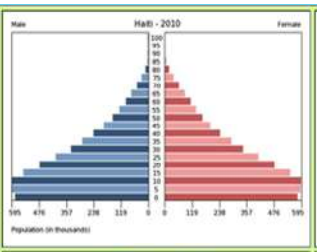
- Demographic transition
- Demographic dividend
- Demographic fatigue

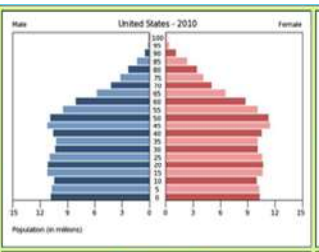
Demographic transition implies the shift from high to low mortality and fertility through four or five distinct stages.

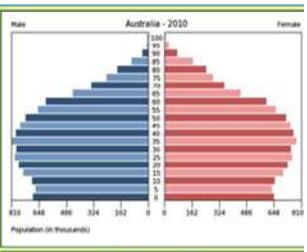
These stages are: High stationary, early expanding, late expanding, low stationary and declining.

The four stage demographic transition is illustrated in Figure 13.









Stage 1	Stage 2	Stage 3	Stage 4
Expansive.	Expansive.	Stationary.	Contractive.
Concave sides.	Straight sides.	Convex sides.	Convex sides.
High birth rate.	Still high birth rate.	Declining birth rate.	Very low birth rate.
High death rate.	Falling death rate.	Low death rate.	Low death rate.
Short life expectancy.	Slightly longer life expectancy.	Long life expectancy.	Longer life expectancy.
Rapid fall in each upward age group due to high DR.	Fall in DR so more people living into middle age.	An increasing proportion of the population is in the 65+ age group.	Higher dependency ratio.
Niger	Haiti	Morocco	Australia

Figure 13: Demographic transition stages.

Poorer countries will experience the highest future population growth:

Demographic dividend refers to an accelerated economic growth that may result from a quick decline in a country's mortality and fertility rates.

Demographic fatigue is inability to meet the social, economic, and environmental challenges imposed by rapid population growth and aging population.

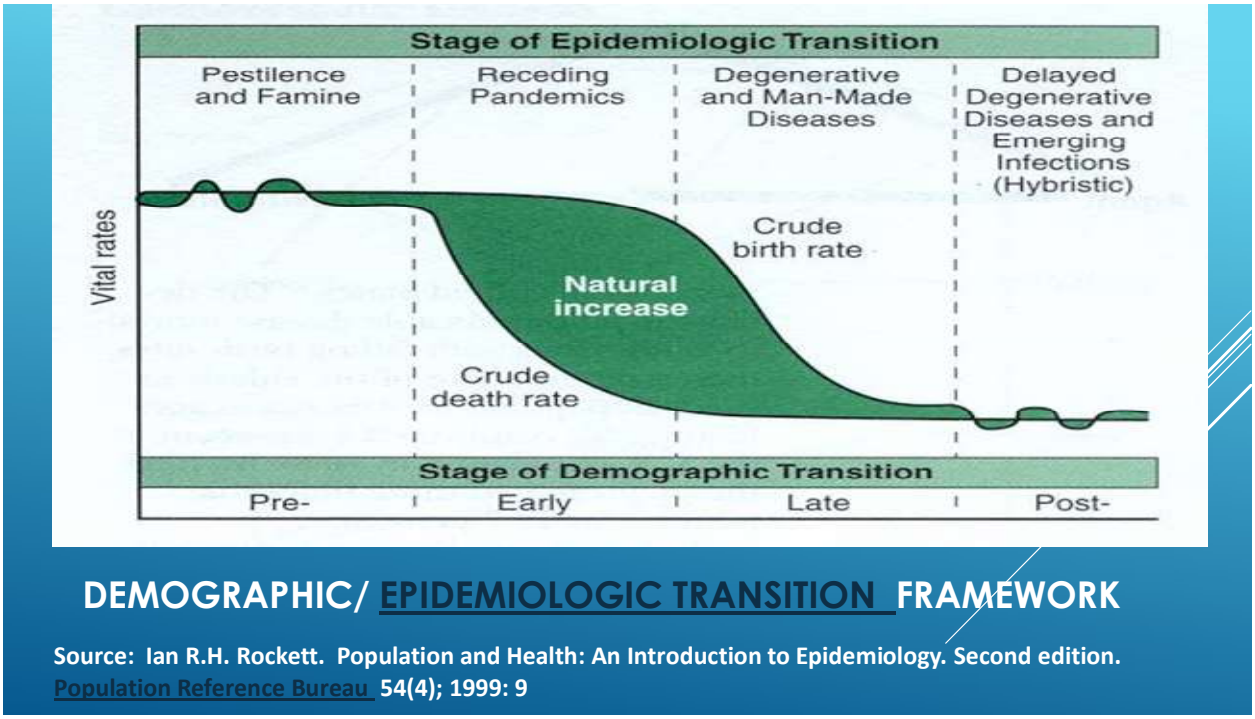


Figure 14: The four stages of epidemiologic transition.

Demographic transition: an opportunity or a challenge?

An opportunity

- Guided with good policy if population is developed through:
  - ✓ Education and skill acquisition
  - ✓ Proper health and welfare system
  - ✓ Investment /innovation/research
  - ✓ Women empowerment /literacy/family planning
- Earlier Japan, Later Singapore, Korea, Hong Kong, Taiwan and now China is using this opportunity

A challenge

- Fail to identify the clues of demographic dividend and intervene
- Large uneducated/untrained middle age
- Huge unemployment
- Country fells to war : Where there are armed fight, it tells misused demographic dividend
- If failed to plan and manage chronic health conditions

2.3.2. Diseases of Poverty - Neglected Tropical Diseases (NTDs)

Biruck Kebede; (BSc, MPH - IH), NTDs Team Lead, Federal Ministry of Health

Neglected Tropical Diseases (NTDs) are a group of parasitic and bacterial diseases that cause substantial illness for more than one billion people globally.

Trachoma, Onchocerciasis, Intestinal parasitosis, Filariasis and Schistosomiasis are among the NTDs.

NTDs are endemic in 149 countries.

- NTDs did not receive attention and funding as do "the big three" (HIV, TB, malaria)
- Evidence has shown that NTDs increase morbidity and transmission of "the big three"

The global burden from NTDs

- Globally, lymphatic filariasis causes 1 billion annual productivity losses.
- Trachoma is estimated to cost $2.9 billion in lost productivity due to low vision or blinding trachoma.

The eight identified NTDs' priorities in Ethiopia are: Trachoma, Lymphatic filariasis, Onchocerciasis (river blindness), Schistosomiasis, Soil-transmitted helminthiases, Leishmaniasis, Podoconiosis, Dracunculiasis (guinea-worm disease).

- ✓ The first NTD master plan (2013-2015) was launched on June 2013.
- ✓ The second master plan (2016-2020) is on the final stage

2.3.3. Non-Communicable Diseases: Today and Beyond

Kunuz Abdella (MD, MPH)

- None communicable diseases, also known as chronic diseases include chronic mental illnesses, violence and injuries;
- Four major NCDs (cardiovascular diseases, cancer, chronic respiratory diseases and diabetes) are responsible for **82%** of NCD deaths;
- NCDs currently cause more deaths than all other causes combined and NCD deaths are projected to increase from **38 million** in 2012 to 52 million by 2030;
- There is a potential for $84 billion loss in economic output from 2006-15, in the 23 countries from NCDs (the burden and cost of chronic diseases in LMIC. Lancet 2007; 370:1929-38);

The presenter projected two risk factors of none communicable diseases as modifiable and none modifiable.

1. The modifiable risk factors are further classified into behavioral and biological
    - Behavioral: *Unhealthy diet, Physical inactivity, Tobacco use, Harmful use of alcohol;*
    - Biological: *Raised Blood pressure, Raised serum cholesterol/lipids, Raised Blood sugar, Obesity;*
2. The none - modifiable risks are Age, sex and genetics

Government commitments

- ✓ The National Strategic Framework for Prevention and Control of NCDs, 2011-2014
- ✓ The National Action Plan for Prevention and Control of NCDs, 2014-2016
- ✓ National Guideline for Screening and Treatment of Cervical Cancer, 2015
- ✓ The National Cancer Control Plan 2016-2020

2.3.4. Triple burden of disease: Conceptual framework

Professor Yigzaw Kebede

Professor Yigzaw started his presentation by defining **Epidemiologic Transition** as the general shift from acute infections and deficiency diseases characteristic of underdevelopment to chronic non-communicable diseases characteristic of modernization and advanced levels of development. The most evident indicators of this transition are changes in the pattern of mortality and morbidity. Demographic changes and changes in risk factors are the two most important mechanisms for epidemiologic transition;

Four models of epidemiologic transition were substantiated

1. The Classical Epidemiologic Transition
2. The Accelerated Epidemiologic Transition
3. The Delayed Epidemiological Transition, and
4. The Third Epidemiologic Transition

Triple burden of disease (three groups)

1. **Group I:** Communicable, maternal and peri-natal conditions that cause most of the preventable illnesses and death;
2. **Group II:** Non-communicable conditions such as chronic diseases & malignancies
3. **Group III**: Injuries

Triple burden of disease in the Ethiopian context:

- Ethiopia is challenged by the mix of persistent infectious diseases and increasing non communicable diseases and injuries;
- The prevalence of non communicable diseases is increasing due to mainly lifestyle changes;
- The increase in life expectancy is also contributing to the increase in the prevalence of non communicable diseases;

The role of professional associations in addressing the triple burden of disease should focus on:

- Supporting the government in the development of health systems and policy
- Supporting universities in curricula development which addresses the major health problems
- Providing training for health professionals
- Conducting research activities

Questions/ answers, comments and discussion

Questions directed to Dr. Nega

Q. As I learn from Dr. Nega's presentation, population is increasing and this poses more impact on the integrity of the environment, and Professor Yigzaw on his part indicates that new and chronic diseases that cost the lives of people are coming. Hence, considering the harsh environment as a result of population growth coupled with poverty and poor treatment facilities that face us, how can we expect a broader age pyramid depicted for 2030?

R. Population growth rate is not increasing. It is in fact decreasing. However, there is still net population growth over time. Due to this the concern is correct. Awareness creation in environmental conservation is critical.

Questions directed to Professor Yigzaw

Q. Is there a country which suffers from epidemiological transition?

R. The future is uncertain. It is difficult to imagine how horrible the consequences would be if one or two catastrophic disease such as Ebola come to a developing country.

Questions directed to Mr Bruk Kebede

Q. The word neglected is not correct. Most of the diseases mentioned in your presentation as neglected tropical diseases were in fact getting the utmost attention in previous days. It is not fair to bring them back as neglected after we ignored them quite for a long time. Trachoma for example had a vertical program with a lot of investment. The same is true for Guinea Worm and Onchocericasis. Intestinal parasitosis and Schistosomiasis were also major programs under the ministry of health. They were not neglected, but perhaps the program implementation was not effective or it was unsustainable. Hence, it is not clear why they should emerge as neglected. Suggested is to rephrase them as 'infectious' or 'emerging' tropical diseases. What is your reflection?

R. Two reasons are given concerning as to how these diseases are considered as **neglected**:

1. We acknowledge that there was an effort, but it was not inclusive
2. We have to go in parallel with international consensus

Questions directed to Dr Kunuz Abdella

Q. We know that the ministry identified high disease burden districts (woredas) in Ethiopia. What happened to that initiative? We need to hear about that.

R. Preparations are underway. A major planned activity is capacity building.

General remark from participants

Population growth as mentioned by the presenter is a blessing not a curse. But we also have to stress that population growth becomes a blessing only when it is in parallel with economic development. In short, people have to work hard and be productive enough to benefit from the gifts of population growth. The government and the people at large have to strive for improving the work culture of the society.

2.4. THE URBAN HEALTH CONCERNS IN ETHIOPIA

Moderator: Professor Mengesha Admasu

Panelists:

1. Mr. Zelalem Adugna
2. Dr. Mirgissa Kaba
3. Mr. Zeleke Teferi
4. Mr. Gadissa Hailu

2.4.1. Urban Health: Global and Ethiopia Perspectives: Mr. Zelalem Adugna, John Snow Inc, (JSI)

Presentation outlines:

- The evolution of public health*: from the sanitary to the new public health era;*
- Globalization, urbanization and health;
- Urban health concerns in Ethiopia;
- Some suggestions for future consideration to address 'urban health' concerns in Ethiopia;

Global shift from sanitary to modern public health:

- Sanitary era of public health (1830-1870)
- The new public Health (1870-1945)
- The microbiological era (1870-1945)

Globalization: *Vulnerability of health risks* are transcending boundaries and cultures: *the impact of globalization on life styles!* Look how celebrities influence lifestyle.

SDGs goal 11 is about cities:

→ Make cities and human settlements, inclusive, safe, resilient and sustainable!

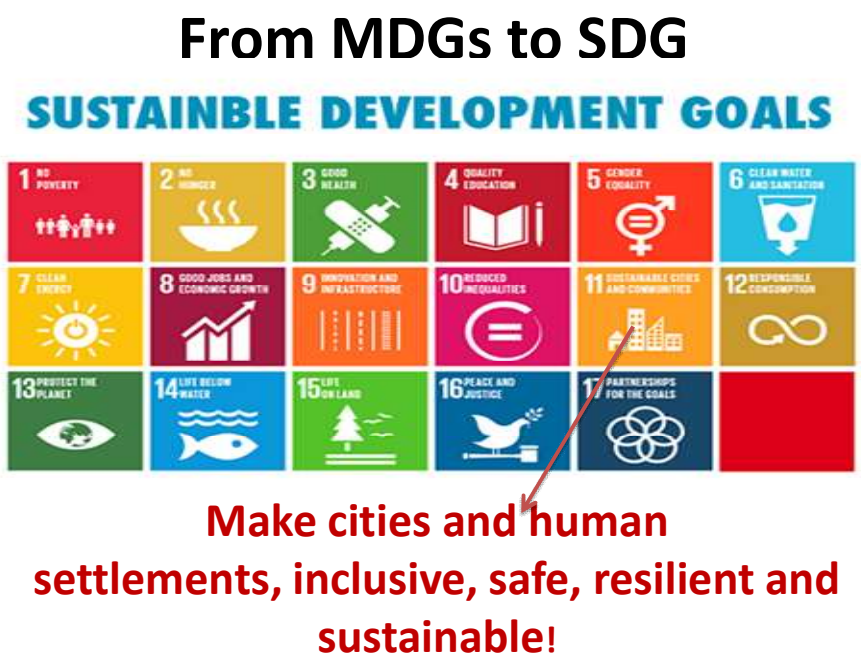


Figure 15: Elements of the sustainable development goals (SDG's)

Ethiopia's Urban Health Concerns:

Concern 1. Double burden of diseases - Overall, 59% of the deaths were attributed to Group I diseases, and 31% to Group II diseases and 12% to injuries.

Concern 2. Health risks and behavior modifications

Concern 3: Injuries/road traffic accidents

Concern 4: Lack of coordinated, integrated and evidence-based Policy and legal frameworks

Table 2: The status of Maternal, Neonatal and Child Health in **Ethiopia**

MNCH statistics of Ethiopia at glance

Indicators	Urban	Rural
NMR (per 1,000 LB)	41	43
IMR (per 1,000 LB)	59	76
Under 5 mortality (per 1,000 live births)	83	114
% of ANC (4 or more visits)	46	14
% of delivery attended by skilled birth attendants	50	4
PNC coverage within 2 days of the birth	32.1	2.7

Source: Ethiopian demographic and health survey (DHS 2011)

The question is:-

In urban population segments, what are the characteristics of the population groups who are not receiving the services?

Way forward:

- Enact and enforce laws that decrease accessibility of cigarettes
- Ban smoking in public places
- Prohibit tobacco advertisement and promotion thorough media and movies
- Educate adolescents about the danger of tobacco

2.4.2. Urban Health Concerns in Ethiopia- Determinants of Health Inequality/Inequity in Urban Ethiopia: Dr. Mirgissa Kaba, AAU.

Presentation outline:

- Setting the context
- Urban health inequality or inequity?
- What are the key determinants?
- Key messages

Setting the context: What is happening with urbanization?

- Urban is becoming predominant mode of living and in the 21st century (WHO, 2010);

- An estimated 54% of the world's population is residing in urban areas in 2014 which is projected to reach 66% by 2050 (UN, 2014);
- Ethiopia is one of the least urbanized countries in the world;
- Yet during the last 25 years urban population leaped from 13% in 1990 to 19% in 2014. This is projected to reach 38% in 2050 (UN, 2014, WB, 2014);

Urbanization is both an opportunity and a threat to public health;

Inequalities exist in urban-rural settings;

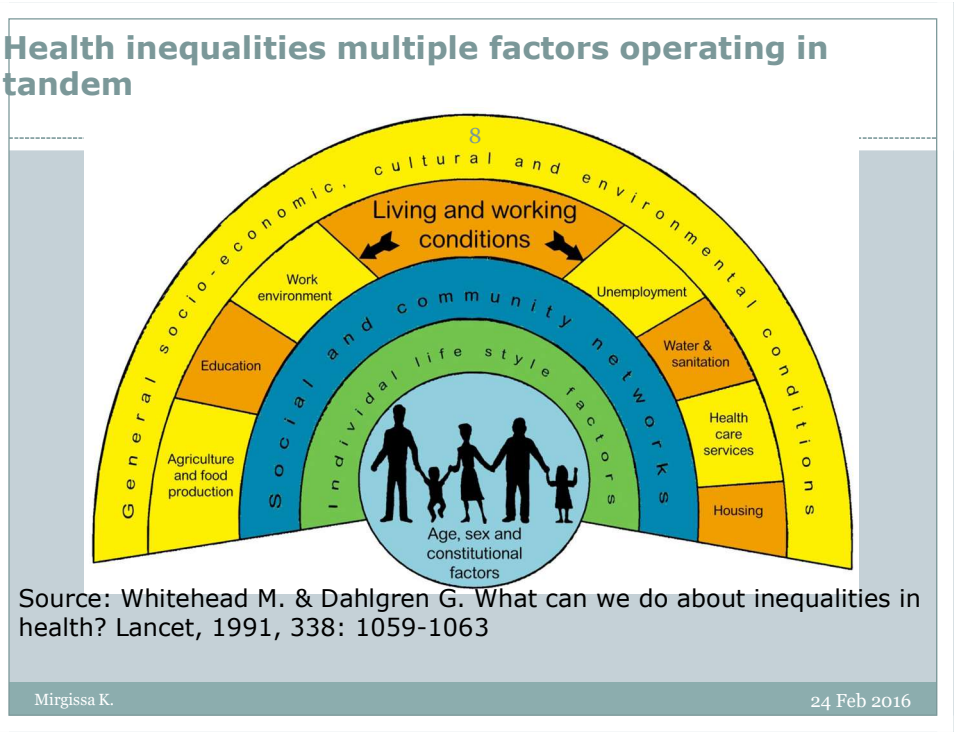


Figure 16: Multiple factors to health inequalities

Health inequity in urban setting appears to be the case although overshadowed by Aggregation:

- Do urban residents enjoy better health as compared to rural counterparts? Yes, but very little is known about differences in health outcomes within urban setting (WHO and UN Habitat Urban health inequity, why it matters, 2014);
- Government's initiative from 2009: the Urban Health Extension Program which aims to improve access and equity to health services is yet to be studied;

Table 3: Health inequalities, Urban Vs Rural setups in Ethipia

Health inequalities urban-vs-rural Ethiopia (Source: Mini-EDHS, 2014)

9

Selected indicators	Urban	Rural
Improved water source	92%	45%
Improved sanitation facility	15%	3%
Lowest wealth quintile	2%	24%
No education (Female)	27%	53%
No education (Male)	15%	41%
No ANC	16%	45%
Home delivery	40%	89%
No PNC	43%	88%
Stunting	9%	20%

Mirgissa K. 24 Feb 2016

Condominiums are changing cities into slums because of their design and construction defects (They do not have basic and proper facilities)

Take home message 1: meeting global expectations of Healthy City by dealing with the social determinants of health inequity (WHO, 2015);

Take Home Message 2: facts and figure is lacking regarding who is vulnerable and why

Meeting global expectations of Healthy City by dealing with the social determinants of Health inequity (WHO, 2015):

- Improve daily living conditions
- Tackle the inequitable distribution of power, money, and resources;
- Measure and understand the problem, and assess the impact of action
- Put in place a multi-sectoral and coordinated responses

Facts and figures are lacking regarding who is vulnerable and why

- Migration and slum are creating wide opportunities for sustained health inequity;

- Yet, evidences are lacking on who and which section of the city are vulnerable, and available evidence remains aggregated;
- This calls for commitment to strengthen urban focused interdisciplinary research and urban health data set for policies and programs;

A new and promising response: establishment of the USAID assisted CENTER FOR URBAN HEALTH DEV'T IN ETHIOPIA at AAU.

→ All are invited to visit the centre

2.4. 3. Partnership Action for Urban Health: Mr Zeleke Teferi, AA Water and sewerage Authority

Mr. Zeleke introduced the project entitled **FRAMEWORK FOR INTEGRATED WATER RESOURCES PROTECTION ADDIS – ADAMA**

- **Project name:** Source to Tap and Back (S2T&B)
- **Goal of the Project:** to insure water security to the population within the S2TB project area
- **Beneficiary Population:** ~ 4.5 million
- **Funding :**
    - The Netherlands' Ministry of Foreign Affairs (60%)
    - Partners in the consortium (40%)

Background-----

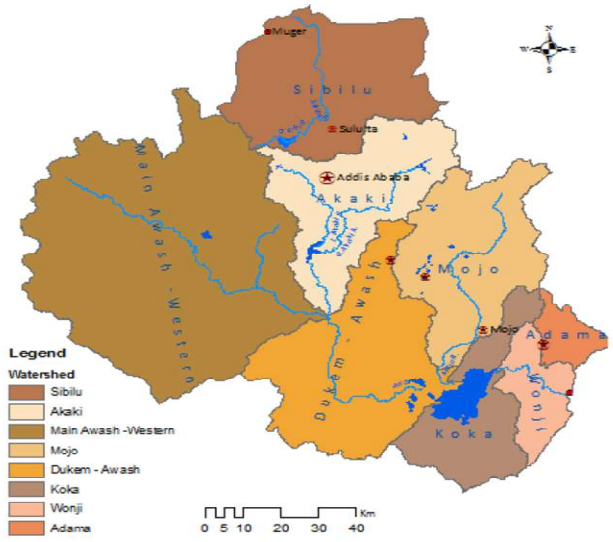


Figure 17: The source to tap and back project sites in Addis Ababa and adjacent cities

Purpose of the project: Adoption of an innovative problem based multi-stakeholders approach to water supply chain management has resulted in improved water quality and services for people in the metropolitan area of Addis Ababa and Adama.

The Rationale of the PPP is based on:

- Integrated water chain approach towards drinking water safety and water security;
- Water resources protection (surface and groundwater);
- Reducing effluent loads from the cities so as to secure water availability and ensure quality and sustainability of services;

The Challenge:

The overall problem that the PPP will address relies on the **threat to water resource availability and quality:**

- **The limited availability of safe drinking water:** Due to deteriorating quality of water resources and the intermittent supply, the overall quality of tap water in the project area is considered not safe for human consumption;

The occurrence of waterborne diseases: It is estimated that 70% of all diseases are water related.

The Solution:

The solution that the partnership will bring is the **introduction and demonstration of a comprehensive water chain approach** (′source to tap and back′); it will improve water and sanitation services.

2.4.4. Sustainable Sanitation, Transformation for Peri-urban and Urban Ethiopia Experience and Lessons: Mr Gadisa Hailu, SNV.

- According to Mr. Gadissa, urban sanitation has two critical components:
  1. Faecal waste management, and
  2. Solid waste management (ACIPH, 2014);
- A proper functioning system is required for both faecal waste management and solid waste management. Faecal waste management is the collection, storage, treatment, transportation, re-use, and/or disposal of excreta (IWA, n.d.);
- Moreover, solid waste management includes onsite storage, onsite waste recovery and reuse, collection, transportation and disposal of solid and liquid waste (ACIPH, 2014);

- Only 29 and 40 per cent of the urban population with access to improved and shared sanitation facilities respectively leaving 31 per cent with no access to sanitary facilities;
- Urban sanitation has two critical components: Faecal waste management and solid waste management (ACIPH, 2014);
- The Ethiopian Demographic and Health Survey (EDHS), 2014 reports only 14 percent of the urban population had access to improved sanitation facilities (CSA, 2014);
- The Joint Monitoring Program, 2014 reports 27 per cent of Ethiopians living in urban towns have access to improved sanitation facilities (UNICEF/WHO, 2015);

Challenges of Sustainable Sanitation in Urban Setting:

- Globally, urban sanitation is a complex challenge which is intensified by increasing rates of urbanization;
- The population is not a static feature of service provision as population growth, and there are challenges such as: rural to urban migration or vice versa; population movement due to internal or cross-border refugee movement, or both, in response to conflict, flooding or other such disaster related causes;

- Unplanned and un-serviced slums or in informal areas of towns often referred to as peri-urban areas;
- Urban sanitation has two critical components/challenges: Faecal waste management and solid waste management;

Urbanization in Ethiopia:

- According to The Growth and Transformation Plan (2011-2015), and as reported by WSUP-A (2014), in order for the Government of Ethiopia to transit the country from a rural economy to an urban economy, Ethiopia's cities and towns must be competitive, attractive to business, attract skills and well-functioning to meet the standards desired by their residents;
- In turn sanitation and hygiene are crucial. However, there exists amongst other challenges, "inadequate and unsustainable refuse and liquid waste collection and disposal systems," (WSUP-A). In other words within Ethiopia, despite the progress in reducing open defecation and addressing the needs of rural sanitation, there are still sanitation challenges existing in the urban towns.

SNV Experience in WASH Intervention:

- SNV Ethiopia has been working in Ethiopia for more than 40 years;
- Currently, SNV Ethiopia is operating in four regions; some are operating at national level;
- Sector wise SNV is operating in WASH, Renewable Energy and Agriculture
- WASH in Schools----------Rural
- Sustainable Sanitation and Hygiene for All ------ Rural
- Functionality of Water supply systems----------Rural
- Sustainable Sanitation Transformation---------- Urban

Questions and comments:

Questions directed to Mr. Zelalem

Q. The shift from sanitary to public health has been highlighted for global context. But, how about Ethiopia? Isn't it too early to talk about this shift in the Ethiopian context?

R. That is true, but we should also consider the rapid epidemiological transition in Ethiopia. There is a high burden of chronic diseases too. We are operating under the global context.

Q. Given the cost of meat, we may not expect it to reflect the standard of living and hence become a cause for many chronic illnesses in urban centers. What do you think is then the problem and where does the problem originate?

R. The answer to this question requires research. However, it is assumed that the source of the problem might be linked to the type and quality of commercial food items like canned butter, oil, and othe food items.

Q. As you remember, the country planned essential health package, but it became neglected as soon as borne.?

R. The country has one of the best apporaches and policies in healht care. However, there could be problems linked to program management. We will sort out problems and establish sound practices.

Questions directed to Dr. Mirgissa

Q. What is mentioned about urban health problems in Ethiopia seems good, but it is not inclusive. More assessment needs to be done because the problem is multidimensional and too complex. At least the following areas need to be covered:

- SW in urban setting – leachate of heavy metals
- Industrial and toxic waste
- Infectious and hazardous waste
- Domestically packed/ adulterated foods
- Housing/ Crowding, infrastructure, aesthetics and recreation
- Etc...

R. The comment is valid. That is why the center for urban healht is established. We will give due emphasis in identifying the extent of the suggested problems and other issues.

Q. As we are shifting from standard houses like villas to condomeniums, what health problems do we anticipate?

R. The problems are more diverse and much more complicated. As you might know, the quality of most condomeniums is poor; infrastructure is less evident. There is no proper

waste handling, especially liquid waste. So, a lot of effort is required from professioanls and EPHA to advise the responsible authorities.

Questions directed to Mr. Gadissa

Q. What is the current practice on SWM in Ethiopia?

R. The solid waste problem in Ethiopia is getting more and more complex. Dump site is also a critical concern. Currently, there is a huge and advanced project at REPI dumpsite that intendes to generate energy and biofuel from the closed landfill site.

Questions and comments to all presenter and EPHA

Q. What role should EPHA play in addressing Urban Health problems?

R. The role of EPHA should involve advocacy;

Q. Papers being presented at EPHA conference should be published at least in special issues. What is the plan for this year?

R. All papers and posters presented at EPHA will be posted on EPHA website; furthermore, prominnent papers will appear in the Ethiopian Journal of Health Development.

2.5. HEALTH INFORMATION, KEY COMPONENTS OF THE HEALTH SYSTEM

Chair: Dr. Yibeltal Assefa – EPHI, FMoH.

Pannelists:

1. Dr. Jemal Aliy (Tulane University)
2. Mr. Mengisty Woldie (Representing Mr. Noah Elias of the FMoH)

2.5.1. Health Information for Universal Health Coverage: Dr. Jemal Aliy, FMoH.

Universal health coverage refers to a health care system which provides health care and financial protection to all citizens of a particular country. It is not a one-size-fits-all concept and does not imply coverage for all people for everything. UHC is not only about assuring a minimum package of health services, but assuring a progressive expansion of coverage of health services and financial

risk protection as more resources become available. The three dimensions of UHC are **population covered**, **services** and **costs**.

Goal of UHC:

Ultimate goal of UHC for service coverage is 100%, but it is practical to set targets based on:

- Empirical baseline data,
- Past trends in the whole population and among the poorest,

Minimum targets set by WHO/World Bank; Service coverage: A minimum 80% coverage of quality, essential health services, regardless of economic status, place of residence or sex.

Efforts towards Ensuring Universal Health Care in Ethiopia

1. **Policy and Strategy**

   Currently, the health sector transformation plan (HSTP) is developed and is being implemented with goals to

   - improve equity, coverage and utilization of essential health services,
   - improve quality of health care, and
   - enhance the implementation capacity of the health sector at all levels of the system.

2. Health services delivery based on expansion, rehabilitation, and equipping of health care facilities. The country currently has 311 hospitals, 3,547 health centers and 16,440 health posts;
3. **Health Workforce**

   Invested in Health Workforce Development & Management;

   Large number of all categories of Health Workers produced

4 **Medical Products, Vaccines and Technologies**

   Reformed supply chain and logistics management to ensure equitable access to quality medical products and vaccines;

5. **Health Care Financing Initiatives**

   Community health insurance has been initiated as pilot, and it is being expanded as Social Health Insurance

6. **Health Information System**

   HMIS reform and implementation

   Establishment and conducting National Surveys and Surveillance EDHS, NHA…

Monitoring UHC:

To track UHC, we need reliable data on a broad set of:

- health service coverage indicators
- financial protection indicators
- Disaggregating data to expose coverage inequities;
- Measuring effective coverage, which includes

2. Application of Health Information Technology – Experiences: Dr. Jemal Aliy, Tulane University.

What is Health Information Technology?

Health informaiton technology is the use of information and communication technology in health care to record, store, protect, retrieve, analyze, and secure exchange of health information between consumers, providers, payers, and quality monitors, and it also deals with the use of health care information and knowledge for communication and decision making.

What does it need?

- Availability of reliable power supply
- ICT infrastructure: network, computers and accessories,
- Skilled human resource: Health workers, IT professionals
- Budget for ICT materials
- Close monitoring and follow up

Tulane Experience – Integration approach

An electronic systems developed by Tulane to automate the "Paper HIS System"

- TenaCare^{EMR}.
- TenaCare-eHMIS/PHEM
- TenaCare-eHMIS- For Result (Health Indicators ScoreCard)
- TenaCare-eCHIS and mobile reporting for Health post
- m-health linked to HMIS at Health post
- HRIS-Manage/HRIS-License to link HRH to Health Information System

All are Geo referenced.

2.5.3. Health Information Revolution: The Agenda of HSTP; Ato Mengistu Woldie, FMoH

HSTP has set four interrelated transformation agendas. These are:

1. Quality and equity of health care

2. Woreda Transformation,
3. Movement towards compassionate, Respectful, and caring health professionals, and
4. Information revolution,

Implementation of the transformation agendas will help achieve the stretched targets we set in the HSTP.

What does HIT mean?

HIT is the phenomenal advancement on the methods and practice of collecting, analyzing, presenting and disseminating information that can influence decisions in the process of transforming economic and social sectors.

It requires a radical shift from traditional way of data utilization to a systematic information management approach powered by corresponding level of technology.

It is also about bringing fundamental cultural and attitudinal change regarding perceived value and practical use of information.

Why should HIT be an agenda?

- Appropriate and timely use of health and health related information is an essential element;

In the process of transforming the health sector:

- Effective information use is momentous across range of activities in the health system;
- The need for multi-dimensional, accurate and timely information is eminent in light of addressing issues related to equity in the health sector;

What is needed for health information revolution?

- It is needed to advance the data collection, aggregation, reporting and analysis practice;
- Promoting the culture of information use;
- Harnessing ICT;
- Data amiability and access;
- Addressing the human element;

- Strengthening verification and feedback systems;
- Multi-sectoral approach;
- Insuring the ownership of HMIS at every level;
- Strengthening Research, evaluation and survey;

Road map into the revolution

- Cultural changes on health information system
- Surveillance and response
- Patient safety and response

Digitization of health information system

- Placement of infrastructures
- Proactive technology search and adoption (satellite imaging, geo-spatial,)
- Standardization (DICOM, HL7, ICD10 ….)
- Establishing data warehouse
- Data visibility and presentation
- FF digitalization

General Comments, Questions and Answers

- We know that there are a lot of indicators for HMIS. Are these indicaters also used for NTDs?
- Who will be responsible for actions and recommendations made by this important conference? Do we have prepared declaration?
- It is good to hear that the government is revolutionarizeing HMIS. Does the government prepare a unique Identification Number (ID)?

Answers/ Reflections

- We acknowledge that a lot more is needed before we use a unique ID number. As you all might know, IMS will have a lot of attributes, and hence we expect there will be a lot of effort before its introduction. The government is doing its best to give a unique ID number.
- In regestering causes of death, we are working with VERA. Workers are also trained in Autopsy. That system is linked to unique I.D. No.

- Important decisions made by this conference will be distributed to concerned bodies for action

Conclusion by the Chairperson

Two important points:

1. The country is dependent on health information system. Revolution is the extreme form of transformation
2. What does the ministry expect from us?
   - Generating evidence/ data to influence policy
   - We need to use /apply the data
   - We need to advocate on the need to hava a data
   - We need to get engaged in capacity building

Conclusions from the plenary meetings as presented by hte MC

As this was the last plenary session of the 27th EPHA conference, the MC of the conference, Dr Aster Tsegaye, forwarded the following summary:

To assist the effort of the Ministry of Health in producing compasionate, caring and respectful health professionals, EPHA will discuss with the ministry itself, sister associations, universities and researchers.

1. Demographic transition is going to be a threat if not managed, so we need to act now.
2. Urban /Rural health and equity issues are critical. EPHA will play a catalytic role in addressing the imbalance.
3. EPHA board has been influenced by this meeting and decided to have a series of meetings with respective actors. Brief communications will be issued to reach policy makers.
4. The next EPHA conferences are suggested as follows:

   28th – Harar

   29th – AA

   30th – Jimma

III. GENERAL ASSEMBLY/ BUSINESS MEETING: Chair – Dr. Teshome Gebre and Dr. Agonafer Tekalign

3.1. Welcoming Speech and Setting the Agenda

The Chairperson of the General Assembly (G.A) Dr. Teshome Gebre welcomed the audience to the general assembly meeting that he describes it as the very important event that EPHA organizes every year. He further mentioned that the G.A is a highest organ of the association that makes decisions and approves new programs, strategies and policies of the association.

He then asked organizers to check if the G.A is full; according to the new instruction from Charities and Civic Societies agency, at least (50+1) G.A members should appear in the meeting to make decision;

The chairman indicated that, as it had always been difficult to get a 50+1 attendance from an estimated 5000 active EPHA members, a new strategy was designed (as advised by the Charities and Civil societies Agency) to conduct the general assembly meeting by representations. He then announced that EPHA had 83 represented general assembly members, and to proceed the meeting he expected to get at least 42 of them.

The chairman asked to count only the representatives. Counting was done, and 49 out of 83 members were present. So, the chairman officially opened the meeting.

3.2. Agendas set for Discussion

1. EPHA 2015 annual report
2. Revised legislation of EPHA
3. Audit report
4. Other administrative issues/ Perdiums and allowances
5. Election to fill the missing board members
6. Discussions and decisions

The chairperson asked if the members had comments on the agenda. There was neither additional agenda mentioned nor objection to any of the suggested agendas forwarded. He asked the audience for approval, and it was unanimously approved.

Agenda 1. Annual Report of EPHA (For the year 2015).

1. **Summary from the annual performance report (Reported by EPHA president, Dr. Fikreab Kebede)**

1.1. Introduction of the new CEO of EPHA

Dr. Fikreab first introduced the new CEO Dr. Alemayehu Mekonnen who replaced the late CEO, Dr. Hailegnaw Eshete

1.2. Key points mentioned in the annual performance report include:

- For the strategic planning there has been 13 regular and 3 emergency meetings of the executive board conducted;
- EPHA which was established in 1989 (27 years ago) has now 62 staff at its headquarter;
- Members have reached some 6000, and the association has 24 chapters and subchapters distributed in all regions;
- EPHA is implementing various project and none project based activities; some of which are: Supporting sister associations like the African Federation of Public Health Associations (AFPHA) and Ethiopian Public Health Officers Association;
- Working hard to establish regional office for African Public Health;
- Research advisory groups in different thematic areas drafted and submitted their plan to the Board;

- History book that was suspended temporarily for lack of fund is now activated;
- Members registration – 315 and 104 (a total of 419) new members are registered last year and this year respectively. The house endorsed their membership upon the request of the chairman;
- Proceeding of the 26th conference distributed in soft and hard copy to members;
- Editorial board members strengthened by taking additional high track record professors from other universities;
- Online submission to the Ethiopian Journal of Health Development made possible;
- Naming of the Association: There were two options:
  1. Local charity NGO, and
  2. Ethiopian resident society
- The second choice was recommended for us from The Charities and Civic Society's Agency with some windows of hope in recognition to our national reputation;

Acknowledgement

The chairperson proudly introduced two prominent EPHA Ex-presidents who are present in the meeting. They are:

1. Dr. Mengistu Asnake, former EPHA president, and now he is the president of the World Federation of Public Health.
2. Dr. Tewabech Bishaw, also former president of EPHA, and she is currently, serving as Secretary General of the African Federation of Public Health;

   The full report of the fiscal year 2015 is annexed (Annex V).

Discussion

Ato Tiruneh

1. We really thank you for your effort to make this Association an Ethiopian association
2. We have sensed that EPHA did not reach all its members to announce this meeting. We recommend that we use traditional means in addition to the modern electronic media.
3. We are doubtful that EPHA encompassed and gave equal opportunity to all disciplines of health.
4. What will be the role of EPHA in accreditation?
5. I am not personally happy with the quality of abstracts and posters. Perhaps, it will be good if EPHA sponsors pre-identified research topics that have national significance, and it

needs sufficient time and resources to review them critically. It will be better if EPHA sponsor fewer and good quality research papers covering different thematic areas instead of compiling and presenting some 300 papers.

Ato Melese Gebre

1. What would be the role of EPHA in solving illegal and unethical health services and in motivating health professionals in Ethiopia?
2. Who is controlling illegal and unethically functioning private training health institutions in the country?
3. What possible options are available to enable EPHA to assist the government in improving the quality of health professionals training?

Concluding remarks were given by the chairperson and the report was fully endorsed!

Agenda 2. Presentation of the revised EPHA Legislation – Presented by a consultant

- The need for revision of the legislation comes from the need to make it consistent with the new EPHA status itself as suggested by the Charities and Civil Societies Agencies;
- The new legislation has 36 clauses;
- Some of the modifications made on basis of EPHA status and the advice from the agency include:

  Clause 36 indicates that the number of expected number of attendants for the General assembly is 83

  A change in organogram is suggested

Reactions from the GA members on the presented legislation

- Why should job description be limited to fewer EC members?
- The document is not only full of editorial problems but is also incomplete. Hence the plenary meeting decided that the document should be corrected and channeled to the Board for endorsement.

Agenda 3. Audit Report

An external auditor presented the Audit report of EPHA to the General Assembly. Accordingly, it was mentioned that financial management of EPHA is healthy. The fund balance was reported to be Birr 66, 565, 816.94

Agenda 4. Other Administrative Issues

4.1. Election Protocol (VIGAR)

The chairman explained that this document was reviewed by the represented General Assembly and decided to be presented to this meeting. As the document was not previously communicated to the members, Dr. Alemayehu, the EPHA CEO was requested to elaborate what the components of the document were, and he did.

4.2. Issues in Payment (Allowance for GA members and Chapter Representatives when called for Meeting)

The chairman reported that this agenda is presented for decision because EPHA is constructing a house, and it has a difficulty in covering per diem to panelists, moderators and G.A members. The executive board wanted us to make decision on this issue.

- The house suggested that this issue should not have been dealt by the G.A; it should have been discussed by either the EB or the represented GA. However, the board members insisted that this issue should be discussed by the G.A. They claimed that though they discussed this issue before, they found it difficult to reach any sort of consensus on it.
- Some members of EPHA suggested that members have to be committed to serve their association and one of the criteria for being identified as a chapter, moderator or a panelist should be commitment to give free service by covering their own cost or covered by their institutions.
- After making suggestions, the G.A finally returned the issue back to the EB to critically investigate and decide. But for this year, it has to be done according to the previous trend.

4.3. Election to fill Missing Members

Approval requested for the temporarily elected board member to substitute the late Dr. Hailu Yeneneh by Dr. Agonafer Tekalign. Approval secured!

Other elected members were:

- Dr. Kebede Derebie
- Dr. Belayneh Wassie

Waiting list: Yohannes Jorge

General Assembly Suggestions

- The EPHA executive board needs additional and strong board members like Executive Secretary and Treasurer;
- It will be very difficult to digest and decide every point in this short time and in a large audience. Hence it is recommended that some of the issues and recommendations be presented and further scrutinized by an advisory board;
- Errors related to member registration and communication needs lasting solution. Alternative approaches to solve these problems needs to be investigated.

Agenda 4.2 should again be critically assessed and decided by the executive board of EPHA as it was difficult to reach decision in a large group like the G.A.

V. Concurrent sessions.

A total of 25 concurrent sessions on 11thematic areas involving 116 +\ presentations were conducted in 5 rooms during the 3 days (table 4).

Table 4: Number of presented papers per thematic area of oral presentations at the 27th EPHA conference.

S. No.	Thematic area	No. of papers presented
1	Biomedical sciences	14
2	Pharmacology and drug use	7
3	Food and Nutrition	15
4	Communicable diseases	15
5	Behavioural science and communication	17
6	None communicable diseases	11
7	Demography and population	17
8	Neonatology, infant, child and adolescent health	5
9	Health services, Health economics, HR	6
10	Mental health and substance abuse	4
11	Environmental health	5
Total		116

Each concurrent session was chaired by a senior specialist whose expertise was directly linked to the thematic area of the study. Each concurrent session had on average 4-5 papers to be presented. Members were given the freedom to choose the topic of their interest in attending the sessions.

The tables presented below summarize the thematic areas in each room, the papers presented, the presenters and the chair persons.

Table 5: Summary of thematic areas, presenters, presentation topics and Moderators of concurrent session (Day 1, session 1).

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR1	Biomedical Sciences	Ezra Belay	Correlation of Fasting and Postprandial Plasma Glucose with HbA1c in Assessing Glycemic Control: Systematic Review and Meta-analysis.	Dr.Amha Kebede
		Ashenafi Assefa (Feven)	Assessment of Common Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency Allelic Types in Ethiopia.	
		Molla Abebe	Lipid Profile Level Correlation with Anthropometric and Clinical Variables among Type 2 Diabetes Mellitus Patients at University of Gondar Hospital, Northwest Ethiopia.	
		Henock Ambachew	Dyslipidemia among Diabetic Patients in Southern Ethiopia: Cross-sectional study.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR3	Pharmacology and drug use	Ketema Getachew	Predictors of Treatment Failure among Adult Antiretroviral Treatment (ART) Clients in Bale Zone Hospitals, South Eastern Ethiopia.	Mr Meskele Lera
		Dagninet Derbe	Investigation on Antidiarrheal and Antimicrobial Activities of 80% Methanolic Leaf Extract of *descopodium penninervum (hochst.)*	
		Eshetie Shume	Drug Use Evaluation (DUE) : The Use of ceftriaxone at All Wards in Dessie Referral Hospital.	
		Shewatatek Gedamu	Chemo Preventive Potential of *coffee arabica o*n Colorectal Cancer, Initiated and promoted by dmh in Rat Model.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR4	Food and Nutrition	Desalegn Markos	Determinant of Timely Initiation of Complementary Feeding among Mothers of Children aged 6 to 23 Months in Robe Town, Ethiopia.	Prof.Tefera Belachew
		Tezera Moshago	Predictors of Nutritional Status in Adolescent School Girls in Southwest Ethiopia.	
		Jemal Ayalew	Modelling the Predictor Factors of Household Food Insecurity Using Ordinal Logistic Regression Approach.	
		Girma Nega	*Household* Dietary Diversity and Associated Factors among Rural Households, South Gondar Zone, Northwest Ethiopia.	
		Eskeziaw Agidew	Dietary, Diversity Feeding Practice and Determinants among Children aged 6-23 Months in Southern Ethiopia:	

			Implication for Public Health Intervention.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR5	Communicable diseases	Mitiku Bajiro	Prevalence of Schistosoma Mansoni and Therapeutic Efficacy of Praziquantel in School Children in Mana District, Jimma Zone, Oromia, Southwest Ethiopia.	Dr Fikre Enquselassie
		Berihun Assefa	Determinants of Poor Visceral Leishmaniasis Treatment Outcome in Northwest Ethiopia.	
		Mesele Damte	Improved Malaria Case Management in Formal Private Sector through Public Private Partnership in Ethiopia: Retrospective Descriptive Study.	
		Yitagesu Habtu	Magnitude of Malaria and Factors among Febrile Cases in Low Transmission Areas of Ethiopia: A Facility Based Cross Sectional Study.	

		Misganaw Ayalew	The Magnitude of MDR TB and Related Co Morbidities in Amhara Region, Ethiopia, August 2010-Dec.2014.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR6	Behavioural sciences and communication	Kedir Yimam	Knowledge, Attitude and Practice towards Blood Donation and Associated Factors among Adults in Debre Markos Town, Northwest Ethiopia	Mr Melake Damena
		Mahlet Mekonnen	Assessment of Breasts self Examination Practice and Associated Factors among Women Attending Public Health Centres in Addis Ababa, Ethiopia,2015	
		Mihiretu Molla	Willingness to receive Text Message Medication Reminders Among Patients on Antiretroviral Treatment in North West Ethiopia.	
		Israel Mitiku	Factors Associated with Loss to follow-up among Women in Option B+ PMTCT Programme	

			in Northeast Ethiopia: a Retrospective Cohort Study	
		Fire Abamecha	Assessment of Storage and Utilization of Information, Education and Communication (IEC) Materials and Associated Factor in Health Facilities of Bench Maji Zone.	

Following the presentations, respective chair persons/ Moderators thanked all the presenters and opened floor for discussion. Hot discussions followed. For instance, in CR5, some of the questions and comments were:

- In the methodology, hospital selection is random but patient selection is not. Revisit your methodology;
- 25% were confirmed by direct microscopy. What about the other 75%?
- It is not correct to talk about multiple drug resistance without identifying and testing the efficiency of first line drugs.
- You studied a treatment that is already known and recommended by WHO. That doesn't add much value. Rather it would have been better if you compare the efficacy of multiple drugs.
- Recommendations are vague and broad. Revise them in a way that can be addressed by an identified responsible body.
- You can not recommend 'increasing utilization of bed nets' in a condition where you already mentioned lack shortage of bed nets for distribution.
- In biomedical sciences research, inclusion and exclusion criteria were critically criticized for ethnic basis.

.

Table 6: Summary of thematic areas, presenters, presentation topics and Moderaters of concurrent session (Day 2 session 1)

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR1	Biomedical Sciences	Degu Abebe	Postoperative Wound Infection: Bacterial aetiologies and Antimicrobial Susceptibility Patterns in Hiwot Fana Specialized University Hospital and Jugul Hospital, Harar, Ethiopia.	Dr Mitike Molla
		Aman Mehari	Establishment of Reference Intervals to value of Thyroid Function Tests in Cord Blood of Neonates born in Addis Ababa, Ethiopia.	
		Awoke Deribe	Antibiogram Profile of uropathogens isolated at Bahir Dar Regional Health Research Laboratory Centre.	
		Henock G/ Yebyo	C-reactive Protein Point-of-care Testing and Antibiotic Prescribing for Acute Respiratory Tract Infections in Primary Health Care Settings of Tigray/Ethiopia.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR3	Behavioural sciences and communication	Adugna Endale	Predictors of Compliance with Community-Directed Treatment with Ivermectin for Onchocerciasis Control in Kabo Area, Southwest Ethiopia.	Dr Woldaregay Erku
		Molla Mekashaw	Assessment of Health Risk Protection Behaviors among Solid Waste Collectors in Addis Ababa, Ethiopia.	
		Likawunt Samuel	Health-seeking Behaviour and Associated Factors in Hosanna, Southern Ethiopia: Community Based Cross-sectional Study.	
		Habtamu Mellie	Voluntary HIV Counseling and Testing Service Utilization among Pregnant Mothers in North West Ethiopia In 2014.	
		Fanos Yonas	Infant and Young Child Feeding Practices and Associated Factors among Mothers of under 24 Months Children in Shashemene Woreda, Oromia Region, Ethiopia.	
		Mesele Damtie	Magnitude and Factors Associated with Self-Medication Practices among University students: The Case of Arsi University.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR4	None communicable diseases	Wondimye Ashenafi	Double Burden of Diseases as Causes of Adult Mortality: Evidence from Verbal Autopsy (VA) Analysis in Kersa HDSS.	Dr Kunuz Abdella
		Wubarege Seifu	Prevalence and Associated Factors of Hypertension among Adult Population in Jigjiga Town, Eastern Ethiopian, Somali Regional State, 2015.	
			Cervical Cancer: Assessment of Diagnosis and Treatment Facilities in Public Health Institutions in Addis Ababa, Ethiopia.	
CR5	Demography and Population	Haymanot Negussie	Assessment of Trends and Determinants of Adult mortality in Butajira, Ethiopia.	Dr Wubegzer Mekonnen
		Wondimye Ashenafi	Levels and Causes of Migration in Harar Health and Demographic Surveillance System, Eastern Ethiopia.	
		Achenef Asmamaw	Magnitude of Adverse Reproductive Health Outcomes and its Correlates with Gender-Based Violence among Married Women in Northwest Ethiopia.	
		Abiyi Seifu	Quality of Obstetric and Immediate Newborn Care in Health Facilities in Ethiopia: Observation of Deliveries and Immediate Neonatal Care.	
		Teketo Kassaw	Level of Partograph Utilization and Its Associated Factors among Obstetric Caregivers at Public Health Facilities in East Gojam Zone, Northwest Ethiopia.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR6	Food and Nutrition	Melese Sinaga	Association of Fasting Animal Source Foods with Metabolic Syndrome And Body Composition Among Employees of Jimma University.	Dr Seifu Hagos
		Gemechu Kumera	Prevalence Of Zinc Deficiency And Its Association with Dietary, Serum Albumin and Intestinal Parasitic Infection among Pregnant Women Attending ANC at the University Of Gondar Hospital, Gondar, Northwest Ethiopia, 2015.	
		Habte Samuel	Household Food Insecurity and Associated Factors among Households in Areka Town, Wolaita Zone, Southern Ethiopia.	
		Mohammed Abdulahi	Factors Associated with Overweight and Obesity among First Cycle Primary School Children in Diredawa Town, Eastern Ethiopia.	
		Markos Tesfaye	The Effect of Nutritional Supplementation on Quality of Life among People Living with HIV: a Randomized Controlled Trial.	

Following these presentations, hot discussions continued in each room. In CR5, the following questions, answers and discussion were aired.

- Health education is not a good term; use health communication;
- The best way to look into domestic violence is from the perspective of attitude;
- Demonstrations with role exchange brings significant attitudinal change (test a role play men playing women and vice versa) and ask the man what he feels if he was in reality facing what he demonstrated;
- There is a methodological error in the study in Butajira. Omitting none Amharic speakers from the study by itself is not logical; therefore, the conclusion that Muslim women are more likely to die than Christian women is ethically incorrect at least for the fact that the conclusion is made on the basis of insufficient data;
- What does low achievement mean? Is it because of absence of motivation of health professionals? Is it due to unavailability of Vitamin K? Or is it absence of facilities? We need to know the reasons;
- Assessment of knowledge of health professionals should have been done better by interviewing than questionnaire administration;

Reflections from the presenters

- All comments are taken very well;
- The conclusion that Muslims die more frequently than Christians is because of Polygamy among Muslim community in Butajira;
- The comment in relation with language discrimination in the study of gender based violence is sound. However, it is not discrimination; since most of the residents speak Amharic and the data collectors are Amharic speakers, we need to exclude other languages to avoid language barrier. However, in practice, there is no language discrimination because most of the respondents are Amharic speakers.

Table 7: Summary of thematic areas, presenters, presentation topics and Moderators of concurrent sessions (Day 2 Session 2)

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR1	Neonatology, infant, child and adolescent health	Mekonnen Assefa	Survival and Morbidity of Breastfeeding Versus Formula Feedings Infants and Young Children of HIV-Infected Women Who Were on PMTCT Follow Up in Addis Ababa, Ethiopia, 2013: A Retrospective Cohort Study.	Dr Workabeba Abebe
		Azanaw Tsegaw	Prevalence of Diarrhea Disease and Associated Factor among Under-Five Children, in Dehana District, Wag-Himra Zone, Amhara Region, North West ,Ethiopia.	
		Melkamu Dedefo	Causes of Death among Children Aged 5 To 14 Year Olds From 2008 To 2013 in Kersa Health And Demographic Surveillance System (Kersa HDSS), Ethiopia.	
		Legesse Kidane	Assessment of Child Vaccination and Knowledge of Mothers on Polio Vaccination and Other Childhood Vaccines in Core Group Polio Project Implementation Districts in Ethiopia.	
		Muluken Azage	Spatial Variation and Determinants of Childhood Diarrhea in Ethiopia: A Spatial and Multilevel Study.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR3	None communicable diseases	Seble Belachew	Assessment of Factors Contributing to Late Diagnosis of Cervical Cancer in Selected Hospitals of Addis Ababa, Ethiopia 2015.	Dr Alemayehu Bekele
		Atkilt Esayas	Prevalence of Hypertension and Associate Risk Factors among Workers at Hawassa University, Ethiopia: An Institution Based Cross Sectional Study.	
		Kelemu Tilahun	Prevalence of Hypertension in Ethiopia: Systematic Meta-Analysis.	
		Frew Tadesse	Prevalence And Associated Factors Of Hypertension among Adults in Ethiopia: A Community Based Cross-Sectional Study.	
CR4	Communicable diseases	Abebe Megersa	Predictors of Lost to Follow Up from Antiretroviral Treatment for Adult Patients in Oromiya Region: A Case Control Study.	Dr Adugna Woyessa
		Getaneh Alemu	Prevalence of Malaria and its Association with ABO/Rh Blood Groups among Blood Donors Attending ArbaMinch Blood Bank, A Cross-Sectional Study, 2015.	
		Dejene Oljira	Prediction of Malaria Species Morbidity Using Data Mining Technique: The Case of Chewaka Health Center Ilu Aba Bora , South West Ethiopia.	

		Deresse Legesse	Trend Analysis of Malaria Occurrence in Wolaita zone, Southern Ethiopia.	

Room	**Thematic area**	**Presenter**	**Title of Presentation**	**Moderator**
CR5	Demography and Population	Mulugeta Dile	Proportion of Maternal Near Misses and Associated Factors in Referral Hospitals of Amhara Regional State, Northwest Ethiopia.	Dr Tizita Tilahun
		Solomon Abraha	Level of Institutional Delivery and Associated Factors among Women of Reproductive Age Group in Wolaiata Zone, Southern Ethiopia.	
		Yohannes Addisu	Predictors of Intention for Institutional Delivery among Pregnant Women in Yirgachief Town, Gedeo Zone, South Ethiopia: A Community Based Cross-Sectional Study.	
		Achenef Asmamaw	Magnitude of Adverse Reproductive Health Outcomes and Its Correlates with Gender-Based Violence among Married Women in Northwest Ethiopia.	
		Kifle Lentiro	The Magnitude And Determinants Of Induced Abortion among Preparatory Schools Females: A Cross-Sectional Study, May 2015.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR6	Behavioural and communication	Eyerusalem Getachew	Knowledge Attitude and Practice on Cervical Cancer and Screening among Reproductive Health Service Clients, Addis Ababa, Ethiopia, 201.	Dr Afework Ayele
		Bantamlak Gelaw	Assessment of Magnitude and Factors Affecting Intention of Women Living with HIV to use Long Acting And Permanent Family Planning Methods in Addis Ababa City Government Public Hospitals, Addis Ababa, Ethiopia.	
		Mesfin Tafa	Breast Self-Examination: Knowledge, Attitude, and Practice among Female Health Science Students at Adama Science and Technology University, Ethiopia.	
		Alemtsehay Berhanu	Level of Knowledge and Practice of Tuberculosis Patients towards Multidrug Resistant Tuberculosis Prevention and Associated Factors in Public Private Mix Directly Observed Treatment Service Provider Facilities Of Addis Ababa.	
		Sara Dereje	Assessment of Knowledge, Attitude and Practice of Adult Women towards Breast Cancer Screening in Addis Ababa, Ethiopia; 2015.	

		Tesfalidet Tekleab	Assessment Of Knowledge and Practice of Menstrual Hygiene Among High School Girls in Western Ethiopia	

The concurrent sessions at each room were successfully conducted as planned. Each presenter was given 15-20 minutes depending on the number of presenters at each room; 15-20 minutes were given to discussion.

Reflections from CR5:

- The data collection tool for health education is based on Yes or No questions. Is there a mechanism in your method to verify if their response is biased?
- Which university in Ethiopia do you think is using a user friendly RH program?

Reflection from the presenter:

The means of verification for health education is to visit a school and ask the school master if they have a regular health education program.

It is very difficult to say this or that university is user friendly because evaluation is not done. But from the current practices in general we cannot say universities have designed a high level of user friendly RH program.

Table 8: Summary of thematic areas, presenters, presentation topics and Moderators of concurrent sessions (Day 3, Session 1).

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR1	Health services/ Health economics/ HR	Abera Botore	Willingness to join and pay for Community Based Health Insurance among Households in Rural Community of Wachale District , Oromia, Central Ethiopia ; Community Based Cross Sectional Study.	Professor Amsalu Feleke
		Getiye Dejenu	Willingness to join and pay the Newly Proposed Community Based Health Insurance and Associated Factors in East Gojjam Zone, Northwest Ethiopia.	
		Mirgessa Kaba	Why Women in Urban Setting Fail to use Available Maternal Health Service: A Qualitative Study in Selected Towns /Cities of Ethiopia.	
		Edoa Sado	Availability and Affordability of Essential Medicines for Children in the Eastern Part of Wollega Zone: Implication for Access to Essential Medicines in Children.	
		Bikesegn Asrat	Burnout Status at Work among Health Professionals in Tertiary Teaching Hospital, South West Ethiopia.	
		Fekadu Assefa	Achieving Alignment in Academic Health Science Centres in Ethiopia: The Case of Four Teaching Hospitals.	
Room	**Thematic area**	**Presenter**	**Title of Presentation**	**Moderator**

CR3	Demography and population	Aboma Motuma	Utilization of Youth Friendly Reproductive Health Services and Associated Factors Among Youth in Harar Town, East Ethiopia: A Mixed Method Study.	Dr. YIrgu G/ Hiwot
		Getachew Mullu	Risky Sexual Behaviours and Associated Factors among Jiga High School Preparatory School Students, Amhara Region, Ethiopia.	
		Misrak Getnet	Improved Knowledge of Emergency Contraception among Students of the University Of Buea: A Comparison of Talk Versus Educational Leaflet.	
		Ewnetu Ferdawek	Maternal Near Miss and Still Birth in Developing Countries: A Systematic Review With Meta-Analysis.	
CR4	Mental health and substance abuse	Fikir Addisu	Lengthen of Stay of Psychiatric Admissions in General Hospital in Ethiopia: A Retrospective Study.	Mr. Fentie Ambaw
		Yared Reta	Public Stigma against People with Mental illness in Jimma Town, South West Ethiopia.	
		Telake Azale	Treatment Gap and Help-Seeking for Postpartum Depression in a Rural African Setting.	
		Amanuel Alemu	A Systematic Review and Meta-Analysis of the Association Between Unintended Pregnancy and Prenatal Depression.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR5	Pharmacology and drug use	Eshtie Melesse	I Vivo Antidiarrheal Activity of Indigofera Spicata, Fabaceae.	Mr. Mengistab W/ Aregay
		Essayas Kebede	Adjunctive Dezamethasone Therapy in Unconfirmed Bacterial Meningitis in Resources Limited Setting: Is It a Risk Worth Taking?	
		Hassen Mamo	Effect Of The Crude Leaf Extract of Osyris Quadripartitaon Plasmodium Berghei in Swiss Albino Mice.	
Cr6	Environmental health	Albel Abebe	Does ISO 14001 Accreditation Reduce Environmental Impact of Industries: A Case Study in Addis Ababa.	Dr Alemayehu Haddis
		Daniel Bogale	Assessment of Occupational Injuries among Addis Ababa City Municipality Solid Waste Collectors.	
		Cheru Tesema	Environmental and Host Related Determinants of Tuberculosis: Ethiopia A Case Control Study Design.	
		Anteneh Amsalu	The Exposure Rate to Hepatitis B And C Virus among Medical Waste Handlers in Three Government Hospitals, Southern Ethiopia.	
		Fikrealem Mezgebu	Latrine Ownership, Use And Socio Economic Correlates: A Cross Sectional Study Conducted in Rural Becho District, Ethiopia.	

Presentations and discussions from CR6:

Alebel:

- Industry has 50% share in pollution in Ethiopia
- 5 industries and 1 company secured accreditaiton
- Research quesiton: Are these industries better in managing their waste than others?
- All use primary treatment options

→ Conclusion: No significant difference!

Cheru:

Environmental and host related determinants of TBc;

Anteneh:

Exposure rate of Hepatitis B &C:

- The environment doesn't have a mechanism of screening workers;
- Individuals working in the laundry are 10 times more likely to get infected;

Fikrealem:

Latrine ownership

- If people have accesss to latrine, they use it;
- Nearly half of the people are without latrine;
- Having a school kid is directly associated with larine ownership;
- Still large number of people use open defecation;

Comments, Questions and Answers:

- You can not study impact by making a cross sectional study;
- Accreditation can be blurred with confounding factors. You should have checked the effect of these confounding factors;
- There is a confusion in using terms like accreditaion, licensing and ISO certification; Accreditation doesn't necessarily lead ot ISO certification. You need to differentiate the terms accreditation and certification. And you had better change the title to **certification**;
- Why should foreigners be excluded so long as they live in the same environment? This is not ethical.
- # of windows/ per room is vague. Instead use # of people/habitable room

- To the 3rd presenter: What did you do to those who are infected? – ethical issues

What is the source of your definition for improved and unimproved?

Table 2: Summary of thematic areas, presenters, presentation topics and Moderators of concurrent sessions (Day 3, Session 2).

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR1	Food and Nutrition	Dube Jara	Prevalence of Malnutrition and Associated Factors among Children 6-59 Months in Rural Community of Jabie Tehinan Woreda , West Gojjam Zone, Northwest Ethiopia, 2014.	Afework Mulugeta
		Dessalegn Ajema	Assessment of Magnitude of Double Burdon of Malnutrition and Its Associated Factors among Selected in-School Adolescents in Arba Minch Town, Southern Ethiopia: Cross Sectional Study.	
		Tadess Alemu	Dietary Diversity during Pregnancy Reduced the Risk of Maternal Anaemia, Low Birth Weight, Pre-Term Delivery and Still Birth in a Prospective Cohort Study in Rural Ethiopia	
		Kalkidan Hassen	Household Food Insecurity and Its Associated Factors among Coffee Farming Households in Jimma Zone, South West Ethiopia.	
		Mastewal Erango	Effect of Outpatient Treatment Program Integrated on Nutritional Status of Outpatient Treatment Program Enrolled Young (6-24 Months) Children in Dilla Zuria Woreda, Gedio Zone , Southern Ethiopia.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR3	Demography and population	Mengistu Meskele	Birth Preparedness and Birth Complication Readiness and Associated Factors among Women in Wolita Zone, South Ethiopia.	Dr Abebaw Gebeyehu
		Mulumenet Abera	Cause-Specific Mortality Trends in Gilgel Gibe Field Research Centre, South West Ethiopia: Using Verbal Autopsy.	
		Girma Kassie	Annual Program Trend Analysis and Outcome Monitoring Using Random Follow Up Visits: The Experience of Integrated Family Health Program (IFHP) in Ethiopia.	
CR4	None communicable diseases	Kalayu Birhanie	Knowledge and Perception towards Cervical Cancer among Female Debrebirhan University Students.	Dr Solomon Mekonnen
		Nebiyu Dereje	Prevalence and Determinants of Chronic Non-Communicable Diseases in Hossana Town; A Population Based Cross Sectional Study.	
		Haregewoin Kerebih	Prevalence of Hypertension and Diabetics and Associated Factors in Ethiopia, Implication of Public Health Intervention: Implication for Priority Policy Attention for Intervention: Systematic Review from 2000-2015.	
		Yosef Cherinet	Prevalence of Undiagnosed Diabetes Mellitus and Its Risky Factors in Selected Public Institutions at Bishoftu Town, East Showa, Ethiopia.	

Room	Thematic area	Presenter	Title of Presentation	Moderator
CR5	Communicable diseases	Fentabil Getnet	Delay in Diagnosis of Pulmonary Tuberculosis in Low And Middle Income Setting: Systematic Review and Meta-Analysis.	Dr Agonafer Tekalegn
		Daniel Gebretsadik	The Prevalence of Pulmonary Tuberculosis and Intestinal Parasitosis among ART Attendant HIV Patients at Kombolcha Health Centre, South Wollo Zone, Northeast Ethiopia.	
		Eyassu Ejeta	Rucellosis among Patients with Febrile Illness in Four Districts of East Wollega Zone, Western Ethiopia.	
		Fira abamecha	Sero-Prevalence and Associated Factors to Toxoplacma Gondii in Pregnant Women Following Antenatal Care at Mizan Aman General Hospital, Bench Maji Zone(BMZ), Southwest Ethiopia, 2014.	
		Wake Abebe	Measles Outbreak Investigation in Nedjo Districs, West Wollega Zone, Oromia Region, Ethiopia.	
		Belay Bezabih	Strengthening the Public Health Emergency Management (PHEM) System: The Amhara Region Experience, 2011-2015, Ethiopia.	

Room	Thematic area	Presenter	Title of Presentation	Moderator

CR6	Biomedical Sciences	Belete Biadgo	Haematological Indices and Their Correlation with Fasting Blood Glucose Level and Anthropometric Measurement in Type 2 Diabetes Mellitus Patients in Gondar, Northwest Ethiopia	Dr Dawit Abebe
		Olifan Zewdie	Molecular Typing of Mycobacterium Tuberculosis Complex Species Isolated from Tuberculosis Lymphadenitis Cases in Addis Ababa, Ethiopia.	
		Getu Diriba	Comparison of Mycobacterium Growth Indicator Tube BACTEC 960 with Lowenstein-Jensen for Recovery of Mycobacterium Tuberculosis Complex at Ethiopian National TB Reference Laboratory, Addis Ababa, Ethiopia.	
		Melese Abate	Bacterial Contamination of Raw Cow's Milk Consumed at Jigjiga City of Somalia Regional State, Eastern Ethiopia.	
		Nigus Zegeye	Throat Carriage of Gram Negative Commensals in Children with Rheumatic Heart Disease who Received On-Going Monthly Penicillin G Prophylaxis.	
		Bihil Sherefedenin	Performance of Xpert Mttb/Rif Assay for Rapid Diagnosis of Extraplumonary Tuberculosis in Selected Public Health Care Facilities of Addis Ababa, Ethiopia.	

Questions and Answers/ Discussion:

What will be the contribution of handwashing in preventing malnutrition?

Did you check the relationship between HIV/AIDS and Malnutrition?

You have excluded other risk factors for low birth weight . Is that sound?

What ethical precausions did you take for your intervention/ intervenion outcome?

You should have investigated cash crop production with food insecurity. For example, take coffee growing regions and see if they are food insecure. There are studies that show food insecurity even in cash crop areas. What are the reasons? It needs investigation.

One senior EPHA member commented:

I am saying this because I feel happy after listening to the presentations. I am a grandfather to all these young people. I usually hear comments that say "there is no physician, nurse, etc. today. The comments go on further saying "we had the best of them earlier". I was worried if these comments were true. I was asking myself why we the seniors failed to transfer knowledge and skill to our ancestors in the health care system. Today, I realized that the comments are not genuine, and I happen to know that we have an energetic scientific community. I ask you to interprete the knowledge you obtained from your research in a way that benefit your people.

Conclusion from the moderators:

Malnutrition is a serious problem in Ethiopia. There is a strong need to integrate it with healht education, sensitization and awareness creation with some kind of demonstration and nutritional support to the needy.

More over, nutritional supports should aim at creating an enabling condition for the family to sustain its own food, not depend on food aid.

5.1 Summary of Major findings, conclusions and recommendations from selected oral presentation in selected thematic areas.

Note that the seletion of these presentations is random and what is presented here does not indicate that these papers are of better quality than others. They are presentted here randomly just for completness of the proceeding.

5.1.1 Biomedical Sciences

1. **Correlation of Fasting and Postprandial Plasma Glucose with HbA1c in Assessing Glycemic Control; Systematic Review and Meta-analysis** – Ezra Belay Ketema and Kelemu Tilahun

Main findings

PPG Shows better correlation with HbA1c than FPG

Based on Pearson's correlation coefficient (r):

- PPG was better correlated with HbA1c than FPG in 7 studies.
- the other three studies revealed a better correlation between FPG and HbA1c than PPG
- Pooled correlation:
  - r= 0.61(95% CI; 0.48 to 0.72) for FPG
  - r= 0.68 (95% CI; 0.56 to 0.75) for PPG

PPG contributes more to overall hyperglycemia than FPG

- 3 studies estimated relative contribution of FPG & PPG to the overall glycemia.
- They observed that:
  - More patients who have achieved PPG target of <140 mg/dl, achieved HbA1c target of <7% (94% Vs 64 %).
  - A decrease in PPG was accounted for nearly twice as much as FPG did for the decreases in HbA1c.

PPG showed more sensitivity & specificity than FPG

Four studies calculated the specificity, sensitivity and PPV of FPG and PPG tests in detecting the HbA1c changes.

Three of them found better sensitivity, specificity and positive predictive value for PPG than FPG

FPG is insufficient to obtain optimal glycemic control

In resource poor setting, glycemic control efforts have emphasized on achievements of FPG targets.

But evidences revealed that FPG was either insufficient to obtain optimal glycemic control or ameliorates HbA1c only partially

The review showed that PPG is either a better correlate or accurately predicts HbA1c value or its contribution to the overall hyperglycemia is greater than FPG

PPG contributes more to DM complications

Conclusion

Our result signifies that control of postprandial hyperglycemia is more important to achieving target HbA1c goals than FPG

Hence, monitoring of PPG will be more helpful to achieve optimal glycemic control and prevent long term diabetes complication than FPG alone in the absence of HbA1c.

2. **Lipid profile level correlation with anthropometric and clinical variables among type 2 diabetes mellitus patients at University of Gondar Hospital, Northwest Ethiopia -** Molla Abebe, Belete Biadgo and Solomon Mekonnen.

Lipid profile and blood sugar level of the study participants:

Significant increase in TC, LDL-c, TAG and FBS levels were observed in diabetic patients as compared to control group

There was significant decline in mean concentration of HDL-c in T2DM compared to controls (56.5±20.4 vs 62.1±13) p=0.007 respectively

The most commonly observed lipid abnormalities in the study were:

Hypertriacylglycerolemia followed by LDL hypercholesterolemia, hypercholesterolemia and low HDL cholesterolemia for T2DM patients

LDL hypercholesterolemia followed by hypercholesterolemia, hypertriacylglycerolemia and low HDL cholesterolemia for controls

Table 2. Pearson's correlations (r) between lipid profiles with BMI and WHR among T2DM and healthy controls at University of Gondar Hospital, Northwest, Ethiopia, 2015, (n=296)

	Type 2 DM group		Control group	
Variables	**BMI**	**WHR**	**BMI**	**WHR**
	r(p)	r(p)	r(p)	r(p)
Low density lipoprotein	**0.293**(0.000)**	**0.283**(0.000)**	**0.364**(0.000)**	**0.349**(0.000)**
High density lipoprotein	-0.053(0.519)	-0.025(0.766)	-0.172(0.036)	-0.065(0.431)
Total cholesterol	**0.167*(0.042)**	**0.349**(0.000)**	**0.231**(0.005)**	**0.396**(0.000)**
Triacylglycerol	**0.335**(0.000)**	**0.200*(0.015)**	**0.499**(0.000)**	0.117(0.156)

Conclusion and recommendations

There was statistically significant difference in lipid profile level between diabetic patients and healthy controls

Statistically significant increase in FBS, SBP, DBP, BMI & WC in diabetics than healthy subjects

Significant correlation was observed in lipid profiles with anthropometric and clinical variables

Periodic medical checkup and appropriate life style change is recommended for both T2DM and healthy controls to improve dyslipidemia and reduce cardiovascular risk

Further cohort studies are needed to confirm our result

5.1.2 Environmental Health

1. **Does ISO 14001 accreditation reduces environmental impact of industries?: A case study in Addis Ababa, Ethiopia –** Alebel Abebe and Prof. Dr. Ir. Harry Verlest

Table 4: Effluent concentration of acc & non acc. Ind & NGV (Unit in mg/L)

Parameter	ACC Tann	Non acc Tan	National stand.	ACC brew	Non acc brew	National stand.
pH	7.92	7.55	6-9	6.93	6.88	6-9m
TSS	1220	1453	50	624	997	50
Cr^{X+}	7.2	11	2	_	_	_
DIN	19.9	22.73	30	23.73	23.88	10-15(EUD)
SRP	0.23	0.47	10 total P	72.92	29.21	1-2(EUD)
BOD_5	1350	1350	200	1200	2652	60
COD	2970	3221	500	1920	3765	250
Chloride	4893	3400	1000	42.98	112	_

Conclusion

Inspection and internal audit was not sufficient

Scarce resource use is the same for acc and non acc.

Degree of pollution on rivers proved by the ↑conc. of pollutant DS.

No significant difference in the efficiency of treatment (↑Env. burden)

Chromium is better managed by both tanneries.

Recommendations

Focus on revisiting and internal audits (regular)

Upgrade treatment technology (primary deficient).

Policy and enforcement*

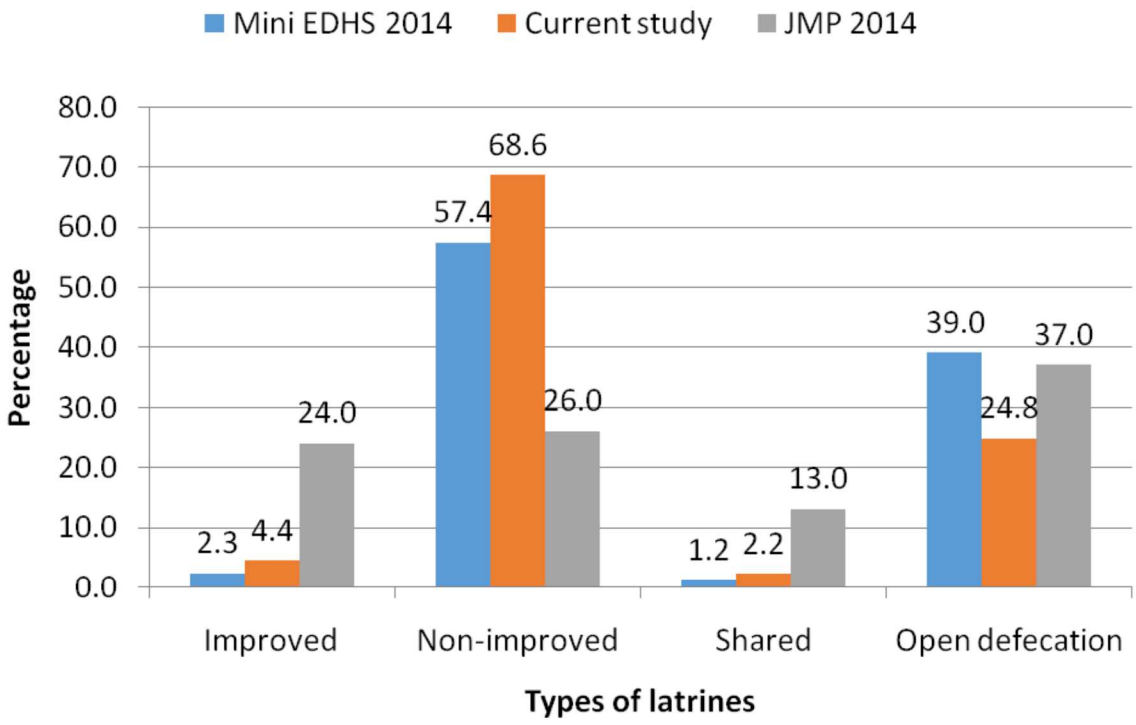
accreditation should look in to technical evaluations

Resource use (Chrome replacement, efficient chemical use, sulphide-free unhairing, water reuse, solvent free finishing.

Country wide study is recommended

2. **Latrine ownership, use and socio demographic correlates in rural Becho district of Ethiopia** - Fikralem Mezgebu, Abera Kumie, Girmay Medhin, Teshome Gebre, Janvier Gasana.

Type of sanitation facilities



Conclusion

The ownership of any kind of latrine by 73% of study participants with 98% utilization rate among owners is a good indication of progress

Improved latrine ownership of 4.4%, ownership of hand washing facility of 8%, hygienic disposal of under-five child faces of 50% need for a focus by current sanitation programs for the better health impact

Persuasive intervention like CLTSH approach might be more likely to be effective, further study is needed to substantiate this observation

Environmental and Host Related Determinants of Tuberculosis in Metema district, North Gondar Zone, Ethiopia: *Case Control Study Design* - Cheru Tesema, Takele Tadesse, Mulat Gebrehiwot, Azanaw Tsegaw, Fitsum.

Environmental determinants

Majority 77.4% (80.3% among cases and 76.0% among controls) have only one HHs in the compounds

Most of respondents 51.8% (66.5% among cases and 44.4% among controls) have a family size less than or equal to 4

The majority 349(53.3%) (36.2% among cases and 61.8% among controls) were living in a house less than 4 meter square per person

Most 564(86.1%) (86.2% are cases and 86.0% among healthy controls) have no previous history PTB

Most 428(65.3%) (33.5% among cases and 60.99% controls) have no TB contact history

The majority 473(72.2%) (68.8% among cases and 91% among controls) were live in a room whose roof was made from CIS while the rest 107(16%) (31% among cases and 9% among controls) live in a room whose roof was made from thatched

The majority, 565(86.3%) (84.9% among cases and 87.0% among controls) have

Behavioral Determinants

Five hundred forty seven (83.5%) (83.9% from cases and 83.3% from healthy control) have no history of cigarette smoking in their life,

While 108(16.5%) (16.1% from cases and 16.7% from healthy control) were have been practicing cigarette smoking

Conclusion

With respect to opportunities for intervention, this study has identified several possibilities Family size, educational status, room space, contact history, window number, kitchen and ceiling were the major factor associated with tuberculosis

Recommendation

Based on the finding of this study the following recommendation will be recommended

The regional health bureau and district Health office should give attention to improving the provision of family planning for the community to limit their family size

5.1.3 Food and Nutrition

1. Predictors of Nutritional status in adolescent school girls in Southwest Ethiopia – Tezera Moshago. and Feleke M.

Table 2: Multiple Regression Analysis model for Factors predicting HAZ score of adolescent school girls southwest Ethiopia (n=822)

Variables	Bi-variate Beta(β)	Multivariate Beta(β)	95%CI for (β)	
Intercept		-2.10	-4.1	-0.19
Residence (urban)	0.58	0.32	0.35	0.81
Breakfast (regularly)	0.28	0.22	0.44	0.11
Live with (relatives)	-0.11	-0.15	-0.21	-0.02
Hand Wash after toilet use (always)	0.18	0.14	0.01	0.35
Place for cooking (in separate kitchen)	0.27	0.16	0.06	0.49
Work for pay (no)	0.17	0.07	-0.12	0.46
Heavy bleeding (no)	0.55	0.13	-0.02	1.10
Source water (improved)	0.20	0.10	-0.05	0.45
Fuel used for cooking (gasoline)	0.10	0.10	-0.03	0.22
Mothers occupation (professional)	0.04	0.08	-0.03	0.11
sedentary life	-0.03	-0.08	-0.09	0.02

Residence(urban), regularity of breakfast, No episode of illness in the preceding one month to interview, fuels used for cooking in the household, hand-washing habit after toilet use, time spent

on sedentary activities, consumption of sweet food items, consumption of cereal, mothers' occupation were significant predictors ($p<0.05$)

Respondents who were engaged one more hours longer per day on sedentary life had on average 0.11(95% CI: 0.01, 0.09) units increase in BMI for age Z score

Similarly respondents who did not suffer any illness in the preceding one month from the time of interview were on average 0.15 units higher scores than respondents who reported illness 0.15(95% CI 0.09, 0.53).

Conclusion

Over nutrition or obesity is not the major problem of female adolescents' student

More attention needs to be given to the regular consumption of breakfast, hand washing all the time after toilet use and preparing separate kitchen for cooking

2. ASSOCIATION OF FASTING ANIMAL SOURCE FOODS WITH METABOLIC SYNDROME AND BODY COMPOSITION AMONG EMPLOYEES OF JIMMA UNIVERSITY - Melese Sinaga, Tefera Belachew, Amanuel Tesfaye, and Makeda Sinaga

There was significant difference ($P<0.0001$) in metabolic syndrome between fasters of ASF (24.6%) and non-fasters (29.3%)

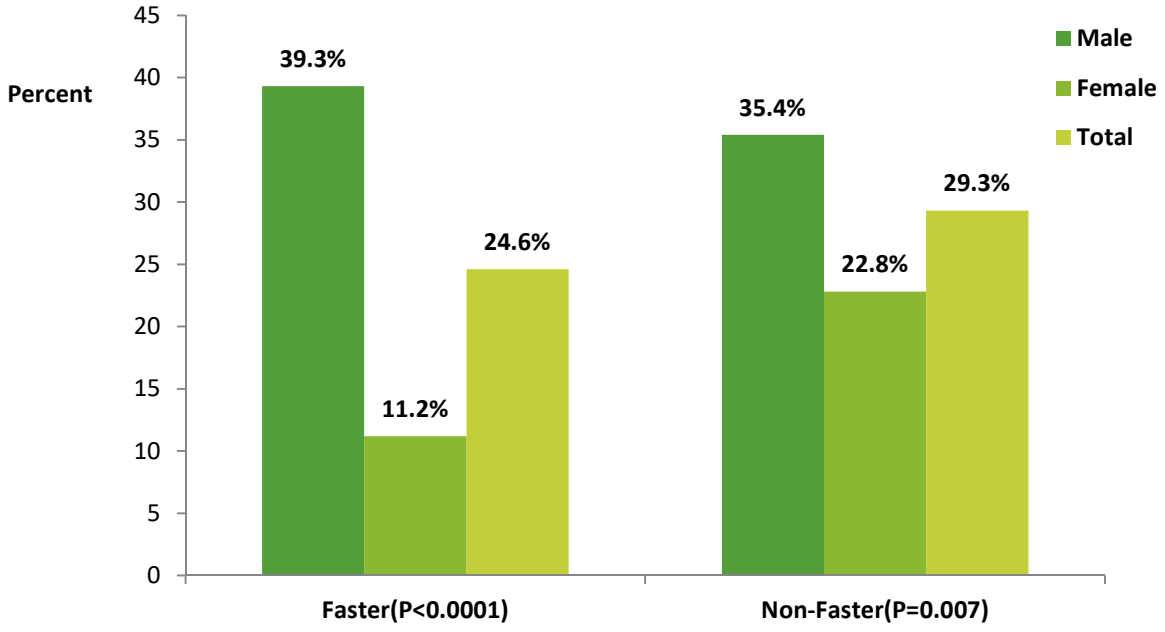


Figure 2: -Prevalence of metabolic syndrome by sex and ASF fasting status among employees of Jimma University, March to April, 2015

Study participants who consume ASF were **nearly 2 times** more likely have metabolic syndromes than those individuals who don't consume animal source (P= 0.020).

Our finding showed that, alcohol consumption had statistically significant association with metabolic syndrome.

Drinking alcohol during the last 12 months was 2.319 times more likely to be associated metabolic syndrome.

Conclusion

The prevalence of metabolic syndrome high non-faster ASF as compared to fasters.

Drinking alcohol, age, sex, frequency of ASF consumption in a typical week and consumption of solidified vegetable oil, **were significant independent predictors of metabolic syndrome.**

Fasters, as compared to non-faster animal source foods, had decreased levels of TG, FBS, waist circumference, fat mass percent, hip circumference and BMI.

Independent predictors of high Body fat Mass percent were:

Positive predictors: Age, ASF fasting, household wealth, Alcohol drinking in the last 12 months
Negative predictor: Male sex

Recommendations

Concerning major finding in order to control the problems of metabolic syndromes among employees of JU the following points are recommended for

- The government
- Ministry of health
- JUSH, College of Health Sciences
- Health Office of Jimma Town and
- Other responsible bodies.

As metabolic syndrome is **associated with killer diseases, interventions on decreasing/avoidance of saturated fat** and alcohol consumption targeting males and middle aged adult population need to be considered.

Behavioral change communications (**BCC**) on **life style modifications including reduction** of ASF consumption,

Alcohol consumption in moderation

Targeting those above 40 years as well as the general population is very critical to curb the consequences of metabolic syndrome and consequent chronic degenerative diseases.

JUSH should screen individuals at risk of MetS to focus on weight management and engage in appropriate physical activity levels.

Moreover, future interventions by **health policy makers and public health officials** ought to focus on the individuals at risk for MetS who have one or two risk factors in order to control any potential burden of the syndrome.

For researchers, future research should look in to the effect of fasting ASF on body fat percent and risk of metabolic syndrome, using a longitudinal study, quantification of the level of alcohol intake, chewing khat and smoking practices of the last one year should be considered.

3. **Prevalence of zinc deficiency and its association with dietary, serum albumin and intestinal parasitic infection among pregnant women attending ANC at the University**

of Gondar Hospital, Gondar, Northwest Ethiopia, 2015 - Gemechu Kumera, Tadese Awoke, Tesfahun Melese, Setegn Eshetie, Getnet Mekuria and Dereje Gedle.

Dietary intake.

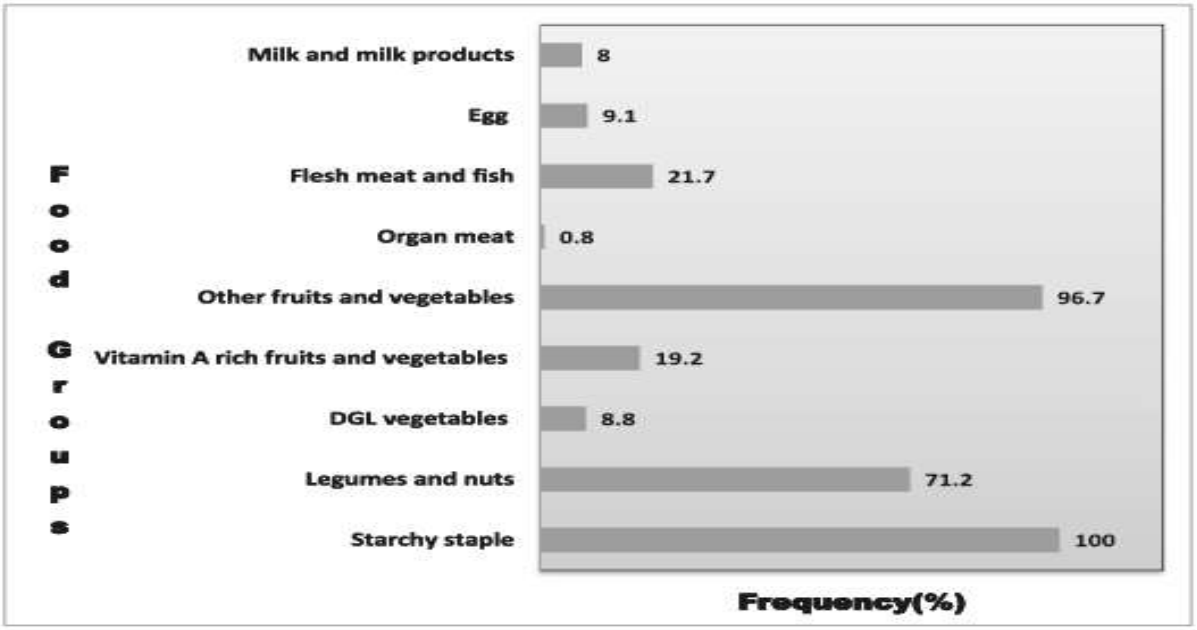


Fig 2: Dietary diversity of pregnant women attending ANC at UOG hospital, Gondar, Northwest Ethiopia, 2015

More than half, (57.4 %) (95 % CI: 52.2 % – 62.9 %) of pregnant women had ZD based on low serum zinc concentrations.

The mean serum zinc concentration was 48.1(±21.6) µg/dl.

The prevalence of ZD during the first, second and third trimesters were 15.8, 30.6 and 53.6 %, respectively.

PW living in rural area were two times more likely to be ZD as compared to those living in urban areas [AOR = 1.92; 95 % CI (1.04, 3.56)].

PW with short birth interval (<2 yr) were 4 times more likely to be ZD as compared to PW with no birth [AOR = 3.97; 95 % (1.30, 12.13)].

Compared to PW who consumed animal source foods, the risk of ZD was 2.29 times higher among those who did not consume animal source foods in the reference period [AOR = 2.29; 95 % CI (1.35, 3.89)].

Similarly compared to pregnant women with adequate DD Score (≥ 4), the risk of ZD was two times higher among those with inadequate DDS (DDS ≤ 3) [AOR = 2.09; 95 % CI (1.24, 3.51)]

PW who did not receive nutrition education was 1.78 times at greater risk of being zinc deficient compared to those who received nutrition education during pregnancy [AOR =1.78; 95 % CI (1.10, 2.86)].

Albumin deficient pregnant women had two and half fold [AOR = 2.55; 95 % CI (1.40, 4.63)] greater risk of being zinc deficient compared to those with normal serum albumin levels.

Pregnant women who had one or more intestinal parasitic infection were 2.6 times more likely to be zinc deficient as compared to those who had no intestinal parasitic infection [AOR = 2.60; 95 % CI (1.49, 4.54)].

Conclusion

Zinc deficiency is of a public health concern among PW in the study area.

Living in rural areas, history of too close births, inadequate DD, low intakes of foods of animal origin, lack of nutrition education, low serum albumin and intestinal parasitic infection are key predisposing factors to ZD.

Recommendations

Promoting higher agricultural productivity and diversity

Rural livelihood promotion and empowerment of women

Nutrition intervention must be well integrated into maternity services.

Sustained nutrition education to increase knowledge as well as practices concerning the consumption of zinc rich foods and optimal dietary diversity

5.1.4 Neonatology, infant, child and adolescent health

1. **Prevalence of diarrhea disease and associated factor Among under-five children, in Dehana District, wag-himra zone, Amhara region, North West ,Ethiopia -** AZANAW TSEGAW, GASHAW ANDARGIE, MULAT GEBREHIWOT, CHERU TESEMA.

The two-week period prevalence of childhood diarrhea morbidity in this study was 14.9%.
HHs having family size >5people were two times higher odds having diarrhea than those children living with ≤5family size [AOR: 1.9, 95% CI (1.2, 3.1)]
The odds of having diarrhea in children whose mother illiterate was five times greater than the odds of children whose mother is literate [AOR: 5.1, 95% CI (1.2,21)],
Using unprotected water source for domestic purpose had two times diarrheal disease than those who used protected source with [AOR: 2.4, 95% CI (1.5, 3.5)],
Distance for fetching water also had significance with childhood diarrheal disease, time taken more than 15 minute had three times having diarrhea than less than 15 minutes [AOR: 3.4, 95% CI (1.6,7.2)]
Children from HH where there was Unimproved sanitation were about two times more likely to have diarrhea than those children from the HH where improved sanitation [AOR: 2.2, 95% CI (1.2, 3.8)]

Conclusion

In conclusion, Diarrhea morbidity was a major health problem among under-five children in Dehana district
Family size in the household, maternal education, history of maternal diarrhea, water source, water accessibility and unimproved sanitation had a significant association

Recommendations

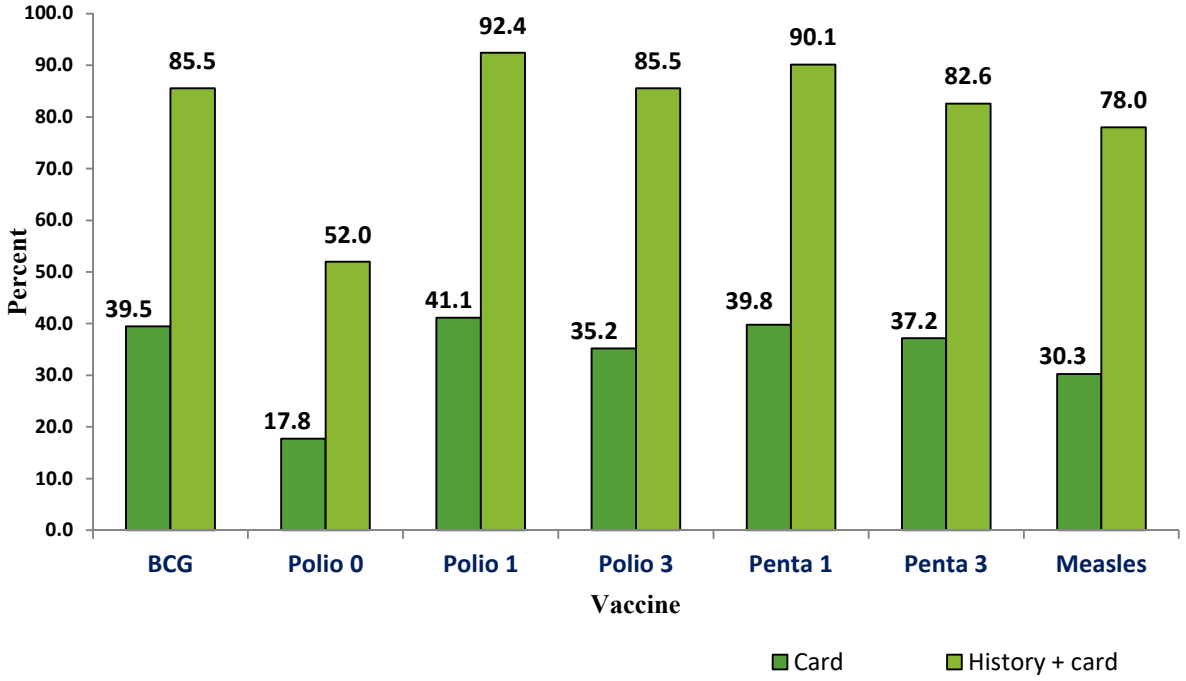
The regional water resource bureau and district water office should give attention to access safe drinking water
Dehana district health office and Amhara regional health bureau well- designed health education should be strengthened

The district Implemented interventions targeting sanitation especially proper disposal of feces

Further study of seasonal variation is recommended to the researcher

2. **Assessment of Child Vaccination and Knowledge of Mothers on Polio Vaccination and other Childhood Vaccines in CORE Group Polio Project Implementation Districts In Ethiopia –** Legesse Kidane

Vaccination coverage



Conclusion

Though higher than EDHS 2011 report,

Vaccination coverage was still low in the project communities,

Antigen specific dropout rate was significantly higher,

Large proportion of mothers or caretakers claimed their child is vaccinated; however, the observed coverage was low,

More than half of the mothers had positive knowledge on the advantage of repeated doses of polio vaccination

Recommendations

There is a need to increase engagement of all concerned bodies to increase mothers'/caretakers' knowledge on vaccination timing,

These all call the need for collaborative efforts to increase immunization coverage, reduction in dropouts and increase mothers'/caretakers' knowledge,

Innovative strategies should be developed, in such a way that copy or the vaccination cards can be maintained and stored at home level supplemented by education of mothers,

Future data collection activities need to consider adding the collection of all vaccine doses and interval between doses so that better information.

5.1.5 None communicable diseases

1. Assessment of factors contributing to late diagnosis of cervical cancer in selected hospitals of Addis Ababa, Ethiopia 2015 - Seble Belachew, Adamu Addissie, Wondimu Ayele and Eskinder Kebede

Family monthly income, occupational status, distance from oncology center and total diagnostic delay were significantly associated with late stage diagnosis.

Most of the patients had long total diagnostic delay more than two month and long HCP delay more than one week.

Most of the study subjects have short referral delay, short diagnostic waiting time and short patient delay less than one week.

IDI: symptom misrecognition and interpretation, long waiting time to see a doctor, waiting time for test, being far away and waiting time in treatment center are the main reasons.

Recommendations

Government

Emphasis should be given on improving and building new radiotherapy centers.

Increase the community knowledge about prevention and early treatment methods of cervical cancer.

Health care system

Health care providers should give special attention for identification of early symptoms and initiation of cervical cancer screening.

Give health education to the women attending health facilities about cervical cancer

Researcher

More studies regarding cervical cancer and other facility and treatment related factors

2. Prevalence of hypertension in Ethiopia: systematic Meta-analysis – Kelemu Tilahun

After analysis of 12076 subjects from 8 studies, the pooled over all prevalence of hypertension according to random effect DL model in the Ethiopian population was found to be 19.23 % (95%CI: 12.96%, 25.49 .0%)

Subgroup analyses showed that the prevalence of hypertension in the urban population was 23.69 % (95% CI 16.75, 30.62) that of rural/urban population was 14.7% (95% CI: 9.7, 19.68)

The prevalence of hypertension was observed to be higher in the urban compared with the rural population

The higher prevalence of hypertension in urban areas compared with rural areas strongly implicates differences in lifestyle as an explanatory factor

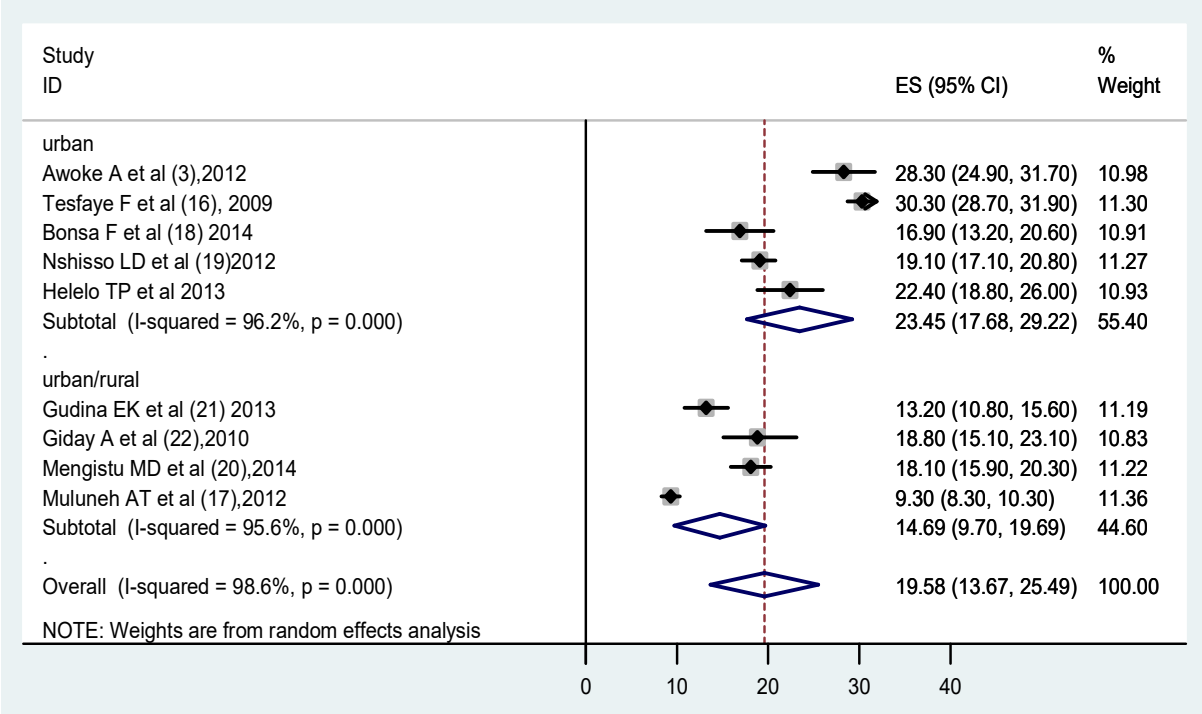


Figure 2: Forest Plot of the 8 Studies that

Conclusion and recommendation

The pooled estimate does provide an overview rising prevalence of hypertension in the Ethiopian population.

This evidence gives clue that Ethiopia is being affected by double burden disease

Interventions should give attention for reduction of hypertension in the Ethiopian adult population.

It is recommended that primary prevention measures should be implemented

Further national population based studies required for precise estimate of the prevalence of hypertension in the urban and rural population of the Ethiopia.

3. **PREVALENCE OF UNDIAGNOSED DIABETIES MELLITUS AND ITS RISK FACTORS IN SELECTED PUBLIC INSTITUTIONS AT BISHOFTU TOWN EAST SHOA ETHIOPIA** - Yoseph Cherinet, Mistire Wolde, Samuel Kinde, Ahmed Raja & Demo Yamane.

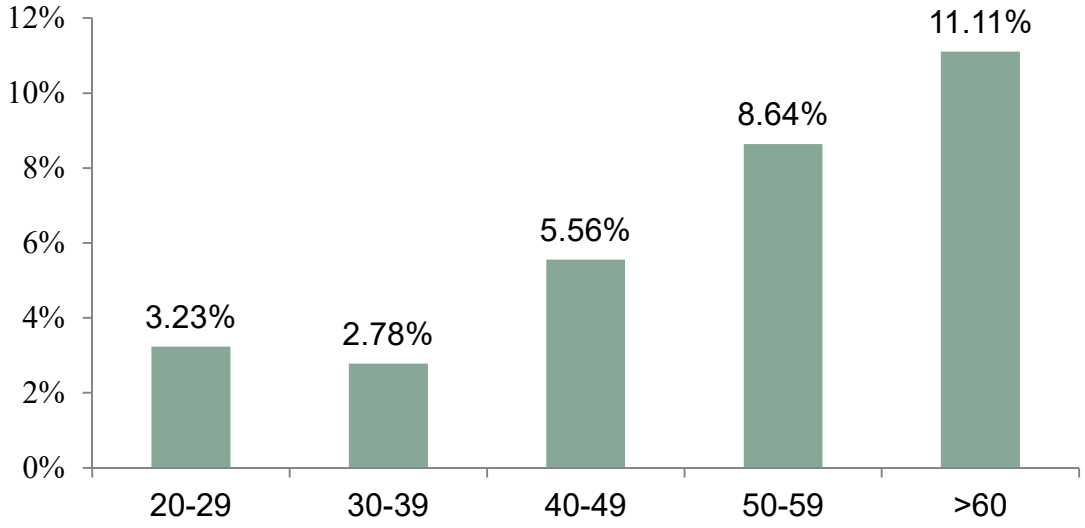


Figure 2: Age specific prevalence of UDM (n=422)

Conclusion and recommendation

The study illustrated 5% prevalence UDM. It should be noted that the result is technically alarming.

It was observed that UDM affected all adults.

UDM was only associated with modifiable risk factors.

In light of the study findings the following are recommended

Targeting to prevention of modifiable risk factors

Wide scale study to bring more oblivious patients for medical attention

5.1.6 Pharmacology and drug use

1. **Predictors of treatment Failure among Adult Antiretroviral Treatment (ART) Clients in Bale Zone Hospitals, South Eastern Ethiopia -** Ketema Gashaw, Demewoz Haile, Abulie Takele, Habtamu Demelash, Dabere Nigatu

Table 1. Baseline clinical characteristics of adult ART clients Bale Zone Hospitals, South East Ethiopia; 2015.

Baseline characteristics	Number	Percent
Baseline functional status		
Working	3,771	78.46
Ambulatory	786	16.35
Bedridden	249	5.18
WHO stage at baseline		
WHO Stage 1	683	14.20
WHO stage 2	881	18.32
WHO stage 3	2,870	59.68
WHO stage 4	375	7.80
Initial CD4 Count		
≤200	2,834	58.93
201-300	906	18.84
>300	1,069	22.23
TB co-infection at initiation of ART		
Positive	531	11.04
Negative	4,278	88.96
Patient develop TB after ART initiation		
Yes	103	2.14
No	4, 706	97.86
Presence of other opportunistic infection		
Yes	78	1.62
No	4731	98.38
BMI at Initial visit		
<18.5	2060	42.84
18.5-24.9	2401	49.93
≥25.0	348	7.24

- Treatment failure incidence rate was 9.38 (95% CI: 7.79-11.30) per 1000 person years.
- The highest rate of treatment failure was occurred between 6 months and 10 months of ART initiation.
- Lower baseline CD4 count was significantly associated with higher odds treatment failure.

- ART clients who had TB co infection during ART initiation were 3 times higher to experience treatment failure.
- In this study those patients who had used (AZT+3TC+EFV) drug regimen had higher odds to experience treatment failure as compared to (d4T+3TC+NVP).

Conclusion

- The rate of treatment failure needs attention.
- The highest rate was occurred between 6 months and 10 months of ART initiation.
- Age of clients, male ART clients, bedridden clients, ambulatory clients, TB co-infected clients at ART initiation, develop TB co- infection after ART initiation, type of drug regimen used, drug adherence, clients with low CD4 count at art initiation, and clients who reported other opportunistic infection were factors associated with treatment failure.

2. **Investigation on Antidiarrheal and Antimicrobial activities of 80% methanolic leaf extract of *descopodium penninervum (hochst.)-*** Deginet Abebe

Extraction

The percentage yield was 16.67% (w/w)

The extract was dark-brown

Phytochemical screening

flavonoids, terpenoids, phenols, sapons, tannins → present

Cardiac glycosides, Sterols, and Alkaloides → absent

Acute toxicity study

LD50 found to be greater than 2000 mg/kg

Antimicrobial Activity

No activity against *Staphylococcus aureus* and *Salmonella typhi*

Poor activity against *E. coli* and

High activity against *Shigella specie*

Castor oil induced Diarrhoea

Tested at a doses of 100 mg/kg, 200 mg/kg, and 400 mg/kg

Decrease the number of defection at all tested dose

Conclusion

Effective in castor oil induced diarrhea

Has antimicrobial against of *Shigella species a*nd E.coli

Secondary metabolites may be responsible

So the plant can be used

Recommendations

Further phytochemical screening

Structural elucidation of secondary metabolites

Further antidiarrheal test

Further toxicological studies

***In vivo* Antidiarrheal activity of root extract of *Idigofera spicata* Forssk.(Fabaceae) -** Eshetie Melese Birru, Assefa Belay, Getnet Mequanint, Asegedech Tsegaw

Hydroalcoholic solvents (especially 80% methanol)

expanded polarity range : more efficient in extracting the most important bioconstituents

Percentage yield

12.53%

Phytochemical screening

tannins, alkaloids, saponins, glycosides, flavonoids, terpenoids, steriodal cpds

reported anti-diarrheal effect [Otshudi et al, 2000]

Oral acute toxicity: limit dose test

LD50 > 2000mg/kg

Agrees with the previous toxicity test [Birru et al, 2015]

The plant demonstrated hepatotoxic, abortifacient like and teratogenic effects in animals [Fletcher et al, 2015]

Conclusion

The leaves extract of *Brassica nigra* showed statistically significant antidiarrheal but insignificant antisecretary and antispasmodic activities.

validates the traditional use of the plant

potential source of new and novel agent(s) in the therapeutic armamentarium of diarrhea

Recommendation

- Bioassay guided chemical fractionations: active component isolation
- identification & characterization of potential anti-diarrheal cpd(s)
    - *In vivo* and *in vitro* sub-chronic and chronic toxicity tests

V. Poster presentations.

Poster presentation for day 1 was scheduled during break times and the rest of the time after business meeting. Posters from 1-80 were set to be visited for day 1were clustered into four thematic areas namely:

1. Behavioral sciences and communication (Posters 1-17)
2. Biomedical sciences (Posters 18-30)
3. Communicable diseases (Posters 31-46)
4. Demography and population (Posters 47-80)

   See the details of each poster in the abstract book which was distributed during the annual meeting.

Poster presentation for day 2 was scheduled during break times. Participants were advised to visit these sessions at any time when they have free time too.

The second day's posters focused around 3 thematic areas namely:

1. Demography and Population (Posters 61-85)
2. Environmental and Occupational health (Posters 86-97)
3. Food and Nutrition (Posters 98-118)

Similarly in day 3, the following posters were planned to be displayed and visited during break times throughout the day.

1. Health economics (Posters 119 – 121)
2. Health services (Posters 122 – 132)
3. Human resources for health (Posters 133 – 137)
4. Mental health and substance abuse (Posters 138 – 147)
5. Neonatology, infant, child and adolescent health (Posters 148 – 157)
6. None communicable diseases (Posters 158 – 162)
7. Outbreak surveillance (Posters 163 – 166)
8. Pharmacology and drug use (Posters 167 – 173)

See the details of each poster in the abstract book which was distributed during the annual meeting.

VI. Action Points and Way Forward

- Donor and partner management (continuation of partnership , maintain donor requirements etc);
- Contribution maximization (successful implementation of Health Sector Development Program and for the improvement of the health of Ethiopian people at large, enable EPHA to assist the government in improving the quality of health professionals training and increase visibility, mainly to FMOH, CSO);
- Ensuring the sustainability of joint Masters training program which the association is supporting in partnership with the Ministries of Health and Education;
- The significant increment of budget allocation has enhanced the possibility of disseminating findings and conducting various locally based science and technological researches;

- Maintain strong commitment of the Federal Ministry of Science and Technology to support the research endeavors undertaken by institutions like EPHA and other national institutions which are engaged in conducting science and technological researches;
- Maintain EPHA award ceremony (category- 4), number of awardees, Prize (gold, bronze, silver) selection criteria etc.;
- Maintain and sustain recognition of prominent people that significantly contributed to EPHA (consultations, invitations, etc....);
- Improve and strengthen the website (www.ejhd.org) of the Ethiopian Journal of Health Development (EJHD) for online submission of articles;
- Making Panel discussions useful (theme selection, equal opportunity to all disciplines of health, panelists (number, time setting), use of key messages from the panel etc, cost incurred by Panelist);
- Making Concurrent sessions useful (quality of abstracts and posters selected and large scale pre-identified research sponsored by EPHA versus usual concurrent sessions , cost incurred by presenters) – all the abstracts selected for presentation at EPHA annual conference must have a publishable quality in the EJHD;
- Ensuring General Assembly Meeting is successful (quorum, cost incurred by representatives (83);
- Development of EPHA's Strategic Plan (3-5 years);
- Members management (use of traditional means in addition to the modern electronic media to announce EPHA conference) and new members registration;

- Strengthening support and make sure Research and Training Advisory Group (TRAG) is properly functioning;
- Follow up on EPHA's Features : work for getting registered as Ethiopian resident society and make sure EPHA receives 90% fund from external donor;
- Maximize the role of EPHA in solving illegal and unethical health services and in motivating health professionals;
- Raise the issue of controlling illegal and unethically functioning private training health institutions in the country;
- Revision of the legislation should be corrected and channeled to the Board for endorsement;
- Make decision on allowance for G.A members and Chapter representatives when called for meeting; the issue returned back to the EB to critically investigate and decide on it;
- The need for the EPHA executive board additional and strong board members like Executive Secretary and Treasurer;
- The need for some of the issues and recommendations to be presented and further scrutinized by an advisory board (member registration and communication, allowance for G.A members and Chapter representatives when called for meeting);

ANNEXES

Annex 1. Opening speech by Dr Fikreab Kebede, President of EPHA

<u>የእንኪን ደህና መጣችሁ ንግግር</u>

<u>ዶ/ር ፍቅረአብ ከበደ (የኢጤአማ ፕሬዝዳንት)</u>

ክቡር ፕሮፌሰር አፈወርቅ ካሡ የኢፌድሪ ሳይናንስ ቴክኖሎጂ ሚኒስትር ዴኤታ

የተከበሩ ዶ/ር ማሕሌት ክፍሌ የክቡር የኢፌዲሪ ጤና ጥበቃ ሚኒስትር ተወካይ እና የሚኒስትሩ ልዩ ጽ/ቤት ዳይሬክተር ጄኔራል

የተከበሩ ዶ/ር ጀፍሪ ሀንሰን የሲዲሲ ኢትዮጵያ ዋና ካንትሪ ዳይሬክተር

የተከበራችሁ የኢጤአማ አባላትና የጠቅላላ ጉባኤ አባላት

የተከበራችሁ የኢጤአማ የሥራ አመራር ቦርድ አባላትና የጠቅላላ ጉባዔ የሥራ አስፈጻሚ

ጥሪ የተደረገላችሁ እንግዶች እና አጋር ድርጅቶች

ክቡራትና ክቡራን!

ከሁሉም በማስቀደም ከ26ኛው ዓመታዊ ጉባኤያችን ወዲህ ከዚህ ዓለም በሞት ለተለዩን የማሕበራችን አባላት 1ኛ. ዶ/ር ሃይሉ የኔነህ (የጠቅላላ ጉባኤ ጸሃፊ) 2ኛ. ዶ/ር ዮሐንስ ከበደ 3ኛ. አቶ ደረጀ ሥዩም የአንድ ደቂቃ የሕሊና ጸሎት እንድናደርግ እጠይቃለሁ።

ከሁሉ አስቀድሜ በዛሬው ቀን በመካከላችሁ ተገኝቼእንኪን ለ27ኛው የማሕበራችን ዓመታዊ የሳይንስ እና ጠቅላላ ጉባዔ በሰላም አደረሰን እንኪን ደህና መጣችሁ ስል በታላቅ ደስታና አክብሮት ነው።

የኢትዮጵያ ጤና አጠባበቅ ማሕበር በጤናው ዘርፍ በሀገር አቀፍና በዓለም አቀፍ ደረጃ ያለውን ተሳትፎና ጉልህ ሚና ከጊዜ ወደ ጊዜ እያሳደገ የመጣ የሙያ ማህበር ሲሆን ለዚህም ስኬት ከተለያዩ የመንግሥት እና

መንግሥታዊ ያልሆኑ አጋር ድርጅቶች ጋር በቅርበትና በትብብር በተለያዩ የሕብረተሰብ ጤና ጉዳዮች ላይ በጋራ እየሰራ ይገኛል።

ከእነዚህም ውስጥ የክልል ጤና ቢሮዎችን ጨምሮ ከፌዴራልና ከጤና ጥበቃ ሚኒስቴር፣ ከፌዴራል የትምህርት ሚኒስቴር፣ ከሣይንስና ቴክኖሎጂ ሚኒስቴር ከሲዲሲ፣ኢትዮጵያ ከፓካርድ ፋውንዴሽን እና አሁን በዝርዝር ውስጥ ካልተካተቱ በርካታ አጋሮች ይገኙበታል።

የ27ኛው የኢጤአማ ዓመታዊ ኮንፈረንስ "*Attaining Universal Health Service Coverage and Sustainable Development Goals Related to Health: Opportunities and Challenges.*" በሚል አብይ የትኩረት አቅጣጫ የዛሬውን ዕለት ጨምሮ ለሚቀጥሉት ሁለት ቀናት በርካታ ተግባራትን ያከናውናል ተብሎ ይጠበቃል። ቁጥራቸው 300 የሚሆኑ የቃልና የፖሰተር ሳይንሳዊ ጽሁፎች፣ በዋናውና በንዑስ የትኩረት አቅጣጫዎቹ ላይ የሚያጠነጥኑ በአምስት ዋና ዋና ክፍሎች በተመረጡ ርዕሶች ላይ የፓናል ውይይት እንዲሁም የማሕበሩ ጠቅላላ ጉባዔ የሚከናወንበት የቢዝነስ ስብሰባ ይካሄዳል።

በኢጤአማ ልምድ መሠረት በየዓመቱ በተለያዩ ዘርፎች እውቅና የሚያሰጠው ዓመታዊ የሕብረተሰብ ጤና ሽልማትም በዚሁ ጠቅላላ ጉባዔ ላይ ይከናወናል።

ክቡር ፕሮፌሰር አፈወርቅ ካሡ!

የተከበሩ ዶ/ር ማሕሌት ክፍሌ የክቡር የኢፌዲሪ ጤና ጥበቃ ሚኒስትር ተወካይ እና የሚኒስትሩ ልዩ ጽ/ቤት ዳይሬክተር ጄኔራል

የተከበሩ ዶ/ር ጄፍሪ ሀንሰን የሲዲሲ ኢትዮጵያ ዋና ካንትሪ ዳይሬክተር

ዋነኛው የማሕበራችን ጥንካሬ አባላቱ ናቸው። የጤና አጠባበቅ ተማሪዎችን ጨምሮ አዲስ ተመራቂዎች፣ በሥራ ዓለም የማይናቅ ልምድ ያካበቱ ተመራማሪዎች፣ የከፍተኛ ትምህርት መምህራን፣ በከፍተኛ ፖሊሲ አመራር ላይ የሚገኙ እና የመሳሰሉት የማሕበራችን ሕልውና መሠረት እና ኩራት ናቸው። እነዚህ የማሕበራችን አባላት በበጎ ፍቃደኝነት ለማሕበራችን እድገት እና ለሀገራችን የሕብረተሰብ ጤና እድገት በበጎ ፈቃደኝነት እያደረጉ ላለው ከፍተኛ አስተዋጽኦ በዚህ አጋጣሚ በሥራ አስፈጻሚ ቦርድ ስም እንዳመሰግን ይፈቀድልኝ?

በመጨረሻም የማህበራችን አባላት በከተማም ይሁን በገጠር፣ በከፍተኛም ይሁን በመካከለኛ የሥራ ሃላፊነታቸውን እንዲወጡ እና ለሀገራችን የጤና እድገት አስፈላጊውን እገዛ በይበልጥ እና በጥራት ማበርከት እንዲችሉ የአቅም ግንባታ ሥራዎች ላይ ትኩረት ሰጥተን መስራት እንደሚጠበቅብን እንገነዘባለን። ይህንንም ለማስፈጸም አባሎቻችን እና አጋር ድርጅቶች ከቀደመው የላቀ ትብብራችሁ እንደማይለየን በመተማመን ነው።

ከዚህ በማስከተል 27ኛው የኢጤአማ ዓመታዊ ጉባዔ እውን እንዲሆን አስተዋጽኦ ላበረከቱ

1. ለኢትዮጵያ ጤና አጠባበቅ ማሕበር ሴክሬታሪያት ሠራተኞች
2. ለ27ኛው ዓመታዊ ጉባኤ የሳይንቲፊክ ኮሚቴ አባላት
3. ለ27ኛው ዓመታዊ ጉባኤ የሽልማት ኮሚቴ አባላት
4. ለሲዲሲ ኢትዮጵያ
5. ለዴቪድ ሉሴል ፓካርድ ፋውንዴሽን
6. ለአይፓስ ኢትዮጵያ
7. ለ ጂ ኤስ አይ
8. ለሕብረተሰብ ጤና ትምህርት ቤት አዲስ አበባ ዩኒቨርሲቲ
9. በኤግዚቢሽን ለተሳተፉ ድርጅቶች
10. በዝርዝሩ ላይ ላልተካተቱ በሙሉ ምስጋና እንዳቀርብ ይፈቀድልኝ

በመጨረሻም ጉባዔያችን አዲስ ሳይንሳዊ ሃሳቦች የሚገኙበት፣ አንገብጋቢ እና ወቅታዊ ሀገራዊና ዓለም አቀፋዊ የጤና ትኩረት አቅጣጫዎች የሚዳሰሱበት እና የማሕበራችን ቁልፍ ጉዳዮችን አንስተን በመወያየት ከውሣኔ የምንደርስበት እንዲሆን እየተመኘሁ በኢጤአማ የሥራ አስፈጻሚ ቦርድ እና በራሴ ስም በድጋሚ እንኳን ለ27ኛው ዓመታዊ ጉባዔ በሰላም መጣችሁ እላለሁ።

አመሰግናለሁ!!!

Annex 4. Opening speech Dr Mahlet Kifle, representing H. E. Dr Keseteberhan Admassu, Minister of Health of FDRE.

የኢትዮጵያ ጤና አጠባበቅ ማህበር 27ኛው ዓመታዊ ጉባኤ

የክቡር ዶ/ር ከሰተብርሃን አድማሱ የኢፌድሪ ጤና ጥበቃ ሚኒስትር

የመክፈቻ ንግግር

ክቡር ፕሮፌሰር አፈወርቅ ካሡ የኢፌድሪ ሣይንስና ቴክኖሎጂ ሚኒስትር ዴኤታ

የተከበራችሁ የኢትዮጵያ ጤና አጠባበቅ ማህበር የጠቅላላ ጉባዔ ሥራ አስፈፃሚዎችና የሥራ አመራር ቦርድ አባላት

የኢትዮጵያ ጤና አጠባበቅ ማህበር አባላት

ጥሪ የተደረገላችሁ እንግዶች

ክቡራትና ክቡራን!

ከሁሉ አስቀድሜ በ27ኛው የኢትዮጵያ ጤና አጠባበቅ ማህበር ዓመታዊ ጉባኤ ላይ ተገኝቼ የመክፈቻ ንግግር ለማድረግ በመጋበዜ የተሰማኝንልባዊ ደስታ በራሴና በኢፌድሪጤና ጥበቃ ሚኒስቴር ስም ለመግለጽ እወዳለሁ።

የኢትዮጵያ ጤና አጠባበቅ ማህበር በሀገራችን የጤና ልማትና አገልግሎት ዘርፍ ላይ እያደረገ ያለው በጎ አስተዋፅኦ ከጊዜ ወደጊዜ እያደገ መጥቶ ወደላቀ ደረጃ እየተሸጋገረ መምጣቱን በሙሉ ልብ ስመሰክር ከፍተኛ ደስታ ይሰማኛል። ማሕበሩ ከሃገር አቀፍ አልፎ በአህጉራችን፣ አፍሪቃና በዓለም አቀፍ ደረጃ ያለው ተቀባይነትና መልካም ገፅታከጊዜ ወደ ጊዜ እያደገ መምጣቱ በአገራችን ውስጥ ካሉ ሙያ ማሕበራት አንጋፋና ጠንካራ ማህበር እንዲሆን አስችሎታል።

ኢጤአማ የአባላቱን አቅም በአጭርና ተከታታይ ስልጠና በመገንባት፣ በጤና ፖሊሲዎችና ፕሮግራሞች ዝግጅት እና ግምገማ ላይ በንቃት በመሳተፍ፣ እንዲሁም የምርምር ስራዎችን በማስፋፋት ልማታዊ ተሳትፎውን ከመቼውም ጊዜ በላይ እያሳደገ መምጣቱ በአጋሮቹ ዘንድ ያለውን ተቀባይነት ወደ ላቀ ደረጃ እንዲሸጋገር ረድቶታል።

የኢትዮጵያ ጤና አጠባበቅ ማህበር ከፌደራል ጤና ጥበቃ ሚኒስቴር፣ ከክልል ጤና ቢሮዎች እና በሀገሪቱ ከሚገኙ ከፍተኛ የትምህርት ተቋማት እንዲሁም ከሌሎች አጋር ድርጅቶች ጋር በርካታ የአቅም ግንባታና የምርምርተግባራትን በትብብር እያከናወነ እንደሚገኝ ይታወቃል።

በተለይም በቲቢ፣ ኤች አይ ቪ እና ክትባት መርሃግብር ዙሪያ በሀገር አቀፍ ደረጃ የተቀናጀ እና ወጥ አሰራር እንዲኖር የሚያስችል የማነቃቂያ ስልጠና ከሚኒስቴር መስሪያ ቤታችን ጋር በመተባበር ለባለሙያዎች እየሰጠ ይገኛል። ከዚህም ባሻገር በተለያዩ የአገሪቱ ክፍሎች ከፓካርድ ፋውንዴሽን በተገኘ የገንዘብ ድጋፍ ከጤና ጥበቃ ሚኒስቴርና ከክልል የጤና ቢሮዎች ጋር የቅርብ የሥራ ትብብር በማድረግ ተከታታይ የአቅም ግንባታ ስልጠና በመስጠት የጤና ባለሙያዎች ለሀገሪቱ የጤና ዘርፍ የሚሰጡትን አገልግሎት ጥራት እና ደረጃ እንዲሻሻል የበኩሉን ያላሰለሰ አስተዋጽኦ እያደረገ የሚገኝ የሙያ ማህበር ነው።

የጤና ጥበቃ ሚ/ር የቤተሰብ ዕቅድን ለማሳደግ በሚያካሄደው እንቅስቃሴ ውስጥ ዋነኛ የሆነው የረጅም ጊዜ የቤተሰብ ዕቅድ አገልግሎት አቅርቦትን ማሳደግ ሲሆን፣ ማሕበራችሁ ከሚኒስቴር መስሪያቤታችን ጋር በመተባበር ቀደም ሲል በደቡብ ብሔር ብሔረሰቦች የጀመረውን ሥራ በአጥጋቢ ሁኔታ ካጠናቀቀ በኋላ በአሁኑ ጊዜ በኦሮሚያ ክልል ኢምፕላኖን በማስገባት እና በማስወጣት ቁጥራቸው በርካታ ለሆኑ የጤና አክስቴንሽን ሠራተኞች እና በጤና ጣቢያዎቻችንበመካከለኛ ደረጃ ላሉ የጤና ሙያተኞች የክህሎት ስልጠና በመስጠት እንዲሁም በመካከለኛእና በከፍተኛ የአመራር እርከን ላይ ላሉ የጤና አመራር ሃላፊዎችደረጃውን

የጠበቀየአመራር ክህሎት ስልጠና በተሳካ ሁኔታ እያካሄደ መሆኑ ከፍተኛ ግምት የሚሰጠው ጉዳይ ነው። በዚህ አጋጣሚ የፓካርድ ፋውንዴሽን እና ኢጤኣማ እያደረጉልን ላለው ድጋፍ ሳላመሰግን አላልፍም።

ክቡራን እና ክቡራት፣

የመንግስት የጤና ፖሊሲ እና ጤና ልማት የትኩረት አቅጣጫን በሚመለከት በአሁኑ ሰዓት የ 4ኛውን ዙር Health Sector Development Program (HSDP)አገባደን በሚቀጥለው 20 ዓመት እስከ እ.ኤ.አ በ 2035የሚተገበር የጤና ሴክተር ትራንስፎርሜሽን ፕሮግራም(HSTP)ነድፈን ወደ ሥራ ከገባን ወራትን አስቆጥረናል።

በዚህም የፖሊሲና ስትራቴጂ ቀረጻም ላይ የማህበሩ አባላት በተለያዩ ደረጃዎች ላበረከቱት አስተዋጽኦ በዚህ አጋጣሚ ላመሰግናቸው እወዳለሁ። በተጨማሪም የማህበሩን ዘርፈ ብዙ እንቅስቃሴዎች የሚከታተል ጠንካራ ሴክሬታሪያት ያላችሁ መሆኑን እየገለጽኩ ይህንን እንደ ግብአት በመጠቀም ለበለጠ ሥራ እንደምትነሳሱ እና ለጤና ሴክተር ትራንስፎርሜሽን ፕሮግራም ትግበራ የላቀ አስተዋጽዖ እንደምታደርጉ ሙሉ እምነቴ ነው።

ማህበራችሁ በመስክ ላይ ያተኮረ የፊልድ ኢፒዲሞሎጂ ሥልጠና መልካም ተሞክሮዎችን በመቀመር በመንግስት ደረጃ ለማስፋፋት ጉዳዩ ከሚመለከታቸው ዩኒቨርስቲዎች ጋር ከጤና ጥበቃ ሚኒስቴር ጋር የጀመረው እንቅስቃሴ ያለ ሲሆን እንደ ኢቦላ ያሉ ድንገተኛና ወረርሺኝ በሽታዎችን ለመከላከል በጋራ ያለንን አቅም ለማጎልበት እንደምንችል ከወዲሁ መገመት አያዳግትም። እንደዚሁም በቅርብ ጊዜ ከሚኒስቴር መስሪያቤታችን እና ከትምህርት ሚኒስቴር ጋር የጀመራችሁት "Public Health Education in Ethiopia for the 21st Century"ጥናት አገሪቱ ለምትፈልጋቸው የጤና ባለሙያዎች ብቃት ወሳኝነት ያለው መሆኑን እየገለጽኩ ድጋፋችን እንደማይለያችሁ ከወዲሁ ልገልጽ እወዳለሁ።

መንግስት የጤናውን ዘርፍ ልማት ለማጠናከር በተለያዩ ጊዜያት የተለያዩ ስልቶችን በመንደፍ እየተንቀሳቀሰ ይገኛል። በዚህ ረገድ በአሁኑ ሰዓት መንግሥት የትኩረት አቅጣጫው በማድረግ እየተንቀሳቀሰ ከሚገኝባቸው ወሳኝ ስራዎች ውስጥ፡ የጤና ኤክስቴንሽን ፕሮግራም ጥራትን በማሳደግ መሰረታዊ የጤና ሽፋንን በተፈለገው ደረጃና ጥራት ማዳረስ፤ የጤና ኤክስቴንሽን ባለሙያዎችን አቅም በቀጣይነት መገንባት፤ ምቹ የስራ አካባቢን መፍጠር፤ በእናቶች እና ህፃናት ጤና ዙሪያ የተጠናከረ ሁሉን አቀፍ ስራ መስራት ከብዙዎቹ ውስጥ ለናሙናነት የሚጠቀሱ ናቸው።

በዚህም ረገድ የኢትዮጵያ ጤና አጠባበቅ ማህበር ከዚህ ቀደም እያደረገ ያለውን አስተዋፅኦ በመቀጠል እና በማሳደግበቀጣይ አባላቱን በማሳተፍ፤ በምርምርና ስርፀት፤ እንዲሁም በፖሊሲ ማማከር ስራ ከፍተኛ የሆነ ሚና እንደሚኖረው ስገልፅ የማይናቅ አስተዋጽኦ እንደሚያደርግ በመተማመን ነው።

የኢትዮጵያ ጤና አጠባበቅ ማሕበር ላለፉት ዓመታት ከተለያዩ የመገናኛ ብዙሃን እና አጋር ድርጅቶች ጋር በመተባበር በአልኮል ፤ ሲጋራ እና አደገኛ ዕፆች ዙሪያ ተከታታይ እና መጠነ ሰፊ የትምህርት እና የግንዛቤ ማስጨበጫ ፕሮግራሞችን ለሕዝባችን ሲያስተላልፍ መቆየቱ ይታወሳል። ይህ ተሞክሮ ጠቃሚነቱ የማያጠያይቅ በመሆኑ በቀጣይ ተጠናክሮ እንደሚሰራበትብሎም ሀገሪቱ በጀመረችው ትኩረት በሚሹ በሽታዎች ቁጥጥርና ማጥፋት ሀገራዊ እንቅስቃሴ እና ተላላፊ ያልሆኑ በሽታዎች መከላከልና መቆጣጠር ረገድ የራሱን አስተዋፅኦ እንደሚያደረግ አልጠራጠርም።

እንደዚህ ያሉ መድረኮች ሙያዊ ሀሳቦችን በማንሸራሸር ልምድን በማካፈል እና የጋራ ሀገራዊ ጉዞን በማጠናከር በዘርፉ ያሉ መልካም አጋጣሚዎችን ለመጠቀም እና ፈተናዎቹንም በጋራ ለመቅረፍ የሚያስችሉ ናቸው። የጤና ጥበቃ ሚኒስቴር ከሕዝብ ክንፍ አባላት ጋር በየጊዜው እየተገናኘ በሚያካሄዳቸው ፕሮግራሞች የፖሊሲና ስትራቴጂ እቅዶችና በአጠቃላይ መልካም አስተዳደርን ከማስፈን አኳያ የጀመረውን የጋርዮሽ ሥራ የሚቀጥሉበት ሲሆን ማሕበራችሁም በዚህ ረገድ

እያሳየ ያለውን የነቃ ተሳትፎ ላመሰግን እወዳለሁ። በመሆኑም በጋርዮሽ መድረኩ የሚታቀዱ ሥራዎች ከግብ ለማድረስ እና አመርቂ ውጤት ለማስመዝገብ ሁሉም የማሕበሩ አባላት፤ ለጋሽ ድርጅቶች እና አጋሮች የራሳቸውን አስተዋፅኦ እንዲያደርጉ በዚህ አጋጣሚ ጥሪ አስተላልፋለሁ።

ክቡራን እና ክቡራት

የኢትዮጵያ ጤና አጠባበቅ ማህበር የራሱ የሆነ ሕንጻ ግንባታ ጀምሮ በማከናወን ላይ ያለ መሆኑን እያደነቅሁ በቅርቡ በህንፃው ተጠቃሚ በመሆን የምርምር እና የአቅም ግንባታ እንቅስቃሴውን ወደ ላቀ ደረጃ እንደሚያሳድግ ተስፋ አደርጋለሁ። የማሕበሩ አባላትም ይህን እውን ለማድረግ አስፈላጊውን እገዛ እንዲያደርጉ እያበረታታሁ መንግሥት ቀደም ሲል ለማሕበሩ አድርጎ የነበረው ድጋፍ ወደ ውጤት ሲሸጋገር ማየት እንደሚመኝ እና ለዚሁም እውን መሆን ከጐናችሁ እንደሚቆም በዚሁ አጋጣሚ ልገልፅላችሁ እወዳለሁ።

በመጨረሻም የ 27ኛውን የኢትዮጵያ ጤና አጠባበቅ ኣመታዊ ጉባኤ መጀመር በይፋ ሳበስር በቀጣይ ሁለት ቀናት ለጉባኤው በተዘጋጀው አጀንዳ ላይ በንቃት በመሳተፍ ብዙ ቁም ነገሮችን የምትወያዩበት እና ለጤናው ዘርፍ ግብዓት የሚሆኑ የፖሊሲ አቅጣጫዎችና ስትራቴጂዎች የምትጠቁሙበት እንዲሁም ለማህበሩ እድገት ብሎም ለሀገሪቱ የማህበረሰብ ጤና አጠባበቅ እድገት የራሱን ጉልህ አስተዋፅኦ የሚያደርግ እንዲሆንላችሁ እመኛለሁ።

አመሰግናለሁ!!!