Findings from the ESAP2 programme: Health sector interventions, March 2016

1. Introduction

In the past two decades Ethiopia has made remarkable progress in improving access to primary health care units and hospitals. The overall level of health service coverage has now reached 100%. Availability, accessibility, equity, efficiency and quality of health services depend on the distribution, functionality and quality of infrastructure.

According to Ethiopia's Ministry of Health, the cumulative number of health posts reached 16,251 in 2006 EFY (up from 14,192 in 2002 EFY). The cumulative number of functional health centres increased to 3335 by the end of EFY 2006, accordingly the health centre population ratio has shown significant improvement and reached 1:26,390 by the end of EFY 2006. The number of hospitals reached 156 by the end of EFY 2006 (and increase of forty compared to 2002.

Health statistics have similarly shown impressive gains: Life expectancy at birth now stands at 63 (2013). Births attended by skilled personnel are now well over 25% (2013), up from 10% in 2011. The DTP vaccination rate: 78% (2014) up from 45% in 2006. Ethiopia's maternal mortality rate is 350 per 100,000 live births, the infant mortality rate is 42 per 1,000 live births and the under-five mortality rate is 60, per 1,000 live births (all statistics are WHO estimates for 2015, unless otherwise stated).

Despite this great progress, there are still many areas in which the health sector can improve. Indicators such as births attended by skilled personnel; maternal, infant and under five mortality rates need to improve further. Efficiencies in the health sector should be improved to ensure greater access for all citizens. Since 2012, the Ethiopia Social Accountability Program –phase 2 (ESAP2), has targeted the health sector along with other basic services. In the course of the programme, ESAP2 has supported citizen-service provider dialogue which has led to significant improvements in health service delivery in many locations.

1.2 The Ethiopia Social Accountability Programme-Phase 2

The ESAP2 programme has been working on the improvement of basic services in Ethiopia since the programme's inception in 2012. Social Accountability is a process by which ordinary citizens - who are the users of basic public services – voice their needs and demands and create opportunities to hold policy makers and service providers accountable for their performance. The process aims to improve the quality of and access to public basic services. Working with 49 Social Accountability Implementing Partners (SAIPs), the programme has been implemented in 223 woredas in five key sectors: health, education, agriculture, rural roads and water and sanitation.

In total, 40 SAIPs chose to focus on the health sector in 103 woredas. The achievements in the health sector to which the SA process has contributed are in line with Ethiopia's Health Sector Transformation Plan, which is aiming to transform Ethiopia's health system into one

"that will ensure quality health services and be equitable, sustainable, adaptive and efficient to meet the health needs of a changing population between now and 2035."[1]

By December 2014, ESAP2's Management Agency (MA) conducted a 'mini research' on the social accountability projects' contribution in the health sector. The results are summarized in the below table:

Type of result	**#**	**Type of contribution**		
		Community (cash, in kind)	**Government**	**Others** (e.g. NGOs, private sector)
Supplies and drugs availed to the health facility	lump sum	2,000.00	12,387,569.16	288,000.00
More qualified health staff (health officer, nurses, extension workers) recruited (#)	94	0.00	2,037,540.00	60,000.00
Water and sanitation facilities constructed / maintained	53	521,625.00	497,150.00	158,000.00
Laboratory facilities equipped with materials & detergents	lump sum	90,000.00	1,684,115.00	237,000.00
Construction and renovation, e.g. TB room, additional rooms (#)	48	218,000.00	2,277,950.00	1,991,000.00
Sub Total Health		**831,625.00**	**18,884,324.16**	**2,734,000.00**

This report will provide a brief overview of the key findings that have emerged from ESAP2's engagement in the health sector. It shows the main trends that have emerged from the reports and monitoring visits to the SAIPs that are working in the health sector:

1. Knowing and meeting 'the standard' in health: SA leads to the recruitment of additional staff, increases the number of beds, and improvements in laboratory services
2. Behaviour change makes health centres more welcoming places for all
3. Trust has been restored through SA
4. SA addresses cross-sectoral issues: electricity, water supply and access roads at health centres
5. SA improves vulnerable people's access to healthcare

[1] Federal Democratic Republic of Ethiopia Ministry of Health (2015) Health Sector Transformation Plan, p. 102.

6. SA reveals that suboptimal drug purchasing systems can lead to shortages of medicine in health centres
7. SA can lead to the uncovering of incorrect practices
8. Safe disposal of medical waste: reducing contamination risks for health workers, patients and the community alike
9. SA helps to improve access to healthcare in remote locations

In addition, the MA also conducted research to establish whether the SA programmes have had any impact on the number of people who use the targeted health facilities. To gather data, the MA distributed a research questionnaire, which was filled in by 20 randomly selected described in section 2, below.

2 Key findings from the health facility user data research

During the second half of 2015, the MA conducted research on health facility usage. In its questionnaires it asked health facility staff to record out-patient figures and facility birth data for clinics which were targeted for SA interventions. The result shown represent a mere sample of facility data from 22 different clinics and health posts (out a total of 204 health facilities targeted through ESAP2).

Figure 1: Cumulative outpatient numbers for 22 health facilities, February 2013-March 2015

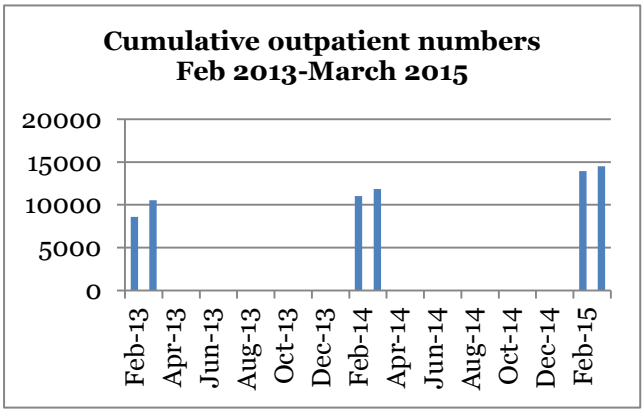
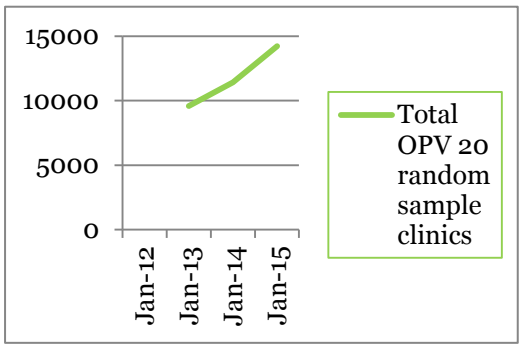


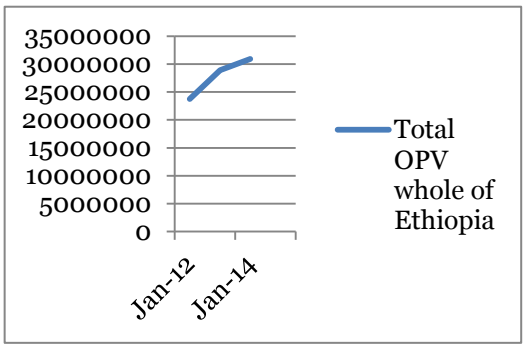
Figure 1 shows the cumulative out-patient data collected in February and March of 2013, 2014 and 2015, for the 20 clinics that noted outpatient numbers for the research. The full table of data of all 20 facilities can be found in Annex 1. Striking is the outpatient increase in the 20 clinics, which went from a total of 8,601 recorded patient visits in February 2013 to 14,499 in March 2015, a 68.6% increase in outpatients within a space of just over two years.

The research shows that in selected clinics and health posts where SA interventions took place performed slightly better than average in terms of outpatient attendance (see figures 2 and 3), where the 'ESAP2 research'-curve is slightly steeper than the 'national increase' curve. The Ethiopian trend shows a steady increase in outpatient department usage, due to continuous investment in the health sector, which provides access to government health facilities to ever greater numbers of citizens.[2]

[2] Annual Ministry of Health user statistics show there were a total of 30,927,623 OPD visits in EFY 2006, an average of 0.35 OPD visit per person per, which was an increase compared to the previous year, which counted 28,932,439 OPD visits, 0.34 OPD visits per person, and in 2004 EFY there were only 0.29 OPD visits per person.

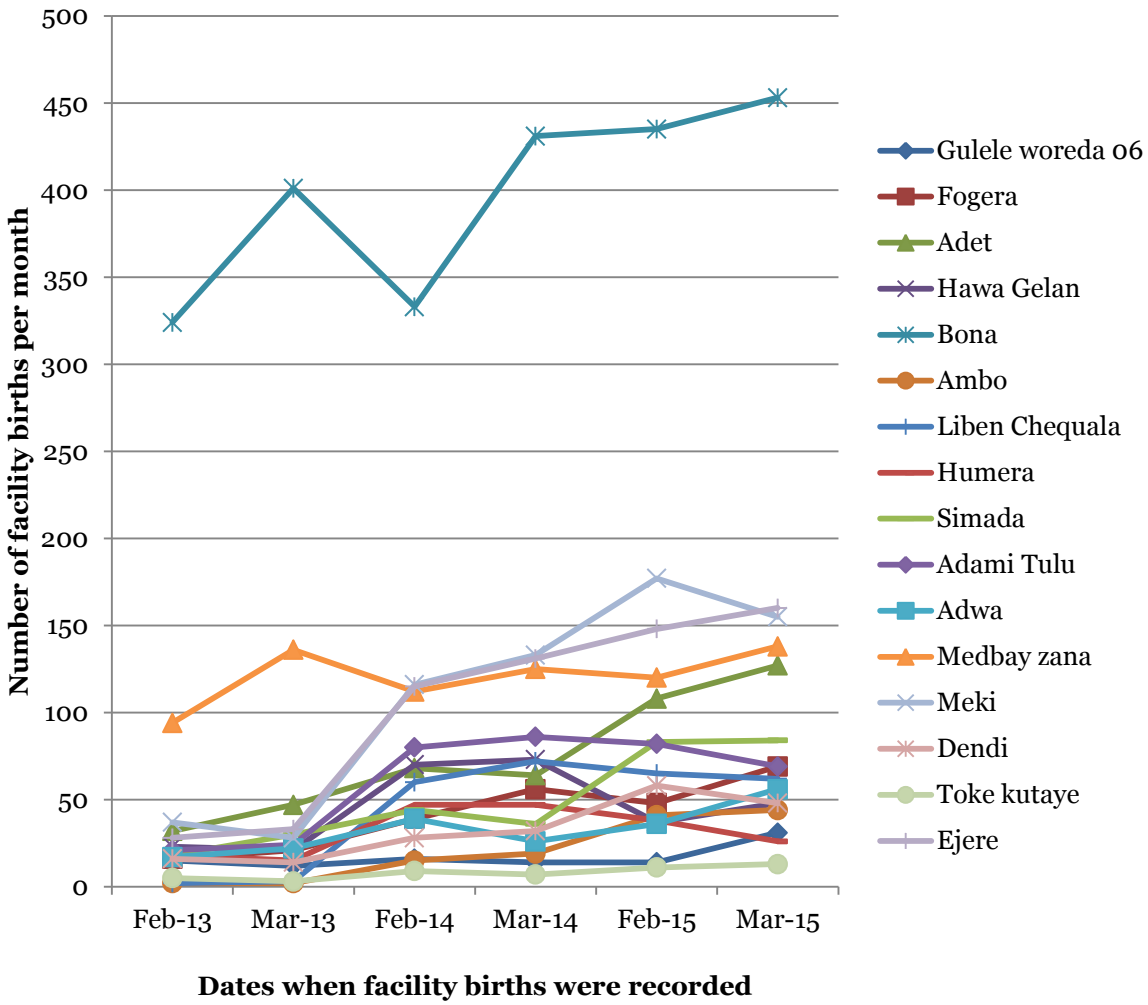
Figures 2 and 3: Out-Patient Department Visit increase curves in ESAP 2 research (on left) and national statistics (on right).





The slightly elevated attendance rates in health facilities that were targeted for SA interventions are most likely down to the fact that, at all of those facilities, additional investments were made linked to the SA focus. This meant that in the 2013-2015 period, these facilities increased their capacity and quality of service by adding more beds, more staff, more medicine, more electricity, longer opening hours, friendlier service and sometimes even better access roads, which is bound to encourage additional usage.

Figure 4: Facility births at 16 selected clinics where SA took place



The second data set worth looking at is the facility birth figures. *Figure 4* shows facility delivery rates at selected clinics in Feb and March 2013, 2014 and 2015. The data shows an increase in facility births at every facility.

Figure 4 shows that even clinics that saw a modest increase in facility deliveries at the health facility, such as in Gulele Kebele 6, Addis Ababa, where 15 births were recorded in February 2013 and 31 births in March 2015, still witnessed a doubling in deliveries. The facilities in Ambo and Liben Chequale saw rises from 2 births in February 2013 to 44 and 62 deliveries in March 2015. Many other clinics saw five and six-fold rises in facility births (Annex 2 shows all figures).

3 The solutions patterns identified through ESAP2

When we look at the themes that emerge from the M&E reports and case studies collected from the SAIPs that are active in the health sector, we notice that there are a number of similarities in the way health sector problems present themselves and in type of solutions that are found. Overall, it is clear that the physical upgrades of facilities resulted in significantly more health structures, which housed more beds, laboratory facilities, and staff quarters. Physical upgrades also led to health facilities becoming more accessible through the construction of roads and bridges, but also through the construction of ramps or the paving of paths. The second most significant change that the SA process contributed to was the hiring of additional staff. A total of 94 individuals were hired as a result of being included as priorities in Joint Action Plans. Finally, as the table on page x shows, health centres that were part of SA interventions obtained at least x birr's worth of additional medicine, and in many cases recurring budgets for medicine purchases were expanded.

The above is just a brief summary of the main achievements that our SAIPs have contributed to. So much more than that happened in SA target areas. Overall, we have noted the following trends:

3.1 Knowing and meeting 'the standard' in health: SA lead to the recruitment of additional staff, increases the number of beds, and improvements in laboratory services

One of the most significant changes that SA processes have managed to bring about in the health sector, is making communities, health facility staff, and Woreda Health officers aware that facilities are operating below the existing standards in the health sector. This has led to the hiring of at least 94 additional staff.

In the process of evaluating services, communities have often raised the issue of staff shortages, only to find that the local health facility wasn't always aware of the staff entitlements that are determined by a facility's size and catchment population. In a large number of cases, the Woreda health authority's request for the recruitment of additional staff was met with a positive response from regional health authorities, who ensured that additional staff members were recruited quickly.

Case study 3.1.1 Communities of Limona Tijo Kebele, Shirka Woreda, Oromia had recently witnessed the opening of a new health centre in the kebeles. However, while patients were able to receive a diagnosis at the new facility, they were being referred to other places to purchase any medicine they needed. This was due to the fact that the pharmacy had not yet been established and the health centre did not have a pharmacist. As a result, community members were unnecessary incurring additional costs of buying medicines privately (which are more expensive than if bought from the government supplied health centre's pharmacy) and at times people simply chose not to buy the medicine they needed for a certain treatment. Through SA, this service gap was recognized and the woreda health office recruited a pharmacist. The necessary budget was allocated for drugs purchases, and as a result, the pharmacy is now operational.

The standard

"Compared to the standard, a shortage of staff and equipment was identified. When the JAP was compiled, we immediately wrote to the region to request for an ambulance, additional staff and equipment. These things are handled at regional level. The region sent us an ambulance, the CD4 count machine and sanctioned the recruitment of six additional staff: 3 health officers and one pharmacist have already been recruited. The money for salaries for all healthcare staff comes out of the Woreda block grant. The amount of the block grant is calculated based on the standard set for minimum healthcare staff per health centre."

Wz. Junadin, the deputy head of the Meki Woreda health sector office

Case study 3.1.2 In many locations, the SA process was responsible for bringing health centres up to the standard by adding additional buildings and staff. The SAIP reported: Major improvements are underway at Koriso health centre. We are starting the construction of a delivery room, one delivery waiting room and placenta pit. The JAP has already ensured that there is an improved medicine supply for Koriso health centre, and an improved ambulance service (one additional ambulance has been purchased as a cluster level ambulance to serve all kebeles). The working hours of health workers have now been adjusted to provide 24 hour care, including Saturday, Sunday and public holidays.

At least 11 other SAIPs have all reported that since implementing SA, construction projects have gotten under way to build additional clinic rooms, maternity rooms, health posts, medicine storage, living quarters for staff, ambulance drivers' accommodation, guards' huts etc. Six SAIPs reported that laboratory services were improved due to the hiring of technicians, the improvements of laboratory facilities and the purchase of new equipment and reagents.

3.2 Behaviour change makes health centres more welcoming places for all

One issue that is continuously being highlighted in case studies about the health sector is the 'post-SA' change in attitude from the staff who work in health facilities. Many reports that sum up focus group discussion findings noted rude or selective behaviour among some health workers, who treated relatives and those of higher social classes better than the

vulnerable or the poor. Health workers were often known to close their office in the afternoon and return home, some even had a second job, so they rushed their health worker duties and moved on to their other work. Due to SA, health workers have become aware of the standard of service that is expected, and many more facilities are now open all day and at night and on Sundays for emergencies.

Both service providers and service users have reported a greater sense of ownership of the health centre and its services. Not only have health workers become more service oriented and friendlier to patients, those who receive patients and register them have also become more aware how important their jobs are in making patients feel at ease at a health facility. The improvement of patient registration has often reduced waiting times and new, transparent registration systems have made it easier for patients to understand that different queues exist, depending on what service a patient need. As a result, people now find health centres open all day, and staff is waiting for patients to serve them.

Case studies 3.2 Almost all of the health-focused SAIPs mention a change of health worker behaviour as the first, no-cost, sustainable change in health service delivery.

ODA reported that behaviour change and connecting the health centre up to the electricity grid means that Bulbula Health Centre now provides 24-hour service.

MSCFSO reported that in Debrework health centre minor surgery can now be performed, which was not possible before. The patient registration rooms are re-organized in two classifications; new cases and repeated cases, and these two rooms are computerized. The health centre is now getting 24 hours electric supply after a broken down generator was maintained, costing Birr 1700. For facilitating better access to ambulance services, 6 wheelchairs are bought so that patients do not have to walk to where the ambulance is parked.

3.3 Trust has been restored through SA

The social accountability process has a strong emphasis on joint problem analysis and joint action planning. It provides a vehicle for the community to honestly appraise the services they receive and it gives frontline health service providers a chance to self-evaluate and helps them to demand support from the health authorities to enable them to improve services. This non-confrontational approach does not only help to provide better services, it also helps to restore trust between communities and service providers, who understand that nobody has come to apportion blame, it is all about working together to find a way forward. This sentiment is reflected in many of the SAIPs' reports.

Case studies 3.3 Mums for Mums: Now community has trust in Health Centre as 'before the community did not come to the Health Centre due to poor service delivery. But one person came to the Health Centre and told everyone about the good service'.

AFSR noted: Service users of Tinkaro keble of Malga woreda, have developed a sense of ownership to demand quality services and contribute to its improvement. In this regard, the Melkias Fara, Iddir representative, said "We are seeing service improvements because people are able to voice their concerns. Service users are also starting to contribute their

time and resources to improve service provisions. For instance, the community fenced Tenkaro health centre and started cleaning the health centre every 15 days."

Not only was there a lack of trust among patients, health workers often had no confidence that they could treat patients well, because of a lack of facilities. Mums for Mums reported health workers as saying: "Before, we feared to have patients in a health centre, because there was no electricity or water supply. We had to use candles." The SAIP noted further: Now this has improved and the health centre has electricity and water supply. The woreda officials and health centre employees are committed to address citizens' needs. They are ready to address the remaining activities mentioned in the JAP.

3.4 SA addresses cross-sectoral issues: electricity, water supply and access roads at health centres

A significant number of SA-related improvements that have been carried out at health facilities have been so-called cross sectoral issues, such as the repairs of dysfunctional water supply systems, the purchase of a generator to provide electricity or the construction of access roads or bridges in order to make the facility accessible to ambulances. Most of these interventions are usually handled by health sector staff, and this, some woreda officials have admitted, has made it more difficult to get done: the Woreda health office simply can't authorise the construction of a road! When during the SA process, the community's priorities turn out to be 'cross-sectoral issues', it brings staff from several woreda offices together (health officials, woreda finance officers and water or road engineers, for example) to collaboratively solve the problem.

Case study 3.4.1 In the case of Save Lives (SL) the communities have been great contributors of labour and funds. In the health sector a 'community bridge' was constructed in Geze Gofa Woreda to improve health centre's access to ambulance services, and a maternal waiting home is currently being built. KMG also reported that a bridge was constructed. It came out as the number one priority during to the SA process in Angacha woreda. The new bridge at Adancho kebele has made an existing health centre accessible to people who live on the other side of the river.

Innovative fund raising

The SAIP ILU wanted to help the community to address the lack of a guard for Senkelle Health Post, Ambo. The community found some farmers willing to pay to graze their cows within the Health Post compound, and that money paid for the grazing now pays for the Health Post guard.

Case study 3.4.2 Electricity for health centres: A lack of regular electricity from a mains' connection, or a completely lack of electricity in areas without power lines, made it very hard for many health centres to function properly, especially at night. A lack of electricity puts many women off from coming to the health centre for delivery, and in case of emergency, many health centres and health posts have had to treat patients by the light of a candle or a mobile phone. It was therefore no surprise that many communities prioritised the purchase of a generator to ensure that health facilities can have light at night:

MSCFSO wrote: The health centre and health posts did not have sufficient water, electricity and sanitation facilities, but at this time these services are improved. The health centre had no generator; but now the community has finalized everything to buy it. Weekend services were not adequate for the community due to a lack of budget; but since SA, the government has budgeted for this service.

Similarly, ADA reported: Very impressive service improvement results are happening which is encouraging for SA stakeholders. For instance, a generator was purchased so that the health centre can give 24-hour services, especially to women delivering their babies. VECOD also reported changes due to the provision of electricity: Abol Woreda Health Centre and Bonga Health Post got electricity because of a new generator. Additional health officers' duty payment are now made, and this has ensured that service is now provided 24 hours a day. The SAIPs AMUDAEAS, HIDA, MLYAM and CFAFI all reported generator purchases too, while with support from ODA in Bulbula, the SA process has ensured that the health centre gets connected to the main power line.

3.5 SA helps to improve vulnerable people's access to healthcare

SA has a strong focus on vulnerable people. Throughout its sensitisation sessions, SAIPs explain that government entitlements to services are there for *all citizens*. Community groups are asked to think of who might find it even harder than most to receive the services they are entitled to. Many citizens conclude that those with disabilities, people living with HIV and Aids, the elderly, orphans and other groups that are be stigmatised for some reason are the most vulnerable. Discussions like this often lead to an assessment of what can be done to ensure that vulnerable groups are not left behind. The government already has some support system in place, such as free healthcare for the most vulnerable, but these systems do not always function anymore. SA interventions have led many communities to re-examine how vulnerable groups can be supported to ensure they can gain access to basic services.

Case study 3.5.1 AFSR reported on a significant improvement of health services for people living with HIV and AIDS in the area of Adet town: When the SA process started, Adet town Health Centre did not have a 'CD4 count' machine, because these machines can only be made available at hospital level. The nearest CD4 count machine was in Bahir Dar, and this meant that for vital monthly check-ups, PLWHAs had to travel for more than 1.5 hours every month. Adet is a big town, and the government had been considering constructing a hospital, but, AFSR concluded until that hospital is finished, there was not going to be a solution to the problem. However, due to the SA process, PLWHA became more visible to the health authorities, and when the regional health authorities discovered that there were over 600 PLWHA in the area, they had to act. As a result, the regional health board decided to provide more extensive services for PLWHA in Adet Town. A CD4 count machine has now been bought for the health centre and professionals to carry out the testing are being recruited.

Case study 3.5.2 SA's focus on meeting the needs of vulnerable groups, has allowed many vulnerable people to speak up for the first time. This example shows that when vulnerable people are able to attend regular meetings and speak up about problems, big and small, solutions can often be found. HIWOT implemented SA at the health sector Kirkos sub-city in Addis Ababa, woreda 9. Apart from the usual issues such as the shortage of drugs, limited hygiene/latrines, staff behaviour and ethics, the users also mentioned some very easy to solve issues which have resulted in great credibility for SA. Two persons with a disability mentioned that they regularly have to bring a small container with urine for laboratory testing, and the small containers provided by the centre have no lid. The two people explained that for persons with a disability, it is impossible to deposit these containers at the laboratory without making a mess. Once highlighted, the management of the centre decided to hand out closed containers from now on. Some solutions to existing problems do not require massive investments. It is simply enough to observe, discuss and act accordingly.

Many other SAIPs also report that communities have prioritised making improvements to accommodate vulnerable groups: *ADA: The community has planned to cover health centre grounds with cobble stones to make the whole facility more easily accessible to persons with disabilities. Mums for Mums: Because the road access has improved, disabled people can access the health centre more easily, and disabled people now receive services free of charge. YMCCD: A toilet for the physically disabled is constructed in one of health stations. The compound of kebele 04 health centre is made suitable for vulnerable groups through the construction of cobble stone roads. The information gap about the free health service for the poorest of the poor is also being addressed.*

CFAFI: SAC members in Addis Alem kebele become sensitive and responsive in assisting vulnerable peoples like elders, people with disabilities, mentally ill and homeless persons. SAC members took several destitute persons to Bahir Dar for higher medication covering all expenses and gave proper support. The Addis Alem SAC also provided blankets to eight elders and fenced the compound of the Health Centre of Addis Alem. In another location CFAFI reported that since the SA process, the kebele officials have provided letters that entitle vulnerable members of the community to free health care. One kebele with 7 villages has provided such exemptions to 70 people, mainly women. The SAC assisted with the screening and decision making, which is normally done by the Kebele administration only.

Increased awareness of rights and greater capacity for influencing service delivery

Since the start of the social accountability project, the patients have become more aware of their rights… if they feel that they have been mistreated, they go with their complaints to the health centre head or one of the SAC members. Issues of maltreatment, misunderstanding over service, and availability of personnel are some of the issues that patients have raised with us.

Health service provider

3.6 SA reveals that suboptimal drug purchasing systems can lead to shortages of medicine in health centres

In many locations, health facility users have highlighted the shortage of medicines at their local clinics. In many cases, these problems were not known by those in the Woreda or Regional Health Authority offices. This was often because the catchment community using a clinic is larger than the number of people budget allocations to that clinic are calculated for, or health centre staff is unclear if they have the authority to use their own revenues to buy drugs if there is a stock-out. By jointly assessing the source of this problem during the SA process, it has been possible to find solutions: sometimes budgets have been increased, catchment community figures are adjusted, revolving drugs funds are set up, and health centres have received clarity that they can use a certain percentage of their income to purchase essential drugs.

Case study 3.6.1 ODA reported that facilities are providing health services to larger populations than the government's standard. For example, one health centre is designed to serve 25,000 people but many health facilities have catchment communities much larger than that. ODA stated: In our target area, Shalla Woreda, Sanbate Shalla Health Centre provides health care for up to 45,000 people. This leads to severe shortages of medicine, as the amount of drugs delivered to the health centre is only enough for 25,000. After this problem was highlighted in the interface meeting, the medicine shortage has been solved; due to government involvement all 11 essential drugs are now always available, and 74% of the budget of health centre's internal income has been assigned for purchase of medicines and medical supplies.

> *"Before it was difficult to get drugs after they were finished, but now it is allowed to go to Nekemt town and purchase drugs as soon as they are finished."*
>
> Health care provider in Bambasi/ Kebele 02
>
> (GSA, sub-partner of SWDA)

Case study 3.6.2 Oromo Grassroots Development Initiative (HUNDEE) and GURMUU Development Association implemented SA in target Woredas Wolmara, Lume, Kuyyu, Dandi, Jimma Raree, and Oddo Shakiso. The two organisations were among the few SAIPs to use the Public Expenditure Tracking Survey (PETS) tool. The PETS focused on the drug budget flow and utilization in 5 (out of 8) health centres in Dandi Woreda The choice to study drugs purchase and expenditures was made because the shortage of drugs was identified as a major concern of citizens during the CSC process. The study produced some interesting findings:

Community participation: While government officials claim to have involved community representatives from localities in planning and budgeting, in practice they consult with Kebele government structures. For instance, in the preparation of the Health Sector plan and budget, the health sector planning experts contacted the Kebele Health Board members (Kebele administrator, health extension worker, Kebele manager, community elders, health volunteers' focal persons, etc.) before presenting the Kebele Health plan to Kebele council members. Other 'participatory processes' Woreda officials talk about is community's labour, cash and material contribution for Health Post construction activities. These contributions are necessary, but the real community empowering participation that involves the community in planning and decision making is lacking.

The PETS process discovered that, similar to other Woredas, the catchment communities of health centres in one woreda vary, but health financing policies are not always able to take this into account. Dandi Woreda habitually allocated the same funds for all health centres, i.e. Ginchi Health Centre, which serves over 56,000 users, well above the 25,000 maximum user range, received the same amount (Birr 180,000) for medical supply purchases, as nearby facilities which serve much smaller populations.

The most pressing issue the PETS uncovered dealt with budget release and financial management procedures: Quarterly performance reporting and WoFED assessment of quarterly budget utilization are a prerequisite for budget release. The health sector office is expected to submit its quarterly work plan based on the approved budget and preparation of bids for procurement of drugs and other goods/services, as the case may be. Once the prerequisites are fulfilled, the sector presents its request for budget release to WoFED. Adherence to mandatory financial procedures is strictly followed up by WoFED. PETS found that financial procedures are adhered to by all concerned bodies in connection with budget release. Despite all financial procedures being signed off on time, budget approval by the council is often delayed until September or later, while the budget year begins on July 7th. This means that health facilities' budgets run out by the end of June, but no funds are disbursed until September or later.

These delays have resulted in conflict between patients and health workers, communities bearing extra costs (drugs purchased from private pharmacies are more expensive), and lead to community dissatisfaction with the health care services. Woreda Officials argued that budgets can be used temporarily pending the approval of the Council, but health officers stated that in reality, this rarely happens.

As a result of the PETS, the woreda health office and the council were made aware of the problems and have made commitments to change the procedures to address the budget disbursement delays, address the issue of health centres with big and small catchment populations receiving the same funds for medical supplies, and to re-evaluate how the community can be better engaged in health sector planning in the future.

3.7 SA can lead to the uncovering of incorrect practices

Migbare Senay Children and Family Support Organization (MSCFSO) implemented SA in Aneded Woreda of Amhara region. Community representatives have witnessed great changes. A woman said "In previous times we never thought of the health centre as our own and when we got sick we would travel to the nearby town seeking better health services. Aneded town's health centre often had drug shortages, health personnel were not available all hours, and we could not afford to use the ambulance services."

These problems were presented during the interface meeting and actions were taken. Since then, services have improved; the health centre is open 24 hrs every day, the delivery rooms have improved and there are fewer drugs shortages. The reason for people not using the ambulance was related to the driver who charged individuals 70 birr for the service, which was supposed to be free. This was not known by the health office at all, but it was

revealed during the interface meeting. On finding out, the Woreda health office terminated the driver's contract and recruited a new driver. The community has been getting proper ambulance service ever since.

CFAFI reported on a similar problem, which made it difficult for the community to get involved in improving their health services: Deneba Kebele's citizens were hesitant to raise funds for the health post construction because they lacked trust in the kebele administrator. When he was removed from his position by the woreda office, the community started to work together and contributed money and materials for the construction of the health post.

3.8 Safe disposal of medical waste: reducing contamination risks for health workers, patients and the community alike

The rapid expansion of health facilities across Ethiopia has contributed to major improvements in the health sector. However, the mismanagement of medical waste disposal is a problem that has come with the arrival of new facilities in rural locations where regular waste management is often still lacking. SA's focus on minimum standards for health facility management has helped to shine the spotlight on waste disposal. SAIPs working in the health sector have noted how the evaluation of minimum standards has led to action being taken to ensure that medical waste if safely disposed of from now on.

Case studies 3.8.1 ODA: We have seen a lot of positive changes in Ilala Kebele's health services. In the past, the health centre staff used to throw used gloves and syringes in the surrounding area, which put our children and animals in danger. This is now changed with a proper waste disposal solution.

CFAFI: Health services have improved in many ways; changes were often made before the targeted period ended. Many health centres have now dug a hole where waste can be burnt and then covered up.

REST: To improve the safety of waste disposal, health centre staff oversaw the construction of a standard waste disposal ditches in each of the 12 health centres in the five woredas, costing about 25,000 birr.

3.9 SA helps to improve access to healthcare in remote locations

SA interventions have not only focused on densely populated areas of Ethiopia, a number of SAIPs have targeted remote locations to ensure that health service quality was discussed in parts of Somali Region, Gambella and Benishangul Gumuz too.

Case study 3.9.1 OWDA worked in Denan Woreda, Somali Region, where many changes have taken place. A Woreda Health Office staff member noted: Shinile Kebele is one of the main kebeles in Danan Woreda and had no Health Post before ESAP2 started. Due to the effect of the SA sensitization workshops, the community sense of ownership has increased, and they have contributed money to build a two-room Health Post. The Woreda Health Bureau paid for the iron sheets and cement. The SAIP further noted: Danan Woreda is finally receiving the service of an ambulance. In the past there was no budget for fuel or

maintenance and as a result the ambulance was left unused. On learning about this issue through SA, the community raised funds so that the ambulance can be used whenever it is needed.

SA has helped to build strong social linkages between all stakeholders like service providers, service users, and the administration, which strengthens cooperation and commitment to bring our common goals to the reality.

4. Conclusions

The reports the SAIPs have returned over the course of the ESAP2 programme show that the SA intervention has contributed to countless improvements in the health sector. Raising awareness about the standards that the Government of Ethiopia has set for the delivery of healthcare has empowered many communities, healthcare providers and health officials to make improvements happen at a local level.

The SA process uncovered many instances in which the system set up for the ordering and delivery of medicines has not worked in an optimal manner. In most cases nobody is to blame for such problems and solutions have usually been found. The SA experience has shown that it can be hard for individual staff members to ensure that medicine quotas are adjusted to increased patient numbers. Not every health facility had a system set up that allowed for stock outs to be remedied with 'internal revenue purchases'. It often takes a group of stakeholders to jointly consider the problems and the possible solutions to change such systems.

Accessing health facilities is not only about the buildings, the medicine and the availability of staff: for potential patients it also about knowing that you will be taken seriously and treated with respect. SA interventions, with their emphasis on dialogue, have helped to communicate problems with staff attitude where they have discouraged people from coming to the clinic. It has helped many health workers understand how important a welcoming attitude is at work: maybe as important as the knowledge they bring. Having a greater appreciation of the standards has also allowed health workers to understand that they are jointly responsible for operating a health facility on a 24/7 basis, and many actions have been taken to ensure that there is a health worker available at all hours.

SA's focus on the vulnerable in every community has also raised questions about health centres' efforts to ensure that people with disabilities can enter the facilities, that people with chronic illnesses can have test done and receive medicine from their nearest clinic, and that people who are too poor to pay for healthcare have access to the relevant exemptions the government has made available.

Overall, we believe we can say that the SAIPs that have targeted the health sector have been managed to make a positive contribution to the fast increasing and rapidly improving healthcare system of Ethiopia.

Annex 1: Outpatient numbers recorded at 22 SA-targeted clinics, February 2013-March 2015

SAIP	**Woreda**	**Feb-13** yekatit 2005 Ethiopian calendar	**Mar-13** megabit 2005 Ethiopian calendar	**Feb-14:** yekatit 2006 Ethiopian calendar	**Mar-14** megabit 2006 Ethiopian calendar	**Feb-15** yekatit 2007 Ethiopian calendar	**Mar-15** megabit 2007 Ethiopian calendar
1. AAWA	Gulele woreda 06	235	357	220	317	280	362
2. ADA	Fogera	729	825	735	791	824	1044
3. AfD	Malle	1	5	16	13	30	17
4. AfSR	Adet	973	1190	1441	1293	1503	1509
5. ECC	5.1 Hawa Gelan	294	318	629	635	677	668
	5.2 Agalo Meti	0	0	155	177	279	285
6. HfC	Bona	277	236	322	335	388	369
7. Ilu	Ambo	58	76	68	71	83	88
8. MENA	Liben Chequala	91	141	134	205	159	172
9. MfM	Humera	219	199	550	412	388	304
10. MLYAM	Simada	982	969	715	1038	1127	1281
11. ODA	Adami Tulu	515	627	849	842	1099	1037
12. REST	Adwa	517	1339	877	1121	1462	2230
13.RTG	Metehara	110	162	152	270	158	199
14.SOS/AFD	Tiyo	15	40	51	83	44	51
15.TYA	Medbay zana	1030	1042	1210	1411	1601	1800
16.UEWCA	Meki	1933	2329	2039	1850	2463	1432
17.WSA	17.1 Dendi	171	214	209	184	192	237
	17.2 Toke kutaye	176	179	248	361	812	967
	17.3 Ejere	275	298	396	421	380	447
Total		**8601**	**10546**	**11016**	**11830**	**13949**	**14499**
Average Feb/ March		**9573**		**11423**		**14224**	

Annex 2: Facility births recorded at 22 SA-targeted clinics, February 2013-March 2015

SAIP	**Woreda**	**Feb-13** (yekatit 2005 Ethiopian calendar)	**Mar-13** (megabit 2005 Ethiopian calendar)	**Feb-14:** (yekatit 2006 Ethiopian calendar)	**Mar-14** (megabit 2006 Ethiopian calendar)	**Feb-15** (yekatit 2007 Ethiopian calendar)	**Mar-15** (megabit 2007 Ethiopian calendar)
1.AAWA	Gulele woreda 06	15	12	16	14	14	31
2. ADA	Fogera	16	21	39	56	48	69
3. AfD	Malle	0	0	0	0	0	0
4. AfSR	Adet	32	47	68	64	108	127
5. ECC	Hawa Gelan	23	21	70	73	37	48
	Agalo Meti	0	0	751	741	1421	1533
6. HfC	Bona	324	401	333	431	435	453
7.Ilu	Ambo	2	2	15	19	41	44
8.MENA	Liben Chequala	2	3	60	72	65	62
9.MfM	Humera	18	15	47	47	38	26
10.MLYAM	Simada	18	30	44	36	83	84
11.ODA	Adami Tulu	21	24	80	86	82	69
12.REST	Adwa	17	22	39	26	36	56
14.RTG	Metehara	0	0	0	0	0	0
15.SOS -AFD	Tiyo	0	0	0	0	0	0
17.TYA	Medbay zana	94	136	112	125	120	138
18.UEWCA	Meki	37	28	116	133	177	155
19.WSA	Dendi	16	14	28	32	58	48
	Toke Kutaye	5	3	9	7	11	13
	Ejere	28	33	115	131	148	160
Total		**668**	**812**	**1942**	**2093**	**2922**	**3116**