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Sub-National Sensitization Workshop on

EPI/ORT

April, 1995

TABLE OF CONTENTS

	TITLE	PAGE
1.	Acronyms	1
2.	Introduction	2
3.	Opening Speeches	3
4.	Conceptual Framework for the MDGs	6
5.	Review of Child Health Programmes and Future Plan to Meet the Mid-Decade Goals By Dr. Mokonnen Admassu	8
6.	Cooperation Between MOH, UNICEF, CRDA, RRC	19
7.	Communication at Grassroots Level By Ato Yohannes G. Tsadik & Ato Abebe Birhanu	20
8.	Health Profile By Dr. Eyob Tsegaye & Dr. Mesfin Kassaye Region 14 Health Bureau	24
9.	Preparation of Plan of Action	28
10.	Discussion	29
11.	Recommendations of the Sub-National Workshops on EPI/ORT	33

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Acronyms

ARI:-Acute Respiratory Tract Infections

CDD:-Control of Diarrhoeal Diseases

CM:-Case Management

DDs:-Diarrhoeal Diseases

GRCs:-Grassroot Communities

MCH:- Maternal and Child Health

MDGs:-Mid Decade Goals

MoH:-Ministry of Health

NCDDP:-National Control of Diarrhoeal Diseases Programme

PHC:- Primary Health Care

PoA:-Plan of Action

RHBs:-Regional Health Bureaus

RRB:-Regional Relief and Rehabilitation Bureau

SEPRC:-Southern Ethiopian People Regional Council

TGE:-Transitional Government of Ethiopia

UCI:-Universal Child Immunization

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Introduction

The MOH, RRC, UNICEF, and CRDA co-sponsored a one-day national sensitization programme workshop on EPI/ORT, which was held on November 23, 1995.

One of the recommendations that came out of that workshop was the need for conducting sub-national workshops that would help underpin the importance of the programme and work out a plan that would enable each region to meet the mid-decade goals in the relatively short time left, i.e., before the end of 1995.

Faced with such a short deadline, and based on the said recommendations, the co-sponsors took immediate steps to organize the workshops at sub-national level. After identifying the venues, i.e., Awassa (for Regions SEPRG and Region 12), Nazareth (for Regions 2, 4, 5, 13, 14, and Dire Dawa Special Administration), and Bahir Dar (for Regions 1,3 and 6), members of the national committee visited these places, and with the support and cooperation of the concerned line bureaus in each region, arranged the sub-national workshops.

They were attended by health professionals from RHBs, zones, and woredas, as well as by NGO frontline health workers, and other invited guests.

The workshops at sub-national levels were opened by executive committee members of the respective regional councils, all of whom expressed their determination to marshal their resources and make an unrelenting effort to meet the MDGs.

This proceeding contains summaries of opening speeches and keynote addresses as well as presentations by resource people. As some topics were covered by the same or different people in each of the three sub-national workshops, we have, in the interest of brevity, presented only one of them where they were identical, or a summary of all where differences, however small, were detected. Summaries have also been used where we felt only highlights need to be given. The highlights of the discussions and the recommendations are also included.

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Opening Speeches

The first workshop was held in Awassa from April 3-5, 1995. The workshop was officially opened by Ato Tamiru Defersha, a representative of the Southern People's Regional Administrative Council. In his opening speech, Ato Tamiru said that anyone country's progress in the social and economic sectors impinges heavily on the quality of health services rendered, and the health status of its people.

While citing the grim national morbidity and mortality statistics that exists as a result of the onslaught of diarrhoeal diseases, he, at the same time, indicated that the situation in the Southern People's Administrative Region might be even worse, because:

-The region has a backward social and economic status
-Health facilities are limited in number
-Health services have not been extended to the rural population
-The region suffers from lack of an effective transport and communication net work

He said that it is the onerous duty of regional administrations to act promptly in order to prevent and control diseases that claim the lives of hundreds of thousands of children that die unnecessarily, despite the availability and inexpensiveness of the required medicines. He added that history will not absolve those that would turn a blind eye before such tragedies. He went on to say that all sectors of the Regional Administration will have to assist efforts to meet the Mid Decade Goals (MDGs). Finally, he concluded by indicating the need to sensitize the GRCs to the need to cooperate with frontline health workers, and expressing the determination of the Regional Government to do every thing in its power to help meet the MDGs.

The second workshop was held in Nazareth from April 10 - 12, 1995. In his welcoming speech Ato Hussien Borru, Head of the Health Bureau of Eastern Shoa Zone, said that as health care is a prerequisite for optimal productivity, it is given a prominent place by the TGE and figures as a high priority item on its national agenda.

He went on to say that diarrhoeal and vaccine preventable diseases pose a major threat to the nation as they maim and kill the young, upon whom the future of the country rests. This, he said, is why the EPI/ORT programme, which has already proven its usefulness by preventing the deaths of hundreds of thousands of children both here and outside of Ethiopia, would deserve everyone's support and assistance.

He added that the steps taken by the NGO community to supplement the efforts of health institutions of regional and central governments were admirable, and expressed the hope that the workshop will draw a useful plan of action that would, in the final analysis, help to promote the health status of the people of the region.

In his keynote address Ato Challa Wordoffa, Secretary of the Oromia Regional Council, said that many government agencies don't recognize that NGO health institutions work towards the same goal as they do, and indicated the need for a change of attitude. He expressed the hope that the workshop will hopefully serve as a forum for sharing experiences and working out an

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effective plan of action that would enable governmental and non governmental organizations to act jointly towards achieving the MDGs.

Bro. Augustine O'Keeffe, the CRDA Executive Director, on his part, indicated that thousands of children die every year from diarrhoeal and vaccine preventable diseases that could have been avoided through the use of medicines that are affordable, could be made available, and accessible to most, if not all, families in Ethiopia. He then underlined the need for commitment, strong support, dedication and concerted effort to solve this major problem.

He went on to say that NGO decision makers that attended the National Sensitization Workshop, held in November 1994, had stressed the need for concerted effort, mutual support and collaboration at all levels, because partnership and intersectoral collaboration do play a pivotal role in the realization of the mid decade goals and objectives.

He then urged the participants to seriously consider the recommendations of the first sub-regional workshop at Awassa which, among other things, highlighted the need for mutual support on training and resource sharing among governmental and non-governmental agencies. In conclusion, he said that CRDA will continue to attach great importance to EPI/ORT programmes and do all it can to encourage and support further efforts of its member churches and agencies in that direction.

Mr. Sobhi Abdel Hai, the Deputy country representative of UNICEF, said that participants of the sub-national workshops have to undertake a joint commitment to give children a better future. As the future of a country relies so much on its children, their education, health, and growth should be a concern of all. This, he said, was why their future should be shaped in a peaceful, healthy, and harmonious atmosphere. He then illustrated with facts and figures the grim reality of child life in Ethiopia, and in so doing, indicated that hundreds of thousands of children suffer from the grave effects of poverty, poor sanitary conditions, hunger, malnutrition, homelessness, epidemics, and illiteracy.

In pointing out Ethiopia's commitment to work towards the achievement of the MDGs within the time frame envisaged in the EPI/ORT programme, he indicated that participants should make a solemn commitment to do more for children, by way of promoting and fully developing their human potential, making them aware of their needs, rights and opportunities. He concluded by indicating that no task is nobler than giving a child a better life.

The third workshop was held from April 17-21, 1995, at the Tana Hotel in Bahir Dar. In the opening speech that Dr. Ambachew Ketema made on behalf of the Regional council, he explained how the programme tallies with the priority considerations of the TGE, which lays special emphasis on the development of preventative and promotive health care, and gives high priority to women and children.

While indicating that the health coverage of Region 3 stands at 30%, he pointed out that most health problems emanate from the prevalence of communicable and vaccine preventable diseases. Diarrhoeal and the six vaccine preventable diseases, he said, are responsible for about 60% of all deaths in children under the age of five.

In indicating that meeting the expected goal of 80% coverage by the end of 1995 might be a bit too ambitious, he, at the same time,

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said that with good community participation, international assistance and cooperation, continuous support from UNICEF, and the determined effort of frontline health workers, there is a good possibility of approximating, if not actually attaining, the MDGs.

Dr. Belaynew Moges who represented RHB3, on his part, indicated that although the problems posed by vaccine preventable and diarrhoeal diseases is immense, the means to minimize and even solve them is at our disposal. He added that the mere fact that CRDA, MOH, and UNICEF and RRC got together to address a serious national problem is an encouraging development as it bodes well for cooperation in other areas of common concern. Finally, he called on participants to carefully draw their plans of action and redouble their efforts to implement them.

Dr. Gebre Asmamaw, a member of the regional organizing committee, in pointing out the hard work that went into the preparation of the sub-regional workshop at Bahir Dar, said that the whole effort would be in vain if it were not to be followed by active participation at the workshop, and deligent effort during implementation.

Ato Tamiru Kassa of RRB, on his part, said that measures taken in the area of health would help mitigate the effects of drought and famine. Efforts in relief, and now the development sectors can bear fruit only if healthy people fully support and participate in the implementation of projects that both the Government and NGOs initiate.

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Conceptual framework for the MDGS

Children are among the most vulnerable segments of society. This is especially true in the developing world, where they have been seriously and adversely affected by natural and man made disasters. Poverty, disease and malnutrition have also taken their toll. As Mr. R.R.N. Tulunghwa, UNICEF's country Director, clearly indicated in his opening speech at the National Sensitization Programme on EPI/ORT, "Africa's children can create a strong link between us and the challenging 21st century only if poverty and underdevelopment are checked, and the major killer diseases eradicated."

As is the case with the rest of Africa, the rate of morbidity and mortality from diarrhoeal and vaccine preventable diseases in Ethiopia is very high. There have, over the years, been several attempts to mitigate the dire consequences of these diseases. One of them is the EPI/ORT programme which was launched in Ethiopia in 1980. The main objective was to achieve 80% coverage through a yearly progress of 10%. However, by 1994 the national coverage stood at only 37%. In the case of ORT, it was 40%.

The major aim of the EPI/ORT programme is to reduce child morbidity and mortality. This is why a new plan with a lower ceiling target, i.e., 80% coverage of EPI/ORT, was drawn, and a fresh campaign launched.

The ORT programme also has a similar target of achieving 80% usage. What is interesting to note about ORT is that it is an ingenious, and inexpensive solution, which as the Lancet, the leading British Medical Journal, rightly pointed out is "potentially the most important medical advance of the century"

ORT has its origins in an Indian traditional medicine, which, in so far as the treatment of diarrhoeal diseases is concerned, was on the right track 3000 years ago. Later on the medical profession got an alternative in I.V. rehydration. Then in 1971, a medical team working with Bangladesh refugees accomplished a near miracle when it treated victims of advanced cholera with ORS, and significantly reduced the otherwise very high death rate. As a UNICEF publication points out, "it at present, saves the lives of more than a million children a year, but much remains to be done to make it accepted universally as the standard treatment and prevention of choice for all types of diarrhoea".

Another important development took place in 1990. In September that year, the largest gathering of world leaders in history assembled at the UN to attend the World Summit for Children, which adopted The Declaration on the Survival, Protection and Development of Children and Plan of Action for implementing the Declaration in the 1990s. The year 2000 was set as a target for each country to attain the seven major goals and 27 specific targets they had identified.

In 1992, OAU member states selected 13 out of the 27 targets to be achieved by the end of 1995. Ethiopia, given its most difficult recent history, chose to set fewer targets, and, as such, agreed to work on only 4 goals, namely 80% EPI coverage, 80% ORT usage, eradication of guinea worm in South Omo and Gambella and universal iodization of salt.

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It should also be noted that UNICEF's Fourth Country Program of Cooperation came into effect on July 1, 1994 and will run until June 30, 1999, inclusive. It was mainly based on a situation analysis report. The main goal of the Fourth Country Programme of Cooperation is to contribute to the development of approaches, systems, and policies that will, among other things, drastically reduce the mortality and morbidity rate in children and women.

The programme has developed two inter-related strategies for the achievement of its goals. These are the Nation-wide and the Integrated Basic services Programme. The objectives of the Nation Wide Programme include increasing Universal Child Immunization (UCI) to 80% or more, as well as achieving 80% ORT use, and sustaining them.

The main thrust of the Woreda Integrated Basic Services (WIBS) program is to establish a sustainable system that would enhance child survival and protection, as well as the development of rural communities in selected woredas. Sustainable and replicable services will be provided through the adoption of low cost, affordable, community managed technologies and by means of community empowerment as well as the full participation of women.

Both of these programmes have significant health components. As such, they strive towards attaining a high percentage reduction in the morbidity and mortality rates of children and mothers. This, therefore, is why UNICEF and other agencies with similar programmes jointly undertook the EPI/ORT programmes.

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Review of Child Health Programmes and Future Plan to Meet the Mid-Decade Goals

Dr. Mokonnen Admassu,
Ministry of Health

Introduction

The EPI/ORT programme, as a priority item on the national health agenda, has been the central focus attention for health professionals and institutions. National and international agencies have allocated significant funds for the prevention and control of vaccine preventable and diarrhoeal diseases which are among the major causes of morbidity and mortality in the country.

The health status of Ethiopian children is extremely poor. This accounts for the very high rate in morbidity and mortality of mothers and children in the country. Children under the age of one and five years of age comprise 3.5% and 18.5% of the total population, respectively. Infant mortality rate is 105/1000 live births, and under five mortality rate is 159/1000 total birth. Almost 50% of the total death occurs in these age groups i.e. 0-5 years of age.

Among the communicable diseases acute respiratory tract infections, diarrhoeal diseases, vaccine preventable diseases, and malaria are the most rampant. These diseases are the causes for 50-75% of morbidity and 60-75% of mortality.

There are other contributing or associated factors that play a major role in so far as the high mortality and morbidity rate in children under the age of five is concerned. These can be divided into health related and non-health related factors. Deaths and sufferings due to these reasons are totally unacceptable, especially as they are easily preventable through:

-appropriate, and low cost technologies,
-feasible, effective, and acceptable strategies, and
-intervention mechanisms that have proved to be effective.

A decade and half has passed since these interventions were accorded international recognition and acceptance, and a number of years since we started to implement the said strategies. These intervention strategies are considered major components of child health programmes. They are:

1. The expanded programme on immunization
2. National control or diarrhoeal diseases and acute respiratory tract infection programme /NCDRP/
3. Child nutrition, which includes, growth monitoring, breast feeding, Vit. A supplementation etc.

The health system of the country is decentralized, with the consequent devolution of power, and delegation of responsibilities to the various regions, woredas, and zones. The TGE has shown a strong commitment to the enhancement of child survival opportunities. Its ratification of the Child Survival Convention, and the high priority it has accorded to child health programmes, as shown in the Health Policy, testify to its commitment to promote child health and welfare. The

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Policy clearly states that special attention shall be given to the health needs of the family, particularly women and children. As explicitly stated in the health policy, child health programmes should be given priority and delivered in an integrated manner in all health institutions.

EPI/ORT are the "twin engines" of primary health care , and a major component of child health programmes. The experience of other countries has proven that success in this area can only come about if the approach is designed in a top-down fashion in order to ensure the standardization of methods in the choice of vaccines, vaccination schedules, training, supervision and evaluation.

In view of the foregoing, if mortality and severe morbidity in children is to be reduced, immunization and ORT use must be increased to 80%, which would guarantee the well being and the survival of children. In order to reduce childhood mortality by half by the year 2000, greater efforts should be made now to meet the mid and end of decade goals.

I. THE EXPANDED PROGRAMME ON IMMUNIZATION

BACKGROUND INFORMATION

GLOBAL The Beginnings of EPI

Immunization has been practiced for the past 200 years, but until the past few decades it had only a marginal effect on the protection of populations against infectious diseases. A major brakethrough occurred during the 1960s and early 70s as the great killer-small pox was eliminated by a massive global immunization campaign. The success was mainly attributable to surveillance and case containment efforts, as well as measures taken to vaccinate contacts only.

Following this success, the World Health Organization established the Expanded Programme on Immunization (EPI) in 1974 with a view to protecting children against tuberculosis, measles, Diphtheria, whooping cough (pertussis), tetanus and polio.

It was estimated that in the 1970s approximately five million children died each year (it represents one third of all deaths) from these six diseases. This was to change after the introduction of EPI. Subsequent to this, national immunization programmes were initiated in many developing countries in the late 1970s and early '80s. In 1977, the World Health Assembly through its Universal Childhood Immunization (UCI) programme challenged the countries of the world to provide immunization services for all children by the year 1990. The 1990 UCI target was 80% antigen coverage of children by their first birthday. The target varied for Africa and China, (75% for Africa, and 85% for China).

In 1982, UNICEF launched the Child Survival and Development Revolution in its "GOBI - FFF Package" which contains Growth Monitoring, Oral Rehydration, Breast Feeding, Immunization, Family Spacing, Female Education and Food Supplements through cost effective and high impact interventions.

In 1984, the "Task Force for Child Survival", an international coalition comprising of UNICEF, WHO, UNDP, the World Bank, and the Rockfeller foundation, was established. In 1985, during the 40th anniversary of the United Nations, its General Assembly ratified the UCI declaration. 1986 was African Immunization Year, and 1987 witnessed the introduction of the Accelerated Child Health Development. 1988

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was the year of the "Declaration Tallories, France". In 1990 the World Summit for children was held. It adopted the Convention on the Rights of the Child.

The number of developing countries achieving the 80% immunization coverage target has been increasing over the years. As such, 16 countries in 1986, 34 countries in 1988, 43 countries in 1989, and 64 developing countries in 1990 achieved the target. So also have 23 African countries met the MDGs. Examples include such African countries as Djibouti, Brundi, Congo, Equatorial Guinea, Central African Republic, Mozambique, Lesotho, Tanzania, Zambia etc.

Such being the case, the global target of 80% coverage for all antigens was reached by the end of 1990. This effort has reduced 3 million deaths from diarrhoeal diseases in 1990 only. In a decade's time the lives of an estimated 15 million have been saved. Reports from many countries documented significant reduction in polio, pertussis, tetanus and measles related deaths.

Morbidity and mortality from such related causes as malnutrition, diarrhoea and pneumonia have also been reduced.

It has been recognized that successful immunization programmes are the result of:-

. Strengthening primary care facilities
. Upgrading the knowledge and skill of health workers through continued training
. Increasing health service accessibility
. Effective management and maintenance of the cold chain system
. Adequate supply of vaccines
. Utilization of a variety of strategies to improve immunization coverage and strengthening their health care delivery and out reach systems.
. Some of the strategies include:-

.National vaccination days
.Involvement of religious leaders, teachers or politicians etc.
.Intensive media campaign
.Increasing the capacity of health service to provide immunization services to children at every possible contact wit health institutions.
.Identifying and registering eligible children and women in their homes
.Careful tracking of each child to ensure completion of the immunization schedule by his/her first birthday
.Encouraging full immunization by making it mandatory to qualify for school admission or other government services or even performing religious rights.

Global EPI - UCI which was initiated in 1990 has, therefore, been the first of its kind in human history. The nations of the world set an ambitious goal. Despite the great odds arraigned, especially in a decade where poverty, war and social inequality are rampant, many success stories were recorded by developing countries that accepted the challenge and worked hard to meet the MDGs. Because of the new level of health education, and mobilization efforts through an extensive use of the mass media, EPI-UCI-1990s programmes have so far been successful, and shall, in all probability, remain so in future too.

NATIONAL EPI

In Ethiopia, the expanded programme on immunization was launched nationwide in 1980 with the assistance of UNICEF, WHO and UNDP. The presumed goal was to provide immunization services to all children (under the age of two years). It was thus believed that by increasing EPI coverage by 10% every year, Ethiopia would attain 100% coverage by 1990. That target was later revised to 75%.

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In 1986, the target age group was changed to under one year. This was because it was felt that children under the age of two could also be immunized whenever they come into contact with a health institution that provides immunization services. The importance of reducing neonatal tetanus by vaccinating pregnant women with two doses of TT was underlined, although the immunization programme has provisions for child bearing women.

The progress of EPI in terms of coverage /output/ is as follows:

Year	Immunization covege of DPT3
1986	7.0
1987	16.1
1988	16.0
1989	26.0
1990	59.0
1991	21.0
1992	13.0
1993	28.0
1994	37.0

When the EPI programme started in 1980, the required service was given in 100 static and 41 outreach sights. Currently there are over 1,500 static and 5,500 outreach sites.

The major goal of the Expanded Immunization Programme (EPI) as set out in 1980 was to increase immunization by 10% each year so as to attain 100% coverage by the year 1990. However, progress in actual immunization coverage has been slower; only 36% DPT_3 coverage in 1994. The lowest was 3.4% in 1983 and the highest 59% (1990). This showed an uneven progress, and imbalance in the amount of both the attention given as well as the material and technical support provided.

Of the major constraints identified for the low coverage of immunization in Ethiopia are:

- poor and inadequate health infrastructures particularly in the rural areas,
- deficiency in the surveillance system,
- high defaulter rates and missed opportunities;
- weakness exhibited in I.E.C. efforts, and the lack of involvement on the part of the other partners and the community at large,

The logistic support given to EPI programmes include, the provision of vaccine, cold chain equipment, sterilization and injection equipment, financial support for operational cost and technical assistance. The main donors are UNICEF, WHO, Rotary International, USAID and JICA.

The cold chain system: There are over 1,500 fixed EPI sites that are using largely kerosine refrigerators. About 100 solar refrigerators have also been introduced in recent years. Ice lined freezers and refrigerators are used in the intermediate levels. There is one central cold chain which is housed in cold rooms.

GOAL

Reduction of morbidity and mortality caused by the six vaccine preventable diseases.

OBJECTIVES

. To increase immunization coverage to 80% for all antigens in children under one year of age.

. To increase immunization coverage including TT_2 to 80% in pregnant women and in women of child bearing age /15-49/.

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STRATEGIES

1. Increasing immunization coverage

. Opening of new vaccination sites /static and outreach/
. Provision of vaccine and other logistic support
. Increasing the capacity of health services in order to enable them to give immunization to children at every contact with the health system /minimize missed opportunities/
. Reduce dropout rates
. Careful tracking of each child or completion of immunization scheduled by the first birthday (to reduce drop outs and missed opportunities)
. Making mandatory or encouraging full immunization to qualify for government services or religious rites
. Monitoring of immunization coverage

2. Establishing an EPI disease surveillance system. This would constitute:

. Improving the routine reporting system
. Establishing a case recording and reporting system
. Improving a data management and information retrieval system
. Monitoring and Evaluating the surveillance system

3. Supporting/strengthening regional capacity

. Encouraging regional planning
. Supporting regions, zones, woreda
. Giving high level training in managerial skills and technical know how
. Expansion of effective management of cold chain system in regions, i.e, decentralized cold chain system
. Follow up of Regional EPI activities through coverage reports, supervision and review meetings

4. Strengthening communication and advocacy programmes through:

. Social mobilization
. Communication strategies
. Monitoring/Evaluating communication activities

5. Monitoring and Evaluation

. Improving the existing health information system and the data base management
. Analyzing/disseminating information regarding coverage to the concerned authorities
. Supervision of activities at all levels
. Periodic reviews of Regional EPI activities by the center, by the region themselves, by others

6. Operational researches / Evaluation

. Conduct national coverage survey
. Conduct regional coverage survey
. Conduct surveys on missed opportunities or drop out rates or other strategies that might negatively impact on efforts to increase immunization coverage
. Review effects of the national EPI programme
. Revise national EPI policy/Guidelines

INDICATORS

1. Input indicators

. Proportion of health facilities that provide EPI activities to the general population

2. Output indicators

. Immunization coverage rate/ BCG, DPT_3, measles/
. Coverage of TT_2
. Drop out rates - BCG_1 /DPT_3 or measles

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II. CONTROL OF DIARRHOEAL DISEASES

1. WHO CONTROL OF DIARRHOEAL DISEASES PROGRAM /WHO CDD PROGRAM

1.1 PROBLEM OF DIARRHOEAL DISEASES-GLOBAL

Mortality:- More than 4 million children die every year due to diarrhoeal diseases. Diarrhoea mortality rate in Ethiopia is 12.5/1000, and 14/1000 in Africa. Diarrhoea killed around 50 million children in the last decade (1980-90) globally, which is comparable to the Ethiopian population, and continues to kill 3-4 million children every year globally.

Morbidity:- There are 1 billion diarrhoeal episodes that occur every year. It is estimated that there are 3.4 episodes/child/ year globally, and 4.4 episodes/child/year in Africa. An African child is said to suffer 30-50 days every year; 1/3 of pediatric beds are occupied by diarrhoeal disease patients that are treated with expensive antibiotics and IV fluids. They also need other services, which, of course, would impose a heavy burden on the country's scarce resources.

In many developing countries when we speak about diarrhoea, the diarrheal diseases outbreaks, especially the cholera pandemic and shegella endemic, claim many lives, and are accompanied by such tragedies as would wipe out whole villages.

Since the diarrhoeal diseases are considered a health hazard for children's growth and development, the WHO - CDD programme was established in 1978 as an essential component of PHC and became operational in 1980 with the following objectives and strategies.

1.2 Objectives

. To reduce mortality
. To reduce morbidity
. To promote national self reliance.

1.3 Components of the WHO - CDD

. Service component
. Research component

1.4 Strategies:- To promote CDD programme

.Effective case management
.Improvement of nutrition level
.Use of safe water
.Good personal hygiene and environmental sanitation
.Measles immunization

1.5 Activities

.Supporting national programmes through:-

.Plan of Action
.Managerial and technical training
.Health education and communication
.Local production of ORS
.Evaluation of NCDDP

1.6 Global targets:- By the end of 1995, to increase

. ORS access rate by 80%
. CM acceptance rate by 50%
. Morbidity reduction by 20%

1.7 Achievements:- Although no evaluation studies have been conducted, the trend at present is one of declining mortality due to dehydrating diarrhoeal diseases. ORS

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use rate is now higher than 50% in many developing counties. ORS is now produced in 69 developing counties. NCDDPs are capable of conducting various types of training to enhance the capacities of their staff members. Effective CM is, therefore, practiced in many health facilities.

The CDD programmes of WHO continue to support the national programmes to bring an impact on the control of diarrhoeal diseases, including their outbreaks.

2. NATIONAL CONTROL OF DIARRHOEAL DISEASES PROGRAMME IN ETHIOPIA

2.1 Magnitude of the problem

Various studies have shown that diarrheal diseases are among the major factors that contribute to the high mortality and morbidity rate in children under the age of five. To mention some:-

i. A 10 year record review /1969 - 1978/ of outpatient consultation at the Ethio-Swedish pediatric hospital has revealed that diarrheal disease were second as causes of morbidity and mortality.

ii. A periodic prevalence study among 6,384 under 5 children has shown that mortality rate stands at 11.4% and morbidity at 11.07%.

iii A two-week prevalence study among 0-2 years of children put the incidence rate at 6.8 episodes/child/year.

iv. A mortality, morbidity and treatment (MMT) household survey also came out with the same estimation. Mortality stands at 9.2/1000 for the under five population with a diarrhoeal death ratio of 46% (22.6 - 60.5%) Morbidity as expressed in terms of frequency of incidence is 4.8 episodes /child/year or 16.2% (range 10.7 - 26.0%).

Hence, 40-50 million diarrhoeal episodes are estimated to occur every year. An Ethiopian child suffers 60-70 days every year, meaning he passes nearly a year or $1/5^{th}$ of his time in sickness due to diarrheal diseases until he reaches the age of five.

The diarrheal diseases outbreaks that came in the wake of major famines killed as many or more people as those directly victimized by the disasters. This was especially true in the rehabilitation centres, situated in the low lands of the Awash Valley. Children are thus the first to suffer under difficult circumstances.

In short, diarrheal diseases affect people of all ages, but have more devastating effect on children. Diarrheal diseases occur in every country, but wreak havoc and destruction in poor nations like ours. Diarrheal disease, therefore, is a serious problem whose control deserves priority consideration.

In order to facilitate the control of diarrheal diseases, the National Control of Diarrhoeal Diseases programme was established in 1981. It became fully operational in 1983. NCDDP was placed under the Department of Epidemiology until 1994.

2.2 Targets and sub-targets:- The MDGs are the targets of the programme. Therefore, what it aims at achieving by the end of 1995 is:

. ORT use rate : 80%
. ORS access rate: 80%
. Acquisition of correct knowledge regarding the 3 rules of home therapy: 50%
. Case correctly managed at health facilities: 90%
. Effectively provided CM by health facilities: 90%

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2.3 Strategies

. Effective case management
. Promotion of preventive activities
. Emergency and Epidemic preparedness
. Communication
. Monitoring and Evaluation

2.4 Activities

2.4.1. To conduct training

.Case Management
.Supervisory skills and Management Programme
.Breast feeding advocacy and counselling

2.4.2. Managerial activities

. Developing policy guidelines
. Setting targets
. Monitoring & Evaluation

2.4.3. Communication Activities

. IEC material development and distribution
. Communication skills development

2.4.4. Procurement and distribution of ORS

2.4.5. Supporting Regional CDD Activities

2.4.6. Technical support in the early warning and epidemic control activities

2.4.7. Monitoring and Evaluation

.Operational researches

2.5 Expected output

2.5.1 Training:-to be conducted

. Inservice training/TOT
. Basic service trainings

2.5.2. Managerial activitie:- production of

. Policy declaration
. Setting national targets
. Introduction of regular reporting systems
. Periodic supervision
. Conducting comprehensive programme review and focus programme review

2.5.3. Communication
. IEC - Material development - Training materials

2.5.4. Procurement and distribution of ORS

2.5.5. Supply - 5 Diarrhoeal Disease Training Units and ORT corner utensils

2.5.6. Involvement in various epidemic control activities

2.5.7. Operational research:- 16 MMT survey, KAP studies etc.

2.7 Constraints:-

2.7.1. Training: Attrition/Turnover rate is very high due to lack of motivation

2.7.2. Management
. Poor communication and coordination with regional CDD programs
. Poor reporting or under reporting
. Lack of regional and zonal planning

2.7.3. Communication - Lack of communication strategies

2.7.4. Low ORT usages in the community

2.8 Solutions

Communication:-
.Develop the skills of health workers in communication

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. Motivate the health workers to undertake communication work
. Develop appropriate IEC material

ORT use rate:-

. Procurement of ORS
. Promotion of ORS

Managerial activities

. Supporting regional CDD programmes
. Developing guidelines
. Monitoring/Evaluation

EFFECTIVE CASE MANAGEMENT /ORT/

The cause of death in acute watery diarrhoea is dehydration. 90% of all diarrhoeal cases die due to dehydration. The major contributor of death in diarrhoea is malnutrition. It is, therefore, assumed that 90% of deaths are preventable through the use of a simple technology called ORT.

What is ORT?

ORT /Oral Rehydration Therapy/ is a simple technology of both curative and preventive interventions that can be performed:

. By all persons (mothers, health workers or other care takers)
. In all places (health facilities, home)
. For all cases (watery, bloody or persistent)
. All the time (whenever diarrhoea occurs)

ORT as a technology has a process which needs to be completed. This aspect of the treatment needs to be given serious attention. ORT is said to be accomplished only when the following procedures are employed:-

1. Diarrhoea causes dehydration, therefore, rehydration i.e. giving more fluids, would be essential; eg. breast milk, juice, cows milk, soup, gruel, ORS or clean water.

2. Diarrhoea causes malnutrition. This is why continued feeding would be of the utmost importance. Parents can resort to breast milk feeding, soup, cows milk, fruits, gruel, thin porridge, any food (what the child is normally fed).

3. When to seek further treatment - fast and timely referral is most essential if a child has the following signs and symptoms: eg. marked thirst, bloody diarrhoea, profuse diarrhoea, fever, vomiting, if he refuses to eat or drink, or does not in general show signs of improvement.

ORT is, therefore, essentially a home remedy solution which happens to be based on scientific knowledge, ORS/Oral Rehydration Salt/, a pre-packed commercial product, was adopted by WHO/UNICEF that sponsored its distribution in developing countries. ORS is used to make an ORT solution in a liter of water/depending on the brand/. As one of the ways to deliver ORT technology, it is considered potentially the most important medical advance of the century.

ORT is a technology which best embodies the principles of PHC. It involves the community in the promotion of its own health care system. It is a simple task that not only a health worker, but also a child's mother can perform. Therefore, having access to ORT technology would empower individuals and parents, and enhance their involvement in the management of their own health problems.

ORT is a package that involves home ingredients that are easily accessible to members of the community. The use of such a

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simple formula requires behavioral change that comes about as a result of public education. This, in the long run, facilitates people's empowerment in managing their own problems through their own technologies.

ORT is part of effective CM. Promotion of effective CM, therefore, means promotion of ORT, or council communities about the importance of ORT technology. But ORT, and effective CM are not synonyms.

The NCDDP at the central level is encouraging the promotion of ORT through its special strategies with a view to achieving the MDGs i.e ORT use rate of 80% by 1995.

Critical Review of Community Health Programme, i.e. EPI/ORT from MDGs perspective.

Identified problems:-
. Low health coverage /38%/
. Problems in the modality of services
  . Poor integration of services
  . Poor quality/irregularity/ inconvenience/

. Poor coordination / communication
. Inefficient reporting system
. Absence of EPI target diseases
. Lack of expertise in the maintenance of cold chain equipment
. Shortage of funds to cover operational cost
. Lack and shortage of transportation
. Lack of knowledge, skills and motivation of health workers
. Shortage in the supply of drugs and medical equipment
. Repeated interference of donor agencies
. Absence of clear guidelines on the part of the health policy

Results of the above mentioned problems comprise:
. Low health coverage
. High defaulter rate (26-42%)
. High missed opportunities (1/3 of health institution attendants)
. Lack of community support
. Poor planning/implementation

Efforts made to solve the problems

. Social mobilization /communication/ advocacy
  . Encouraging the involvement of religious leaders / youth groups/
  . Intensive usage of media channel / multi-media approach/

.Training of health workers
  . Managerial training
  . Clinical training
  . Logistic support / supply/
  . Coordination /communication
  . Regional / zonal structuring of the cold chain system

OTHER OPPORTUNITIES

. High level commitment - central government
. Health policy - priority strategies

Recommendations

1. Modality / provision / services

. Health services at all levels must be integrated
. All health facilities must provide EPI/ORT or MCH services at first line or grassroots level.
. Education of mothers must be a major component of the service. This will result in:

  . increased coverage rate
  . decreased defaulter rate
  . decreased missed opportunities
  . increased motivation of mothers

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2. Supplementary immunization, especially national immunization/ORT must be introduced.

. Programme advocacy at higher levels
. Supporting rules and regulations
. School entry criteria

3. Improving programme management skills at all levels through training

4. Establishing national and regional coordinating committees - MDGs committees /EPI/ORT/

5. Initiation and strengthening of disease surveillance system

6. Revision/endorsement of policy/ guidelines

7. Improvement of monitoring/evaluation mechanisms

8. Strengthening regional capacity building

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Cooperation between MoH, UNICEF, CRDA, RRC

Ato Fekade, who represented CRDA in all of the regional workshops, pointed out the fact that about 63 of its members are actively engaged in health projects. This, he said, was one of the major reasons why especially P.H.C. is one of the priority areas of funding for CRDA.

He explained the kind of financial support and services CRDA provides its members with, and the criteria it has adopted for funding. CRDA focuses on improving the economic and health status of the most vulnerable segments of society; among whom children figure prominently. Emphasis is also laid on the rural poor which the national health policy has identified as one of the most needy. This, he indicated, was the reason why CRDA gladly joined the other co-organizers in the promotion of the EPI/ORT programme, which, it believes, would drastically improve the health status of especially children from poor rural families and save the lives of millions of children in the country. CRDA, which regularly assesses the impact of its projects, would, in this case too, encourage periodic reviews with a view to solving outstanding problems. He concluded by pointing out that CRDA will continue to intensify its coordination activities between NGOs, UNICEF, and MoH, and increase its support for EPI/ORT.

The MoH representatives on their part explained how the EPI/ORT programme that targets children is a national and regional priority. They gave statistical data regarding the EPI/ORT coverage rate of their respective regions and indicated the strategies devised to radically improve the situation. They pointed out that the recently held micro planning workshops that UNICEF organized played a pivotal role in making the necessary preparations at regional levels. They at the same time indicated that although that the plan envisaged the participation of NGOs in the implementation of the EPI/ORT programme, the organizers failed to invite them to the meetings. The present workshops, they said, were important because they would, among other things, help redress that problem.

Finally, although they all agreed that achieving an 80% coverage by 1995 could perhaps be too ambitious, they expressed their readiness to work towards meeting the MDGs.

RRB representatives, on their part, indicated that the capacity of the population to resist natural disasters would depend on their health status before or during the onset of the problem. Efforts of rehabilitation and development, the prime objectives of the TGE, can also be easily attained only if people are healthy and productive. They added that, as the future of a nation depends heavily upon its children, it would be expeted of everyone to care for and nurture children as well as invest on their health.

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Communication at Grassroots Level

Ato Yohannes G. Tsadik and
Ato Abebe Birhanu

Communication and Development

When we talk about development, we talk about people and technology. When we say "people" in relation to development, we must think of their needs. However, there are problems that curtail the satisfaction of such needs. Development interventions aspire to solve these problems. So technicians develop a strategy to solve the problems faced by beneficiaries. Communication is a component of that strategy.

Development interventions are undertaken for people. Therefore, the objectives of such interventions should be introduced to people so that they would understand and wholeheartedly support or participate in the project. Unless the importance of any type of technological advance is well explained to the target beneficiary, it would in all probability, come up against strong resistance. Efforts at introducing family planning methods and the problems faced, could, in this regard, be cited as a good example.

Let us look at a similar case. Immunization as a major preventive measure has to be popularized among people, and they should believe in its use before they would bring their children to vaccination centres. Thus, communication will have to focus on sharing information regarding the importance and use of immunization. This implies that persons that try to convince people about the use of immunization must have some idea on communication techniques.

The Communication Process

In looking at the communication process, what we actually do is examine the necessary ingredients for interaction among people. We must look at the major factors and how they operate. One crucial point, in this regard, is opening a channel, and establishing a wave length so that we can understand others, and others would understand us.

Communication, in short, means trying to establish commonness or "common understanding" with other people. The communication process includes the sender, the message, the channel and the receiver. The communicator sends a message which is colored by his/her field of experience, and the audience interprets it from his point of view or as per his/her experience. In this case, a common area of understanding may or may not be created.

The ideal communication situation is one in which a common area of understanding could be established without any impediments. However, commonness can be established when the sender has sent his message to his audience and the audience is prepared to receive the message.

There are factors which determine a smooth communication process:

1. communication skills
2. attitude
3. knowledge
4. the social system in which the operation takes place

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We might summarize the communication process in a sentence by listing the factors that we have to consider in understanding the process. Here is the sentence: WHO (source), for what reason, says WHAT (message), in what way, over what CHANNELS, to what audience (receiver), with what effect (reaching the goals of the source).

Problem Analysis

What are the factors which create a gap between the existing and the desired behavior of the target group?

- Knowledge/information problem, meaning people don't know.
- Skill problem, meaning they don't have the capability to do it.
- Attitude problem, meaning they don't want or are not ready to do it.
- Resource problem, meaning they know about it and they want to do it. The problem that emanates, therefore, is not due to the lack of information, but rather due to other factors such as:

.Unavailability of basic supplies.
.Unavailability of services at the right time and place by the right health workers.
.Lack of basic infrastructure such as roads and transport in general.
.The prevalence of disincentives or non-existence of incentives such as money, security, health, etc.

Communication interventions should focus on the problems identified. The degree of intervention may vary according to the magnitude of the problem. The nature of the problem determines the type of approach to be chosen.

The Problem of Communication

1. Not saying what we want to say
2. Not hearing what we are supposed to hear
3. Message Distortion: Very often the message transmitted is not received the way the message sender intended it. What we hear and what was transmitted could very well differ. This results in message distortion and hence misunderstanding.

Let us look at an example. Take any news item and pass it on to five persons. The source person tells the story to one person and that person tells it to the next person. It goes on until the story reaches the fifth person. Compare the story told by the source with the story received by the fifth person. Sometimes you will end up hearing two completely different stories.

Once the problem has been identified, communicators should set communication objective using the ABCD approach. Once this is done, media channels for transmitting messages can be identified and utilized.

Essentials for effective communication

1. Audience -Specify a single priority target group

2. Behavior -Define the type of change(s) you expect

3. Condition -Determine when and under what conditions you expect this change to occur.

4. Degree -Specify how much change you expect, and how you assess the effect.

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Media Channels

When a particular source has developed a message, he has to decide what channel he will use to present the message; i.e. what medium or media of communication will be most effective. There are many ways of looking at channels. Perhaps the simplest is to list the five senses that can be used to receive a message. Each of the following kinds of channels that belong to a broad category can be analyzed under the five senses. In other words, the channels of communication are ways of presenting a message so that:

1. The message can be seen through printed and visual forms such as books and films.
2. The message can be heard through radio and recorded messages.
3. The message can be seen and heard through television, field demonstrations and other audiovisual aids.
4. The message can be touched, smelled and tasted through models, exhibits, specimens and experiments.

Generally, communication is more effective when more channels are used, i.e., when more senses are stimulated.

Possible Organizational and Media Channels to Reach the Target Group

- Government administrative system
- School system (teachers and students)
- Extension/outreach system (Agriculture, family planning, health, community development, etc.)
- Non-governmental system (voluntary and religious groups, business establishments, etc.)
- Mass media: Radio, posters, banners, billboards, newspapers, booklets, blackboards, audio-tapes, wall charts, slogans, etc.
- Interpersonal: Home visit, office calls, meetings, role plays (drama groups), group discussion, demonstrations, exhibitions, etc.

Audience Analysis

Before communication objectives are set and media channels are chosen, one has to analyze the audience. To analyze, one needs to take the following steps:

- Identify the audiences which the campaign intends to reach.
- Collect baseline information about these audiences around which a communication strategy can be built.
- Divide the audience into small groups

Example 1:
Target group #1 mothers with infants
Target group #2 village health workers
Target group #3 village school teachers

Example 2:
Target group #1 rice farmers in region 'A'
Target group #2 village extension workers

If your audience includes students, it is possible they would like to participate or help, but don't know how to. On the other hand, your audience may be village women. These women may have the information, but don't accomplish tasks they are expected to do. Your audience may also be officials. And these officials may not seriously care whether development interventions are successful or not. This, therefore, presupposes that problem analysis is vital.

Common Communication Approach

Are we to inform educators or persuade? In what manner? Perhaps we might even have to consider teaching through entertainment. Let us look at a few alternatives.

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- Informing: The "new idea" is introduced and made familiar.
- Educating: The "new idea" is explained including its strengths/weaknesses.
- Persuading: Appeal is made so that the audience will accept the "new idea"
- Entertaining: The attention of the audience is drawn better if we resort to such methods as school drama, audio/video tapes, cinema spots, exhibition, etc.

Let us take the example of EPI communication in Ethiopia. Every communicator can follow the same example for other types of interventions as well.

Reluctance to Change

Sometimes no matter what we do or what we say, people are reluctant to accept new ideas. In such a case, we need not despair. We should try and understand the psychology of the people of that specific area. In any given society, there tends to exist four types of people:

1. 2-3% that accept new ideas without any question or hesitation.
2. About 15% of those who say "let us see the outcome and we will join."
3. About 65% simply say "Eshe Nega," ..... later on.
4. About 17% will never buy the idea no matter what one says or does. But fortunately each of these groups have leaders. It is these leaders that we should identify and focus our attention on. Unless these leaders are identified and convinced to help in bringing out the desired change within a society, we will face serious problems.

Conclusion

The purpose of effective communication, in this particular case, is to motivate people to adopt new ideas, and thereby bring about the desired change. To achieve desired results, communication BARRIERS must be overcome.

Printed media like leaflets, handouts, newspapers, posters, etc. and audio-visuals like radio, television, films, slides, etc. are some of the channels. But multi-media approach is the best. It should also be noted that the chosen medium has to be utilized properly.

Psychologists tell us that:

. We learn 11% through hearing and 83% through sight,
. We retain 20% of what we hear, and 50% of what we see and hear

Therefore, it would be better to use the multi-media approach in order to transmit information in an effective manner.

Unless a feedback from the audience is received, we cannot claim that a common understanding has been achieved. Only after:

. All barriers have been removed,
. The proper media has been chosen,
. A good presentation has been made,
. A two-way communication has been established,
can we say that the sender has established COMMONNESS with his audience.

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Health Profile

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INTRODUCTION

Health as defined by WHO is "a complete mental, physical and social well-being and not the absence of disease or infirmity." In view of this, we can define Health Profile as a compiled report of health and health related issues of a certain geographically defined area.

Health profile will help to determine the magnitude of health problems and provides a baseline data for planing and assessment, as well as future reference purposes. Therefore, any health profile of a certain geographical area should have essential data on all aspects of the area under consideration.

OBJECTIVES OF A HEALTH PROFILE

1. To collect health and health related information
2. To identify major health problems
3. To set priorities and targets
4. To design a plan of action

Health profile preparation thus includes setting priority and designing an action plan. This will then be followed by an "Implementation and Evaluation" report. This is why it is also called "Health Profile and Action plan Report".

We can say there are three major components
1. Health Profile
2. Action Plan
3. Implementation and Evaluation report

Implementation will be based on the action plan designed for a geographically defined area within a specific time frame (one year for example). Evaluation of the plan, on the other hand, is based on the major performance indicators such as EPI coverage etc...

The most important aspect of preparing a health profile is the collection of relevant health and health related information. Furthermore, one needs to know where this information could be obtained. A check list of possible information sources should be made before attempting to gather the necessary information.

DETAILED GUIDELINES FOR HEALTH PROFILE

1. INTRODUCTION

This should contain.

- National perspective
- Short description of national health sevice strategy
- Some findings of PHC
- Objective of the health profile

2. METHODOLOGY

This should comprise of:

- A complete description of the methods used to gather information with clear indication of the source of information.
- Shortcomings of the methods used should be stated.
- Method of survey if conducted.

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3. COMPONENTS OF A HEALTH PROFILE

3.1 BACKGROUND INFORMATION

Health profile should provide information that will help understand the existing health and health related problems. This includes:

3.1.1 GEOGRAPHY AND CLIMATE

The general geography and climate of the region, topography, size, rainfall, population density, arable land etc...

3.1.2. POPULATION

Total population of the area by age and sex

. Sex ratio
. Population pyramid
. Culture and religion

3.1.3 POLITICAL AND ADMINISTRATIVE ORGANIZATION

. Number of districts in the region
. Number of sub districts in the districts
. The political organization of the area
. Number of farmers' associations in the area
. Number and type of other associations available in the area eg. youth, women professional etc..

3.1.4 ECONOMY

. Occupation of the population
. Main crops
. Livestock
. Industry
. Average household income
. Per capita

3.1.5 EDUCATION

. Number of kindergarten
. Number of elementary schools
. Number of high schools
. Institutions of higher learning
. Number of students attending school by sex and age
. Number of teachers by sex
. Proportion of literate population by age and sex

3.1.6 FACILITIES

. Transport
. Telephone
. Postal service
. Electricity

3.2 HEALTH AND HEALTH RELATED INDICATORS

. Infant mortality rate
. Under 5 mortality rate
. Maternal mortality rate
. Life expectancy at birth
. Crude death rate
. Crude birth rate
. Fertility rate and pattern
. Adult literacy rate
. Primary school enrollment ratio by sex
. Proportion of population with safe and adequate water supply

3.3. HEALTH SERVICE

Distribution of health institutions

.Type
.Type of service
.Number of beds by type

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Distribution of health personnel

.No. of doctors by category
.No. Nurses by category
.No. of technicians by category
.No. of Auxiliaries by category

Morbidity and Mortality

.Ten leading causes of illness
.Ten leading causes of death

Health budget of the area

.Proportion to total budget
.Proportion of supplies in relation to total health budget
.Ratio of budget allocation in relation to morbidity and mortality

Level of care (Referral system)

.Type of referral system
.Catchment area and population

3.4. STATUS OF HEALTH PROGRAMMES (& ESSENTIAL ELEMENTS)

3.4.1 HEALTH EDUCATION

.Percentage of population attending health education sessions

.Number of sessions per month
.Topics frequently covered during sessions
.Regularity of program
.Indications of behavioral changes

3.4.2 MATERNAL AND CHILD HEALTH/ FAMILY PLANNING

.No of antenatal care per week
.Proportion of women receiving family planning services
.Proportion of mothers assisted by trained personnel during delivery
.Proportion of pregnant women who received TT immunization
.Proportion of children who received child care
.Proportion of children who received ORS for diarrhoea
.Proportion of children who had their growth monitored
.Proportion of children treated for ARI

3.4.3 IMMUNIZATION

.Number of children under the age of one year in the area
.Number of static and outreach sites with catchment population

Proportion of children who are:

1. fully immunized
2. partially immunized
3. not immunized
4. with DPT3 immunization

3.4.4 WATER AND SANITATION

.Water supply by type of source.
.Proportion of population with safe water supply (urban and rural)
.Number of springs (protected and unprotected)
.Proportion of population with proper excreta disposal
.Availability of waste disposal system (rural and urban)

3.4.5 NUTRITION

.Type and amount of crops available
.Type of staple diet
.Weaning practices
.Major nutritional health problems

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3.4.6 CONTROL OF LOCALLY ENDEMIC DISEASES

eg. Malaria Control
Leprosy Control
Tuberculosis Control
Blindness Control etc..

3.4.7 ESSENTIAL DRUG SUPPLY

.Ten top drugs consumed
.Budget allocation to essential storage and buffer system of drugs.
.Availability of vital and essential drugs
.Existence of pharmacy and therapeutic committee, and
.Overall drug supply management system

3.4.8 TREATMENT OF COMMON PROBLEMS

.List of major common problems
.Availability of poly clinic services
.Availability of drugs and supplies for common problems

4. METHODS OF INFORMATION COLLECTION

4.1 REVIEW OF REPORTS

.Health reports eg. M.O.H. directory of annual reports of regions
.Administrative reports
.Sector reports eg. M.O.A, M.O.E.
.Demographic reports eg. C.S.A.
.U.N. agencies eg. UNICEF, WORLD BANK etc...
.Published works (researches)

4.2 DISCUSSIONS

.They should be held regularly with:
. Health workers
.Government representatives

.Community leaders
.Religious leaders etc...

4.3 OBSERVATIONS

.Especially types of infrastructure
.Health institutions
.Health related institutions eg. schools

4.4 SURVEYS

Only if additional information is required!!

5. ACTION PLAN

Steps to consider while drawing an action plan

.Description of the problem
.Target to be achieved
.Strategy to be used to achieve the set target
.Activities to be performed
.Resource requirement and source
.Time frame
.Monitoring and evaluation mechanism

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Preparation of Plan of Action

One major component of the sub-national workshops was the preparation of plans of action for each zone. This was undertaken jointly by health workers of NGOs and RHBs in each region or zone, as the case might be.

The exercise was meant to help:-

a. establish basic data about each zone
b. identify the human and material resources of each group
c. review the status of CDD/ORT programmes in each region (zone)
d. set objectives, identify targets, map out strategies, and define activities needed for meeting the MDGs in the time frame specified.

These exercises took place towards the end of the programmes, after theoretical presentations by resource people. This was so arranged, because participants had by then not only been better a quainted with the programme, but also with each other. Based on a guideline that co-organizers of the programme provided, each region and zone in each sub-national workshop prepared its own action plan.

Participants found the exercise most interesting and helpful, not only because it helped streamline efforts, but also because it set a good precedent for collaborative efforts in the future.

The outcomes of the said exercises are not reproduced here, mainly because most NGOs pointed out they did not have the basic data essential to prepare a realistic plan as they had not been advised of what was expected of them in advance. The exercise went on, nevertheless, as it was felt that they could use approximate figures then, and change them with realistic ones later when they would meet for preparing their respective zonal plans of action. It should, however, be noted that all NGO participants have committed themselves to the MDG of 80% EPI/ORT coverage.

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Discussion

1. General

In the discussions held in the sub-national workshops, although issues particular to each region or part of the country were raised, participants, on the main, focused on issues of common concern to all.

Although participants were drawn from diverse areas with significant cultural differences, the very fact that they work under more or less similar circumstances, and in similarly remote rural areas, with people of similar economic background, i.e., mostly GRCs - helped them adopt a common language, identify common problems, and seek common solutions with relative ease.

The main trust of the points raised had to do with the need to encourage intersectoral collaboration between the major actors involved, and streamlining efforts with a view to achieving the MDGs within the short time left to them.

2. Specific

Some of the major points raised were:

Incentives for Vaccination

It was reported that some NGOs used the provision of supplementary food as incentives. As such, although mothers should have flocked to the health centres because they were convinced of the importance of the EPI/ORT treatments, they came primarily because of the incentives. This created a dependency syndrome, and worked against sustainability. Government representatives indicated the need for doing away with incentives as they might create animosity and bring about unnecessary competition between those that resort to such measures and those that don't.

Micro Planning

Each region will have to plan for itself by taking into account its own problems, as well as potentials and resources. UNICEF, it was said, would provide matching funds to the Government, and give financial and material assistance to and through the Government.

On the other hand, as NGOs had not participated in the micro planning meetings held a few months before the workshop they pointed out that they felt their participation in the implementation process was not envisaged at the outset. It was, therefore, suggested that it would be better if another meeting was to be organized to accommodate their views and facilitate their participation.

The UNICEF representative, however, indicated that although NGOs did not participate then, the plans were prepared with the understanding that NGOs will help in the implementation of the programme. They, he said, are expected to play a major role, especially with their outreach programmes.

It was, at the same time, indicated that NGOs would find it difficult to participate effectively in the preparation of plans of action for their zones, as they had not been informed before hand as to what was expected at the workshop. In response, it was

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indicated that if both sides could agree on the broad outlines, they could work out the details at a later stage.

Supplies for NGOs

As per the usual practice UNICEF has been giving the material needed for the implementation of the EPI/ORT programme to the Government. So far, NGOs have not benefitted from UNICEF's donations. NGOs, therefore, indicated the need for getting adequate quantities of essential supplies on time.

While representatives of regional governments expressed their willingness to share supplies and work together, the UNICEF representative indicated that they would do everything in their power to foster and encourage a cooperative working relationship between the major actors involved.

Delay in the delivery of funds and materials

This, as some government health institutions pointed out, served as a major hinderance factor. One UNICEF representative explained that one major problem in this regard was that most had not settled accounts of earlier made advances. Regulations, he said, are such that new funds can not be disbursed up until such time as accounts of earlier advances are settled.

Manpower shortage

NGOs need to train some more health assistants to implement the EPI/ORT programme effectively. But, they were not invited to send participants when government agencies conducted such training programmes. They, therefore, suggested that it would help if regional health bureaus assigned quotas to NGOs in order to satisfy the training needs of NGOs in their respective areas.

Coordination and Collaboration

There exists a problem of coordination between the centre and the regional administrations on the one hand, and the regional administrations and the zones and woredas on the other. A problem of cooperation also exists between government agencies themselves on the one hand, and governmental and non governmental organization on the other.

In so far as the EPI/ORT programme is concerned, however, the initial steps taken by the co-organizers have been heartening as such and bode well for the future, as it would encourage the taking of similar measures in other areas of cooperation too.

Government/NGOs Cooperation

It seems both sides, at times, miss the fact that they work to promote the interests of the same region and people. What is so saddening to note here is the fact neither side seems to appreciate the importance of coordinating and streamlining efforts. Each might get its funds from different sources, and work in different zones of a region, but the fact of the matter remains that they both serve the same people.

The Government, both sides agreed, is finally responsible for the administration of the region. NGOs, it was said, are there mainly to assist and complement the efforts of the Government. This, however, need not be construed to mean that NGOs would not take initiatives. They could and should take the lead if the need arises and the situation warrants such an action. But both sides should realize that they should avoid competition, and duplication of efforts. They should in fact get together more often, and work towards avoiding misunderstand-

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ings, and seek ways and means of planning together in a manner that would enable them to divide areas of coverage, share responsibilities, and supplement each others efforts. They should also devise ways of maximizing the outcomes of available resources. The Government, it was said, should take the lead in such matters.

It was, at the same time, pointed out that division of areas of coverage would not be a major problem as NGOs mainly work in remote areas.

With regard to the implementation of the EPI/ORT programme, it was pointed out that the Task Force at the national level will facilitate cooperation between the two sides.

UNICEF/Gov't/NGO Collaboration

UNICEF's mandate is to work with the Government, but that mandate has been extended to cover cooperation with NGOs. As such, financial and material assistance will be given either directly or through the Government.

Intersectoral Collaboration

Those in inaccessible areas suffer from the lack of important services. It would, therefore, be essential to plan with other ministries and agencies on how best to tackle the problems jointly.

Integrated service

It was suggested that the implementation of EPI/ORT could be realized more easily if it were to be delivered as part of a package that also contains relief, nutritional activities, and growth monitoring services.

Time constraints

In Ethiopia, EPI was launched in 1980. The original idea was to make a 10% progress each year, and attain 100% coverage by 1990. However, in 1994, only 37% coverage was attained. So a new target that aimed at achieving an 80% coverage by 1995 was set.

This was why the national sensitization programme was launched in April 1994. By the time the Awassa sub-national workshop was conducted, there, as participants pointed out, were only 272 days left to achieve the MDGs. If one took off weekends and holidays, then we would be left with 181 days, or 6 months. This, it was said, would make the whole plan a bit too ambitious. It was, nonetheless, agreed that it would be better to aim high and strive hard to approximate if not achieve the goal, rather than revising the expected coverage rate at such a late stage.

Sustainability of 80%

Even if the 80% coverage could be attained in the short time left, it, some said, would be impossible to sustain it. The answer was that if the bigger problem of achieving 80% could be solved, then sustenance won't be that difficult. This can be done by ensuring that there are adequate static and outreach sites in a proportion of one to five, i.e., one static site will have five outreach sites.

Communication

In this regard, it was pointed out that:

- Health workers should go to the community and not wait for community members to come to them.

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- Health assistants that go to outreach areas need to employ various means of attracting the attention of the public as they try to convey essential health messages. It would help greatly if they were to use audio visual material more often, and resort to theatrical presentations.

-Health workers might not become communicators. But they can bridge the gap by enlisting the support of community and religious leaders and providing them with essential information. They can then pass the message from the various fora they have easy access to.

-Health workers need to be motivated.

Attitudinal change

Health workers need to work slowly, methodically, and patiently to bring about the required attitudinal change. We can not expect to bring about the desired change over night.

Distribution of NGOs

As the major concentration of NGOs is in the South, it was suggested they be encouraged to work in other areas too.

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Recommendations of the Sub-national Workshops on EPI/ORT

1. Participants of the workshop applauded efforts made with a view to bringing together the various actors involved in the implementation of the MDGs, and indicated that they would appreciate the establishment of a forum that would further enhance such cooperation and collaboration at the national level. The establishment of similar fora at regional, zonal, and woreda levels could follow.

2. Government representatives, while expressing their appreciation for the role played by NGOs in achieving developmental goals in general, and improving health services in particular, they, at the same time, underlined the need to exert more effort to achieve the MDGs.

3. Participants also emphasized the need to strengthen intersectoral collaboration between all the actors involved - i.e. UNICEF, the Government, and NGOs. The task force at the national level should devise a framework for collaboration. It was also pointed out that governmental and non governmental organizations should try to work out problems that might exist between them through regularly held discussions.

4. Attempts should be made to avoid duplication of efforts in order to save time, money and maximize output. It would hence be essential to plan and implement together and act in a coordinated manner. It might even be necessary to divide areas of coverage.

5. The need for immediate resource mobilization was stressed in view of the little time left for successfully implementing the programme within the time frame envisaged at the outset.

6. In the case of Region 2, means of keeping track of the movement of the nomadic people with a view to planning immunization programmes around their migratory patterns, need to be deviced.

7. The need to share information and resources between government agencies and NGOs is deemed most essential.

8. Adequate, continuous and timely flow of resources should be secured at all levels of health units.

9. It was at the same time indicated that attention needs to be given not only to the provision, but also the maintenance of equipments.

10. The need to strengthen the human resources capacity of the regions was highly emphasized. The need to increase the quota allotted for the training of non-certified practical health workers among the NGO staff was also highly stressed. CRDA and other NGOs with training capacities were also called upon to train practical health workers.

11. On the job training should be given regularly to health professionals that work at grassroots levels. They should also get incentives.

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12. Training of TBAs and CHAs as EPI/ORT agents would help achieve the goal faster and much more easily.

13. While the importance of enlisting the support of the community through a strong I.E.C. program was underlined, the need for the use of animators and social mobilization measures was also strongly emphasized.

14. The importance of equipping frontline workers with communication skills was also underlined.

15. Including health education and communication skills in the curriculum of health workers' training institutions, with special emphasis on the judicious use of I.E.C. components, was deemed most essential.

16. Enlisting the support of religious and community leaders as well as opinion makers was also said to be of the utmost importance.

17. The need to use the regional radio stations of MoE for I.E.C. purposes was also stressed.

18. Conscientize students about the importance of EPI/ORT programmes, and encourage them to pass on the message to families and friends.

19. It was recognized that the non-participation of NGOs in earlier micro planning exercises was an oversight. Similar future micro planning exercises should be carried out with the full participation of NGOs in their relevant areas. In order to redress the oversight, it was felt most essential that the 1995 micro plan be reviewed for NGO input and joint activities within the next month.

20. Specific situations of zones and woredas should be given due consideration in planning EPI/ORT programmes. Bottom up approach should, therefore, be encouraged and further strengthened to ensure local community support.

21. All future planning exercises should have more detailed guidelines on background information needs, and their timing should be carefully planned.

22. Whereas attaining the 80% goal could prove difficult, sustaining the 80% coverage might require a much more exerted effort. It would, therefore, be essential to devise a strategy to assure the sustainability of the 80% coverage, and plan for activities beyond 1995.

23. While quarterly review meetings need to be jointly organized by CRDA, MOH, UNICEF, and RRC to assess progress made towards achieving MDGs, supervision, monitoring and evaluation exercises should also be undertaken regularly.

24. While deploring the negative association of incentives by those that use them in such a way and a manner, it was at the same time indicated that the integrated activities of NGOs in areas of relief assistance, and provision of supplementary food etc. should be encouraged rather than discouraged.

25. NGOs and other health institutions that have not attended these workshops be contacted by the respective RHBs with a view to enlisting their support in achieving the MDGs.

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List of Participants
CRDA - UNICEF Workshop - Awassa
April 3-5, 1995

No.	Name	Organization
1.	Almaz Merdekios	North Omo
2.	Desalegn Gullo	KAT
3.	Deneke Necha	Hadiya Zone
5.	Fekadu Kumi	Alaba
6.	Shiferaw H/Mariam	Koffecho
7.	Tesfaye t/Micheal	Yem Special W.
8.	Tilahun W/selassie	Shekicho Zone
9.	Tadele Bekele	Dodolla/Bale
10.	Mekonnen Janka	Geresse N/Omo
11.	Getu Workie	Maji Special W.
12.	Abebe Zeberga	Bench Zone
13.	Gebeyehu Ketsela	Amaro Special W.
14.	Temesgen Zewdie	Homecho - Hadiya
15.	Sebsibe Gorfie	Amaro Special W.
16.	Adnew sayorie	Gemedo
17.	Tesfaye Mamecha	Tonto
18.	Wolde Beyene	Awassa
19.	Rowualda Ratti	Fullasa
20.	Dr. Meletezega Zeggie	Tenticha
21.	Sr. Laura Gemignani	Galcha
22.	Sr. Lythi Duili	Shafina
23.	Dana Sefa	Awassa
24.	Seifu Bezuneh	Awassa
25.	Marta Gabisso	Bushullo
26.	Adelaydie Muhur	Dengora
27.	Belaynesh Abebo	Wolaita Sekie
28.	Melkenesh Ketema	Negele/Borena
29.	Luchiana Adhanom	Galcha/Borena
30.	Senait Filipos	Awassa
31.	Ojulu Okhekach	Gambella/Pokow
32.	Alemayehu Tekle	Checha/Guragie
33.	Belayneh Kamie	Arbegona/Sidamo
34.	Miftah Atey	Wolkittie/Guragie
35.	Tamiru Berisha	Konso Special W.
36.	Tadesse Bontoche	Yirgachiffie
37.	Geremew Otiso	Hagereselam
38.	Yacot Dika	Bensa/Sidamo
39.	Chubero Wana	Arbaminch

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40.	Kussie Kushushu	Woito Clinic
41.	Kekebo Debeko	Gidole
42.	Mulugetta Mamo	Waka
43.	Belaynesh Gelgelo	Alta Wondo
44.	Angelo Okelo	Gambela
45.	Kiro Abala	Gambella/Gilo
46.	Okelo Akuaye	Gambella
47.	Woletji Terfa	Gambella
48.	Demozie Firdie	Awassa
49.	Asaminew Godana	Gobezie/Gidolie
50.	Sahle Sita	South Omo
51.	Mekonnen Admassie	Arbegona
52.	Mesfin Kassaye	AAU
53.	Fisseha Masresha	CRDA
54.	Fekade Tsegaye	CRDA
55.	Agonafir Tekalegn	CRDA
56.	Asaye Mitiku	CRDA
57.	Adanetch Tadele	Woteresa
58.	Ayalew Tadesse	Woteresa
59.	Getachew Tesema	Gedeo/Dilla
60.	Almaz Leza	Duramie/KAT
61.	Theresa Fernandes	Jajura-Soro/Kat
62.	Ayelech Michael	Wassera/KAT
63.	Kebebush Kandido	Shinshicho/Kat
64.	Shiferaw T/Mariam	Regional Health
65.	Demissie Bubamo	Awassa
66.	Alemayehu Bossie	Burji
67.	Iticha Dana	Derashie
68.	Terssie Geresu	Dongola
69.	Helen Tennelle	Bushulo-Sidamo
70.	Monica Reeves	Gosa-Borana
71.	Kassahun Negash	Awassa
72.	Agnese Lee	Dilla
73.	Wondimu Aynew	Awassa
74.	Meseret Kidane	Awassa
75.	Makonnen Daka	Awassa

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List of Participants
Sub-national EPI/ORT Planning
CRDA - UNICEF Workshop - Nazreth
April 10-12, 1995

No.	Name	Organization
1.	Rupelin Gorospe	Seventh Day Adventist
2.	Azene Basha	Region 13 Health Bureau
3.	Mengesha Regassa	EECMY/WS AIRA Hospital
4.	Margaret G/Mariam	Finnish Mission
5.	Almaz Damena	S.M.A.
6.	Deldmo Dalechu	S.E.S.
7.	Fekade Bayisa	MOH
8.	Tekelay Ijigu	EECMY
9.	Edelian F. Glulera	M.C
10.	Adele Zerihun	Comboni Sisters
11.	Zafu Mosazghi	Comboni Sisters
12.	Gudeta G/Mariam	MOH E/Wellega
13.	Mulatu Raaree	MOH W/Wellega
14.	Wubitu Antonio	MOH/Arsi
15.	Alemu Kebede	MOH/ZH.D
16.	Alemu Mekonnen	CPAR
17.	Eyob Kamil	MOH
18.	Victor O.Cole	UNICEF
19.	Luula M. Mariano	UNICEF
20.	Abdul Hamid Ossman	MOH
21.	Abdella Assefa	Region 4
22.	Mohammed Ali	MOH
23.	Reta Belete	MOH
24.	Hana Mekonene	EECMY
25.	Haimanot Hunduma	EECMY
26.	Endalew Megersa	EECMY
27.	Tamiru Dafa	A. Acadam i Wellega
28.	Awel Shehisso	Jimma Zone
29.	Gurmessa Abdi	G.A. Hospital
30.	Tenagne Kebede	DAY
31.	Girma Kebede	GOAL
32.	Adeba Tasissa	Catholic Church
33.	Mary Hefferman	Catholic Mission
34.	Obsee Ocato	MOH
35.	Almazneh Goshu	Zone Head Office
36.	Yasin Nur	Killil Afar

CRDA

37.	Aynalem Abraha	Shebe Health Centre
38.	Tsegaye Hailemariam	Zone 5 H/D/R.14
39.	Tsedeke Teloro	R.5. H.13
40.	Samia Awel	M/C/H
41.	Yimegnushal Belay	Shebe Health Center
42.	Harar Abdulahi	Region 13 H.B
43.	Mulugeta H.Gebriel	NACID
44.	Alemu Tolera	EECMY-CES,IRDP
45.	Husein Boru	O.H.B.
46.	Haile Meskel Balcha	Oromia H.B.
47.	Adem Ibrahim	Oromia H.B.
48.	Raggasa Bayisa	ORCB
49.	Gidey Kassa	HCS
50.	Yohannes Guta	EECMY
51.	Beyene Assefa	ADAA
52.	Ayka Agena	EECMY
53.	Tadele Bekele	EECMY
54.	Temesgen Gadissa	EECMY
55.	Werati Sodi	EECMY
56.	Alebachew Debel	EECMY
57.	Abebech Basore	MOH
58.	Abdissa Wakjira	EECMY
59.	Tesfaye Yakob	MOH
60.	Tsegaye Kalo	MY
61.	Solomon Tesema	W/Shoa Zone H.D
62.	Addisu Gobena	7th Day Adventist Church
63.	Dawit Belew	Finnish Mission
64.	Sirkolem helisten	Finnish Mission
65.	Naji G/Mariam	Kilil 4 Zone 3
66.	Mekonnen Admassu	
67.	Mohamed Amin	AFAR
68.	Biaznelegn Yilma	S.Shoa Health Dept
69.	Gemechu Maremi	Oromia
70.	Habte Ejeta	EECMY
71.	Melkamu Shiferaw	Bethel Synod
72.	Gobena Dinku	EECMY
73.	.Mesfin Engidayehu	MOH
74.	Fekadu Mamo	EECMY
75.	Rosanna Bellando	ECS
76.	Cecila Puig	ECS
77.	Francisco Heyes	ECS
78.	Triscivzzi Isabella	NGO
79.	Sahilu Menday	NGO
80.	Mebrahtu Yihdego	NGO
81.	Tesfaye Adera	ADAA
82.	Belaynesh Debele	Zonal health Dep.

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83.	Eyob Tsegaye	Region 14
84.	Tesfaye Beyene	Region 14 H.B
85.	Alemante Afardew	FANA Radio
86.	Haile Meskel Balcha	Oromia Health Bureau
87.	Mergia Itcha	East Shoa Zone H.Dep.
88.	Tsedey Worku	MOH
89.	Telise Geleta	EECMY Bako
90.	Melkamu Shiferaw	Bethel Synod - EECMY
91.	Helen Cholay	UNICEF
92.	Dejene Tsegaye	MOH
93.	Emebet Goshu	Good Sheperh F.C.S.
94.	Warati Sedi	EECMY
95.	Margareth G/Mariam	ECS

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List of Participants
Sub-national EPI/ORT Planning
CRDA - UNICEF Workshop - Bahirdar
April 10-12, 1995

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3.	Asefa Cherinet	NACID
4.	Hassen Mohammed	Zonal Health Dept.
5.	Hadush G/Mariam	Catholic Churhc
6.	Temesgen Amlaki	N. Commend Hosp.(MCH)
7.	Wolde Dawit Damtie	North Gonder, ZHD
8.	Selam Bezabih	Easter Zonal
9.	Kissi Buli	Zonal Health dep.
10.	Yisihak Abraham	CONCERN
11.	Assefa Woyessa	Zonal health detp.
12.	Melisew Ayenew Fantahun	Relief & Rehab. Bureau
13.	Yaregal Ayesheshum	Relief & Rehab. Bureau
14.	Talefe Beyene	Zonal Health Dept.
15.	Worku Adugna	N. Shoa ZHD
16.	Moges Amdie	N. Wollo ZHD
17.	Eyayu Sibhat	W.H.H.D
18.	Gebre Mekonnen	MoH - ZHD
19.	Berhune Gidey	REST
20.	Haile Desta	MoH
21.	Samson Eyasu	MoH
22.	Hagos W/Selassie	MoH
23.	Shewatatek Lidetu	MoH - RHD
24.	Assefa Worku	MoH - ZHI
25.	Dereje G/Hiwot	Menseneu fish Mensun
26.	Amette Brant	EECMY
27.	Zebayel Baue	MoH - ZHD
28.	Menbere Shiferaw	FHI/Ethiopia
29.	Hiwot Abriham	MoH
30.	Isaias Merdassa	WVI/E
31.	Yoseph Agonafir	CVM
32.	Eyob Tsegaye	R.H.H.B
33.	Firdawok Asfaw	R. 3 N/Shewa
34.	Abraham Olana	WVI/E
35.	Bashaye Taffese	SCF/UK
36.	Berhanu Bekele	H. Bureau
37.	Assefa Abera	Relief & Rehab. Bureau

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38.	Elias Senbete	Relief & Rehab. Bureau
39.	Mekonnen Admassu	MoH
40	Fekade Tsegaye	CRDA
41.	Yalem Fiker Hika	MoH
42.	Asnakew Yigzaw	RHB
43.	Fisseha Masresha	CRDA
44.	Haileyesus Flatie	MoI
45.	Kassahun Asheber	-
46.	Bekele Teferra	SCF/UK
47.	Belaynew Moges	RHS
48.	Gebre Asmamaw	-
49.	Belaye	MoH
50.	Umer Mohamed	RIB
51.	Mustefa Yesuf	Gonder ZHD
52.	Berihun Kebede	RHB (Bahir Dar)
53.	Mussie G.Giorgis	Health RHB (Dessie)
54.	Awoke Alemneh	Health RHB (W. Gojjam)
55.	Melake Guenet	SCF/UK
56.	Gerawork Eskindir	RHB (N. Wollo)
57.	Seid Ali	RHB (Kemisse)
58.	Getahun Buzuneh	RHB (N. Shoa)
59.	Ayalew Debash	RHB (Sekota)

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