Access to Health and Education Services in Ethiopia

Supply, Demand, and Government Policy

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Fra von Massow
Research team leader

Glossary

Almaze	a skin disease which can become acute
ANC	antenatal clinic
Ato	the term used for 'Mr'
Baldi	a bucket with a capacity of 20 litres
Bega	the dry or sunny season
berberri	hot pepper spice
birrd	a generic term for colds, rheumatism, and chest problems
bonesetter	a traditional physiotherapist who specialises in fractures
buna bet	coffee shop
'chat	an addictive stimulant, consumed mostly by men, who chew the leaves of this plant
damakesse	a herb commonly used for practically all types of ailments
debtera	a churchman, trained for the priesthood, who treats the sick by writing some script on a piece of paper and scrolling it into a very small piece, which is then sewn into a small piece of cloth to make it into a charm that the sick person wears on his/her neck by suspending it on a piece of thread. The *debtera* is believed to have the ability to make somebody sick by using the same ritual.
Derg	the commonly used name for the regime of Mengistu Haile Mariam which ruled Ethiopia following a popular revolution which unseated the government of Emperor Haile Selassie in 1974
DPPC	Disaster Prevention and Preparedness Committee
EC	Ethiopian Calendar
ENT	ear, nose, and throat
EPI	extended programme for immunisation
EPRDF	Ethiopian People's Revolutionary Democratic Front
FGD	focus-group discussions
FGM	female genital mutilation
FP	family planning
Ginbot	May
gote	a village of 70-100 households. There are between five and eight *gotes* in one Peasant Association
Hamiley	July
Harafar	a Muslim holy day
Hidar	November
idir	a community savings club for the eventuality of a death or marriage in the community
IEC	Information, Education, and Communication
injera	a national staple: a flat pancake made with *teff* (a local grain), barley, or sorghum. It is typically eaten with a spicy sauce or stew.
Kebele	the administrative unit which provides a link between the urban government administration and the community. *Kebele* leaders were local party members, elected by the community, during the time of the Derg. They are now appointed by government as state employees.
Kerray	informal savings association for weddings, funerals, and religious festivals
Kerray Abatoch	the Elders of the *Kerray*, who meet to plan important community activities and to solve serious crime and local disputes
Kiremt	winter
'kolo	roasted barley or maize grain
MCH	mother and child health
meda	open fields
Megabit	March
Meskerem	September
Miazia	April

MoA	Ministry of Agriculture
mogne bagenge	a common illness whose treatment requires a surgical incision
Nehassey	August
NGO	non-government organisation
OPD	out-patients' department
Peasant Association (PA)	the link between community and development or local government administration, with an organisational structure down to village level
PNC	postnatal care
PRA	participatory research and action methodology which has its origins in 'Participatory Rural Appraisal'
PTA	Parent Teacher Association
RTI	respiratory-tract infection
samba	lungs
SCF	Save the Children Fund
Sene	June
shamma	a white hand-woven shawl worn by most women
shurro	a sauce made with finely ground chickpeas
STD	sexually transmitted disease
streetism	the trade practised by young female sex workers
suk	small corner store
Tahissas	December
TBA	traditional birth attendant
tella	beer brewed locally from barley or wheat
TGE	Transitional Government of Ethiopia
Tikmt	October
Tirr	January
TPLF	Tigranian People's Liberation Front which, together with Eritrean forces, overthrew Mengistu's regime in 1991
tsebel	treatment at holy waters
TTI	Teacher Training Institute
TTBA	trained TBA
VCH	Voluntary Council for the Handicapped
Weziro (W/ro)	the term used for 'Mrs'
WFP	World Food Programme
WIBS	Woreda Integrated Basic Services, a UNICEF-funded programme including education, health, and water and sanitation services
wogeisha	traditional physiotherapists who are particularly used for setting bones after a fracture
Woreda	urban administration
Yekati	February
zabanya	a guard or night watchman

Executive summary

This report presents the findings and recommendations arising from a research and advocacy project initiated by Oxfam GB. The field study ('the micro research') took place in Ethiopia in the three months January to March 1999; the analysis of political and economic factors ('the macro research') was conducted in November/December 1999. The four study sites were selected to represent the diversity of traditions and culture, and livelihood structures, in Ethiopia. They included Cherkos, a slum area in the city of Addis Ababa; Delanta, the highlands of North Wollo (Amhara); the highlands in Eastern Hararge (Oromo); and the lowlands of Jijiga, Somali Region. Four detailed site reports were produced, closely reflecting the experience and views of the participants, and their perceptions of how the provision of social services, and their access to it, had changed over the past few years. Edited summaries of findings in four sites are given in individual case studies as appendices to this report. (There were five case studies in all; the first site selected in Jijiga had to be abandoned after two days, but sufficient information was gathered to merit a short case study, not reproduced here.)

A total of about 500 men, women, girls, and boys participated in the research. The research team comprised nine men and women, and more than 50 people were involved in co-ordinating and implementing the research. In single-sex focus groups of youths and adults, participatory research tools were used, including mapping, poverty ranking, seasonal calendars, and matrix ranking to explore health-seeking behaviour and the quality of health and education services, and Venn diagrams. The team was especially impressed with the information gathered from youth groups – with their level of knowledge, awareness, and openness. They made valuable recommendations for improving access to and quality of education and health services. In each site, individuals (70 per cent of them women) from 35 households were interviewed, having been identified during the mapping and poverty ranking as representatives of a range of groups: the worst-off, those of medium rank, and the better-off. Providers of health and education services, both professional and traditional, were also interviewed.

The field study demonstrates the definitive interconnections between livelihoods, income, food security, and access to health and education services. It mirrors and compares the realities and problems faced by service users with those confronting service providers. It is intended to be useful to those planning and programming projects at local level, and to inform policy and planning at regional and federal government levels, and campaigns at national and international levels for the relief of unpayable debt and increased investment in human development – the planning of which should take into account the views of the poorest women, men, and youth.

Main issues emerging from the four sites

- Populations are increasing; resources are static or diminishing.
- All households have become poorer because of drought, lost harvests, and dying livestock, and in the Addis Ababa site because of a huge loss of jobs among members of the armed forces.
- Increased poverty and loss of livelihood base (the male head of household's main source of income) have increased the workload on women in particular, and on girls and boys.
- There are few productive alternative sources of income, apart from selling firewood and petty trading.
- With the exception of Metta, traditional institutions, the church, and traditional practices are widely prevalent in the absence, or minimal presence, of external government or donor organisations.
- Women, their experience and concerns, are under-represented in all forums.
- In all sites, external donor presence was minimal, and some donors had stopped funding immunisation services, for example, without ensuring a replacement source of funds.

- In Jijiga, the site was devoid of any donor or government presence, no children went to school, and most of the adults were illiterate and felt completely disempowered.

The research identified numerous barriers to people's access to good-quality primary education and professional health-care services.

Supply-side barriers

- There are insufficient schools and health centres to cater for the potential demand.
- Existing facilities are under-funded, ill-equipped, and lacking in basic requirements: books, furniture, water and sanitation in schools; equipment and medication in health facilities.
- Staffing in existing facilities is inadequate, and the health and education services are short of qualified personnel.
- Services are based too far from the rural population; the majority of users are urban.
- Outreach services, and health and reproductive-health education services, are under-funded and under-staffed.
- There is evidence of schools providing some education on environmental health and reproductive health.
- Traditional birth attendants (TBAs) in the sites visited have no access to training or medical kits.
- Herbalists (many of them men) have no dialogue with medical professionals.
- Both TBAs and herbalists tend to be elderly by Ethiopian standards (aged 60+).
- Few people have access to the system of exemption from health-care fees, and many do not know about it or how it works.

Demand-side barriers

- Most people are too poor to meet the costs of education, which include food, clothes, uniforms (in Addis), exercise books and pens, and soap; and the costs of health care: transportation, fees, medication, nutritious food, bribes to guards, and lodging.
- Children are too hungry to go to school; many are sick with diarrhoea and other malnutrition-related diseases, and have no clothes; others leave school when there is not enough cash to buy an exercise book.
- Adult illiteracy is high, and an understanding of the value of education among parents is said to be low. Illiteracy also affects access to health services and other government institutions.
- Most worst-off households (the majority in each site), especially women, go to traditional healers or holy waters first, and seek professional advice only when their problems are very serious.
- The proportion of men using curative services is marginally higher than the proportion of women using them; preventative services are mostly used by women.
- Health education and reproductive-health education do not reach men and young people.
- Rural women use outreach services if the services come to them, but they tend not to attend clinics that are too far away from their homes.
- Most women and girls give birth in the villages without a trained attendant: health centres/hospitals are too far away and too expensive.
- Sending children to school competes with the need for girls' domestic labour and girls' and boys' income-generating activities, including traditional roles in herding and agriculture.
- Boys are given preference over girls when families have to make choices about schooling, most markedly in the Muslim communities of Eastern Ethiopia.
- Girls lack support, and their lives are at risk from circumcision, female genital mutilation, early marriage and early pregnancy, and a heavy labour-intensive workload from an early age.

The official policy context

The government's policies on health, education, population, HIV/AIDS, and women's status all contain elements that purport to respond to concerns expressed in villages and by first-level service providers. But the needs of the poorest households and the demands of service providers, especially in terms of health education, reproductive-health education, and environmental health, do not feature prominently in the policy documents and cannot be met by the currently low budgetary allocations for non-salary recurrent costs, and with existing staffing and logistics capacity. Investments in improving staff training and development, and a significant improvement in logistics and management capacity would have to be made by the government and the international donor community, in order to work towards achieving the human-development commitments made to the poorest.

The gap between policies and demand is matched by a gap between policy intentions and the ability of existing government structures to implement them under current resource constraints, both human and financial. The process of transition to a federal state with increased local government autonomy is suffering from a low level of local planning, management, and budgeting capacity. Ethiopia's capacity to raise financing for social-sector development cannot begin to cover the cost of expanding health and education services and consolidating existing ones, which are very depleted. Ethiopia is committed to covering 55 per cent of its total budget for health, and 73 per cent of the total education budget, from domestic resources; but with 65–85 per cent of the population living below the poverty line, the state's capacity to raise local taxes is limited. At the same time, Ethiopia is crippled by external debt, and the interest payable on it (debt constituted 159 per cent of GNP in 1997; and while 0.9 per cent of GDP was spent on health, 2.3 per cent was spent on repayment of interest in the period 1991-97).[1]

There are demonstrable links between the low status of women and increasing population growth, infant and under-five mortality, and children's poor health and education status. Maternal mortality rates in Ethiopia are among the highest in the world, and fertility rates are 6-7 children per woman. All social-sector policies emphasise the need to change attitudes towards women and to recognise their contribution to development; but laws inherited from the past inhibit the widespread distribution and use of family-planning methods, allow for marriage at 15, and prohibit abortion.

At least 70 per cent of women and 60 per cent of men are illiterate. Illiteracy is an impediment to participative democracy and local accountability. As a result men, responsible for their communities through traditional structures, feel impotent to seek assistance or take action to improve the condition of their families. Women are under-represented in all decision-making forums. Oxfam's research does not indicate that there will be a significant improvement in the educational status of the next generation, particularly in rural areas. The worst-hit areas are agro-pastoralist communities such as Jijiga in Somali region, where an estimated 88 per cent of children are not in school. Unemployment in urban centres and the insecurity of drought-affected rural livelihoods are resulting in increased poverty and hunger-related illnesses and deaths. Hunger and illiteracy are impediments to local initiative and action, despite the strongly expressed desire of women and men to work for real improvements in livelihoods and for the well-being of their families.

Summary of recommendations

Financing social-sector development

- To secure the confidence of donors and to increase accountability between government and grassroots communities, the government should design and implement a fully transparent standardised system of reporting income from donors, expenditures by region and sector, and recurrent and capital expenditures.
- Donors need to agree on the format and timing of budget reports, to avoid demanding different reporting procedures and time schedules.
- To release new resources for meeting health and education targets, the World Bank and IMF should demonstrate a stronger commitment to the HIPC initiative and write off or significantly reduce Ethiopia's debt stock.
- The World Bank, together with the government, should review the impact of the economic liberalisation policy on the reach of non-salary recurrent budgets, which are currently not succeeding in maintaining basic supplies, including essential drugs and textbooks, to the health and education sectors.
- OECD countries should increase the proportion of national income allocated to development aid. This will facilitate the release of increased financing for non-salary recurrent budgets for health and education, in order to improve the quality of service delivery and meet donors' renewed commitment to achieving human-development targets by the year 2015.

Management and accountability

- Implementation of policy and management of capital and recurrent budgets at all levels of regional government require training, support, and motivation of local government staff, with technical assistance provided by local and external consultants, as deemed necessary.

- Attention must be paid to gender equity in planning, managing, and allocating resources at all levels of government and social services.
- NGOs can be engaged (with official development assistance funding) to mobilise and train local government organisations and community-level institutions such as traditional representatives, respected women, and health and education committees (with an improved gender balance). Groups of women, men, and young people, representing different clan, religious, and age interests, should be encouraged to participate in shaping and monitoring the development of health and education services in their areas.
- To this end, adult literacy programmes for participative democratic involvement should be planned and budgeted for.

Expansion and consolidation of services

- There is a need to balance resources according to regional demand, for expansion or consolidation of health and education services. Expansion without an increase in non-salary recurrent budget expenditure for essential supplies, equipment, staffing, and staff training will not result in increased service provision. Some new health centres in Delanta were reportedly unused, because of the lack of staff and supplies.
- Expansion in health-service provision can best be achieved by responding to demands to take health care to the poor with outreach service provision. The outreach should be accompanied by increased funding for health and reproductive-health education and investments in food-for-work, water, and sanitation programmes, and it should involve both health and education personnel.
- Expansion in education provision requires regional and rural/urban differentiation; while the government concentrates on extending schooling to the poorest rural areas, it should encourage private-sector investment, for those who can afford it, in urban centres.
- Government capital expenditure should focus on under-serviced sectors such as agro-pastoralist communities, for example in the Somali region, and recurrent expenditure should concentrate on provisioning existing schools with much-needed basic materials and equipment.

Reproductive health

- Reproductive-health education must be prioritised in view of the high fertility rate; the prevalence of female genital mutilation, high-risk births, and early marriages; a growing incidence of HIV/AIDS; and a high reported incidence of sexually transmitted diseases, which tend to treated only (and then only partially) by men.
- A rapidly growing population will constantly undermine the government's efforts to extend social-service provision. Population growth needs to be tackled with a carefully considered programme, and treated as an issue of human rights and development.
- Family planning should be legalised, and communications media and local-level organisations should be involved in campaigns to raise public awareness. High fertility rates and high rates of maternal and infant mortality need to be significantly reduced.
- There needs to be interaction between the education and health services in tackling reproductive-health problems, increasing access to clean water, and improving sanitation, as well as highlighting the risks of harmful traditional practices and HIV/AIDS. Non-government organisations (NGOs) can play a strong supportive role with external funding.

Traditional medicine

- The government should invest in research into traditional practice, with a view to regulating bad practice and integrating valuable skills and resources into outreach services and service provision in health centres.
- The government should reconsider the benefits of training traditional birth attendants and integrating them into the formal health-care system, to provide a service at village level and refer high-risk cases to the local health centre in good time.

Drugs

- The government should draw up a standard list of essential drugs and equipment, taking into account the problems of reproductive health raised by many participants. Issues of reproductive health feature more prominently in Oxfam's research than in the official health statistics reviewed, because most interventions are managed in the traditional health sector, outside the government health