LIDETA SUB CITY HEALTH OFFICE

Three Years Health and Communication Bulletin (2009 – 2011 EFY)

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Contact Information: The editorial team is happy to receive comments and questions regarding the bulletin. For further information, please contact us with: E-mail- tare_ase@yahoo.com, Mobile- +251-921114201

FOREWORD

This Annual Health Statistical Bulletin presents activity reports of the 2011E.C. The main objective of this bulletin is to provide valuable information for assessing health status; health services utilization and health outcomes as well as providing program interventions for monitoring health sector performance. This information is important because it enables the health sector to plan for more effective and better targeted interventions.

Information indicated in this report is for 2009 to 2011EFY reporting period and hoped to provide performance of the sub city regarding health provision. Therefore, the woreda health offices (WHOs) and Health Centers (HCs) are encouraged to take this lesson of producing similar annual health bulletins at woreda and Health Center level so that detailed health facility level information is availed for informed decision-making.

In order to ensure that the quality of this data and its enhanced reliability, there is need to strengthen supportive interventions, Mentoring and Coaching already in place for the improvement of the quality of routine data at all levels of health care delivery.

I also wish to indicate that the use of this information either at facility, woreda or the sub city level is an invaluable aid in resource allocation at different levels. If utilized appropriately, the information provided here have the potential to enhance efficiency in planning, specially, allocation of resources, as well as development/planning of more appropriate interventions to diseases affecting our society.

In order to further strengthen publications of such reports in the future, any feedback on the contents or presentation is greatly appreciated and supported.

Finally, I would like to acknowledge Doris Duke Charitable Foundation and JSI through Addis Ababa University for its financial support to publish this bulletin and Lideta sub city Health Office staffs, specially Mr. Yosef Tsehaye (BSC, MPH) for his support in writing this bulletin.

Mr. Asefa Taresa Eticha (Bsc, BA, MPH/RH), Head of Lideta Sub City Health Office
E-mail- tare_ase@yahoo.com, Mobile- +251-921114201

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1. Introduction

Lideta Sub City is one of the 10 sub cities of the Addis Ababa City Administration located in the central part of the city. It is bordered by Arada sub city to the north, Kolfe Keranio sub city to the west, Kerkos sub city to the east and Nefas Silk Lafeto sub city to the south. The total area of the sub city is about 918.4 km². The Sub City has 10 Woredas. According to the 2009 EC census projection, the Sub City has a total population of 265,187 (127,290 male and 137, 897 female). The road network link between different sub cities, Mini Buses and City Buses are the main transportation system for the peoples and the train system also started service giving in the sub city. There are different hotels in the sub city managed by the private sectors.

The Ethiopian health system is structured in to a three-tier system with the primary care level comprised of Health Posts, Health Centers and Primary Hospitals, the secondary care Level including General Hospitals, and the tertiary care level of Specialized Hospitals. Lideta Sub City Health Office has emphasized health promotion and disease prevention by investing heavily in PHCUs over the last decade, constructing new facilities as well as upgrading them to the next level. As of 2011EFY, the sub city has reached over all primary health care coverage 86 % with a total of 6 health centers.

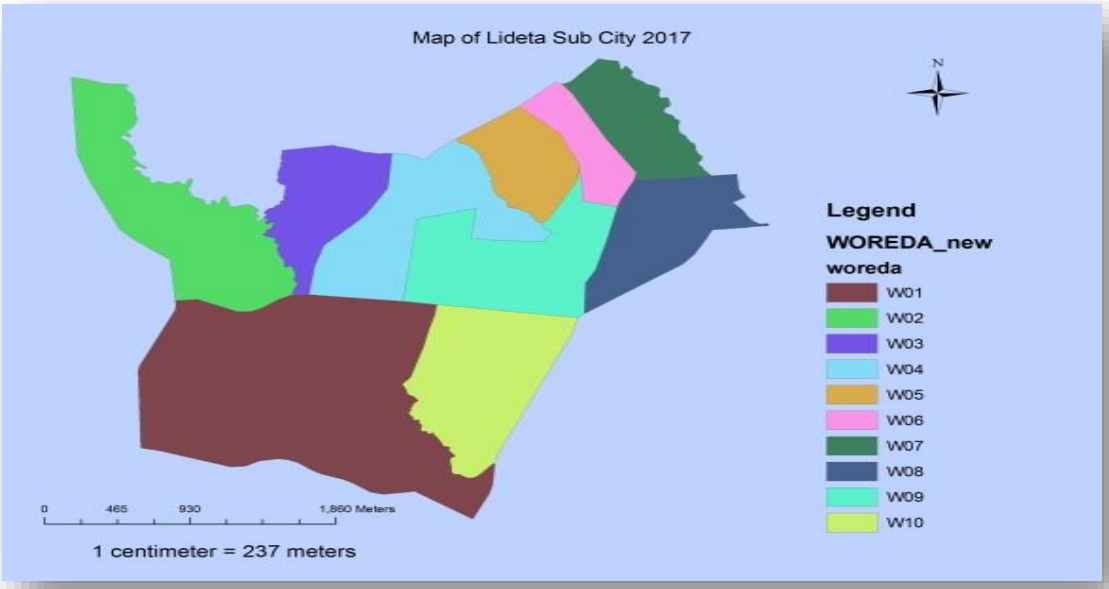

Figure 1:- Map of Lideta subcity; Addis Ababa, Ethiopia

2. Disease Burden

Disease burden is measured using the incidence and case fatality rates of any given disease. Disease incidence is defined as the number of new cases of a disease in a specific population over a period of time while case fatality rate is measured as total number of deaths from a specific illness out of the total number of cases admitted in a given health facility.

2.1 Major Causes of illness for all ages combined

Table 1 compares information on the top ten (10) causes of morbidity to health facilities for 2009, 2010, for all age groups combined. The two tables show that AURI is the leading cause of morbidity in Lideta Sub City, with an incidence rate of 30.12 per 1,000 populations in 2009, 32.06 per 1,000 populations in 2010. In 2009 and 2010, infection of the skin and subcutaneous was the second highest cause of morbidity and dyspepsia being the third highest.

Table 1:- Ten (10) Major Causes of Morbidity to Health Facilities (for all ages combined), Lideta Sub City, 2009 and 2010 EFY.

2009 EFC				2010 EFC			
Rank	**Disease**	**Freq.**	**%**	**Rank**	**Disease**	**Freq.**	**%**
1	Acute upper respiratory infections	48327	30.12	1	Acute upper respiratory infections	25488	32.06
2	Infection of the skin & subcutaneous	20175	12.57	2	Infection of the skin & subcutaneous	9503	11.95
3	Dyspepsia	14375	8.96	3	Dyspepsia	6952	8.74
4	Disease of the musculoskeletal system	13802	8.6	4	Urinary tract infection	8792	8.54
5	Urinary tract infection	12951	8.07	5	Disease of the musculoskeletal system	6298	7.92
6	Acute febrile illness	12855	8.01	6	Diarrhea (non- bloody)	5931	7.46
7	Diarrhea (non- bloody)	11401	7.1	7	Acute febrile illness	5258	6.61
8	Parasitic diseases	9211	5.74	8	Hypertensions & related diseases	5035	6.33
9	Trauma	8798	5.48	9	Parasitic diseases	4180	5.26
10	Hypertensions & related diseases	8574	5.34	10	Trauma	4068	5.12

3. Summary Report on Health Service Delivery and Quality of Care

One of the HSTP strategic themes is excellence in health service delivery and quality of care, which refers to the provision and management of curative, preventive, rehabilitative and emergency health services, and the promotion of good health practices (in personal hygiene, nutrition, and environmental health) at individual, family, and societal levels. It includes provision of maternal, neonatal, child, youth and adolescent health services and public health emergency services.

According to HSTP, the expected result will be a community that practices and produces good health, is protected from emergency health hazards, and has access to quality health care. Therefore, in EFY 2011 several activities were carried out to improve maternal, child, adolescent and youth health, nutrition, hygiene and environmental health services, and to reduce/combat HIV/AIDS, TB, and other communicable and non-communicable diseases.

3.1 Maternal and Child Health Services

3.1.1 Maternal health Service

This section presents information on key indicators of importance to maternal health and these include antenatal coverage, average antenatal visits, institutional deliveries, first postnatal attendance and new family planning acceptors. The health care that a mother receives during pregnancy, at the time of delivery, and soon after delivery is important for the survival and well-being of both the mother and her child. The reduction in maternal mortality has resulted from greatly improved coverage of the four primary maternal health services (family planning, ANC, institutional delivery, and PNC) in the last here years as seen in Figure1,there was an increment on CAR from 21% in EFY 2009 to 55% in EFY 2011. ANC coverage (at least four visits) increased from 60% in EFY 2009 to 100% in EFY 2011. Similarly, the percentage of deliveries attended by skilled health personnel increased from 44% to 54% in the same period and also PNC coverage increased from 8% in EFY 2009 to 50% in EFY 2011.

Prevention of Mother to Child Transmission of HIV

On the other hand, the proportion of pregnant women counseled and tested for the prevention of mother to child transmission (PMTCT) of HIV increased from 43% in EFY 2009 to 96% in EFY 2011 (Table 2).

Table 2 CPR, 4th ANC visit, Skilled Delivery, PNC and PMTCT coverage Lideta, Addis Ababa and National (EFY 2009-2011)

Services	2009			2010			2011		
	Lideta	Addis Ababa	National	Lideta	Addis Ababa	National	Lideta	Addis Ababa	National
CPR	21	36	71	15	35	70	55	54	
4th ANC visit	60	133	72	72	136	72	100	117	
Skilled Delivery	44	138	71	49	140	66	54	121	
PNC	8	45	82	30	119	77	50	112	
PMTCT	43	46	52	96	175	92	96	83	

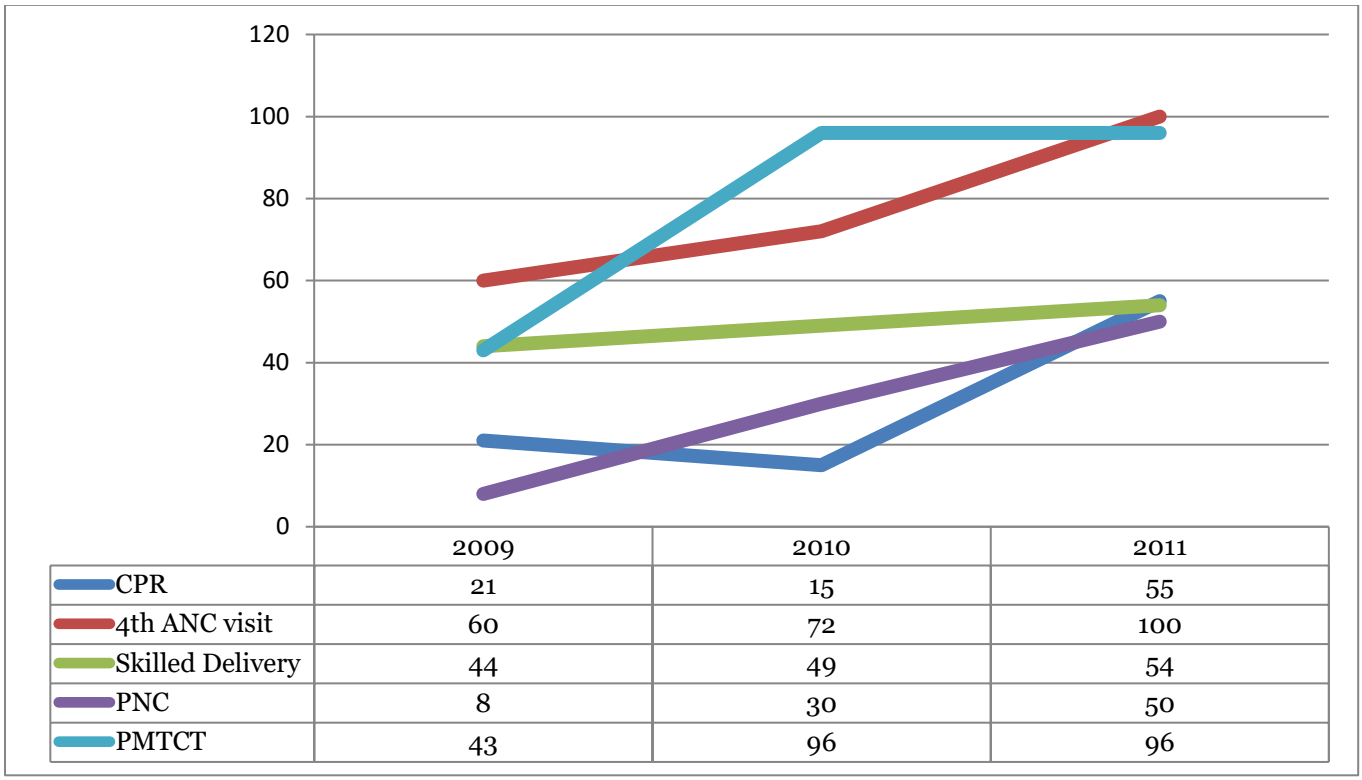

Figure 2:- Maternal Health Indicators in Lideta Sub City, 2009-2011 ETC

3.1.2 Child Health Service

Many early childhood deaths can be prevented by immunizing children against preventable diseases and by ensuring that children receive prompt and appropriate treatment when they become ill. This including strengthening routine immunization, expanding community and facility-based Integrated Management of Neonatal and Childhood Illnesses (IMNCI),

establishing newborn corners and Neonatal Intensive Care Units (NICU), capacity building on program management for child health services, strengthening HEP.

This section presents data on key indicators of importance to child survival. Information is presented on underweight prevalence and child vaccination.

Figure 3 shows data on the trends of immunization coverage. The figure shows that immunization coverage has been fluctuating during the period 2009 to 2011. There was an increment on Pentavalent 3 immunization coverage from 59% in EFY 2009 to 91% in EFY 2011. Measles coverage increased from 61% in EFY 2009 to 94% in EFY 2011. Similarly, the percentage of fully immunized children increased from 61% to 94% in the same period and also Vitamin A supplementation and screening for SAM among children aged6-59 months increased from 14% and 25.8% in EFY 2009 to 88% and 100% in EFY 2011, respectively.

Table 3 Pent-3, Measles, Fully immunized and Vitamin A coverage of Lideta, Addis Ababa and National (EFY 2009-2011)

Services	2009			2010			2011		
	Lideta	Addis Ababa	National	Lideta	Addis Ababa	National	Lideta SC	Addis Ababa	National
Pent-3	59	138	97	67	142	96	91	108	
Measles	61	137	94	68	142	90	94	101	
Fully immunized	61	126	91	68	130	87	94	97	
Vitamin A	14	74	95	88	76	59	88	130	

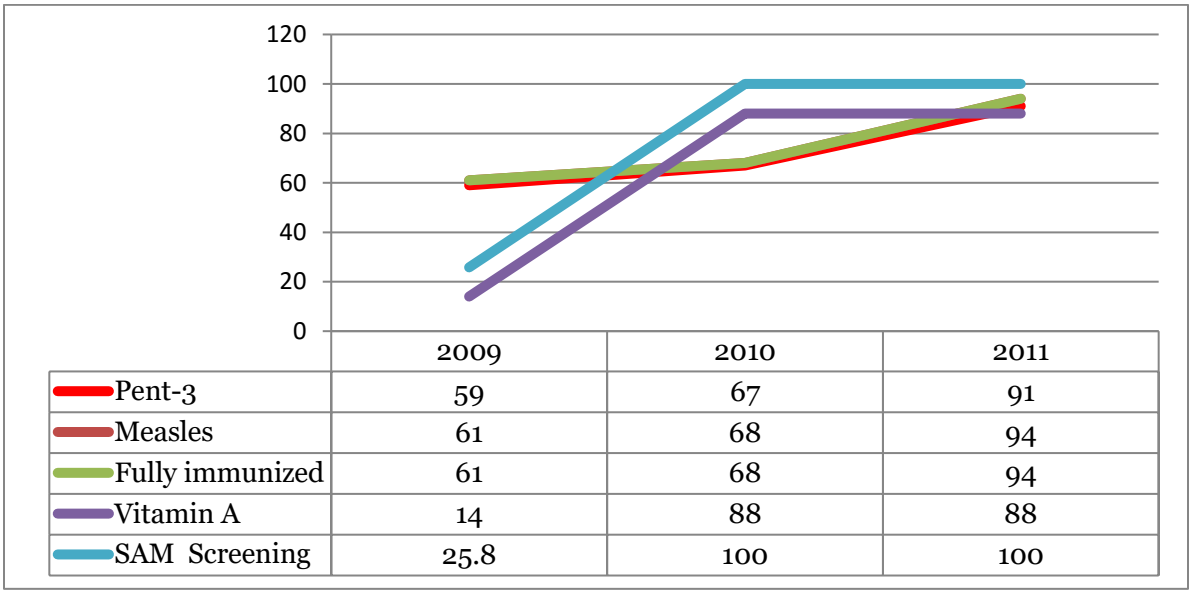

Figure 3:- Child Health Indicators in Lideta Sub City, 2009-2011 ETC

3.2 Prevention and Control of Communicable Diseases

Different activities were implemented done to reduce the disease burden related to communicable diseases, especially HIV/AIDS and TB. The following section briefly explains what has been targeted and what has been achieved during the last three years.

HCT Service

The number of HCT services increased from 28592 in EFY 2009 to 37181 in EFY 2010 and then decreased to 13568 in 2011 (Table 4)

Antiretroviral Treatment

An incremental was observed in the number of People Living with HIV/AIDS (PLWHA), currently on ART and newly on ART over the past three years (Figure 4); in particular, there was an increase between EFY 2009 and EFY 2011 from 3057 to 3181 for those currently on ART and from 236 to 237 for those newly on ART.

Table 4 Number of HCT and Currently on ART performed *of Lideta, Addis Ababa and National (EFY 2009-2011)*

Services	2009			2010			2011		
	Lideta	Addis Ababa	National	Lideta	Addis Ababa	National	Lideta	Addis Ababa	National
HCT	28592	493,648	7,721,556	37181	641,743	9,204,746	13568	485110	
Currently on ART	3057	89584	426,472	3093	90,322	457,951	3181	94508	

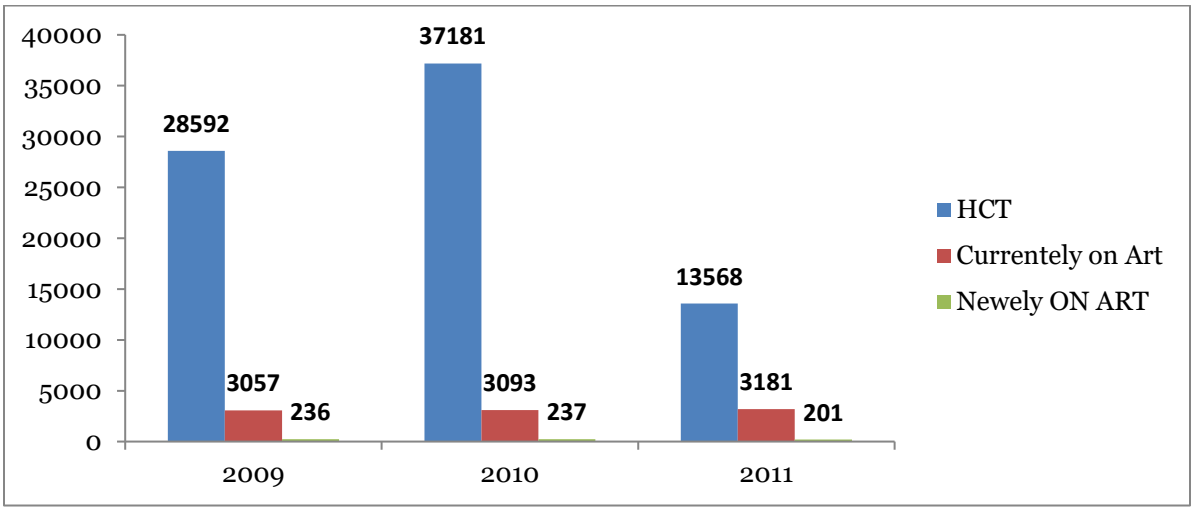

Figure 4:- HIV Care and Treatment selected indicators 2009-2011 EFY

90-90-90 Status (3(90) Approach

To meet the 90-90-90 target set for the year 2020, the FMOH adopted the target testing approach that aims to raise the proportion of people who know their HIV status to 90% in 2020 through an appropriate approach in responding the community demand for testing and by focusing on the most at-risk populations for better yield. In line with escalating the first 90, efforts are underway to put 90% of people diagnosed with HIV on ART at existing ART sites with further expansion. In the same token, to meet the third 90, the FMOH is working to strengthen the regional laboratory with further expansion to perform viral count for patients who are on ART.

Figure 4 shows data on the summary of performance under the 90-90-90 target set for three HIV/AIDS indicators, 2011 EFY.

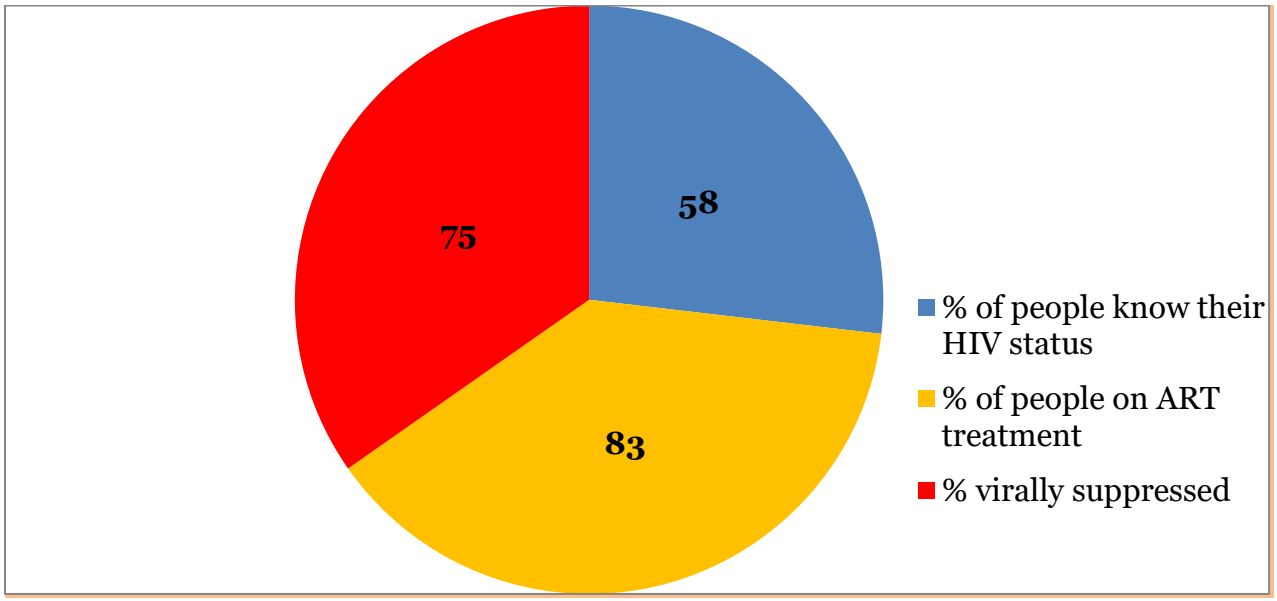

Figure 5:- 90-90-90 Status (EFY 2011)

Tuberculosis Prevention and Control

TB is among major public health problems throughout the world and its burden will remains enormous in Ethiopia. Ethiopia is among the 30 high burden countries for TB, TB/HIV and MDR-TB with annual estimated TB incidence of 207/100,000 populations and death rate of 33 per 100,000 population for 2014 (WHO 2015 report).

Concerning treatment outcomes, two indicators are presented: TB Treatment Success and Cure Rates. TSR showed a decrease from 96% in EFY 2009 to 81% in EFY 2011 and TCR increased from 86% to 95% in the same period (both indictors are above the target set for EFY 2011). There was an increment on the TB case detection rate from 68% in EFY 2009 to 75% in EFY 2011(Figure 5).

Table 5 TB case Detection, TB success Rate and TB cure rate of ***Lideta, Addis Ababa and National*** *(EFY 2009-2011)*

Services	2009			2010			2011		
	Lideta	Addis Ababa	National	Lideta	Addis Ababa	National	Lideta	Addis Ababa	National
TB case Detection	68	110	64	72	124	65	75	120	
TB success Rate	96	89		81	86	82	90	93	
TB cure rate	86	84		89	80	81	95	88	

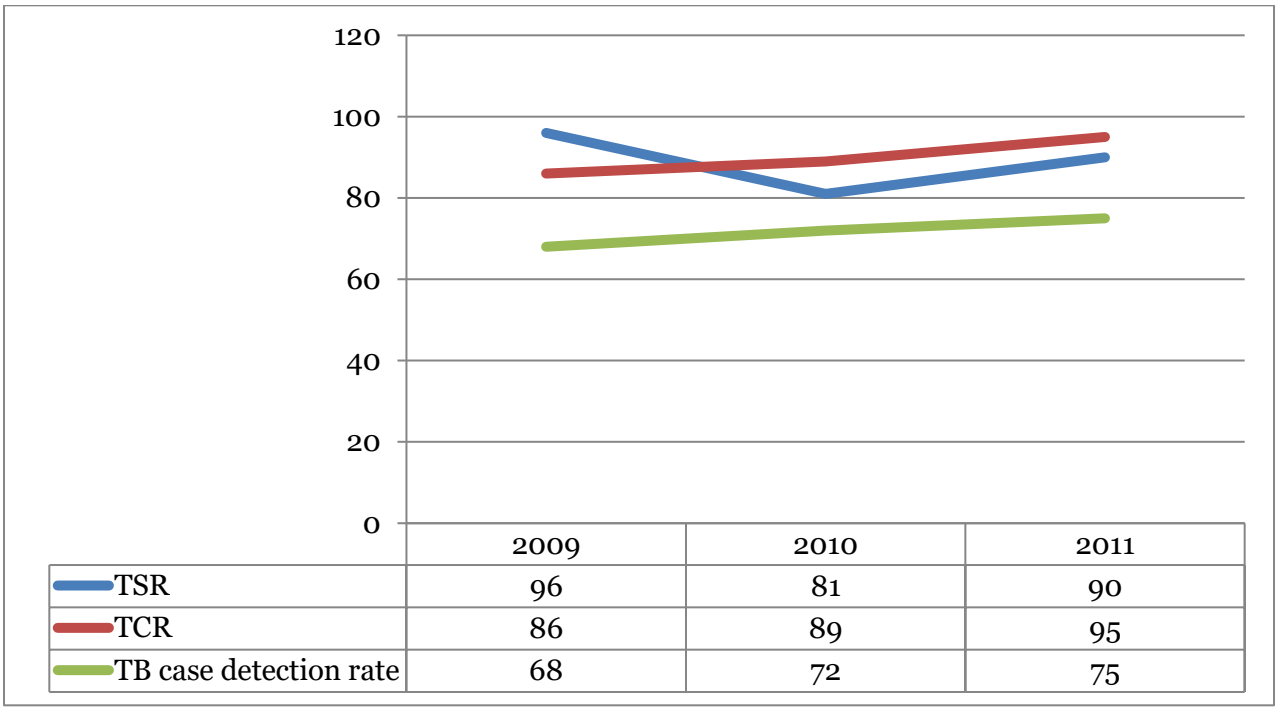

Figure 6:- Tuberculosis Indicators, 2009-2011 EFY

3.3 Public Health Emergency Preparedness and Response (PHEM)

Public Health Emergency Management (PHEM) aims to improve how the health system deal with existing and evolving disease epidemics, malnutrition, and natural disasters of national and international concern. At this stage, HSTP assumes to improve health risk identification, early warning, response and recovery from the disasters. Therefore, the strategies were set towards an effective early warning, preparedness, response, recovery and rehabilitation system.

The trends of malaria, typhoid fever and scabies cases are given in the graph below during the reporting period; as of week 52 WHO Epi-week

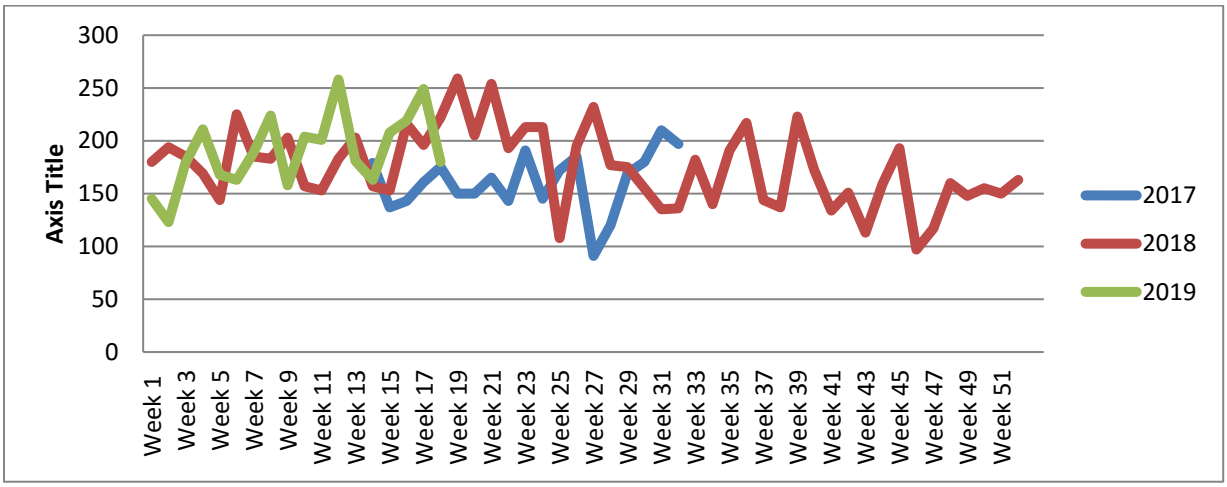

Figure 7:- Trends of malaria cases by epidemiologic week, 2017- 2019

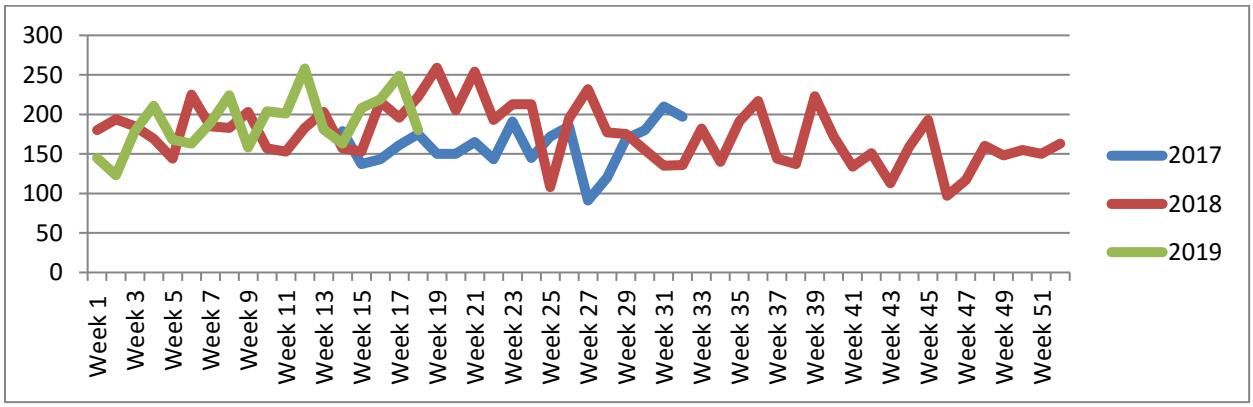

Figure 8:- Trends of typhoid fever cases by epidemiologic week, 2017- 2019

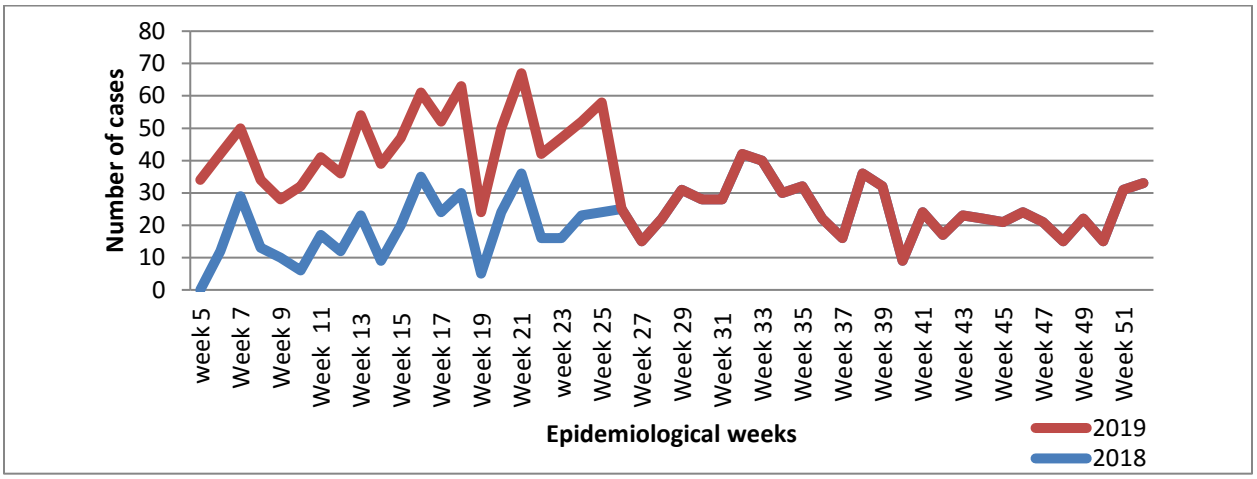

Figure 9:- Trends of scabies cases by epidemiologic week, 2018- 2019

3.4 Pharmaceutical Supply and Services

Drug availability like human resource, is an important component in the delivery of health services. The demand for provision of quality health services is determined by among other factors, availability of essential drugs, qualified medical personnel, supplies and equipment.

Figure 9 shows that the percentage of essential and vital drugs availability reduced from 88.3% and 97.5% in 2010 to 86% and 96% in 2011 EFY respectively.

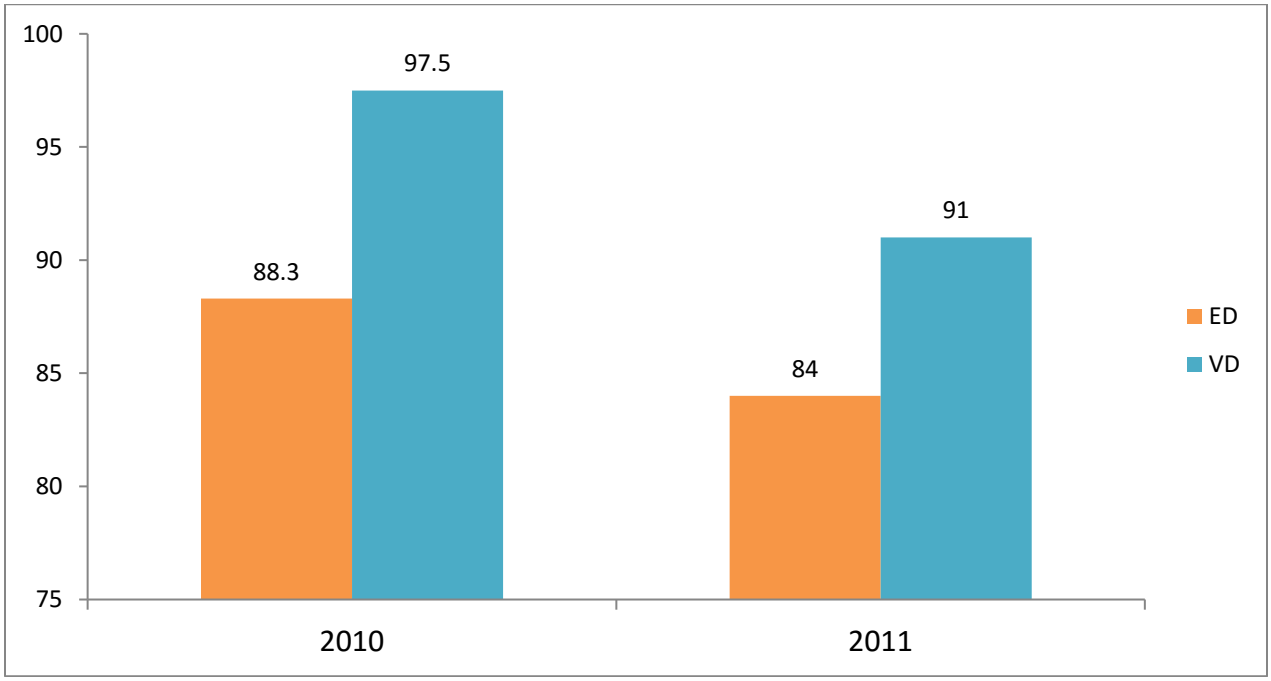

Figure 10:- Essential and Vital Drugs Availability, 2010-2011 EFY

3.5 Quality of Health Services

The strategic objective to improve quality of health services includes provision of health services as per the standard by health facilities at all levels. This standard includes speed of delivery, effectiveness of the services and patient safety, ethical considerations and professionalism in service delivery, and availability of the required inputs (HR, finance, pharmaceuticals etc.). The delivery of quality health services is central to improve the health status of the population.

The performance of the sector with respect to improving quality of services is presented in this section.

The new EHCRIG Guideline aimed at ensuring customer satisfaction through provision of effective and quality health care is being implemented by health centers since EFY 2009. The guideline comprises of 81 standards which contain detailed operational guides on Leadership & Governance, health center and health extension linkage, Medical Record Management, patient flows, pharmacy services, laboratory services, infection prevention, medical equipment management, human resource management, service quality improvement & Data mgt.

Figure 10 shows that the Lideta Sub City average EHCRIG attainment increased from 36.4% in 2009 EFY to 85% in 2011 EFY, meeting the set target of 80%.

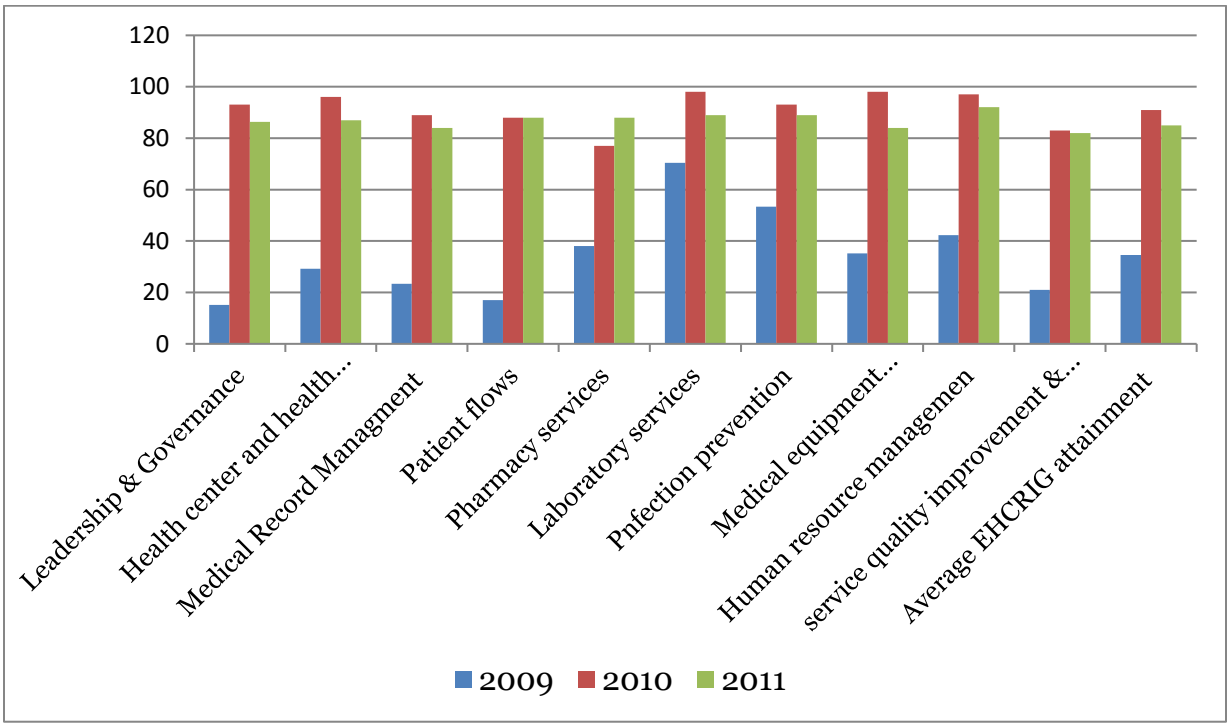

Figure 11:- EHCRIG Performance, 2009-2011 EFY

3.6 Community Based Health Insurance

Community-based Health Insurance (CBHI) is a not-for-profit type of health insurance that has been used by poor people to protect them against the financial risk of illness. In CBHI schemes, members regularly pay small premiums into a collective fund, which is then used to pay for health costs if they require services. Based on the concepts of mutual aid and social solidarity, many CBHI schemes are designed for people that live and work in the informal sectors who are unable to get adequate public, private, or employer-sponsored health insurance.

Achievement of Implementation of CBHI

Establish service contracts with health facilities for provision of health care to CBHI membership;

The service contract, up to the reporting period CBHI has contracted with 6 health centers and five referral hospitals. Those facilities are being functioned in the city. In the contractual agreements, there are clear clauses mentioned about benefit packages and general conditions to ensure mutual benefit between service users, providers, and purchaser.

In general, the contract duration is limited in one year due and both contracting parties could propose revising or amending if there is necessary clause to be considered which would ensure mutual interest of both parties.

To ensure the contract to be observed by contracted facilities, CBHI core process has been utilizing some mechanisms to evaluate its improvement and effectiveness. After contract got in to effect, CBHI Officer and Financing Officer conducted monitoring at health centers and hospitals through collecting patient satisfaction in order to assess quality of care, the respect for benefit package,

Enrolment of CBHI members

Within the reporting period (June-July 2010), CBHI promotion and enrolment were broadly carried out in 28 selected ketena. These activities were carried out by CBHI staffs, women's forum, women's leg, eder, village chief, and some key persons in the communities. The way in doing enrolment, promotion strategy mostly managed through village meeting, small group mobilization, and house to house visit. The enrolment period starts from June to July of the year. Resulting from enrolment is shown on table 2 below:

Table 6:- CBHI membership- June-July 2010

Woreda	Renewal members		New Enrolled Members		Total	
	HH	IND	HH	IND	HH	IND
Woreda 1	1921	2521	325	305	1246	3026
Woreda 3			2207	4391	2207	4391
Woreda 7			1992	1753	1992	1753
Woreda 10			1613	2331	1613	2331
Total	1921	2512	6137	8980	7058	11501

Prepare CBHI insurance card and distribution

The CBHI officers have been taking account for producing insurance card for new insurance subscriber households and during this reporting period, 8980 new insurance cards distributed to new insured households in the selected woredas. For those who already entitled insurance cards could access free of charge health services among contracted health facilities. The insurance cards were so crucial to be presented to health staff during visiting point of services.

Manage CBHI premium fund and subsidies for reimbursements

By July 1251940 ETB was collected and kept for reimbursement to only health care. Based on CBHI guideline, premium could not be spent for administrative and or other operational cost. It is strongly recommended to use for direct medical benefits.

Health expenditure in insured households has been significantly reduced

CBHI has been providing comprehensive benefit package to cover user fee at health centers and referral hospitals. The insured people enjoy greater benefits from CBHI rather than they contributed premium to the scheme. Huge cost reimbursement during they got illness is an effective financial mean to protect from bigger damage due to catastrophic expenditure on health care.

Total spending for direct benefit to those service users;

Medical benefits (health care cost) reimbursement 977650.16 ETB

3.7 Health Infrastructure Development

Construction Work have been completed during the year, 2011EFY

- ✓ Dagem Hidase, Hidase Fre and Abenet health centers APTS buildings: - The construction of the building is fully completed and provision of services started.
- ✓ Dagem Hidase TB room buildings: - The construction of the building is fully completed and provision of services started
- ✓ Hidase Fre health center Triage and Medical record buildings: - The construction of the building is fully completed and provision of services started.
- ✓ Tekelhayimanot health center APTS buildings: - The progress of construction of the building has reached about 90%.

Pic 1Constructed projects by Lideta Sub City health office in different health facilities in 2011 EFY

Hidase Fre health center APTS

Hidase Fre health center Triage and Medical record

Tekelhayimanot health center APTS

Abenet health center APTS

4. Conclusion

The report has provided a descriptive analysis of key health sector indicators on disease burden, availability of drugs, child health, maternal health, CDC, PHEM, CBHI and health infrastructures indicators. This information is important because it helps both policy makers and program managers to begin to plan more effective and better targeted health sector interventions.

Information contained in this report has shown that there has been an improvement in key health indicators such as proportion of institutional deliveries, fully vaccinated children, antenatal coverage, and number of clients accessing ART services, TB and EHCRIG performance.

However, more efforts need to be done if the quality of data has to be used for effective health sector interventions. There is need to strengthen the sub city routine information system (i.e. the DHIS 2), through a wide range of capacity interventions such as training activities, technical supportive visits, data audit exercises, performance assessment visits, etc.