African Medical Students Association
at the International University of Africa
(AMSA – IUA)

AMSA – IUA Second International Health Conference:
Challenges facing Health Service Providers in Africa

10 – 11 January, 2014 AD / 9 — 10 Rabi
Auwal, 1435 AH
IUA, Khartoum – Sudan

Conference
Proceedings
(AMSA Media and Information Office)

Compiled by:
Muhammad Umar Sani,
Maram El-Zain Awad
(Year 5 Faculty of Medicine)
African Medical Students Association
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(Year 5 Faculty of Medicine)
From the Vice Chancellor

The nineteenth assembly of the University Board of Trustees was held in January 2013, and witnessed during the period of its activities the first International Health Conference organized by the African Medical Students Association (AMSA). The conference had presentations of scientific papers by students under the supervision of their lectures and the theme of the conference was on the “Health problems of Africa: Is there any hope left?”

The initiative of the association was encouraged by Professor Mabyou Mustapha, Deputy Vice Chancellor for Academic and Cultural affairs, who chaired and coordinated the linking of the association to other humanitarian organizations like Physicians Across Continents (PAC). The outcome of that conference was generally outstanding and beneficial.

I was pleased and expressed my views on this association to some higher authorities in the state and those involved in the related sector. I also proposed to see such activities (conferences) sustained. The association along with the faculty of medicine and allied health sciences (Dentistry, Nursing, Pharmacy, and Medical Laboratory Sciences) of the University took to their feet, where Professor Mabyou continued to be patron of the association. Despite his health situation, he was still able to attend the general Ramadan Breakfast of the association last year; this entails his concern for the association where he believes these students have got a future and deserve to have a helping hand.

Professor Mabyou was succeeded in his noble task of being the patron of the association Dr. Mohammed Alhassan Eltikena, Dr. Omer El-Adil and Dr. Kamal Mohammed Khair. It was under their supervision and the enthusiasm of the members of the association that preparations of the second conference kicked off which is scheduled to take place in January 2014—a year after the first conference. The theme of this conference is an advancement of the
scope of the first, which focuses on the challenges facing health service providers in Africa. This conference (and their other activities) is in line with the message of the association of: “let’s join hands to save Africa”.

This conference attracted the interest of the University and the State and Federal Ministries of Health where both Ministers welcomed and supported the project. The conference comes at the time of laying the first foundation of the Rajihi Teaching Hospital of the International University of Africa which will add to the facilities of the university in training of her students who are currently clerking in Ibrahim Malik Teaching Hospital. The renovation of the health clinic of the university in view of improving the health of the staff and students is also in place.

Indeed the efforts of the Medical and allied health sciences students in the formation of this association and their engagement in scientific research activities is a project that though still nascent, will overtime become fruitful, if stakeholders and those with expertise will join and support this task. This will no doubt be appreciated by the University and those sponsors of such projects.

Professor Kamal Mohammed Obeid
Vice Chancellor, IUA.
تقديم مدير الجامعة

عقد مجلس أمناء جامعة أفريقيا العالمية إجتماعه العادي في دورته التاسعة
عشرة في يناير 2013م وكان ضمن البرامج المصاحبة لدورة الإتفاقات هذه
(AMSA) إتفاق المؤتمر الأول للجمعية الطبية لطلاب أفريقيا بجامعة أفريقيا
(IUA) والذي قدم فيه الطلاب عددًا من الأوراق تحت إشراف أساتذتهم وكان
موضوع المؤتمر يدور حول (المشاكل الصحية في أفريقيا هل من أمل في
حلها) وانطلاق الاستاذ الدكتور - سبوع مصطفى نائب مدير الجامعة للشؤون
العلمية والثقافية برعاية الفكرة وتطويرها ونسج جهود الجمعية مع عدد من
المنظمات من بينها (أطباء عبر القارات) وكانت نتائج ذلك المؤتمر باهرة وفائدة
عميقة. وقد عبرت عن اعجابي بذلك البرنامج لعدد كبير من المسؤولين
والمحترمين ودعوت حينها ليكون هذا البرنامج سنويًا فتجاوزت الجمعية ومعها
كارة الطب وسائر الكليات الطبية بالجامعة وواصل بروفيسور - سبوع رشادة
البرنامج حتى ألمت به وعكة وهو يشارك في تشغيلها في أحتفالية افطارها
الرمضاني ويتولى الأمر بعده الدكتور - محمد الحسن التكزنة والدكتور - عمر
العادل والدكتور - كمال محمد خير، وتحت إشرافهم وبحماية متفق من شباب
الجمعية بدأ التحضير للمؤتمر الثاني لينعقد في يناير 2014م بعد سنة بالتمام
من تاريخ اتفاقاته الأول واختاروا موضوعًا جديداً لهذا المؤتمر هو تطوير
الموضوع السابق حيث استعرضوا (التوصيات التي تواجه مدنى الخدمات الصحية

9
في أفريقيا) وأثرهم بمشاهدة (قد فوق بيد إندانج أفريقيا) وحظى هذا المشروع بأهتمام الجامعة ووزارة الصحة السودانية ووزارة الصحة بولاية الخرطوم حيث وقع وزيراً مشكورين بدعم المشروع ورعايتة ويتزامن مع هذا النشاط وضع حجر الأساس لمستشفى الراحي التعليمي الخاص بجامعة أفريقيا العالمية لكون اضافة ولينة فوق لينة بعد أن واصلت الجامعة تدريب طلابها بمستشفى إبراهيم مالك وتجري إجراءات تطوير الوحدة الصحية للجامعة لتوصيب مواعين التدريب والرعاية الصحية للطلاب والعاملين وأدوارهم.

إن مبادرة طلاب كلية الطب والكلية الطبية الأخرى في تأسيس هذه الجمعية وإهتمامهم بالعمل العلمي البحثي المتوريط مشروع قد يبدو صغيراً ولكن بمرور الزمن وترانيم التجارب وتخطيط الخبرات ستسعد أفريقيا وآباؤها بخصوص طيب من عمل هؤلاء الطلاب وأساتذتهم وحيثا يحق لجامعة أفريقيا وداعميها أن يهنأوا بتلك النتائج.

الدكتور مصطفى محمد عبيد
مدير جامعة أفريقيا العالمية
Foreword

The International University of Africa has a quite long history of enrolment and graduating of professionals in its different faculties and departments. The university represents a major platform where people from many countries and continents of the world meet to share knowledge and ideas, and to acquire the professional skills needed to make a positive change in the rapidly growing and developing contemporary world of today. The University has since its establishment trained and graduated individuals that have been of key importance in their positive contributions in the society.

A good initiative in the name of the African Medical Students Association represents the Medical and Allied Health Sciences specialties of the university who have gained the awareness of the various health problems and disease burden of the African continent, and have embarked towards sensitizing the international community of what the situation is and the role they can play in an attempt to intervene in the areas of healthcare delivery. This also represents the role of the University as it boost the human resources adding to the health workforce of the different countries of the continent.

Dr. Ibrahim Fathal-Rahman
Head of Advisory Board
Acknowledgement

Having successfully completed and managed to extract the most priority medical and health problems facing African communities with the series of contributions and recommendations in the first International Health Conference organized by this marvelous association, the idea of the second conference was immediately suggested to focus on challenges facing health service providers in Africa. I acknowledge the completion of yet another milestone in this year’s 2nd International Health Conference which is taking place on the 10th-11th of January, 2014 at the Africa conference hall, International University of Africa, it’s my most sincere pleasure to thank the administration of International University under the leadership of the Vice Chancellor and his entire dedicated staff for the continued support and contributions towards the success of the conference.

Words are too little to express our utmost gratitude to the research and scientific supervisors Dr Amal Abdou Abdalla- Director of Health Observatory -Sudan and Dr Abdul Mageed Osman Musa- Director Medical Education and Research Center-IUA for the support and guidance they rendered to the students scientific committee throughout the preparations. Also to Tarig Farouq Abdalla, I say a very big thank you.

And to the Humanitarian Organizations: Physicians Across Continents, especially Dr Ayham Abdurahim; Sudan Doctors Union, Patients Helping Fund-Sudan for their material support and not forgetting Ministries of Health and other health authorities across African countries for giving us a chance of retrieving information and serving as our references.

Finally, this acknowledgement will never get completed without mentioning the tremendous guidance and support of our senior and colleague in person of Professor Mabou Moustafa A-Wahab Deputy Vice Chancellor Academics. We pray may the almighty Allah continue to guide and protect you.

Dr Omer El-Adil Abdallah Hamid,
AMSA - IUA Patron.
African Medical Students Association at the International University of Africa (AMSA - IUA)

AMSA – IUA Second International Health Conference:

Challenges Facing Health Service Providers in Africa

10 – 11 January, 2014 AD / 9th — 10th Rabi 'Ibuwal, 1435, AH
IUA, Khartoum – Sudan

Challenges facing Health Service Providers in Ethiopia, 2013

Prepared by:
HassenYimer Hassen, Year 5 – Faculty of Medicine.
Introduction

Ethiopia is situated in the horn of Africa between 3 and 5 degrees north latitude and 33 and 48 degrees east longitude. BORDERED by Eritrea in the North and North East, Djibouti and Somalia in the East, Kenya in South, and Sudan in the West and South West. Ethiopia is the countries with high population in Africa and has diversified culture, linguistic composition and large ethnic compositions. The country introduced a federal government structure in 1994 composed of nine Regional States. Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, Southern Nations Nationalities and Peoples Region (SNNPR), Gambela and Harrari and two city Administrations (Addis Ababa and Dire Dawa). The Regional States are administratively divided into 78 Zones and 710 Woredas. The total area of the country is about 1.1 million sq. km. Total projected population of the country is about more than 85 million. Ethiopia is the second most populous country, 34.5% Oromo 26.9% Amhara6.2% Somali6.1% Tigray4.0% Sidama2.5% Gurage 2.3% Welayta1.7% Hadiya1.7% Afar1.5% Gamo1.3% Gedeo11.3% others. (WHO 2007).

Ethiopia is one of the poorest countries in Africa. Poverty is both a cause and consequence of poor health. Infectious and neglected tropical diseases kill and weaken millions of the poorest and most vulnerable people each year. The largest group of poor people in the country is composed of small-scale farmers. The major health problems of the country remain largely preventable communicable diseases and nutritional disorders. Despite major progresses have been made to improve the health status of the population in the last one and half decades, Ethiopia’s population still face a high rate of morbidity and mortality and the health status remains relatively poor. Figures on vital health indicators from DLHS 2005 show a life expectancy of 54 years (53.4 years for male and 55.4 for female), and an IMR of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010 and more than 90% of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often a combination of these conditions. (WHO 2007)
Country Background

Ethiopia is situated in the horn of Africa between 3 and 5 degrees north latitude and 33 and 48 degrees east longitude. It is bordered by Eritrea in the North and North East, Djibouti and Somalia in the East, Kenya in South, and Sudan in the West and South Sudan in the South West. It covers an area of approximately 1.14 million square kilometers and is one of Africa's most populous countries: the 2007 Population and Housing Census counted a population of about 77.5 million, of which males constituted 50.5 percent and females 49.5 percent. Population density was 64.1 per sq. km. Average life expectancy was 53.42 and 55.42 years for males and females, respectively. Nearly 84 percent of the population (32.50 million people) lived in rural areas while the remainder (16 percent, 6.95 million) was urban. Based on the country's annual growth rate of 2.6 percent, the commission estimated the population in 2009/10 to be nearly 80 million (Population Census Commission 2008). Adopted in 1995, the constitution that established the Federal Democratic Republic of Ethiopia provides for a system structurally based on a federal government, nine autonomous states, and two chartered cities (Addis Ababa and Dire Dawa). Ethiopia is one
of Africa’s poorest countries yet is relatively stable. Poverty is both a cause and consequence of poor health. Infectious and neglected tropical diseases kill and weaken millions of the poorest and most vulnerable people each year. The largest group of poor people in the country is composed of small-scale farmers.

Table 1: Show health indicator in Ethiopia.

**Health indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion to population leaving in rural areas</td>
<td>2007 Census</td>
</tr>
<tr>
<td>Per capita income</td>
<td>$232 USD</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>2010 National 5 Year Growth Transformation Plan, MOFED</td>
</tr>
<tr>
<td>Fertility rate</td>
<td>5.32</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>2008 World Bank Development Indicators</td>
</tr>
<tr>
<td>Unmet need for family planning</td>
<td>14%</td>
</tr>
<tr>
<td>MMR</td>
<td>32%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>2005 DHS</td>
</tr>
<tr>
<td>Unmet need for family planning</td>
<td>Last 10K survey 2009 (Oromiya, Amhara, SNNP)</td>
</tr>
<tr>
<td>Proportion of deliveres assisted by skilled birth attendant</td>
<td>2005 DHS</td>
</tr>
<tr>
<td>Proportion of health facilities meeting</td>
<td>18.4%</td>
</tr>
<tr>
<td></td>
<td>2008/9 MOH Health and Health Indicator Report</td>
</tr>
<tr>
<td>Proportion of health facilities meeting</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>2009 National Emergency Obstetric</td>
</tr>
<tr>
<td>Indicator</td>
<td>Value</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Cesarean rate</td>
<td>0.6%</td>
</tr>
<tr>
<td>Neonatal MR</td>
<td>39/1000 live births</td>
</tr>
<tr>
<td>IMR</td>
<td>77/1000 live births</td>
</tr>
<tr>
<td>Under-five mortality rate</td>
<td>123/1000 live births</td>
</tr>
<tr>
<td>Stunting</td>
<td>38%</td>
</tr>
<tr>
<td>Orphans and Vulnerable Children</td>
<td>5.4 million (900,000 from HIV/AIDS)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully immunized children &lt; 1 year</td>
<td>65.5%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>TB incidence (all forms)</td>
<td>378/100,000</td>
</tr>
<tr>
<td>Malaria mortality rate</td>
<td>1.9% among inpatients with malaria (5.6% of all inpatients)</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>7.3% (urban 7.7%; rural 0.9%)</td>
</tr>
<tr>
<td>Male circumcision prevalence</td>
<td>93%</td>
</tr>
<tr>
<td>PLHIV</td>
<td>1.2 million (60% urban, 40% rural)</td>
</tr>
<tr>
<td>PI HIV on treatment</td>
<td>186,154 (67% coverage)</td>
</tr>
<tr>
<td>PMTCT coverage (% HIV+ women who receive ARVs)</td>
<td>175%</td>
</tr>
</tbody>
</table>
Methods

This is a descriptive study taken from secondary data considering the challenges facing health care providers in our country in which tables, pictures, charts and figures are used to present.

General objective

To enlighten the challenges facing health service providers in Ethiopia and their overall consequences in order to suggest possible recommendations.

Specific objectives

- To point out challenges facing overall health care practice and practitioners in Ethiopia.
- To look into the consequences of these challenges and their impact on overall health of the country.
- To suggest possible solution and/or recommendations towards solving these challenges.
**1. Governmental policies in health practice:**

The 1993 Health Policy focuses mainly on providing quality Primitive, Preventive and selected curative health care services in an accessible and equitable manner to reach all segments of population, with special attention to mothers and children. The policy has a particular emphasis on establishing an effective and responsive health delivery system for those who live in rural areas.

**a) Focus Areas of The Health Extension Program**

As a preventive program, the HEP promotes four areas of care: Disease Prevention and Control, Family Health, Hygiene and Environmental Sanitation, and Health Education and Communication. Health service extension program introduced 16 packages in four main areas that include:

A. Hygiene and Environmental Sanitation (Seven packages). There are:
- Proper and safe excreta disposal system;
- Proper and safe solid and liquid waste management;
- Water supply safety measures;
- Food hygiene and safety measures;
- Healthy home environment;
- Arthropods and rodent control;
- Personal hygiene;

B. Disease Prevention and Control (four packages). There are:
- HIV/AIDS prevention and control;
- TB prevention and control;
- Malaria prevention and control;
- First aid;

C. Family Health Services (Five packages)- There are
- Maternal and child health;
- Family planning;
- Immunization;
✓ Adolescent reproductive health;
✓ Nutrition;

D. Health Education and Communication

The Health Service Extension Program is implemented in the following modalities:

- An outreach programme centered around rapid vocational training of health extension workers, two per Kebele, and construction and equipping of health posts (a health post per kebele) through accelerated expansion of PHC facilities.

- A community promotion programme centered around volunteer/private sector community promoters/TBAs, working under the supervision/guidance of health extension workers and providing support to households for behavioral change (e.g. breastfeeding, complementary feeding, immunization, use of bed nets, clean delivery, etc.). The former Frontline Workers (CBRHAs, TBAs) are incorporated into the system by serving as volunteers that work under the supervision of the Health Extension Workers.

- A programme strengthening the quality of demand for clinical care particularly treatment of diarrhea, malaria in children, assisted delivery, early referral for mothers and children with danger signs, HIV testing and counseling as well as prevention of mother to child transmission in existing health stations and health centers.

b) Current Status of the Health Service Extension Program

The total number of health service extension workers demanded throughout the nation is 30,000. The total number of health service extension workers deployed as of March 2008 is 24,534, which is 82% of total demanded. Moreover, 5,466 health service extension workers will be trained and deployed until 2009. (FMOH, 2005-2009).
Table 2: Percentage Distribution of Health Service Extension Workers Deployed by Region (2008).

<table>
<thead>
<tr>
<th>No</th>
<th>Region</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tigray</td>
<td>1399</td>
<td>5.7</td>
</tr>
<tr>
<td>2</td>
<td>Afar</td>
<td>717</td>
<td>2.9</td>
</tr>
<tr>
<td>3</td>
<td>Amhara</td>
<td>8824</td>
<td>35.9</td>
</tr>
<tr>
<td>4</td>
<td>Oromia</td>
<td>5973</td>
<td>24.3</td>
</tr>
<tr>
<td>5</td>
<td>Somali</td>
<td>2785</td>
<td>11.3</td>
</tr>
<tr>
<td>6</td>
<td>Ben-Gumuz</td>
<td>86</td>
<td>0.3</td>
</tr>
<tr>
<td>7</td>
<td>SNNPR</td>
<td>4585</td>
<td>18.6</td>
</tr>
<tr>
<td>8</td>
<td>Gambella</td>
<td>47</td>
<td>0.2</td>
</tr>
<tr>
<td>9</td>
<td>Harari</td>
<td>39</td>
<td>0.1</td>
</tr>
<tr>
<td>10</td>
<td>Addis Ababa</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>Dire Dawa</td>
<td>79</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>24534</td>
<td>99.6</td>
</tr>
</tbody>
</table>

*Source: FMOH, Planning and Programming Department.*

**c) Program Challenges**

The Following are major challenges encountered during the implementation of the program:

- Lack of attention to the details of working conditions and to human resources management (underdeveloped environment).
- Absence of Institutional arrangements for management of health service extension program at all levels.
- Absence of regular supervision not doing monitoring the quality of training and soliciting cooperation of other social sectors.
- In availability of contraceptives, infrastructure, vaccines in sustainable manner.
- In some area, health posts are not fully well equipped with needed equipment and supplies.
2. Neglected tropical diseases (NTD) challenge:

The big three diseases HIV/AIDS, TB, and malaria are a hard nut to crack as long as Ethiopia is concerned. The NTDS, which are a group of tropical infections which are especially endemic in low income populations in developing regions like that of Ethiopia.

Thirteen poverty-promoting diseases have recently been designated as neglected tropical diseases (NTDs). These diseases include
- visceral leishmaniasis (VL),
- human African trypanosomiasis (HAT),
- Chagas disease,
- hookworm infection,
- ascariasis,
- trichuriasis,
- lymphatic filariasis,
- onchocerciasis,
- dracunculiasis,
- schistosomiasis,
- trachoma,
- leprosy (Hansen’s disease), and
- Buruli ulcer.

Except for Chaga’s disease, all other officially designated NTDs occur in Ethiopia, with varying magnitude. Soil transmitted helminthiasis (STHs) and schistosomiasis, the profiles of which have superficially been considered elsewhere, are the most prevalent and yet neglected diseases in Ethiopia.

Figure 1 Cases of Visceral Leishmaniasis, Ethiopia, 2004-201
### 3. Human Resource for health

<table>
<thead>
<tr>
<th>HR Category</th>
<th>End HSDP I</th>
<th>Ratio to population</th>
<th>End 1997 HSDP III</th>
<th>Ratio to population</th>
<th>Africa Regional Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total No</strong></td>
<td><strong>Ratio to population</strong></td>
<td><strong>Total No</strong></td>
<td><strong>Ratio to population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All physicians</td>
<td>1.8 88</td>
<td>1:35,603</td>
<td>2152</td>
<td>1:34,986</td>
<td>1:3984</td>
</tr>
<tr>
<td>Specialist</td>
<td>65 2</td>
<td>1:103,098</td>
<td>1151</td>
<td>1:62,783</td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td>1,2 36</td>
<td>1:54,385</td>
<td>1001</td>
<td>1:76,302</td>
<td></td>
</tr>
<tr>
<td>Public health officers</td>
<td>48 4</td>
<td>1:138,88</td>
<td>3,760</td>
<td>1:20,638</td>
<td></td>
</tr>
<tr>
<td>Nurses Bsc, &amp; Diploma(except midwives)</td>
<td>11, 97 6</td>
<td>1:5,613</td>
<td>20109</td>
<td>1:4,895</td>
<td>1:1069</td>
</tr>
<tr>
<td>Midwives (Senior)</td>
<td>86 2</td>
<td>1:77,981</td>
<td>1379</td>
<td>1:57,354</td>
<td>1:3236</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>11 8</td>
<td>1:569,66</td>
<td>661</td>
<td>1:117,397</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Tech.</td>
<td>79 1</td>
<td>1:84,767</td>
<td>3013</td>
<td>1:25,755</td>
<td></td>
</tr>
<tr>
<td>Source: Adapted from the WHO reports.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Environmental HW | 3 | 1:69,228 | 1,819 | 1:42,660 |
| Laboratory technicians & technologist | 1,695 | 1:39,657 | 2,989 | 1:25,961 |
| Health Extension Workers | - | - | 31,831 | 1:2,437 |

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**Table 4: Total number of available Human Resource for Health by region, 2009**

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tigray</td>
<td>101</td>
<td>1:44,880</td>
<td>188</td>
<td>1:24,111</td>
<td>2,332</td>
<td>1:1,944</td>
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The above table shows health professional to population ratio in selected key categories of health professionals across regions. Anchored in the recent reports, numbers of health professionals in different parts of the country are lower than what is standard especially worsened in agrarian and pastoralist regions. However, the available professionals at the end of HSDP III compared to the HSDP III targets show that the target has been met for community level and most of mid-level health professionals. The number has also significantly increased compared to the levels in the previous HSDPs. However, there is still major gap in highly skilled professionals like Medical doctors, midwives and anesthesia professionals.

4. Lack of in-service training:
Health care delivery in Ethiopia has been seeing and facing numerous setbacks among which is the incompetence of the care providers themselves. This has a link with the poor in-service training.

5. Poor supportive supervision of healthcare providers:
Poor supervision of health care delivery system and providers has many outcomes like negligence, laziness, failure to carry out the task one is being
assigned and so on. Adequate supervision of healthcare delivery is still an issue to the practice in Ethiopia.

6. Harmful Traditional beliefs, behaviors, taboo, and habits:
Up to 80% the Ethiopian population depends on traditional medicine for PHC. This also could be an indicator of poverty (Poor affordability, accessibility and poor quality of health services). As this dominance is huge, concerns are being raised on the challenges traditional medical practices and beliefs, behaviors, taboos, and habits pose. Diversity, safety, effectiveness, and quality, knowledge, and sustainability, patient safety and use. The WHO promotes the use of traditional medicines but so long the above mentioned challenges are not addressed, traditional medicine and other health practices (especially the bad traditional health practices) still remain a threat to the development and advancement in modern medicine in Ethiopia.

7. Language/regional diversification:
Ethiopia has more than 94,000,000 population distributed among 9 Regions and two city Administrations (AddisAbaba and dreedawa) recently according to Wikipedia and there are more than 81 ethnic compositions and different languages. This situation poses healthcare providers in the country; and therefore places a barrier in the delivery of adequate and efficient health services.

8. Health awareness:
When it comes to the simple health measures needed to live a healthy lifestyle, the average Ethiopian is some pace behind. This is a challenge as not only the healthcare provider is needed to attain a state of health an understanding of the simple health measures by the targeted population of health care delivery is critical in completing the process of service delivery.
9. Drain Drain, Drain Circulation and Human Capital Flight:
The minimum standard set by the World Health Organization (WHO) to ensure basic healthcare services is 20 physicians per 100,000 people. While Western countries boast an average of 222, 38 countries in sub-Saharan Africa fall short of the minimum standard and 13 of these have 5 or fewer.

PUSH FACTORS
- Low and eroding wages and salaries
- Unsatisfactory living conditions, lack of transport, housing, etc.
- Under-utilization of qualified personnel; lack of satisfactory working conditions; low prospect of professional development
- Better working conditions; job and career opportunities and Professional development
- Lack of research and other facilities, including support staff; inadequacy of research funds, lack of professional equipment and tools
- Social unrest, political conflicts and wars
- Discrimination in appointments and promotions
- Declining quality of educational system
- Lack of freedom

PULL FACTORS
- Higher wages and income
- Higher standard of living
- Better working conditions; job and career opportunities and professional development
- Substantial funds for research, advanced technology, modern facilities; availability of experienced support staff
- Political stability
- Modern educational system; prestige off foreign training
- Meritocracy, transparency
Results

Ethiopia faces complicated health extension system challenges, deterioration of health indicators, increased preventable communicable diseases, shortage of human resources and misdistribution, incompetence of health care providers and equipment, poor health system information, language diversification, inadequate health awareness, using of traditional medicine and superstition beliefs and also international health travel.

Attribution of results to specific programs is always difficult because of the multiplicity of factors and actors in the social environment, but tangible improvements in key health indicators have been observed since HEP’s implementation began. Supporting our conclusion that HEP is an effective approach to promoting good health in rural communities. It is now present in all rural agrarian areas and is being expanded to include pastoralist and urban areas. Credit for these improvements (Table below) must be shared with global health initiatives that are major players in the implementation of the health sector development program. The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria; the President's Emergency Plan for AIDS Relief; and the World Bank have been major players in health for the last ten years. This has helped the work of the FMOH in HEP implementation.

Discussion

Ethiopia as mentioned. From table 4 page 17 it was clear that the ratio of the physicians internationally was 1: 1000 on average for most of the developed countries and for African countries was 1:3964. In Ethiopia the upper most in is Addis Ababa in which 1: 3056 while the lower most is in afar
In Ethiopia if there is a means or way of attracting health service providers especially GP in all regions of the country the challenges discussed in this paper may be solved.

**Recommendations**

- Comprehensive development
- Increase on the medical scholarship for under/post graduate to different country.
- Encouragement of research by faculties for under/post graduate should be supported.
- Create a co-operation between Africa countries through supporting medical oriented bodies like AMSA-IUA.
- Funding of African medical students association at IUA. Allocate adequate budget to Health Posts
- Strengthen logistic management system and provide regular and uninterrupted supply of essential commodities
- Create conducive health environment and ways and means of attracting back qualified and trained professionals who are working abroad.

**References**

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2. In wikipedia.org/wiki/health in Ethiopia
4. Websites related to the problem