Proceeding of the 2o[th] Annual conference of Ethiopian Public Health Association (EPHA)

An event hosted by the
Ethiopian Public Health Association
26-28 October 2009
Hilton Hotel Addis Ababa, Ethiopia

September, 2010
Addis Ababa, Ethiopia

Proceeding of the 2oth Annual conference of Ethiopian Public Health Association (EPHA)

An event hosted by the

Ethiopian Public Health Association

26-28 October 2009

Hilton Hotel
Addis Ababa, Ethiopia

"Road Traffic Accidents as a Major Public Health concern in Ethiopia"as a main theme

SUB-THEMES:

a. **Multi-sectoral Response to HIV/AIDS**
b. **Nutrition Policy, Strategies and Implementation**
c. **Reproductive Helath Situations at Higher Learning Institutions**
d. **Tobbaccoe Control Intiatives**

September, 2010
Addis Ababa, Ethiopia

Table of Contents

List of Acronym……

Background……..1

Forward……1

Program Highlights……2

1. Inaugural session……..2
2. Keynote addresses……3
3. Opening Speech……5
4. EPHA award ceremony…….
   - 4.1. Senior Public Health Service Award……5
   - 4.2. Senior Public Health Research Award……6
   - 4.3. Junior Public Health Research Award……7
   - 4.4. Institutional Award……8
5. Main Theme: Road Traffic Accidents as a major Public Health Concern in Ethiopia
   - 5.1. Global and National Situation of Road Traffic Injuries.....9
   - 5.2. Impact of RTI on individuals: Individual Experience ……16
   - 5.3. The Magnitude of Traffic Injury and the Role of Public Health in Reducing the Consequences……..17
   - 5.4. Legal perspectives of RTI in Ethiopia ……..22
   - 5.5 Road Safety Situation in Ethiopia……..30
6. Sub Theme 1: Multi-Sectored Responses to HIV/AIDS
   - 6.1. Multi-sectored Response against HIV/AIDS Move towards Universal……..40
   - 6.2. Improving M&E System for Multi-sectored HIV/AIDS Response Community Information System ……..49
   - 6.3. Strengthening Communities' Responses to HIV/AIDS……54
7. Sub Theme 2: Nutrition, Policy, Strategies and Implementation
   - 7.1. Research on Nutrition for National Nutrition Program ……..59
   - 7.2. National Nutrition Strategy/National Nutrition Program (NNS/NNP)……61
   - 7.3. Improving Infant and Young Child Feeding practice through the Essential Nutrition Actions (ENA) Framework in Ethiopia……...64

8. Reproductive Health Situations at Higher Leading Institutions
8.1. Policy Framework of Adolescent and Youth (AYRH).....75
8.2. Policy Environment to Promote Female Education in Ethiopia.....
Focus on Reproductive Health Situation in Higher Education.....86
8.3. Reproductive Health Situation in Higher learning Institutions.....92
9. Tobacco Control Initiatives
9.1. Behavioral Aspects of Tobacco Smoking.....98
9.2. WHO Framework Convention on Tobacco control.....102
9.3. Consequences of Tobacco smoking.....106
10. Bussiness Meeting
10.1 Annual Activity Report.....113
10.2. Annual Chapters Report.....120
10.3. Audit Report by External Auditor 120
10.4. Draft strategic plan (2010-2014) 129
10.5. Identification of the chapter that hosts the 21st (2010) Annual EPHA Conference.....136
10.6. Election of 4 board members to replace those who have served for two terms and who left the board membership.....137

Annex I Speeches
Annex II Preconference Minuet
Annex II List of Panelists
Annex III List of Presenters
Annex IV Conference Program
Annex VI Conference Evaluation

List of Acronyms

AACRT	Addis Ababa City Road Authority
AAU	Addis Ababa University
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Clinic
APHA	American Public Health Association
ARV	Anti Retroviral
ART	Anti Retroviral Therapy
AYRH	Adolescence and Youth Reproductive Health
BCC	Behavioral Change Communication
BDR	Branch Disaster Response
BF	Breast Feeding
BSS	Behavioral Surveillance Survey
CAC	Comprehensive Abortion Care
CDC	Center for Disease Control and Prevention
CD4	Cluster of Differentiation 4
CI	Confidence Interval
CNHDE	Center for National Health Development in Ethiopia
COR	Crude Odds Ratio
CPHA	Canadian Public Health Association
CSA	Central Statistical Authority
CSW	Commercial Sex Worker
DAS	Designed Smoking Areas
DBU	Debre Brihan University
DRT	Disaster Response Team
DSS	Demographic surveillance sites
EDHS	Ethiopian Demographic Health Survey
EDP	Essential Drug Program
EHRNI	Ethiopian Health, Research and Nutrition Institute
EJHD	Ethiopian Journal of Health Development
ENA	Essential Nutrition Actions
EPHA	Ethiopian Public Health Association

EPI	Extended Program for Immunize
ERCS	Ethiopian Red Cross Society
ES	Economic Strengthening
ESHE	Essential Services for Health in Ethiopia
FELTP	Field Epidemiology and Lab Training Program
FGAE	Family Guidance Association of Ethiopia
FGC	Female Genital Cutting
FGM	Female Genital mutation
FGD	Focused Group Discussion
FMoH	Federal Ministry of Health
FP	Family Planning
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
HIV	Human Immunodeficiency Virus
HO	Health Officer
HRS	Reproductive Health Service
HSEP	Health Service Extension Program
ICT	Information and Communication Technology
IDI	In-Depth Interview
IEC	Information Education Communication
IMNCI	Integrated management of Neonatal and Childhood Illness
IPC	Inter Personal Communication
IRB	Institute for Research in Biomedicine
IYCF	Infant and Young Child Feeding
LSITP	Leadership in Strategic Information Training Program
MARPS	Most At Risk Population Groups
MGD	Millennium Development Goals
MTCT	Mother to Child Transmission
MOH	Ministry of Health
MPH	Master of Public Health
M&E	Monitoring and Evaluation
NNP	National Nutrition Strategy
NGOs	Non Governmental Organizations
NNS	National Nutrition Program
OR	Operational Research
OVC	Orphans and Vulnerable Children

PAC	Post Abortion Care
PEPFAR	US President Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHRERC	Public Health Research Ethical Review Committee
PID	Pelvic Inflammatory Disease
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
RTI	Road Traffic Injury
SD	Standard Deviation
SNNPR	Southern Nations and Nationalities People Region
SPH	School of Public Health
STD's	Sexually Transmitted Diseases
SRH	Sexual Reproductive Health
SRP	Student Research Program
SRS	Simple Random Sampling
STIs	Sexually Transmitted Infections
SPSS	Statistical Package for Social Science
SYGE	Save Your Generation Ethiopia
TA	Traffic Authority
TV	Television
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
USA	United States of America
USD	United States Dollar
VCT	Voluntary Counseling and Testing
YFS	Youth Friendly Services
WB	World Bank
WFPHA	World Federal Public Health Association
WHO	World Health Organization

Background

The Ethiopian Public Health Association (EPHA) is legally registered national, independent, not-for-profit, voluntary, multi-disciplinary professional Association established in 1990 with a mission of enhancing better health services to the public and professional standards through advocacy, active involvement, and networking to benefit both members of the Association and the public health professionals in general. It is one of the leading and well-known health professional Associations in the country having over 3,500 professionals as members. The Ethiopian Public Health Association (EPHA) is a member of the WFPHA and is serving in the Executive Board of WFPHA representing the African Region, since 2003.One of the prominent tasks taken care by EPHA is organizing annual conference which is used as a central stage to bring all the members and other concerned body working on the public health.

Forward

This report on the proceedings of the conference summarizes the main points discussed during the seminar and outcomes of a series of collaborative discussions. Ethiopian Public Health association (EPHA) held the conference under the major theme of "**Road Traffic Accidents as a Major Public Health concern in Ethiopia**" from 26-28 October 2009 at the Hilton Hotel in Addis Ababa, Ethiopia. The workshop brought together more than 800 participants from representatives of Minister of Health of the Democratic Republic of Ethiopia, PEPFAR, Transport Authority, Core team members and focal persons of EPHA chapters, Sister Associations and EPHA members. Presenters and panelists from various concerned organizations were invited to provide the presentations and ensuring informed discussions. Annex II and III presents the list of Panelists and presenters of the conference respectively.

In the same manner as previous annual Public Health conferences, this conference aimed to bring the concerned health professionals, researchers and EPHA members to provide research endeavors which will play key roles in provision of substantial and up-to-date information for those who are in safekeeping of the public health. Specifically, the conference was designed to:

i. Provide annual activity and audit report of the association;

ii. Alert the participants that road traffic accidents is becoming major Public Health concern in Ethiopia ;
iii. Provide research based information on HIV/AIDS, nutrition, reproductive health and tobacco control initiatives;
iv. promote the association for the public;
v. Discuss and agree upon the Draft strategic plan of 2010-2014, identification of the chapter that hosts the 21st (2010) Annual EPHA conference and election of board members to replace those who completed their service

Throughout the three-day event, participants attended plenary presentations and analyzed the main issue raised in smaller break out discussion groups led by team of experienced facilitators. The plenary sessions were devoted to panel discussions that aimed at familiarizing and preparing participants for discussion. Following the plenary sessions, participants were divided into three concurrent sessions under various topics such as HIV/AIDS, Reproductive Health, Road traffic accident, Malaria and environmental health, chronic diseases and emerging Public health concerns. Annex II presents the conference program.

Program Highlights

1. Inaugural session

Dr. Mengistu Asnake President, EPHA, convened the workshop by welcoming participants and guest speakers to the induction workshop. He extended his appreciation to His Excellency Dr. Tedros Adhanom, Minister of health for the Federal Democratic Republic of Ethiopia, His Excellency Ato kassahun H/Mariam, Director for the Transport Authority, members of the house of people representatives, Dr. Carmella, Green-Abate Representing CDC Ethiopia and members of the Ethiopian Public Health Association for honoring the organizer's invitation to participate and contribute to the workshop. He also expressed his pleasure the 20th conference is held at a unique time when the association is in the process of finalizing its third five year strategic plan for the period of 2010 to 2014. Dr. Mengistu afterwards announced that theme of conference is "**Road Traffic Accidents as a Major Public Health concern in Ethiopia**". He further elaborated that the theme was chosen based on the feedback from the 19th annual conference and through further discussion with the advisory council of EPHA on the Magnitude of the problem in Ethiopia. In addition to the main theme, as pointed out by Dr. Mengistu a number of panel discussion sessions on major public health issues included:

i. "National Nutrition policy, Strategies and Implementation", looking at progresses made with experiences from the field.
ii. "Tobacco Control: International and National Initiatives", focusing on the impact and the need for concerted actions.
iii. "Reproductive health in Higher Learning Institutions", looking at the magnitude of the problem based on different assessments, current initiatives and future directions.
iv. "Multi- sectored Response to HIV/ AIDS: Strategies to meet the Universal Access Target", focusing on Community Based HIV/ AIDS interventions and experiences.

Dr. Mengistu provided a comprehensive overview of some of the tangible results and major achievements of the association in the past year ranging from training, capacity building, surveillance, and evaluation activities to networking, information exchange and dissemination.

As a final remark, Dr. Mengistu requested all the conference participants to join hands for the better future of public health and our people who expect so much from us. Annex I presents the whole speech of Dr Mengistu Asnake.

2. Keynote addresses

In her keynote address, guest of honor, Dr. Carmela Green- Abate, PEPFAR Coordinator, gave a brief overview how EPHA was formed and it has significantly grown into such a vibrant and important association supporting the health sector in Ethiopia.

She further expressed the EPHA is an important partner for the US government's president's Emergency plan for AIDS Relief- PEPFAR. According to Dr. Caramela Green, at a larger view, Ethiopia has made remarkable progress over the last 5 years in addressing HIV and AIDS with current prevalence of 2.3%. She further added that Ethiopia still is with over 1 million who are HIV infected and that there are still more new infections occurring than the number of people that are being put on antiretroviral treatment.

EPHA, she explained, has been a key partner in a number of basic research activities which provide an evidence base to expanding and strengthening HIV prevention, care and treatment programs. She pointed out the major activity categories as Amhara MARPS study, the on- going National MARPS survey with EHRNI, and Alcohol and

Chat studies are evidence points to a mixed type of HIV epidemic in Ethiopia, primarily urban and peri- urban based with most at risk groups driving the epidemic.
She cited other studies such as AIDS Mortality surveillance is vital in improving HIV/STI/TB related public health practice & service delivery, labeling strengthening the work force of the health service delivery as a key factor.

On the other dimension, she explained, although the government is addressing increasing health workers in a number of ways, it is very important that a proper mix of health workers and available top support these front line workers. As a good example, she remarked, a group that may be forgotten but are crucial are the health management and support staff at all levels of the health system.

However, retention of physicians within the health sector has proved challenging.
In her final remark, Dr. Carmela Green- Abate elaborated the importance of an association such as the EPHA, working in partnership with the government at this crucial time within the health sector. Annex I presents the whole speech of Dr. Carmela Green- Abate.

The second keynote address by Ato Kassahun Ayele, director of Road Traffic Authority has dealt with the severity of the road traffic accident in Ethiopia. He explained that Ethiopia is facing more than 2000 deaths and 8000 sever injuries every year. Among those, nearly 55% of the victims are pedestrians as he explained. According to Ministry of Health report, if the situation kept on the same pace in 20020 more than 1,900.000 might be at the verge of death annually. Since the problem needs due attention some fundamental measures are taken nationally:

- Ministry of health has been putting maximum effort to strengthen the department of Emergency Room services;
- The Road Traffic Authority has tried to revise rules and regulations of the road traffic such as the third party liability insurance and provision of the skill of first aid for drivers;

As a final remark, Ato Kassahun Ayele forwarded his heartfelt gratitude and appreciation to EPHA for considering the road traffic accident as a major public health concern and alerting the public on the problem.

Following the presentations by representatives of the Government, Mr. Deneke gave the floor to participants for questions and answers. Annex I presents the whole speech of Ato Kassahun Ayele.

3. Opening Speech

Opening speech of the 20th annual conference of the Ethiopian Public Health Association was delivered by his Excellency Dr, Tedros Adhanom, Minister of FMoH. After congratulating all the members of EPHA on the occasion of the 20th annual conference, Dr.Tedros Adhanom has tried to elaborate some of the major reforms taken care by the Ministry of Health. As per his explanation, the world is currently entertaining about six health service building blocks. Coming to our situation, Ethiopia has tried to increase those health service building blocks to eight after considering the realities of the country. Those health service building blocks include:

- Improving basic health care services;
- Improving the provision and distribution of medicines;
- Availing health insurance system in all health facilities;
- Strengthening health services data management;
- Availing and strengthening emergency care services;
- Strengthening Research & Technology Transfer;
- Establishing regulatory and
- Building the capacity of the human resource

Furthermore Dr. Tedros has elaborated the work done to prevent HIV, Maternal death, Malaria, TB and other major treats of the national public health.

As his conclusion, he has invited all concerned bodies to forward their comments and suggestions on the strategized health service building blocks so as to fulfill our goals and objectives to the best. Annex I presents the whole speech of Dr, Tedros Adhanom.

4.EPHA Award Ceremony

Following the Keynote remarks and opening speech made by guests of honor, Dr. Mengistu Asnake, president of EPHA, invited Dr. Tedros Adhanom to handover the awards to the following people and organizations.

1. Senior Public Health Service Award: **Ato Hailu Meche**

Under the division of Senior Public Health Service, Ato Hailu Meche was awarded on the 20th annual public health association conference. Ato Hailu Meche is a graduate with B.SC in Public Health from Gondar Public Health College, and has Masters in Public Health from University of California-Losangeles. His professional involvement in Public Health started in 1963 when he joined Health Centers of Gidame and Hosannas. Between 1970 and 1972 with a rank of deputy provincial medical officer of Health and Provisional Medical Officer, he served in the then Sidamo Province. In 1972 he was assigned as head of Public Health services at the Ministry of Health. From 1974 to 1976 he served as General Manager of Malaria control service at Ministry of Health. In 1976 he was appointed as head of Preventive Health Service Department of Ministry of Health and in the same year he was further appointed as head of Addis Ababa Health Service Department.

From 1985 to 1994 he served as head of planning and programming Bureau for the Ministry of Health. Between 2004 and 2006 he served as health system analyst for Center for National Health Development in Ethiopia (CNHDE). Currently he is working as a Health Systems Strengthening Advisor for the HIV/AIDS Care and Support program of MSH.

He has more than 18 publications and presentations on different public health issues and has contributed a lot in the development of public health in Ethiopia over the past four decades.

Today on the 20th Annual Conference of EPHA I am happy to present Ato Hailu Meche to receive a Gold Medal Award of the Ethiopian Public Health Association for senior public health service.

2. Senior Public Health Research Award: Dr. Mesganaw Fantahun

This year's Senior Public Health Research award went to Dr. Mesganaw Fantahun. Dr. Mesganaw Fantahun graduated as a Medical Doctor in 1985 from Kalinin University of the then USSR, in 1992 received Masters of Public Health from AAU and in 1997 PhD in Epidemiology and Public Health from the University of Umea in Sweden.

His professional involvement started in 1987 when he joined *Koladiba* Health Center as a general practitioner and Head of the HC in North West Ethiopia. Starting from 1988 he was assigned as District Health Manager at Libo and Gonder Zuria districts and in 1989 assigned as deputy regional health manager of North Gondar Region.

From 1992 to 1996, with a rank of Assistant professor he served in the Department of Community Health at Gondar College of Medical Science. Between 1995 and 98 he was appointed as chairman of the Department of Community Health at Gondar College of Medical Sciences.
In 1997 he was promoted to the rank of Associate Professor of Public Health, and from 1999 to 2000, he served as an associate dean for undergraduate studies in the Faculty of Medicine at AAU.

He has lead and participated in several research activities and authored and co-authored over 75 publications in peer reviewed journals. His research activity has contributed a lot in the Development of Public Health in Ethiopia.
Today on the 20th Annual Conference of EPHA I am happy to present Dr. Mesganaw Fantahun to receive a Gold Medal award of the Ethiopian Public Health Association for Senior Public Health Research.

3. Junior Public Health Research Award: Dr. Tefera Belachew

The third award which is labeled under Junior Public Health Research was handed to Dr. Tefera Belachew. Dr. Tefera Belachew graduated in 1994 as a Medical Doctor from the then Jimma Institute of Health Science and received his Masters of Public Health in Nutrition from the London School of Hygiene and Tropical Medicine at University of London in 1997. Currently, he is a PhD-fellow at Ghent University, Belgium.

His career involvement started in 1994 when he joined Mana and Kersa districts as a general practitioner. In the same year he was serving as a Medical Director of Jimma Teaching Health Center. Starting from 1998 with the rank of assistant professor he was assigned as head of Population and Family Health Department of the then Jimma Institute of Health Sciences. Between 1999 and 2004 he was assigned as Head of Community Health Program and teaching nutrition for all health science students and in 2004 he was promoted to an academic rank of associate professor.
Between 2004 and 2006 he was appointed as Head of Student Research Program (SRP) of the Jimma University and in 2007 appointed as Director of the Institute of Health Science Research at Jimma University.

He has lead and participated in several research activities and authored and co-authored over 40 publications in peer reviewed journals and his research activity has contributed a lot in the Development of Public Health in Ethiopia.

Today on the 20th Annual Conference of EPHA I am happy to present Dr. Tefera belachew to receive a Gold Medal award of the Ethiopian Public health Association for Junior Public Health Research.

4. Institutional Award: Ethiopian Red Cross Society (ERCS)

The institutional award of the 20th Public Health Association's National conference is handed to Ethiopian Red Cross Society (ERCS) .It was established on 8 July 1935, in the aftermath of the second Ethio-Italian war (1935-1941). Its vision is to see a transformed Ethiopia where adverse effects of disaster are minimized and its people are living in peace and prosperity. Its involvement in humanitarian services began by training and deploying 300 first aiders and 6 Ambulances to various war fronts to care for the wounded.

Volunteerism is one of the fundamental principles of the organization and at the local level, Volunteers are one of the key players in assisting vulnerable people. It also gives due emphasis for the improvement of health care and in line with this, it provides integrated primary Health Care (PHC) such as health education, control of common communicative disease, extended program for immunization (EPI), maternal and child health, essential drugs program (EDP), nutrition, water and sanitation, treatment of common health problems and ambulance services.

Furthermore, the organization realizes the necessity and the importance of disaster preparedness and response in times of natural catastrophes. Over the years, it has established a national Disaster Response Team (DRT) and Branch Disaster Response team (BDR) in order to respond to emergencies as fast as possible.

The Organization also provides first-aid training in schools, factories, private companies, governmental and non- governmental organizations at the community level. It has 11 regional offices, 27 zonal branches, 50 woreda branches and aims to establish more zonal and woreda branches in the future.

The organization is the oldest and the biggest in African Continent, and has served the public for the last 74 years.

Today on the 20th Annual Conference of EPHA I am happy to present the Ethiopian Red Cross Society to receive a Cup and Certificate of Recognition for its institutional contribution in public health.

5. Main Theme: Road Traffic Accidents as a major Public Health Concern in Ethiopia

Moderator: Dr. Mengistu Asnake (MD, MPH)

5.1 Global and National Situation of Road Traffic Injuries

(Dr. Kunuz Abdella, MD, MPH)

Introduction

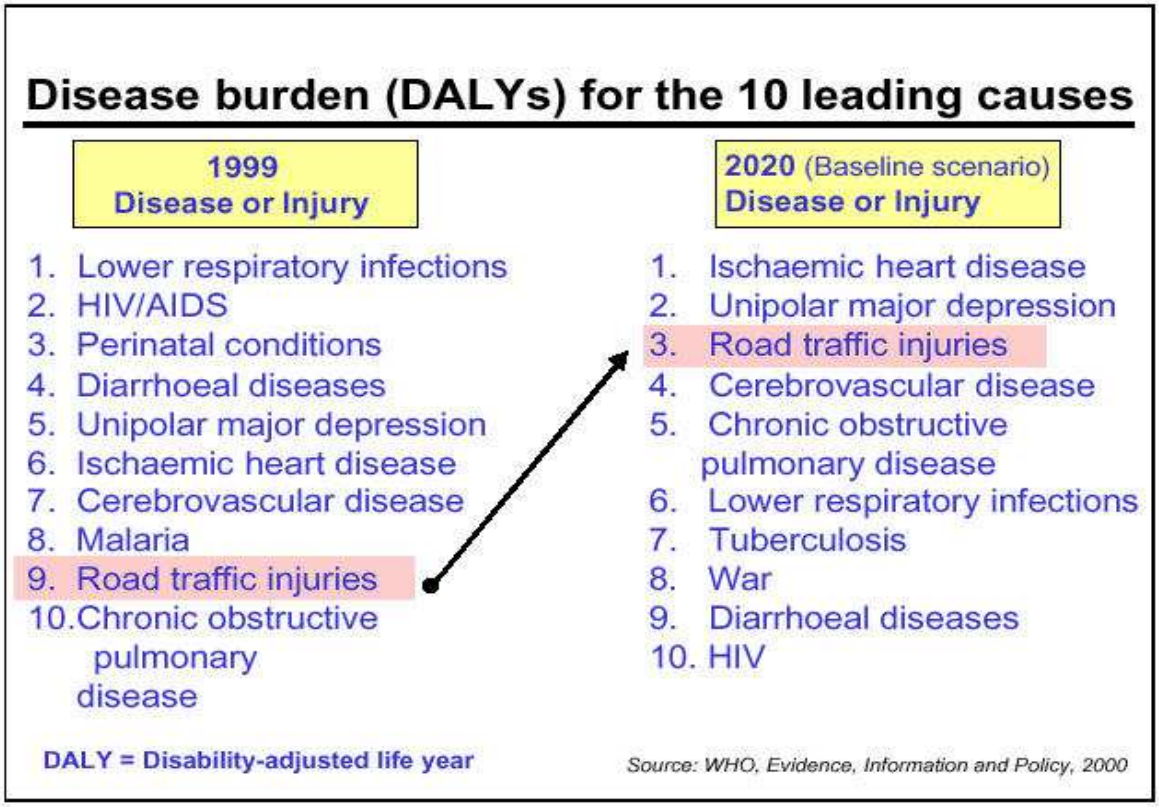
All cars irrespective of their models are prone to accidents. Globally there are 1.2 million people affected by motor vehicle injury. Everyday 16,000 people die from all types of injuries around the world (1/4 due to RTI). Global burden of diseases related to injury is 12%.

The trend of Road traffic injury is increasing from time to time. To mention in 1999, it was the 9th leading cause of death for all ages but in 2020 it is projected to be 3rd cause.

Table 1: Leading causes of death, all ages, 2004

	Disease or injury	Deaths (millions)	Per cent of total deaths
1	Ischaemic heart disease	7.2	12.2
2	Cerebrovascular disease	5.7	9.7
3	Lower respiratory infections	4.2	7.1
4	COPD	3.0	5.1
5	Diarrhoeal diseases	2.2	3.7
6	HIV/AIDS	2.0	3.5
7	Tuberculosis	1.5	2.5
8	Trachea, bronchus, lung cancers	1.3	2.3
9	Road traffic accidents	1.3	2.2
10	Prematurity and low birth weight	1.2	2.0
11	Neonatal infections[a]	1.1	1.9
12	Diabetes mellitus	1.1	1.9
13	Hypertensive heart disease	1.0	1.7
14	Malaria	0.9	1.5
15	Birth asphyxia and birth trauma	0.9	1.5
16	Self-inflicted injuries[b]	0.8	1.4
17	Stomach cancer	0.8	1.4
18	Cirrhosis of the liver	0.8	1.3
19	Nephritis and nephrosis	0.7	1.3
20	Colon and rectum cancers	0.6	1.1

Global burden



Global burden of RTI

RTI accounts for 23% of all deaths from injury

Fig.1 Global Burden and causes of injuries

Source: WHO Global Burden of Disease project, 2002, Version 1

In LMI countries, it accounts for 85% of global road deaths, 90% of DALYS and 96% of all child deaths from RTI. Pedestrians are mostly affected by the problem.

Global burden

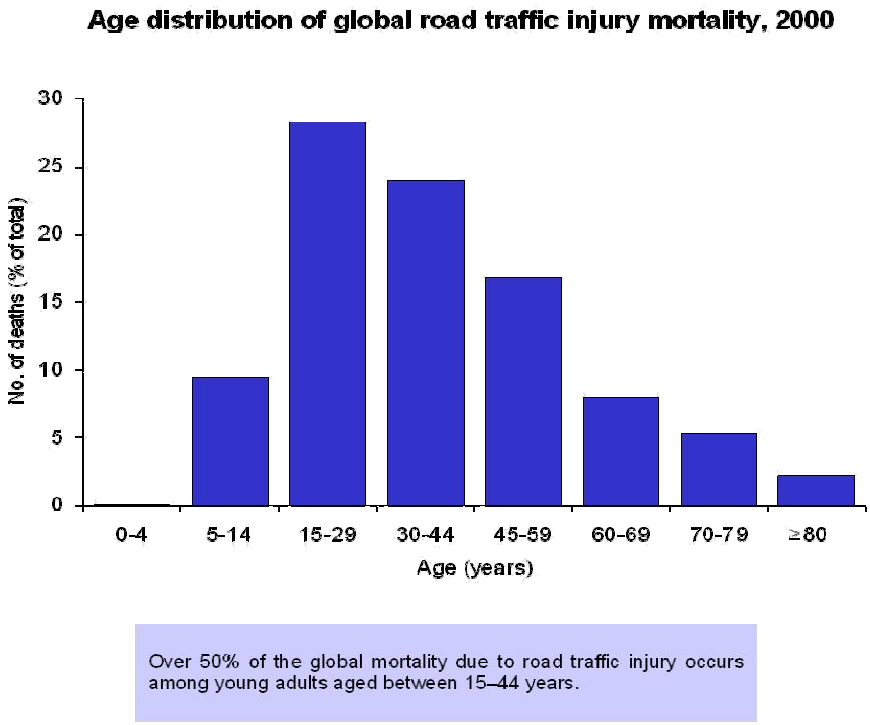


Fig. 2 Age Distribution of global road traffic injury mortality, 2000

Tip of an iceberg: wide gap: 1death: 30-50 injuries
Cost: 1% of GNP, affecting productive age group (e.g. 75% in Kenya)

Highlights of Road Traffic Injuries in Ethiopia

Ethiopia is one of the countries with low motorization ownership but high prevalence of road traffic injuries. The problem is affecting at large the productive age group. Hospital reports showed that there are about 8,958 injuries and 2160 deaths due to road traffic injuries. Fifty five % of deaths involved pedestrians.

The death rate per 10,000 vehicles is 80 that is the highest in the world.
The death rate per 100,000 populations is 3 (it seems low due relatively few vehicle/population).

Road Injury Prevention and Control is the New Understanding. Road safety is a multi-sectored and public health issue. Therefore, Collective responsibility, activity and advocacy is highly required.

Common driving and pedestrian errors should not cause death.
Technology transfer needs to fit local conditions. Research based local needs should be identified and addressed.

Road crash injury is a social equity issue. Hence, Equal protection to all road users is mandatory. LOCAL KNOWLEDGE should inform local solutions

International Response to RTI Prevention

WHO has been concerned with this issue for over 4 decades. In 1962, WHO report discussed- nature and dynamics of RTI. In 1974, declared (resolution WHA27.59) 'Road traffic accident as a major public health issue' and called Member States to address this problem. For the last 2 decades, the WB has encouraged its borrowers to include road safety in transport projects. For nearly 60 years, the UN system has acknowledged the need to reduce RTI death. Road safety has been considered by global and regional organizations (WHO, WB, and others). In 2004 WHO/WB issued the World Report on Road Traffic Injury prevention. It also defined role of many sectors.

Fundamental concept of RTI prevention and effective interventions strategies were designed.
Magnitude and impact of RTIand the major determinants and risk factors were also identified. Key recommendations were:

- Identify a lead agency
- Assess the problem, policies and institutional setting
- Prepare a national road safety strategy and POA

- Implement specific actions
- Allocate financial and human resources

Support development of national capacity and international cooperation

In April 2004 UNGA adopted a resolution 58/289 on '*improving global road safety*' and endorsed all of the above recommendations. After wards the resolution asked WHO, in collaboration with UN Regional Commissions, to coordinate road safety efforts within the United Nations system.The following month, the WHA adopted a resolution (WHA57.10) on '*Road safety and health*', which called on all Member States to prioritize road safety as a public health issue.

In the same manner, UNGA adopted resolutions (in 2005 and 2008) which reinforced the call for Member States to increase attention paid to road traffic injury prevention and implementation of the recommendation from the world report on RTI. Some of those resolutions were:

- First Global Ministerial Conference on Road Safety
- Draw attention to the need for action
- Review progress
- Provide a high-level global multi-sectored policy platform
- Propose actions on other issues (e.g. resource)

Capacity building materials

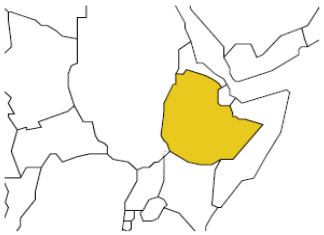
The capacity building material, as a training manual has been used in Ethiopia to train staffs from all relevant sectors: health, transport, roads, police, and academics, private.

ETHIOPIA

Population: 83 099 190

Income group: Low

Gross national income per capita: $220



INSTITUTIONAL FRAMEWORK	
Lead agency	National Road Safety Committee
Funded in national budget	Yes
National road safety strategy	Yes
Measurable targets	Yes
Funded	Yes

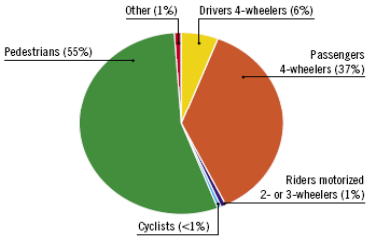
DATA
Reported road traffic fatalities (2006)
2 517[d] (78% males, 22% females)
Reported non-fatal road traffic injuries (2007)
24 792[e]
Costing study available
Yes (deaths and injuries)

[d] Police data, defined as died within 1 year of the crash.
[e] Police data adjusted by comparing with health data.

NATIONAL LEGISLATION	
Speed limits set nationally	Yes
Local authorities can set lower limits	Yes
Maximum limit urban roads	60 km/h
Enforcement[a]	0 1 **2** 3 4 5 6 7 8 9 10
Drink-driving law	Yes
BAC limit – general population	None[b]
BAC limit – young or novice drivers	None[b]
Random breath testing and/or police checkpoints	No
Road traffic deaths involving alcohol	10%[c]
Enforcement[a]	0 **1** 2 3 4 5 6 7 8 9 10
Motorcycle helmet law	No (subnational)
Applies to all riders	n/a
Helmet standards mandated	n/a
Helmet wearing rate	60%[c]
Enforcement[a]	n/a
Seat-belt law	No (subnational)
Applies to all occupants	n/a
Seat-belt wearing rate	20%[c]
Enforcement[a]	n/a
Child restraints law	No
Enforcement[a]	n/a

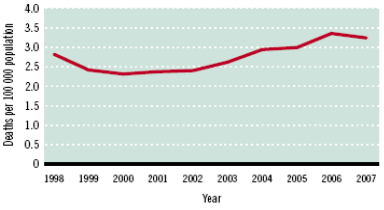
[a] Enforcement score represents consensus based on professional opinion of respondents, on a scale of 0 to 10 where 0 is not effective and 10 is highly effective.
[b] Drink–driving not defined by BAC limit.
[c] 2007, Consensus group estimate.

DEATHS BY ROAD USER CATEGORY



Source: 2007, Federal Police Commission Annual Report

TRENDS IN ROAD TRAFFIC DEATHS



Source: Country questionnaire

VEHICLE STANDARDS
No car manufacturers
ROAD SAFETY AUDITS
Formal audits required for major new road construction projects: No
Regular audits of existing road infrastructure: No
PROMOTING ALTERNATIVE TRANSPORT
National policies to promote walking or cycling: No
National policies to promote public transportation: No

REGISTERED VEHICLES	
244 257 total (2007)	
Motorcars	29%
Motorized 2- and 3-wheelers	3%
Minibuses, vans, etc. (seating <20)	34%
Trucks	27%
Buses	7%

Data cleared by the Ministry of Health and the Ministry of Transport and Communications.

POST-CRASH CARE	
Formal, publicly available pre-hospital care system	No
National universal access number	n/a

— Data not available.
n/a Data not required/not applicable.

In general Road traffic injury is predictable and preventable. It is a multi-sectored issue. World Health organization has been concerned with this issue and worked since four decades back.

Token of challenges witnessed so far to mitigate the problem are:

- Shortage of Resources
- Lack of Coordination
- Lack of ownership

Etc.

Taking those challenges into consideration, awareness creation that the problem is devastating and needs inter-sectored collaboration and multi-sectored response and etc. as the way forward.

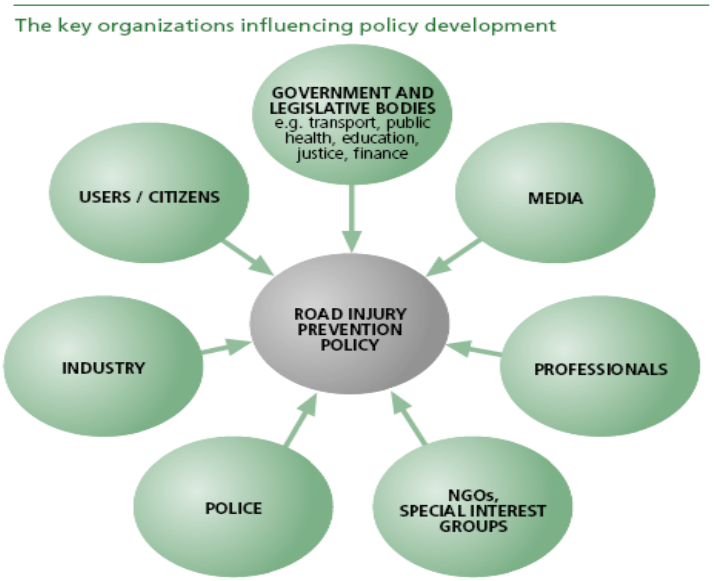


Fig. 3 Key organizations influencing policy development

5.2 Impact of RTI on individuals: Individual Experience

(Sr. Tsige Kebede, BSc, Survivor)

Sr. Tsigie launched her explanation saying, "seeing is believing" since injury causes both physical damage and mental trauma is everyday's scenario of her working environment. She was also one of the road traffic accident victims and sustained the injury while she was crossing Zebra around "Kazanchis" in Addis Ababa.

As she described the accident , at the moment of injury she did not have any bleeding. There appeared the severity of the problem after she was diagnosed to have

acetabular fracture in Yekatit 12 Hospital .Afterwards she was referred and admitted to Tikur Anbessa Hospital. When she was in inpatient in Tikur Anbessa Hospital, most of the injury patients admitted to her room were due to motor vehicle injury and majority of them sustained the injury on "Kazanchis" and "Debrezeit" roads.

After a detailed description of the tragedy, the survivor suggested the following points as the way forwards.

- Strengthening of emergency network ;
- Regular monitoring on the safety of vehicles and
- Blunt traumas should be given special attention as their outcome may be worse.

Finally, the victim passed her heartfelt message saying, "Every one of us should be cautious be it as a driver or pedestrian".

5.3 The Magnitude of Traffic Injury and the Role of Public Health in Reducing the Consequences

(**By Sr. Sosina Belaineh, Msc, and Federal Ministry of Health)**

1. Magnitude of Traffic Accident

Over 1.2 million people die each year on the world's roads, and between 20 and 50 million suffer non-fatal injuries.

Over 90% of the world's fatalities on the roads occur in low-income and middle-income countries, which have only 48% of the world's registered vehicles (World Health Organization 2009). According to (Jacobs and Thomas 2000) transport research laboratory road safety African continent is one of the worst in the world. In several African countries a motor vehicles is over a hundred times more likely to be involved in a fatal road crash.

South Africa and Nigeria, sub- Saharan Africa reported a 42% increase in road fatalities over the past decades. Many of the road fatalities were pedestrians or cyclists. Pedestrians accounted for 86% of the fatalities in Addis Ababa and five countries reported.

For every 10,000 vehicles in Ethiopia 80 people die in traffic related accidents.To compare to United State, where about 21 people die in traffic related accidents, for every 100,000 vehicles; according to the 2001/2002 police data in Ethiopia, over 30% of deaths following motor vehicles injuries in Addis Ababa. All the above facts indicate that traffic accident is a major public health problem of developing countries in general and Ethiopia in particular.

2. Causes of vehicle Accidents

Environmental Factors

Some of the environmental factors for vehicle accidents are narrow and damaged roads, traffic crowdedness, tyre bursts, Poor lighting and the rapidly growing numbers of used cars. When we try to assess come of the psychosocial and environmental factors poor supervision, poor, management and poor administration can be mentioned.

Host factors which predispose to accidents

The major host factors which predispose to accidents are visual and hearing defects, musculo-skeletal and neural disorders, low intelligence/low awareness, disorder of personality, psychiatric illness, lack of driving experience, carelessness of people, driving while drunk or chewing, driving in high speed and lack of knowledge of driving rules and negligence.

Major Risk Factors

Excessive speed, drink-driving, substance abuse- Khat, Not using helmets, Not using seat belt, not using child restraints, driving and use of cell phone and Age of driver

3. The Public health consequences of vehicle accidents are:

Injuries, disabilities, death, psychological problems, damage to people and property Loss of economic assets. The other factor which cannot be ignored is speed. A 5% increase in average speed; 10% increase in crashes the cause injuries and 20% increase in fatal crashes. Pedestrians have a 90% chance of surviving a car crash at 30 km/h or below, but less than a 50% chance of surviving impact at 45km/h or above.

4. Prevention

Preventing accidents is very important in every aspect than reacting on the aftermath. Some of the major points in preventing the problem are , recognition and elimination of any hazard in the agent-host- environment relationship, educating workers as well as the management and observe rules and regulations set up to avoid accident.

Seat-belt Safes Life

Only 38% of low income-countries and 54% of middle income countries require seat-belts to be used in cars by both front-seat and rear-seat passengers.

Approach to Road Injury Prevention

The following are forwarded as general approaches to prevent road injuries: understanding risks, safe admission to the system: licensing of vehicles and people, enforcing or road rules and education and information. In the same manner prevention of crashes that result in injury and death can be tackled through availing safe vehicles, safe speed and safe roads and road sides.

5. Role of Public Health

Public Education

One of the major Public Health roles is educating the public. Under public education, monitor and evaluate the health needs of communities, promote healthy practices and behaviors in populations and identify and eliminate hazards to assure that populations remain healthy are the prominent activities. Furthermore, improving pre-hospital care, improving hospital care and improving rehabilitation services are equally important.

More specifically, in the due course of educating the public activites such as road safety in health promotion and disease prevention, assuring access to preventive services such as child safety seats and bicycle helmets and establishing pre-hospital and hospital care for trauma victims could be possible contributions of public health services.

Interaction of factors: the traditional public health approach

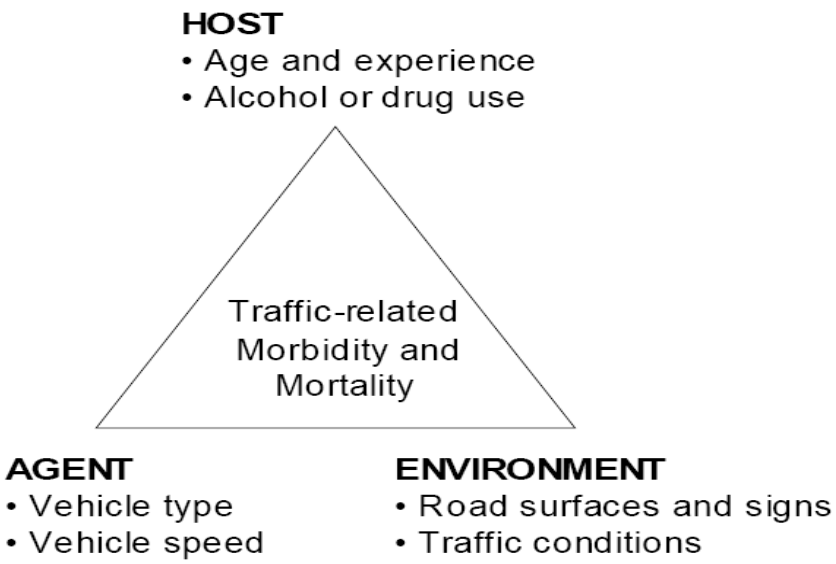
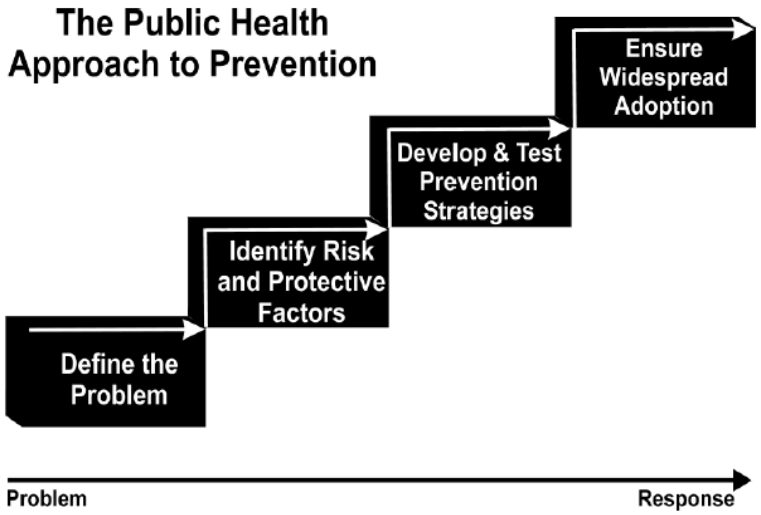


Fig. 4 Interaction of factors: the traditional public health approach



Problem Based Action

Fig. 5 the Public Health Approach for Action

Measure taken by FMOH

The concept of accident prevention addressed in the health policy Document
Developed draft Strategies on road safety. Accident Prevention, First Aid and Referral Package Developed and will be implemented by heath extension professionals at HHs, Schools and Youth centers. In connection to the above measures, introduction of road safety community campaigns in rural areas and road safety audits and the establishment of Emergency Medical Services Unit in all hospital and health institutions were very significant ones.

The ways forward

As of talking and preventing all the above obstacles the following are stated as ways forward:

- Conduct assessment on the problems
- Develop strategic plan based on the assessment result
- Coordinated Multi-sectored response for road traffic injury prevention
- Labeling transport, health and police among the key sectors
- Conducting advocacy workshop
- Promote social mobilization through mass media and workshop
- Periodic medical checkup for drivers
- Promote awareness on accident prevention for drivers
- Increase the use of seat belts
- Fixing speed control
- Safer design of roads and roadside environments
- Developing roadside (crash barriers)
- Avoiding drunk and chewing driving

5.4 Legal perspectives of RTI in Ethiopia

(By Commander Aklilu Seifu, Federal police commission)

Introduction

Road traffic accident is a universal problem. The condition of accident in Ethiopia has been considered alarming given the number of vehicles in the country. It is increasingly becoming a source of concern. The following data indicate some of the recorded realities. Annually there is life lose of 2,230 people on average. Over 8,670

sustain physical serious injury and disabilities. Out of these about 48% of them are travelers, 45% of them are pedestrians and 7% of them are drivers. In 2007 there were 80 deaths per 10,000 vehicles.

Major Causes of Accident in Ethiopia

Data collected by the traffic departments throughout the country attributed road accidents to the number of factors such as the road environment, the road users and the vehicle. It is found to be significant to examine those factors in detail.

The road environment

If the state of the road is poor and often characterized by being bumpy, narrow, curvy, slippery, sloppy (ascending or downhill), etc. there is a high probability for accidents to occur. This is especially true if the vehicle is speeding or over loaded. The condition of the weather is also equally important; for instance, Foggy, frosty or dusty weather resulting in sight reduction to the driver is likely to cause accidents.

The Road Users

Pedestrian road users lack traffic education. Some road users do not understand the basic traffic rules. Wheel carriages for merchandise or horse drawn carts are unsafely move on major roads. Some road users have not acquired positive attitude towards road safety etc**.**

The vehicle

Drivers often complain that highly reflected light from oncoming vehicles as a cause of accident. Defective motor vehicles and Speeding and infringement of road signs and markings are the causes of accidents. Over speeding is one of the major causes of accident in Ethiopia. Over loading carriers and public commuters often take a heavy tool of human life and property damage. Reckless driving, cycling without proper driving skills.

Driver Errors Causing Crashes are not respecting pedestrian priorities, Front to front crash drivers not respecting their lanes, front to back crash drivers following other vehicle too closely, Over speeding, Side to side accident, Overloading, Unsafe use of freight vehicles to transport passengers and other reckless driving behaviors.

In Ethiopia annual traffic statistics follows our fiscal year, which begins in July. In this respect study of the traffic accident trends over five years (2003/04-07/08) shows some revealing facts like Number of vehicles accident, Injury to person, Fatal by age group, Fatal crash type, Time and hour of the day, Condition of road, Compensation of transport passengers and Damage to property.

Table 2: Five Year Total Traffic Accident as Reported to Police, 2009 Addis Ababa

Year	Accident Type				Total
	Fatality	Heavy Injury	Light Injury	Property Damage	
2003/2004	1,630	2,072	2,705	10,569	16,976
2004/2005	1,801	2,368	2,731	10,822	17,722
2005/2006	2,029	2,621	2,653	11,608	18,911
2006/2007	2,047	2,504	2,426	10,170	17,147
2007/2008	1,802	2,156	2,123	9,005	15,086
Total	9,307	11,721	12,638	51,174	85,842

The road traffic fatalities like the number of deaths per 10,000 registered vehicles, or per 100,000 populations could be computed. It is 80 per 10,000 vehicles or 3 per 100,000 populations in Ethiopia.

Table 3: Five Year Fatality and Injury by Road traffic accident Addis Ababa, 2009

Years	Fatality		Heavy and Light Injury	
2003/04	2,111	17	8,507	19
2004/2005	2,176	19	8,885	21
2005/2006	2,522	22	9,391	22
2006/2007	2,517	22	9,553	22
2007/2008	2,160	20	6,798	16
Total	11,498	100	43,134	100

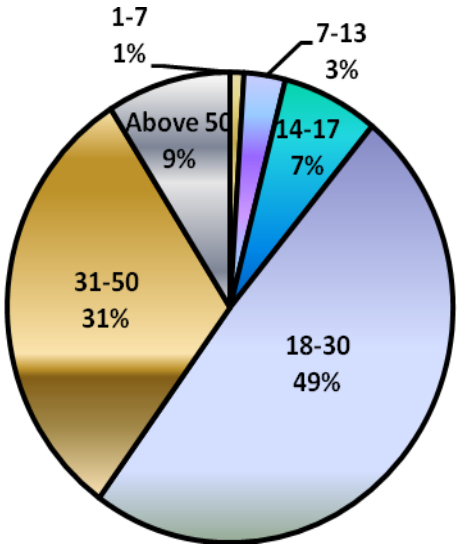


Fig. 6 Fatality by age group in Addis Ababa, 2009

It is shown that the commonly affected age group is 18-30 yrs which is the productive age group.

Table 4: Five Year Total Traffic Accident by Day of a Week

Day	Total	(%)
Monday	12,926	15
Tuesday	12,871	15
Wednesday	13,618	16
Thursday	12,922	15
Friday	12,402	14
Saturday	11,799	14
Sunday	9,304	11

The above table shows that the highest rate of accident is observed to be on Wednesday. The rest have a similar scenario except on Sunday.

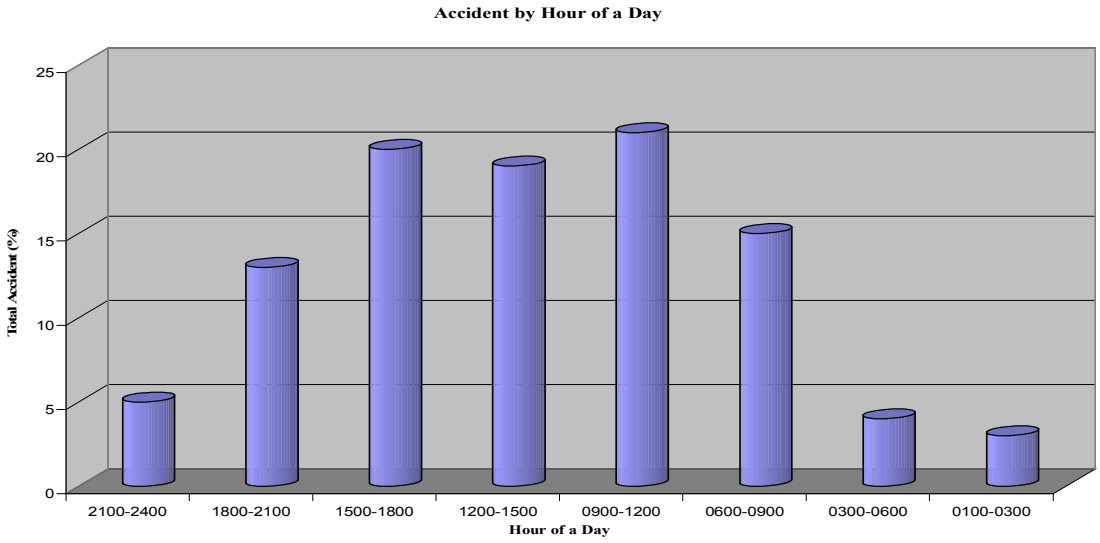


Fig. 7 Distribution of Accident by Hour of a day

Table 5. Distribution of Condition of Road Surface, Addis Ababa, 2009

Dry road	78,517	91%
Wet road	5,859	7%
Muddy road	1,308	1.8%
Other road types	158	0.2%

These data shows that 90% of road accident occurs in dry season because of high speed of drivers.

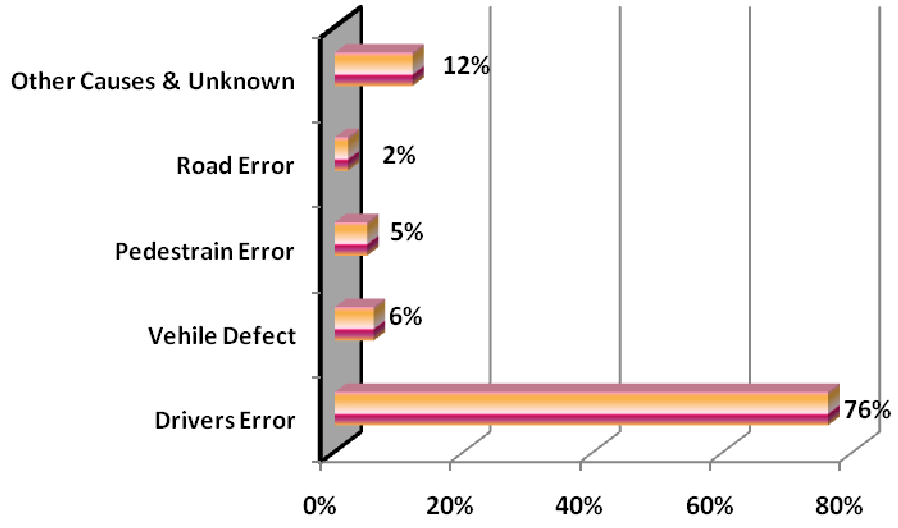


Fig. 8 Trends of Fatal Accident Causes Addis Ababa, 2009.

This figure showed that a great majority accident is caused as a result of drivers' error. The five year accident data on the relationship of accident to vehicle types shows that vehicles other than the private use cars or vehicles that are mainly driven by professional drivers are involved in 76 % of the total accident.

Table 6: distribution by Type of crashes Addis Ababa 2009.

Fatal Crash Types	%
Pedestrian strike	56%
Over turn	19%
Falling from vehicles	6%
Animal carts strike	1%
Vehicle to vehicle and other crash (unknown)	20%

The common type of crash is Pedestrian strike followed by overturn as indicated in the above.

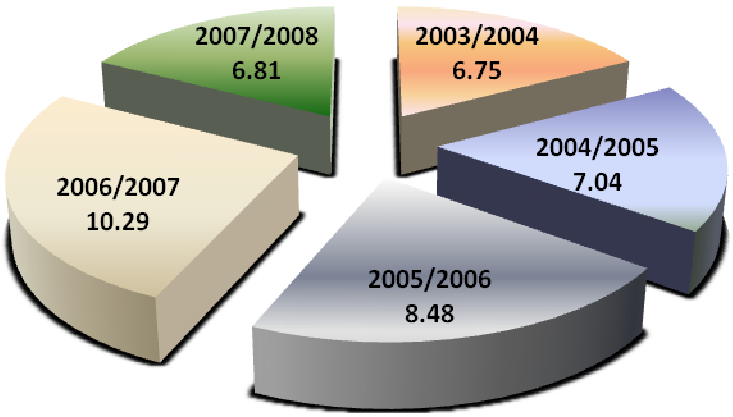


Fig. 9 Prop

As indicated above property damage was high in 2007/2008.

Strengthening the traffic police effort to improve the capacity of the traffic police to enforce law has been made with the provision of Vehicles Motor vehicles and Introduction of roads speed measuring device. The traffic police instructors of the regional states have been introduced to the importance of traffic control targeted to violations that are important causes of crashes. Several training workshops and courses have been conducted for the traffic controllers on accident investigation usage of new accident data recording and basic computer courses. The human resources of the traffic police has been improved and is still improving as it is getting better attention from the decision makers. For example the Addis Ababa traffic police manpower has been strengthened substantially in the last five years both in number and skill. Targeted traffic control on accident causes and hazardous locations has been started. Accident data is used to plan daily traffic control to reduce road crashes.

Conclusion

In summary the road accident data shows the underlined causes for the road accident in Ethiopia to be:

- Improper behavior or low skill of drivers resulting in Drivers not respecting pedestrian priority, Over speeding, Unsafe usage of fright vehicles to transport people, Over loading or improper loading, Drivers not observing the traffic rules(reckless driving)
- Poor vehicles technical condition
- Pedestrian not taking proper action
- Poor traffic law enforcement
- Safety consideration not sufficiently given in road development
- Animal and carts drawn by animals using the highways and
- Poor emergency medical service etc.

Recommendations

The researcher recommends that drivers should take adequet drivers training, testing, licensing inaddition to improvement and monitoring of high vehicles technical inspection standards.Moreover the following measures should be made practical:

- Enforcement of speed limit regulation
- Restriction on driving while drunk or impaired by drug
- Enforcing safety belt
- Restriction on heavy goods vehicles (HGV)
- Driving on busy roads

Pedestrians

Provision of Road traffic education to the general public

Creating awareness and positive attitude towards road safety

Support and strengthen the children road safety education efforts in schools

strengthen the community road safety campaign in regions

As of enhancing the situation of the roads:

- Road safety capacity building should be taken care of;
- Install appropriate road sign and markings
- Implement spot checking's
- Implement highway patrol along the route
- Construct pedestrian facilities
- Construct cattle crossing areas
- Expanding pedestrian walking ways
- Segregating the opposing traffic flows with crash barriers

Enforcement

Improving the capacity of the traffic police to enforce laws have been made with the provision of vehicles

Motor vehicles and introduction of radar speed measuring device

Accident data used to plan traffic control targets to reduce the road accident

Radar speed control equipment have been found to be very effective in enforcing speed limits

Improve motor high vehicles technical inspection standards the transport and the traffics law enforcement

Assisting enforcement with modern technologies

Prohibiting animals like donkeys on motor ways

Improving the accident data collection and reporting the computerization program road accident data

The federal government is responsible for vehicle safety design standard national data sets

5.5 Road Safety Situation in Ethiopia

(By Ato Abebe Asrat National Road Safety Coordinating Office)

Introduction

In Year 2000 EC, 8,958 people were injured and 2,160 people died due to road accident. Fifty five percent of deaths involve pedestrians. The death rate per 10,000 vehicles is 80 whichis of high category in the world.

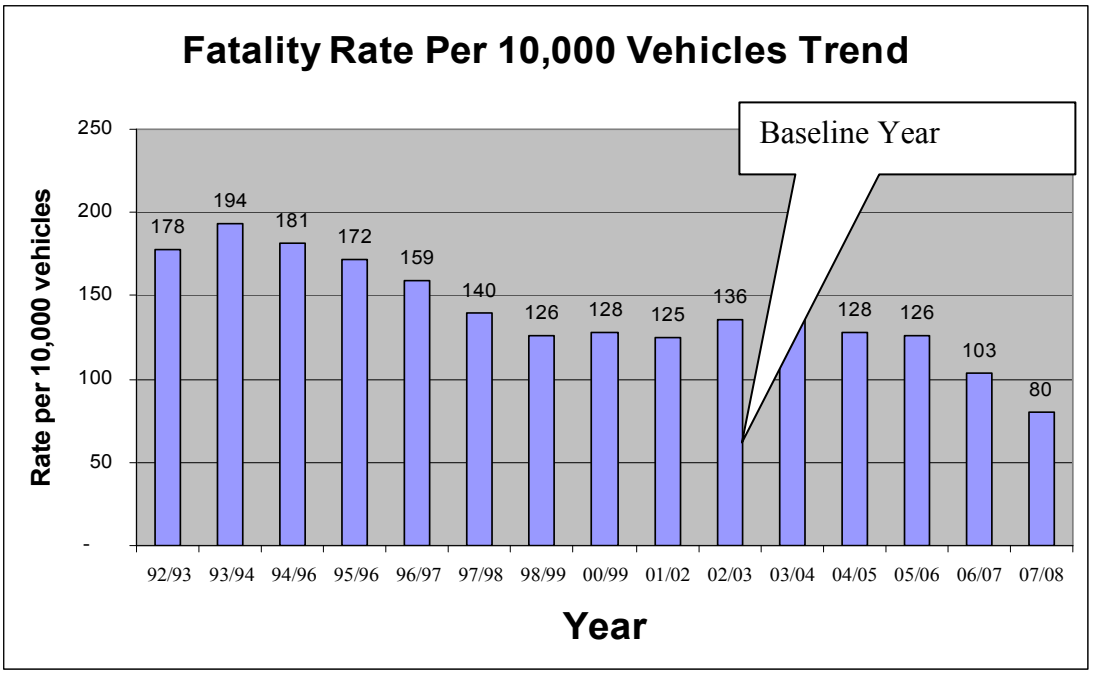


Fig. 10: Road Accident Trends of Ethiopia, 2009

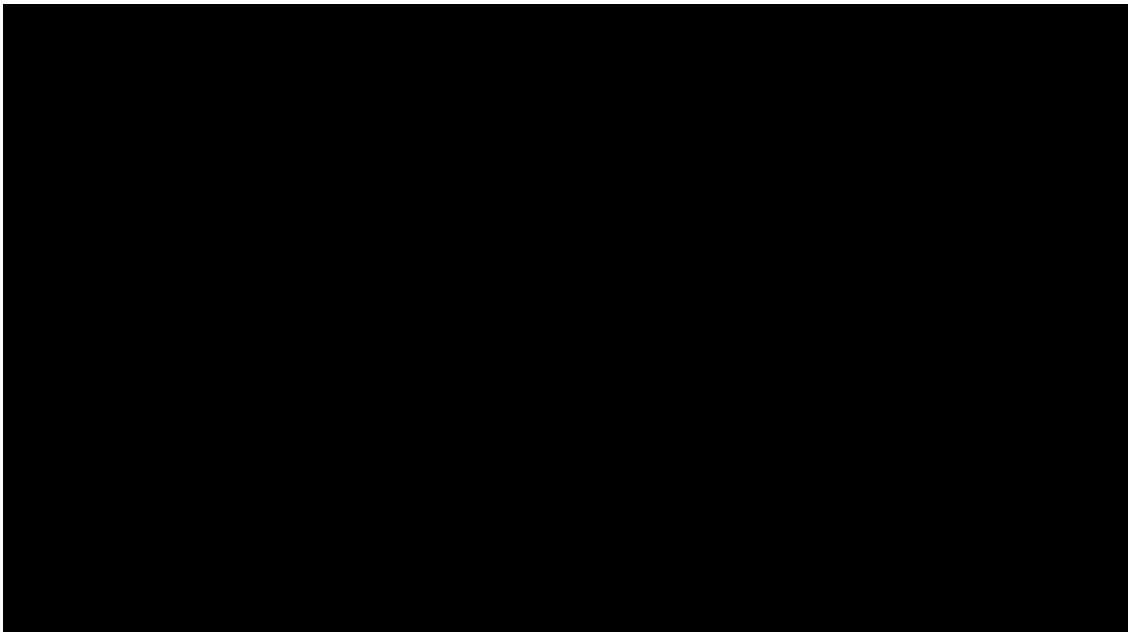


Fig. 11 Fatality and Vehicle Numbers compared to Base line year

Fig. 12 Fatality Rate per 100,000 population trend

Table 7 Main Risk Factors for Road Traffic Accident in Ethiopia

Phase		Human Factors	Vehicles Factors	Environment Factors
Pre Crash	Crash Prevention	Information Attitudes Impairment	Road Worthiness Lighting Braking	Road design Road layout Speed limits

		Traffic law Enforcement	Speed management Handling	Pedestrian facilities
Crash	Injury Prevention During Crash	Restraints use Impairment	Occupant restraints Other protective devices Crash protective design	Forgiving roadside (e.g. Crash barriers)
Post Crash	Life Sustaining	First aid Kits Access to medical services	Ease of access Fire risk	Rescue facilities Congestion

[redacted]

[redacted]

The underlying reasons for accidents in Ethiopia are: -

1. Improper behavior or low skill of drivers resulting in
    a. Drivers not respecting pedestrian priority
    b. Over speeding
    c. Unsafe usage of freight vehicles to transport people
    d. Over loading or improper loading
    e. Drivers not respecting traffic laws (reckless driving)
2. Poor vehicle technical conditions
3. Animals and carts using the highways
4. Pedestrians not taking proper precautions
5. Poor traffic law enforcement
6. Poor emergency medical services and
7. Safety consideration not sufficiently given in roads developments

Fig. 15 Fatal accident Types compared b/n the baseline year 2002/3 and 2007/8

Coordination

National Road Safety Coordination

Regional

Zonal

Wereda (district)

Kebele (community

2. Legislations

The following articles have been developed and implemented

Transport Administration Proclamation August 2005

Penal Code Proclamation May 2005

Third Party Mandatory Motor Vehicle Insurance Proclamation January 2008

Driver's Qualification Certification Licensing Proclamation August 2008

Revised traffic control proclamation

Transport sector

SNNPR and Tigrai regions- traffic control function transferred

Tigrai, Oromia and SNNPR road safety structure down to woreda level

Outsourced vehicle inspection

On process to strengthen vehicle technical inspection using equipments

Strengthened drivers training, testing and licensing

Commercial transport operation directive

Road safety structure strengthened both at federal and regional levels

Publicity

National TV and Radio programs

Regional radio programs

Addis Ababa area (TV)

Amhara

Oromia

SNNPR

Dire Dawa

News papers and pamphlets

Road safety week celebrations

Children road safety education

Grades 1 to 8 in basic education

Evaluation for Addis Ababa schools

Extra curriculum education

Over 3000 traffic safety clubs

Over 1000 schools along the road sides with student traffic control assistants

Community campaign

Kebele road safety committees in SNNPR, Oromia, Amhara and Tigrai regions

Pedestrians of the rural communities of Amhara, SNNPR and in few zones in Oromia region

Traffic law enforcement

Traffic police under the regions police commissions

Organized under the crime prevention departments

SNNPR and Tigrai regions transferred traffic control functions to (Traffic Authority) TA

Traffic control targeted to crash causes and locations implemented on pilot level

Radar speed control implemented on pilot level

Unsafe usage of freight vehicles controlled in Tigrai, Amhara and SNNP regions

Table 8 Types of damage caused by RTI for two years

Accident Severity Severity	May to September 2006 compared to same period of 2005		
	2005	2006	Reduction in percent
Death	84	44	-47.6%
Serious injury	59	27	-54.2%
Light injury	25	11	-56.0%
Property damage	168	110	-34.5%
Total accidents	336	192	-42.9%

Specific interventions implemented in Ethiopia

Road safety engineering

Strengthen safety units setup in ERA and AACRA to regularly
Conducted hazardous location studies
Safety audit manual draft prepared
Carry out safety audit of new roads
Ensure safety engineering measures are carried out as required

Road Safety Engineering Considerations

55-65 % of fatal accidents are pedestrian strike
80% of fatal accidents occur in cities or villages
Speed limit violation is serious and very significant
Pedestrians and carts use the highways intensively. Pedestrian walkways, crossing refuges at intersections and medians on wide two way streets and other facilities (consider people with disabilities) implemented. Construction of speed calming structures at entrances of cities & villages and replacing intersections with roundabouts should be standard safety measures.
Consider widening shoulders (3m) to cater for carts, pedestrians, and to park broken vehicles
Road signs and markings have to be maintained and updated.

Emergency Medical System

Present status of EMS in low-income countries (WHO report, 2008) is poor due to:
Lack of first aid services and trained manpower
Unsafe modes of transportation to reach emergency care
Long delay between time of injury and reaching hospital
Inappropriate referral services
Absence of transportation system
Lack of rehabilitation services

Third party insurance law provisions related to medical services to road accident victims
Article 5/34 – Emphasizes on emergency medical services

Any person who has sustained injury caused by vehicle accident shall be entitled to emergency medical treatment costing up to Birr 1,000 whether he is a third party or not as defined under this proclamation. Any medical institution shall have the duty to provide emergency medical treatment to a victim of vehicle accident when approached by the victim. The medical institutions shall be entitled to claim its fees for the medical treatment directly from the insurer or from the Fund as ……

Third party insurance law provisions related to medical services to road accident victims.

The way forward

1. Support the establishment of the transport management and safety institute for sustained road safety capacity building at all levels
2. Strengthen traffic laws enforcement capacity
3. Expand the Accident data improvement
4. Strengthen road safety audit and safety engineering measures
5. Strengthen the good practices achieved in the previous efforts, Support the establishment of the transport management and safety institute for sustained road safety capacity building at all levels
6. Strengthen the children road safety education.
7. Strengthen the ongoing mass media campaigns.
8. Strengthen the road safety efforts in transport associations and organizations
9. Promote and support Emergency Medical Service improvement efforts of the Ministry Of Health

After the panelists completed their presentations, Dr. Mengistu (the Moderator) opened the floor for discussion. Then, the following questions and comments were raised by the participants.

1. What interventions are being undertaken by different stakeholders to expand utilization of seat belt, safe utilization of road by pedestrians?
2. Some presenters used to say Al-quida Vehicles; But is that the vehicle or the driver that is majorly responsible for Road traffic Injuries?

3. Roads are damaged after being used for long time without timely maintainance or due to constructions underway around the roads. So what is currently happening to avert such problems as they may contribute for the problem?
4. When Road traffic laws are developed, please try to involve associations like EPHA and others; as we are all stakeholders.
5. The presentations are mainy focusing on the magnitude and distribution of the problem. But beyond reflecting figures to show the extent of the problem; What interventions are underway in by your organizations to minimize the problem?
6. Residential houses are built haphazardly near to curves of roads especially in the rural settings. What is the acceptable distance b/n roads and residential houses?
7. What actions are under way to promote the utilization of Helmet?

Then, the moderator gave the opportunity for the panelists to respond to the questions and comments raised.
The panelists responded as follows:

- As to the use of seat belt, promotions are under way to increase the awareness of drivers to use seat belts through massmedia. It is to be endorsed soon by the house of representative as a law so that enforcement measures would be effective. Moreover, the use cell phones while driving is being discouraged and to be endorsed as a law. The police men are also educating about the use of seatbelts.
- While developing rules and regulations on this issue we shall identify our stakeholders and make them take part in the process.
- Pedestrians are being educated and mass mobilization have been made on the appropriate use of roads and there are encouraging results obtained e.g the case of east Gojjam, west Gojjam and Awi Zones of Amhara regional state.
- Concerning the construction of residential houses near to the roads, there are measures being undertaken in collaboration with the community and local administrations. Houses

constructed near to the road before are being dismantelled and constructed somewhere else. E.g SNNPR, Yirga chefie district

- Houses should be constructed at least at 50 meters distance from roads.
- Roads that have been damaged are also being repaired.
- Speed control devices are being purchased and started to be utilized.

Finally the moderator acknowledged the panelists and participants and the session was winded up.

6. Sub Theme 1: Multi-sectored Response to HIV/AIDS (Moderator Dr. Betru Tekle, Federal HAPCO)

6.1. Multi-sectored Response against HIV/AIDS Move towards Universal Access (Ato Meskele Lera Federal HAPCO)

Introduction

National HIV/AIDS Situation

The total population of Ethiopia is 77 million (Rural 83%, 17% urban). The National HIV prevalence is 2.2% in 2008 based on single point estimate. The urban prevalence is 7.7%, and that of rural is 0.9%. Gender wise the prevalence in female is 2.6%, and in males 1.8%. There are 125,000 new infections with 0.28% incidence rate. In addition, there are 79,173 HIV+ pregnancies and 14,093 HIV+ births.

The epidemic is nationally stabilized with declining urban epidemic. It is revealed that small towns and young females at higher risk. It is estimated that there are 1.03 million people living with HI. About 68,136 children are below 14 years and 289,734 PLHIV need ART. There are also 886,820 children are orphaned due to HIV/AIDS. Overall there are more than 5.4 million orphans in the country.

Strategic Issues in the Multi-sectored Response

There were activities undertaken like: Capacity Building for Multi-sectored response focusing on key sectors, Community Mobilization and Empowerment, Integration with Health Programs, Leadership and Mainstreaming, Multi-sectored Coordination and Networking, Focus on Special Target Groups: MARPs, Affected & Infected

How is Multi-sectored Response Organized?

Overarching HIV/AIDS policy was issued in 1998. HAPCO was established in 2000 to coordinate and lead Multi-sectored response. Multi-sectored Strategic Plan (SPM) has been developed from 2004-2008. HIV/AIDS is a key component of PASDEP. Roadmap for health sector was designed and implemented since 2004-2006, 2007-2010. Multi-sectored Plan of Action to Universal Access was developed 2007-2010. Various guidelines on Social mobilization, mainstreaming, CC, HCT, PMTCT, chronic care (OIs), ART, M&E Multi-sectored response governance were issued.

Enhanced Partnership

National Partnership forums like Government, Donors, Parliament, NGOs, FBOs, Media, PLHIV, Women, Youth and OVC were conducted. Regional partnership Forums were carried out. **Regular Consultative Meetings were held with partners like UNAIDS, PEPFAR, World Bank, NEP+ and CHAI. Multi-level Joint Planning, Joint Supportive Supervision** and **Multi-sectored Response Joint review** have been implemented with partners.

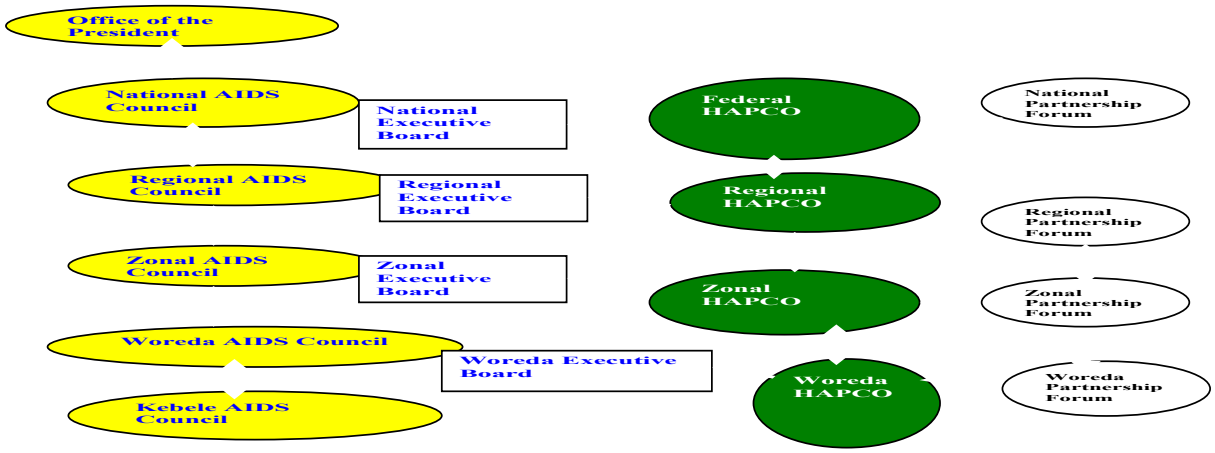


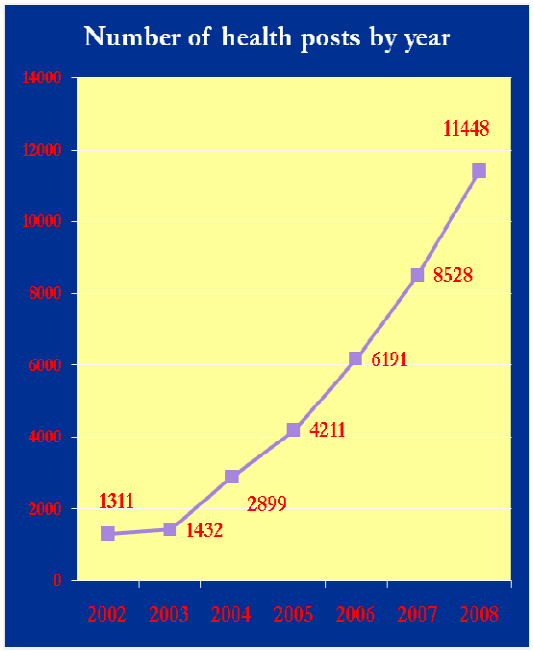
FIG. 17 Multi-sectored Response Coordination (Current)

Table 9. Universal Access Targets Current Status (Access & Utilization)

2005	2006	2007	2008	2009	2010	
Site Expansion						
HCT Sites	658	775	1005	1336		1596
3,276						
PMTCT sites	129	184	408	719		843
3,276						
ART sites	3	93	272	353		522
3,276						
SM via HSEP	2,737	9,900	17,653	25,071	30,193	
Service Uptake						
HCT	0.43M	0.56M	1.9M	4.5 M	5.8M	25
Million						
PMTCT	1,600	3,700	3978	4,478		6,466
75,000						
ART started	8,229	128,719	180,477	150,136	213,156	400,000

HEALTH FACILTY CONSTRUCTION

Primary Health care facility expansion (HEALTH POSTS and HEALTH CENTERS)



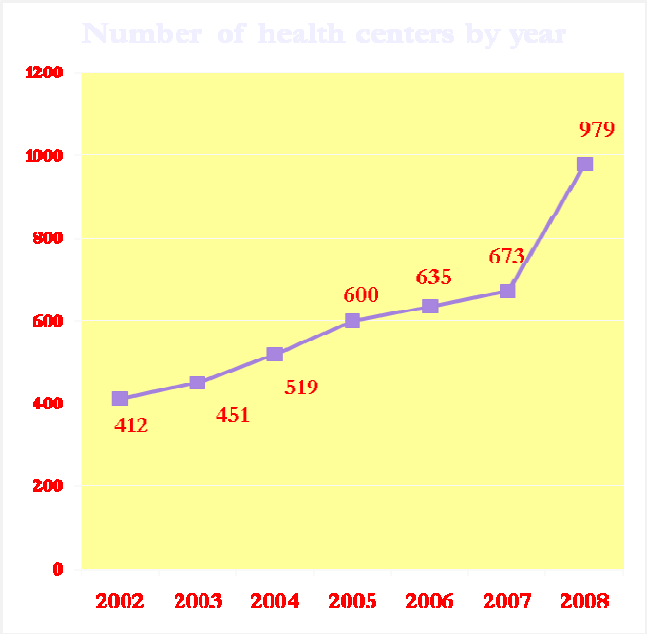


Fig. 18 Trends of Expansion of Primary healthcare facilities (Health Posts & Health centers)

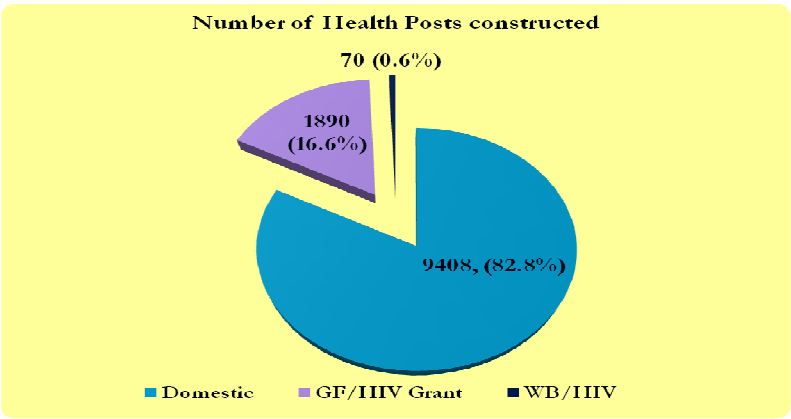


Fig. 19 Construction of Health posts in partnership

Construction of New Health Centers in partnership

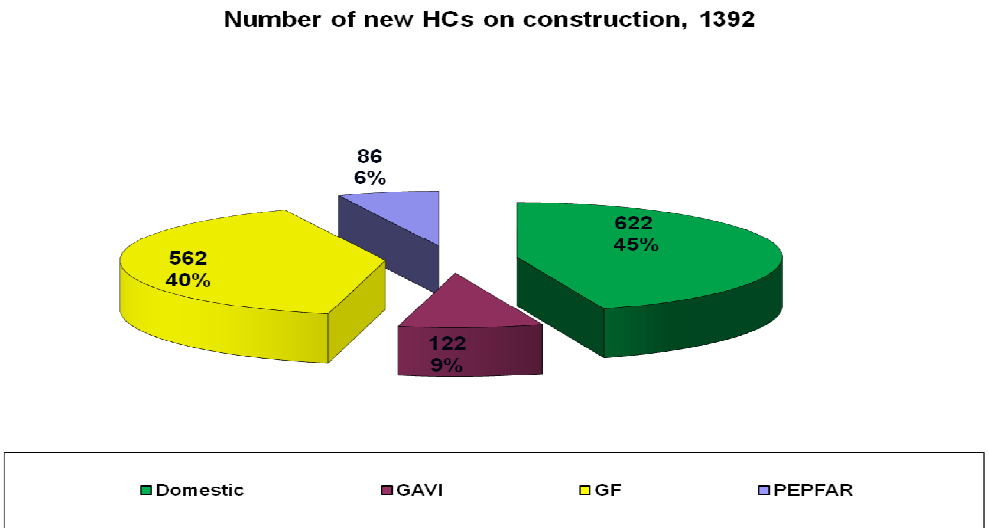


Fig. 20 Construction of New Health Centers in Partnership

HIV SERVICES EXPANSION AT COMMUNITY & FACILITY LEVELS

Fig. 21 The first HSEP trainees

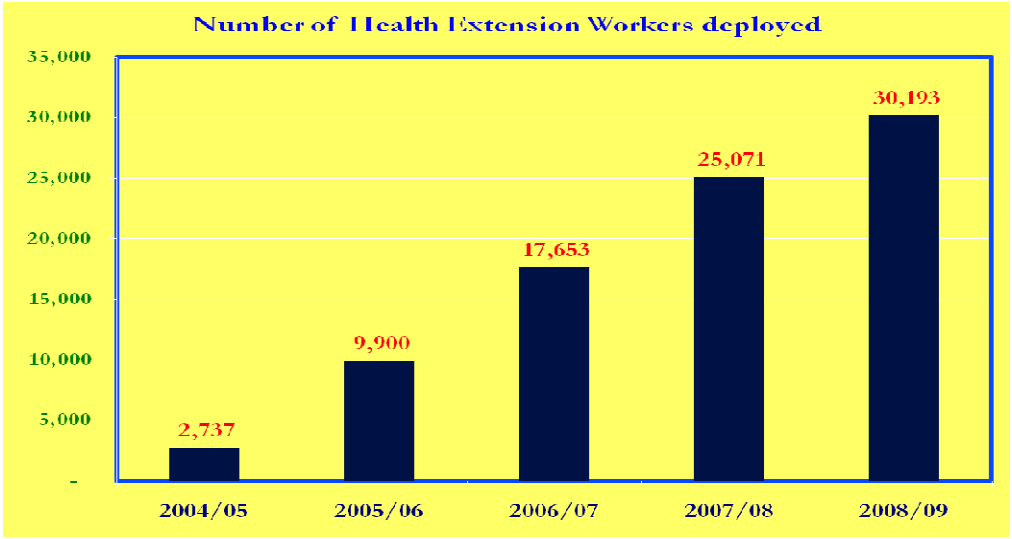


Fig. 22 Salary paid by Government to HEWs70 USD x 30,193 x12 months =USD$25,362,120 per year

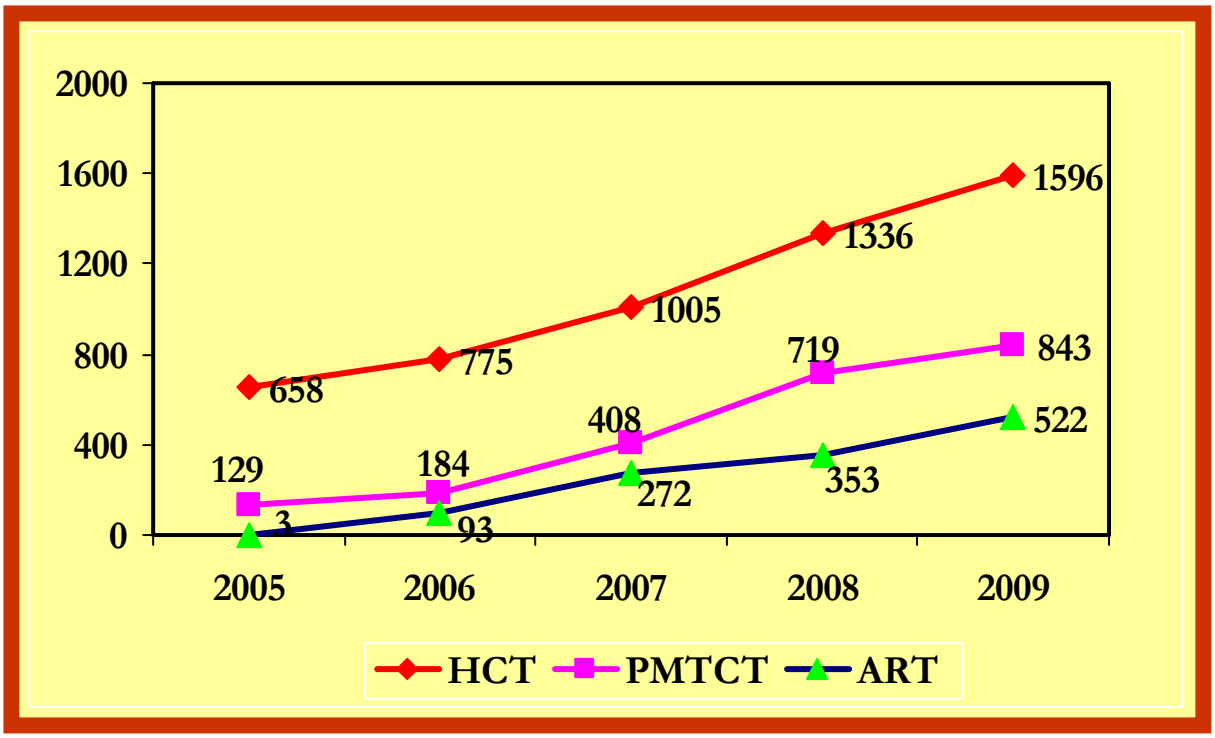
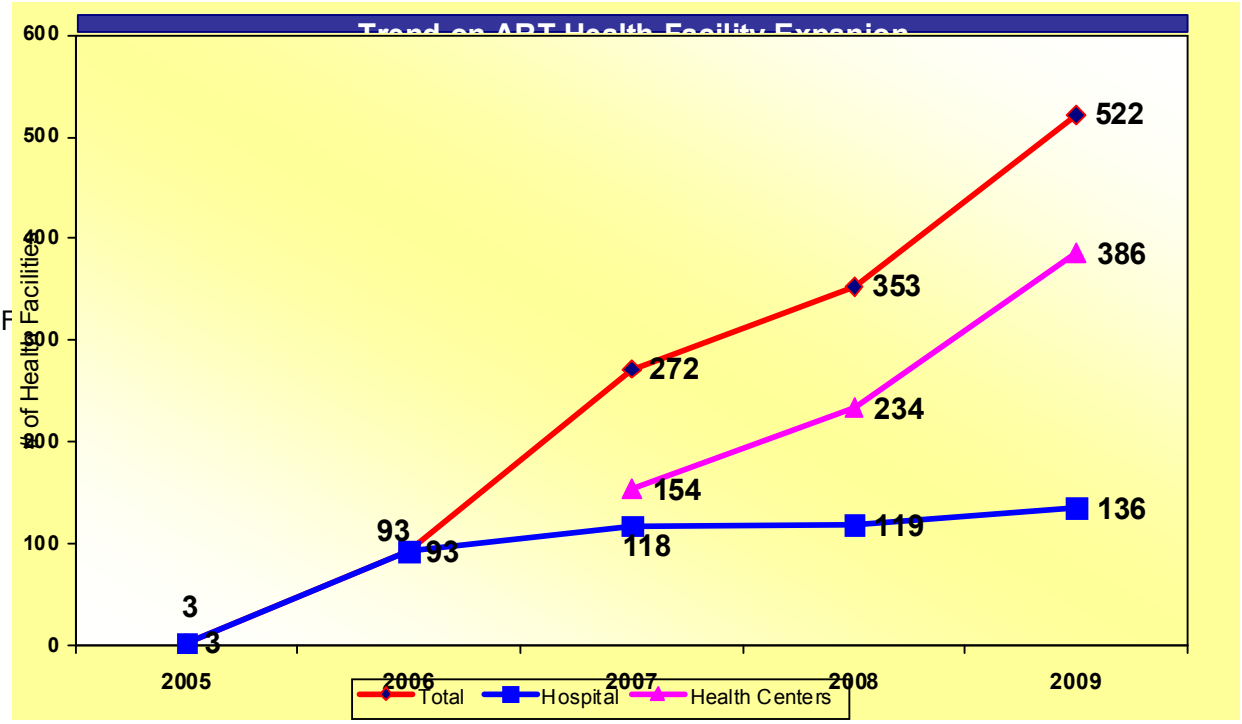


Fig. 23 Trends of HIV Service Expansion



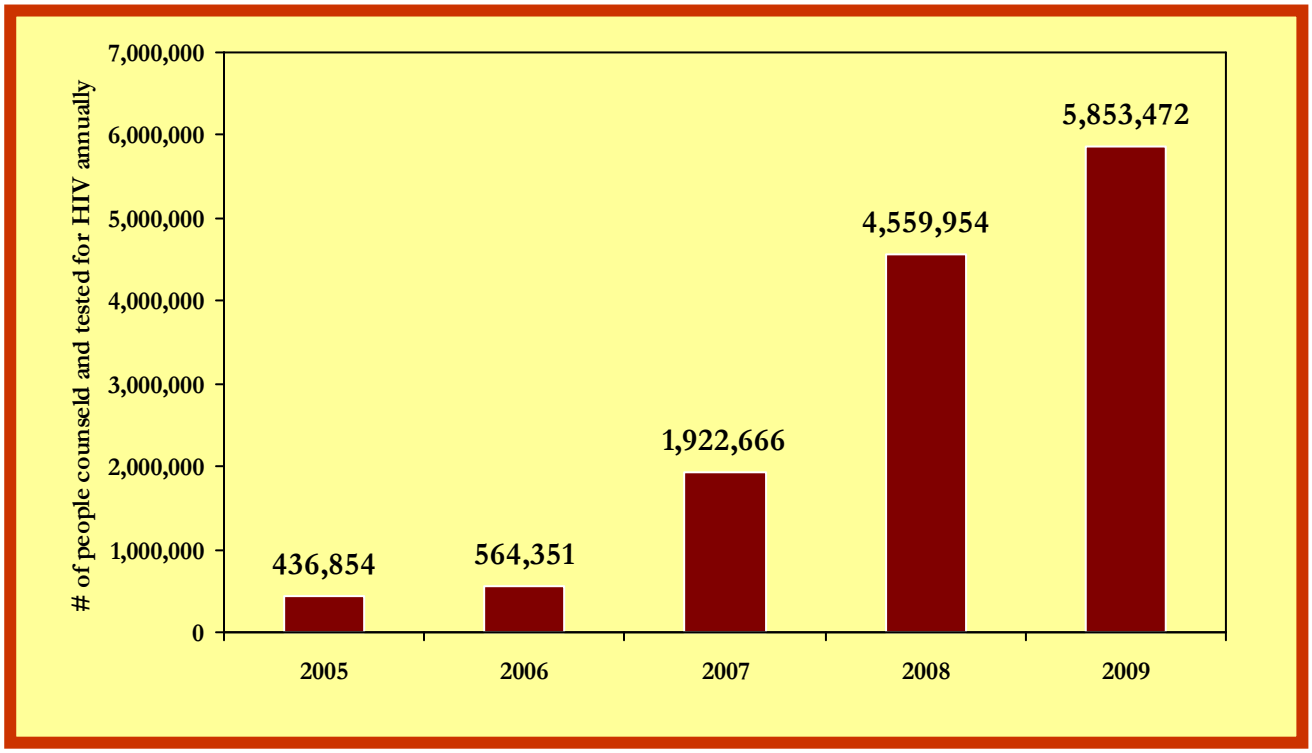
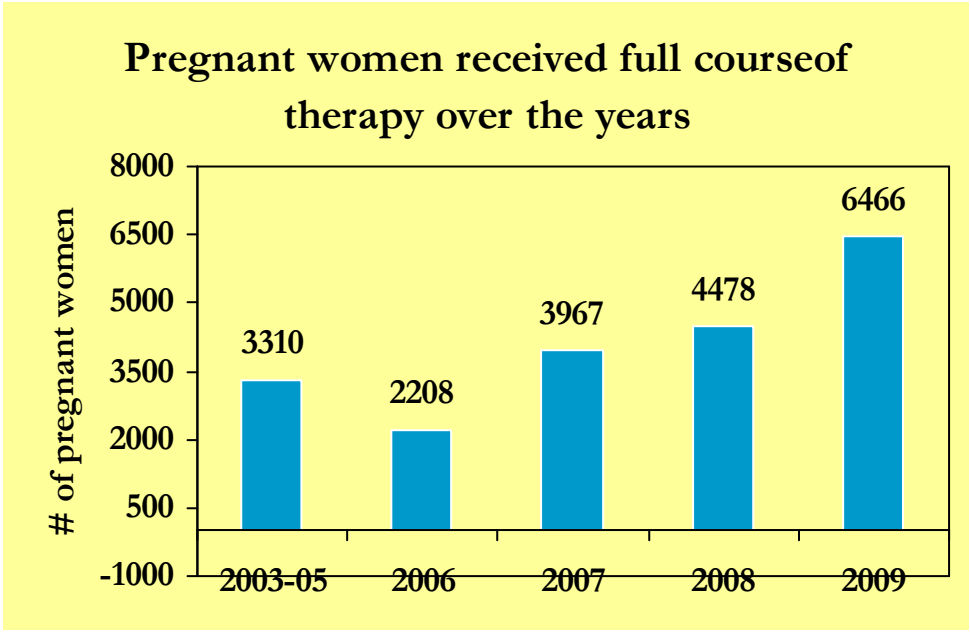


Fig. 26 Trend of PMTCT service utilization



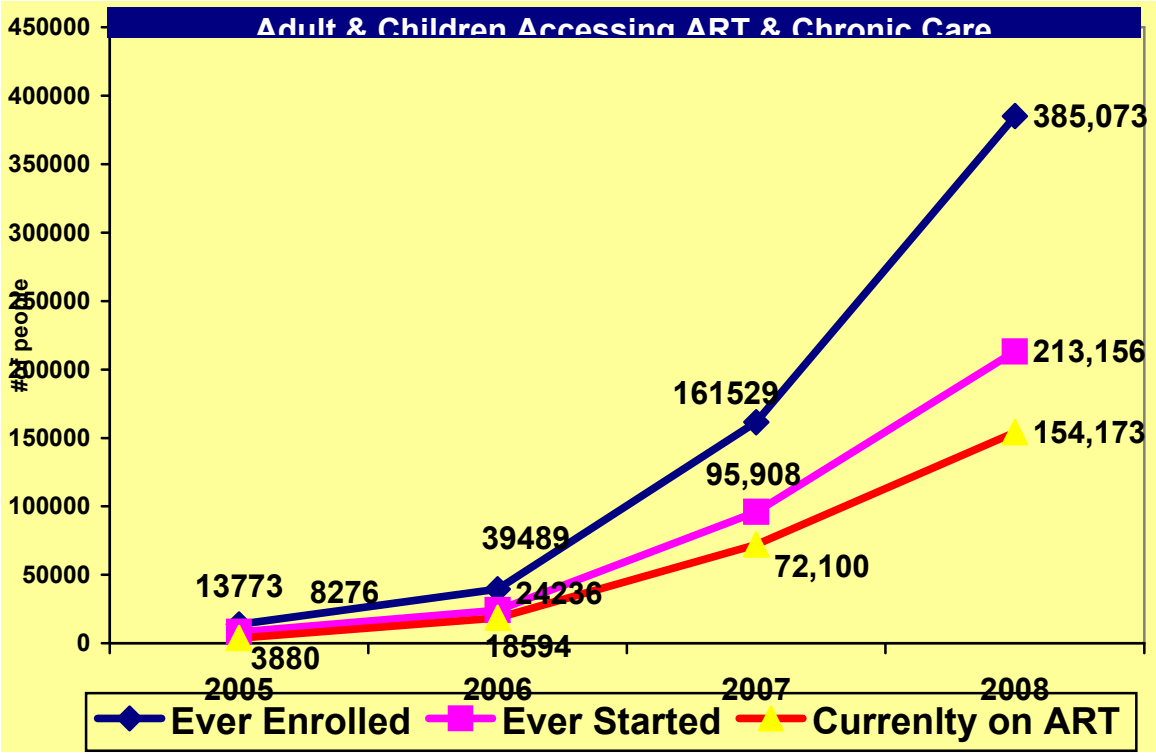


Fig. 27 Trend of ART Service Utilization

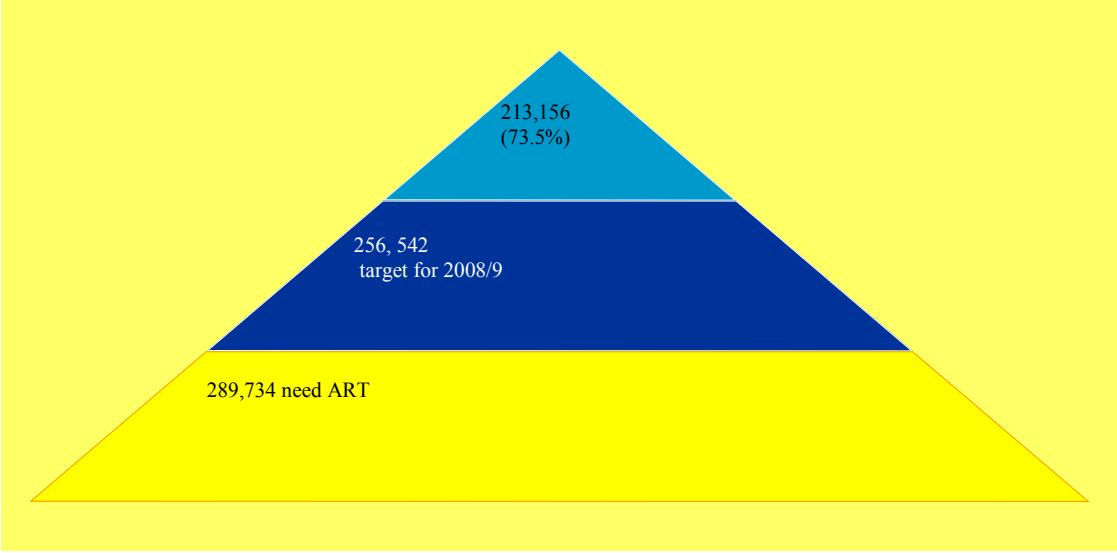


Fig. 28 Annual Achievements of EFY 2001 Care and Support

Achievements of EFY 2001 Care and Support

Community based and Institutionally Supported activities are underway. There are 235,558 Orphans and Vulnerable Children (OVC) received educational support, 167,313 OVCs received food & shelter support, 20,348 PLHIV received IGA support and 23,741 received start up financial support.

Multi-sectored Planning Towards Universal Access

Costed Multi-sectored Planning and Gap Analysis for Universal Access were conducted in 2007. In Six-year period 2006/07-2011/12, the total estimated financial needs to fight AIDS in Ethiopia are estimated at USD 4 Billion. The total funding currently available for these six years is estimated at USD 500Million.The estimated financing shortfall is USD 3.5 Billion.

Multi-sectored Planning Towards Universal Access

Universal Access targets

- Condom use in 15-49 years increases from 10% in 2007 to 60% in 2010
- 94% of STI patients will get treatment by 2010
- 25 million Counseled and tested for HIV by 2010
- 80% of HIV + pregnant woman receive PMTCT service by 2010
- 100% of eligibles receive ART by 2010
- 1.68 million OVC receive care and support by 2010
- 50% of PLHIV receive care and support by 2010

Challenges

a. Inadequate HIV/AIDS Mainstreaming
b. Financial gaps
c. Low Utilization of PMTCT Services

The Way Forward

1. Strengthen partnership to mobilize adequate resources and increase efficiency in utilization

2. Accelerate the Scale up towards Universal Access
3. Mainstreaming HIV/AIDS with focus on key strategic sectors
4. Expand and integrate PMTCT service with MNCH services

6.2 Improving M&E System for Multi-sectored HIV/AIDS Response Community Information System

(By Feleke Dana FHAPCO)

Introduction

HAPCO developed M&E framework in 2003. Twelve Global HIV M&E components were used. it established M&E Units : (Federal level :strong, regions:- 2 persons, & each woreda :-1 Officer). Assessment for the framework was conducted. Jimma University launched a post graduate study in M&E. Structural strengthening in regions was also promoted.

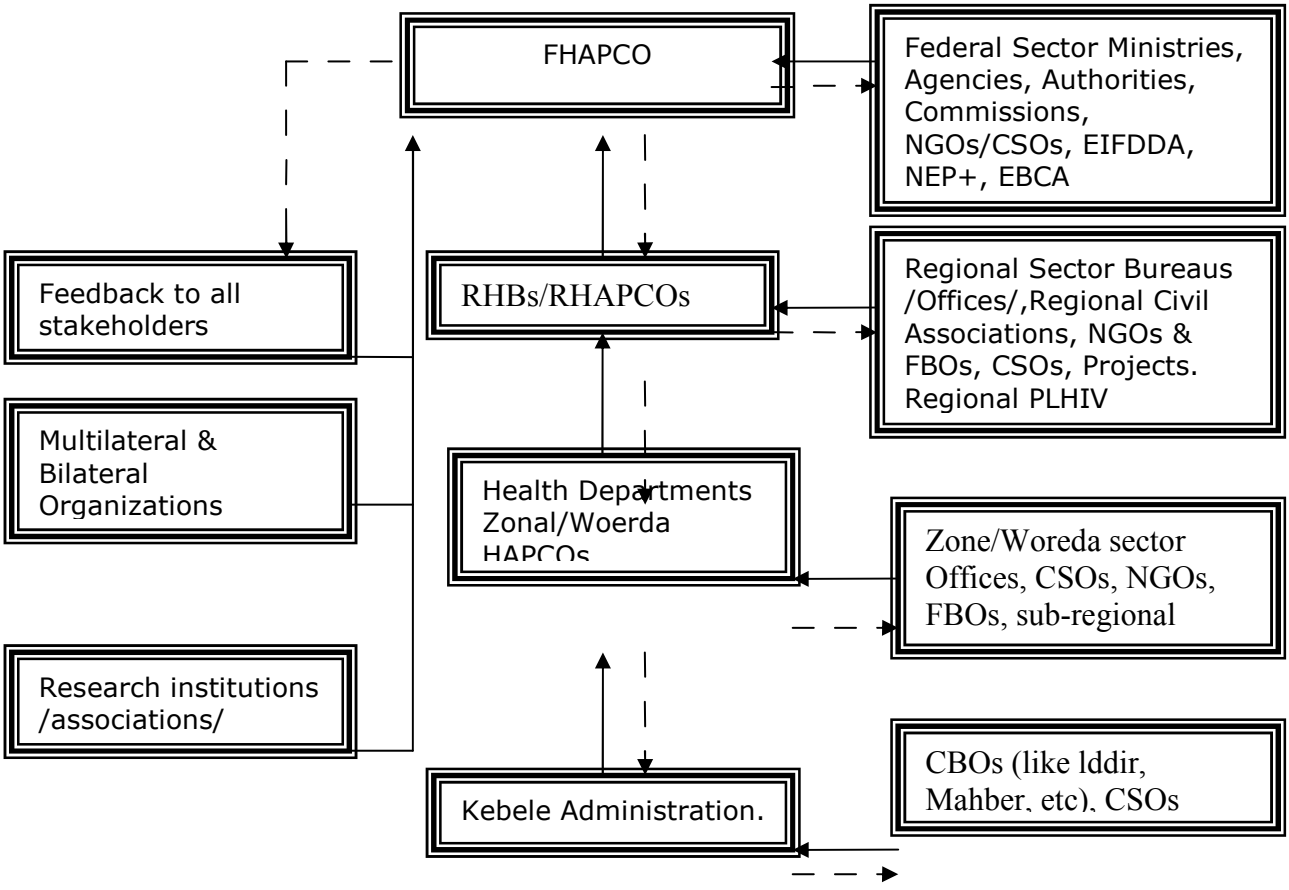


Fig. 29 The Current Information follow

M&E System

In 2004 (UNAIDS, GFATM, WB) agreed on the Three Ones as management principles to consider when planning an HIV response

The three ones are:

One agreed HIV/AIDS Action Framework that provides the basis for co-ordinating the work of all partners.

One National AIDS Coordinating Authority, with a broad multi-sectoral base

One agreed country level Monitoring and Evaluation System

Twelve Components Detailed Explanations People, partnerships and planning

Create enabling environment for HIV M&E

What is it about?

People (component 1)

who are skilled (component 2)

working together (component 3)

to plan (component 4)

operationalise and cost (component 5), and

motivate for an HIV M&E system to become and remain fully functional (component 6)

Collect, capture and verify data

The M&E plan defines which data need to be captured to monitor and evaluate the national HIV response.

The components in this ring helps to collect, capture and verify all the types of data that are needed as part of a national HIV M&E system.

The 12 components are:

1. M&E Advocacy communications and culture
2. Organizational structures with monitoring and evaluation
3. Human capacity for monitoring and evaluation
4. M&E Partnerships
5. M&E Plan
6. Costed M&E work plan

7. Routine program monitoring
8. Surveys and survillance
9. HIV evaluation Research and Learning
10. M&E data base
11. Supervision and data auditing
12. Data dissemination and use

Comp. 7 Routine programme monitoring

Program monitoring provides data about the progress of the programmatic response;

1).Health sector response includes: HCT, PMTCT and ART

2).Non-Health sector response: Community conversation (CC), School CC, Mainstreaming, Life skills education, Condom promotion and distribution, and Care and support (OVC & PLWHA)

Type of Information (Output Indicators)

INDIVIDUAL & SMALL GROUP LEVELS

Number of individuals reached with intended number of sessions for individual and small group level interventions using an evidence-based program: like:

Peer education; (coffee ceremony)

Youth dialogue (youth center)

COMMUNITY LEVEL

Number of the intended audience exposed to at least one mass media spot, episode, or program/Total number in intended audience

Number of the intended audience who participated in a community-wide event/Total number who participated in a community-wide event CC, SCC, Social mobilization events etc…

STRUCTURAL LEVEL

Number of targeted condom service outlets

Number/type of policies developed/enacted

Number of guidelines developed

Component 8 Surveys and Surveillance

Second Generation Surveillance
BSS conducted every 3 years
DHS conducted every 5 years
Sentinel Sero-Surveillance conducted every 2 years since 1996
Health facility survey: conducted in 2005
Special studies conducted in 2008
Epidemiological synthesis
Small scale surveys on condom utilization
MARPs in one region & national level study is underway
ART lost to follow up and survival analysis
HIV/AIDS linkage study
Projects/programs evaluation
Evaluation studies provide data about the progress and success of the programmatic response (how and why)
EMSAP Evaluation
GF impact evaluation
SPM evaluation
Other small-scale project evaluations

Generating and using strategic information

Strategic information has been developed by different partners in Ethiopia.

Successes

Development of guidelines for key programmes
Regularly conducted surveillance and behaviour surveys
Information dissemination
Annual M&E bulletin, Web site, survey results, JRM and ISS reports
Strong health-related monitoring (patient monitoring)
Strong collaboration with partners
Review forums
NAC meeting
JRM

Gaps in the M&E system

Weakness in the non-health response monitoring system

Data for some national and international indicators not easily captured

Absence of non-health service availability mapping

Lack of population size estimates and sero-data on sex workers and other MARPs

Surveillance data is not analyzed and disseminated in a timely manner

Low speed of ICT utilization

Absence of a central database for multi-sectored reporting and analysis

Need for periodic, digestible synthesis reports tailored for decision-makers and programme managers

Way forward

- Strengthen the community-based information system (data collection tools development)
- Establish a database for capturing the overall HIV/AIDS response M&E indicators (CRIS under customization)
- Consider strategies for use of M&E to enhance quality of prevention interventions

6.3. Strengthening Communities' Responses to HIV/AIDS (Dr Zelalem Gizaw, Chief of Party, SCRHA)

Contract over view

Technical office: HAPN

Effective date of commencement: April1/2009

Fund volume: 35,000,000 USD

Project duration: 5 years

Contract type: a three year Cost-Plus-Fixed-Fee completion contract with two one-year option periods

Objectives and goal

Project objective : to provide expert organizational and institutional strengthening technical support to CSOs so that they can take on the role of technical support

organizations—mentoring and overseeing other organizations and associations, including the maheberes

Project goal: to increase awareness of and access to high-quality and more affordable services through local CSOs

Program details

Component 1: Supporting CSO Delivery of Community-Based Palliative Care Elements

Component 2: Supporting CSO Delivery of HIV Counseling and Testing Services

Component 3 – CSO Delivery of Economic Strengthening Services

Component 4 – CSO Capacity-Building for Community-Based HIV/AIDS Services

Component 5 – Human Capacity Development for HIV/AIDS Services in the Community

Program partnership portfolio

Project contractor: Path(Program for Appropriate Technology in Health)

International Partners: IRD, IHAA, Itech, Westat

National implementing partners: DOHE, Mekdim, OSSA, Propride, HFC, PADET, AAU, FGAE, ORDA,SYG

Results framework

Result 1: Improve Access, Coordination, and Integration of HIV/AIDS Services

Comprehensive Community-Based Care

Building Capacity of Local CSOs: Focus on Training

Community- and Home-Based Care

CSO Delivery of HIV Counseling and Testing Services

Development of Coordination and Linkage Framework

Economic Strengthening

Result 2: Strengthen and Monitor the Performance and Quality of HIV-Related Community- and Home-based Services

Monitoring Service Quality

Services responding to HIV/AIDS

Pre-Service Training and Placement of Social Workers with CSOs

Organizational Strengthening of CSOs

Result 3: Raise awareness and demand for high-quality, comprehensive services

Key Themes for Improved CCC
Addressing Stigma and Gender Dynamics

Target

300 urban and peri-urban towns with services, in 8 regional states: afar, tigray, amahara, SNNPR, oromia, benshangul-gumuz, diredawa TA, Gambella
An estimated 900,000 individuals reached with packages of palliative care [care and support] services.
An estimated 90,000 households reached with economic strengthening activities.
900,000 individuals reached with HCT services.
More than 15,000 individuals trained in palliative care, HCT, or economic strengthening activities, as part of a comprehensive menu of available HIV/AIDS-related services.
Key to project success will be collaboration with and among more than 230 CSOs
create a network of organizations delivering high-quality HIV/AIDS services to communities in need.

Components overview

Care and support: provision of basic and advanced PC, training of lay CPC providers, referrals pregnant + mothers, TB, STI, OVC care and support
House hold HCT: training lay counselors, sexual partners of +s referrals for screening, pregnant referred for testing, HCT provision
Economic strengthening: strengthening, families and individuals in ES activities
CSO capacity building: training individuals in finance , programs and grants management, CSOs will receive TA, grants will be mobilized by CSOs
Pre-service social worker training: students will be trained pre-service, educational institutions will be supported and fellow students will be deployed through CSOs

Table 11 Deliverables and component overview of HIV related services

Deliverables	Palliative care/care and support	HCT	ES	CSO-CB	Pre-service social worker training
Manuals	QA	QA, QC	ES	OCA	

Reporting systems for CSOs	+	+	+	+	
Training by nationally accepted curricula	+	+	+		
Community plans	+	+	+		
Quarterly progress reports	+	+	+		+
OCAT				+	

Networks

USG: MSH, Abt associates, SCF-US, LOL, DAI
GOE: participating in TWGs of PC, HCT, TB-DOTS, ARMs, CMIS(non health) at federal level with FMOH and FHAPCO
PEPFAR: monthly PEPFAR network meetings
Impact site level: QRMs [regional, zonal, wereda], MRMs[community level]
IIP review meetings
Program updates with USAID

Following the panelists' presentation, the moderator opened the floor for discussion. Then, participants raised questions as follows.

1. Is that realy possible to abstain from sex as it is an inherent behavior of human being?
2. Is there a plan to integrate PMTCT to MNCH service?
3. Is there future direction for HEW to provide VCT service to the community beyond provision of CC, BCC?
4. Why only 80% coverage is planned for PMTCT in the presence of HEW?

5. Research activities are less compared to other activities of the office. So what did the office plan to carry out more researches as it is one of the capacity building processes?

6. What is currently being carried out with regard to equipping health officer students with basic knowledge and skill of HIV/AIDs treatment during the pre-service training?

7. How do you evaluate the issue of universal access interms of geographical distribution and human resource development?

8. It has been presented that the service utilization of VCT is increasing but what is the reality with the quality of counselling?

Responses given by the Panelists

- It is true that sex is an inherent behavior of human being but still it is possible to equip individuals with skill to avoid risky sexual behaviors. Group efficiency can also be built. More importantly, it is not about practising sex but how to practice it.
- Health extension workers are being trained to provide PMTCT services. For the rural settings counsellers have been trained. In 14 months time we have intended to reach 80% PMTCT coverage.
- As rightly explained, research is one of the capacity building tool and it has been included in our strategic plan. In 2010 we planned to undertake researches.
- As far as the issue of Universal access is concerned, remote or geographically inaccessible areas are not neglected. But service provisions are launched in at the centers where there are more information and gradually decentralized to the periphery.
- The issue of quality is not forgotten but more emphasis is given for coverage.

The moderator concluded the issue by stating that the issue of universal distribution, quality service provision and sustainability are the government priority agenda.

The government has strong commitment and is working together with different partners towards the success of the program. Harmonization is being implemented with the stakeholders. Vertical program budgets are also being utilized to scale up the horizontal programs expansion of HSEP and construction of Health centers.

Inorder to strengthen the pre-service trainings, meetings have been held with University officials on how to incorporate emerging health problems and new guidelines into the existing curriculum. By doing so, service quality and universal distribution will be ensured.

7.Sub Theme 2: NUTRITION POLICY, STRATEGIES AND IMPLEMENTATION (Moderator Dr. Zewdie W/Gebriel)

7.1. Research on Nutrition for National Nutrition Program (Dr. Cherinet Abuye)

Introduction

The program is initiated to harmonize and integrate with other programs so that duplication and resource wastage will be avoided. National Nutrition strategy (NNS) was established in Feb 2008. It outlines the strategy how the country addresses its nutritional problems more urgently, comprehensively and sustainable way. it is also believed to guide the implementation of NNS, National Nutrition Program was launched (NNP) in 2009 with the following two components.

Component I. Focuses on strengthening Nutrition service delivery

Component II. Focuses on Institutional and knowledge base strengthening

Each component of NNP needs to have research component. Because it enables to obtain Baseline information, assess impact, process and end-line evaluation etc. and identifying and solving program problems.

Progress on NNP

As to the progress on NPP, the following activities were undertaken.

1. National nutrition baseline survey
2. Nutrition training need assessment and curriculum review
3. Human resource assessment and mapping
4. Nutrition communication frame work
5. Nutrition data base

6. Nutrition surveillance sites (DSS)

Operations Research (OR)

It is a process, a way of identifying and solving program problems and It Improves implementation and shape the scale up of the program. OR is designed to increase the cost Effectiveness, culturally acceptability, efficiency and ultimately to reduce malnutrition among vulnerable groups.

Operations Research for NNP

It is coordinated by EHNRI. PST has been established. OR thematic and sub thematic issues for the NNP were identified and prioritized. The Thematic areas identified for OR were:

Sustaining the EOS with the TSF and transitioning EOS into Health Extension Program (HEP)

The weaknesses and strengths of local volunteers in the implementation of EOS/TSF

A review/evaluation of the methodology used to identify "hotspots" and priority woreda's for TSF service

Complementary food product development

Why are complementary feeding practices weak in Ethiopia? – Is it a knowledge issue, or due to cultural practices, accessibility, food security, food safety?

School nutrition and potential linkages with communities

Assessment on the role of school curriculum in addressing nutrition education in order to identify the existing gaps and then assess whether the community benefits

Does the family change its nutrition habits etc as a result of the nutrition education?

Do the various nutritional aspects in the curriculum address all necessary issues?

Look at reasons why through conducting positive deviance surveys

HIV and Nutrition

Impact and effect of nutritional support to patients on ART on their children's nutritional status and family wellbeing

Process of harmonizing and standardizing the current guidelines on HIV and nutrition

Rapid assessment of ongoing nutrition/HIV package
to map what is working, share lessons learned and potentially move some ideas forward from that assessment
System Strengthening and capacity building
Mapping of institutions and organisations engaged in nutrition and nutrition-related tasks
Identifying the most effective way of data collection and utilization at local level for timely response
Effective Delivery of micronutrient interventions
Prevalence rate of zinc deficiency
Double-fortification of salt with iodine and iron
Community based micronutrient fortification
Processing and promoting locally available micronutrient rich foods
Anemia control in areas with malaria – OR on using sprinkles versus not using
Compliance to intervention (e.g. Fe supplementation)
Micronutrient inhibitors
Vitamin D got through sunshine but prevalence of rickets is on the rise – why is this happening

7.2 National Nutrition Strategy/National Nutrition Program (NNS/NNP)

By Dr Belainesh Yifru

Introduction

It was in 2006 with plan for accelerated and sustained development to end poverty (PASDEP). PASDEP explicitly calls for the implementation of the NNS and POA.

Goal

Sustainably ensure that all Ethiopians secure an adequate nutritional status, which is an essential requirement for a healthy and productive life

Target groups

The target groups of the strategy are infant and children Under 5, especially under 2,PLW and adolescent girls , PLWHIV/AIDS and those coping with acute food insecurity.

Components of NNS

Promotion of ENA, CGMP and enhanced maternal and child caring practices
Building KAP for improved nutrition
Nutrition and HIV/AIDS
Nutrition in emergencies
Food security
Food standard enforcement
Diet related non - communicable disease
Water and sanitation
Nutrition information system

National Nutrition Program (NNP)

Rationale
Malnutrition is a public health problem and a threat to the economic development of the country
The nutrition situation is improving which is encouraging but not enough to achieve MDG as well as HSDP III targets

Therefore the actions require harmonized and coordinated approach and National scale program. In addition, The NNP is designed to guide the implementation of the NNS and encompass various nutrition interventions under a common planning mechanism, supervision and monitoring framework.

NNP has the following **principles**:
Consolidating and strengthening ongoing national nutrition services and information system

Transitioning programs into preventive and sustainable interventions through HEP using community-based nutrition approach

Improving multi-sectored nutrition linkages

- Strengthening the capacity of institutions to formulate

policies and implement the nutrition programs

- It is not a vertical program: implemented through existing country's decentralized service delivery especially the Health Extension Program.

Program Objectives and key Indicators

The NNP will be implemented in two phases for 10 years (2008-2017), each lasting five years. The NNP I is designed for the next five years.

1. Primary Impact Objective

Improve nutritional and micronutrient status of the population especially mothers and children:

2. Outcome Objectives

Improve child and pregnancy feeding and caring behaviors

Reduce micronutrient deficiencies

Enhance institutional capacity as well as linkages between different nutrition-relevant sectors

NNP Components

1. Strengthening Nutrition Service Delivery

- ✓ Sustaining EOS with TSF and Transitioning of EOS into HEP
- ✓ Health Facility Nutrition services:
- ✓ Management of Severe Malnutrition
- ✓ Nutrition and HIV/AIDS
- ✓ ENA/BFHI
- ✓ Community Based Nutrition
- ✓ Micronutrient Interventions

2. Strengthening Institutions for Nutrition Policy and Program Implementation

- ✓ Strengthening Human Resources and Capacity Building
- ✓ Advocacy, Social Mobilization and Program Communication

- ✓ Nutrition Information System, Surveillance and Operation Research
- ✓ Strengthening Multi-sectored Nutrition Linkages
- ✓ Implementation Arrangements

The implementation arrangement for the NNP is using the existing decentralized government structures rather than establishing a parallel structure. It uses two implementation arrangements:

A. The decentralized MOH organizational and management structure mainly HEP

B. Multi-sectored coordination mechanisms at federal, regional, woreda, and kebele level

7.3 Improving Infant and Young Child Feeding practice through the Essential Nutrition Actions (ENA) Framework in Ethiopia

By Hailemariam Legesse, MD, MNCH and Nutrition Advisor

Essential Services for Health in Ethiopia (ESHE) II PROJECT is a five year, bilateral (USAID and Eth Gov.) project for child survival and health system reform (2003-2008). It was managed by JSI with subcontractors AED, Abt, Initiatives.

The goal of project: contribute to improved child health and nutrition (EHSDP)
The project is integrated into the Ethiopian Government Health system. Nutrition is one component among other child survival interventions (EPI, IMNCI).
The effect of the National Nutritional policy impact will be evaluated in 2010 in DHS III.
Exclusive breast feeding will reduce infant mortality rate by 30%.Early breast feeding will reduce infant mortality rate by 23%.

Project area

The Project is active in 101 districts of 3 largest regions, covering population of 15 million (total 62 million).

Table 12. Southern Nations, Nationalities, and Populations (one project Region)

Large scale implementation			
Region	Population of project areas	Population covered by project	Date Community training started
SNNPR	6 million	40%	January 2004

The Essential Nutrition Actions (ENA) Framework
Optimal Breastfeeding
Complementary Feeding
Women's Nutrition
Nutritional Care of Sick & Malnourished Children
Control of Vitamin A deficiency
Control of Anemia
Control of Iodine Deficiency Disorders

Malnutrition

Root causes

- ✓ Poor potential resources and Ecological conditions
- ✓ Unstable ideological and political structure
- ✓ Underlying Causes
- ✓ Household Food Insecurity
- ✓ Poor Care of Mother and Child
- ✓ Poor Environmental Health, Hygiene & Sanitation

Immediate causes

- ✓ Inadequate diet
- ✓ Poor Health status

Altered nutritional status is the manifestation of the immediate causes. The consequences of altered nutritional status could be morbidity, mortality, Lost productivity, disability and etc.

INPUT

1. Policy, Advocacy & Partnerships (Creating enabling environment)

Partnership –partnership forums
--ENA integrated in IMNCI
Collaborate with USAID/LINKAGES, UNICEF & NGOs

Advocate using "Why Nutrition Matters?" (*Profiles*)

Disseminate National Guidelines (IYCF, MN, CMAM, etc…)

2. Capacity Building & System Strengthening

Brief, simple, skill based training

ENA counseling for health providers

- 1,600+ Health Workers & HEW trained on counseling & negotiation skills

ENA incorporated into child survival training

- 20,000 Community Health Promoters trained on Breast Feeding
- 12,000 Community Health Promoters trained on Complementary Feeding

Follow-up to training, and supportive supervision using standard checklist
Performance review meetings
Making standard job aids, guidelines and reference materials available

3. Behavior Change Communication & Community Mobilisation

Promote action oriented nutrition messages

Use all contacts across the life cycle home visits, traditional meetings, community events

Emphasize inter-personal communication (IPC)

Reinforce IPC with local radio spots in local languages

BCC tools

To assist CHP, HEW and health providers in counseling & negotiation activities

To improve quality of basic health services at each contact

Results

Baseline study was conducted in 2003. The end line was conducted in 2008.

The Sample size for the Baseline (2003) was

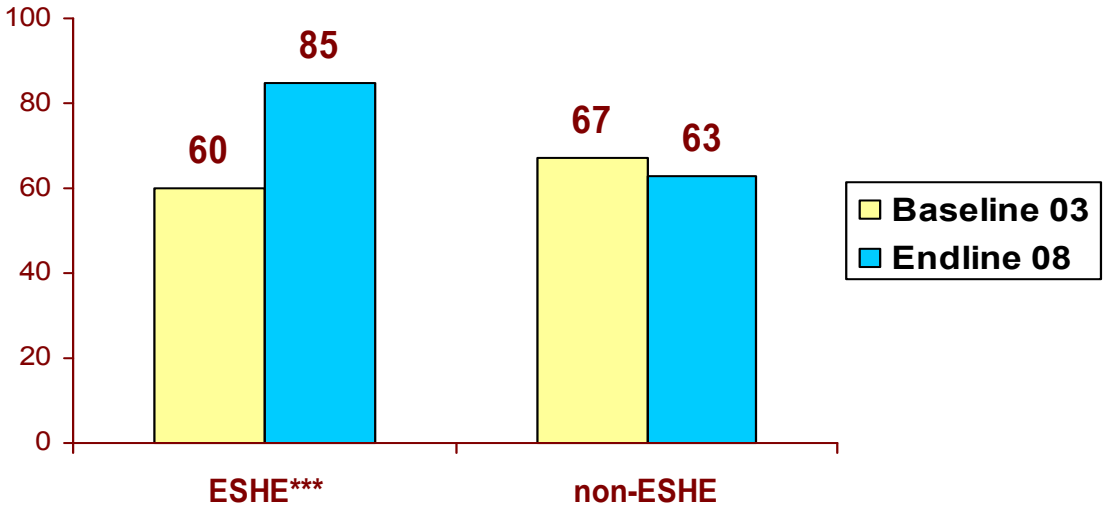
Children 0-11.9months = 898

Children 12-23.9 months = 891

And for the End line (2008) it was

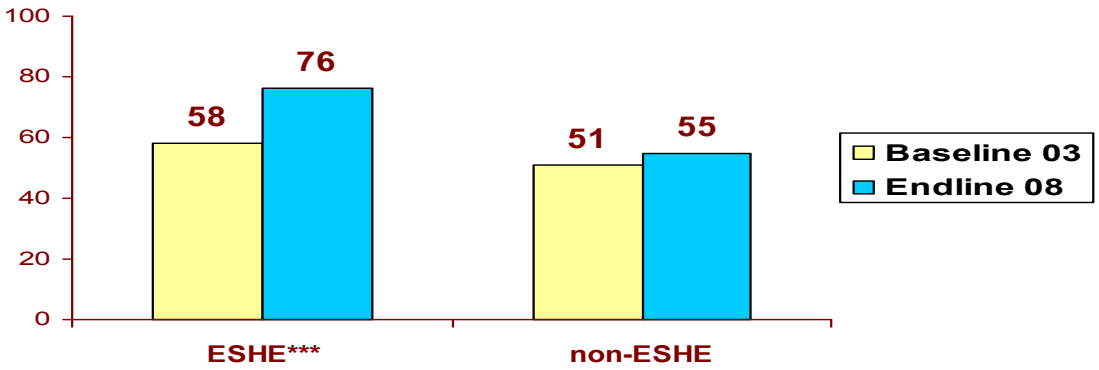
Children 0-11.9months = 600

Children 12-23.9 months = 600



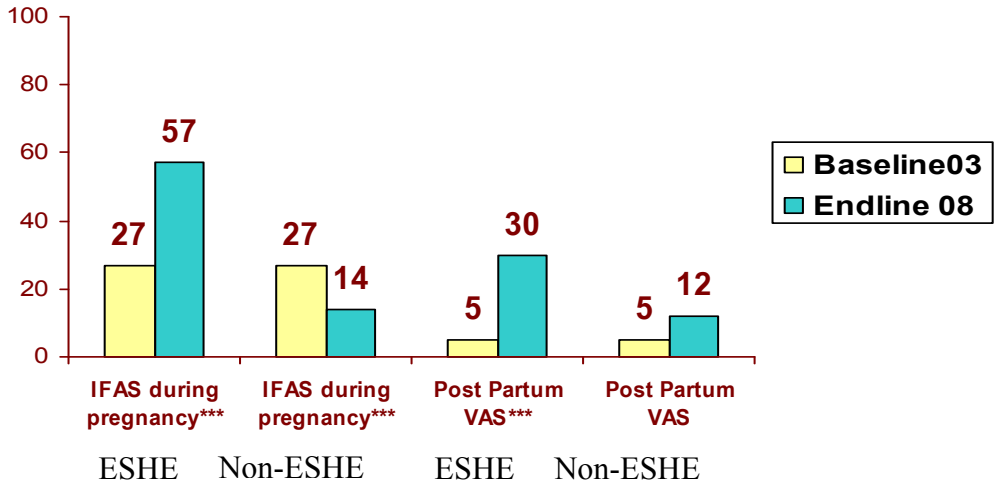
*** p<0.001

Fig 30. Early initiation of breastfeeding (within 1 hr) project vs. non-project areas



*** p<0.001

Fig. 31 Exclusive breastfeeding (0-5 months) project vs. non-project areas



*** p<0.001

Fig. 32 Women's micronutrient supplementation project vs. non-project areas

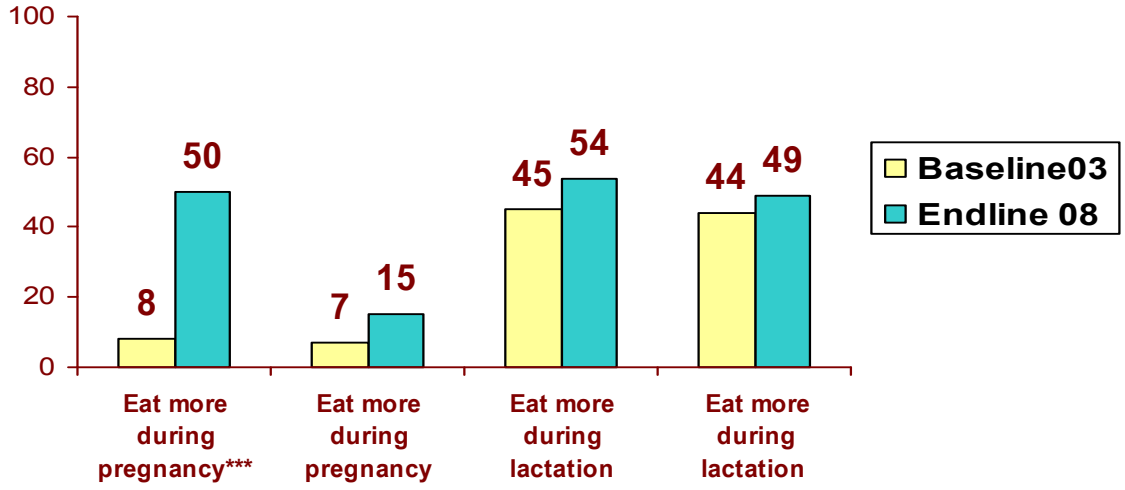
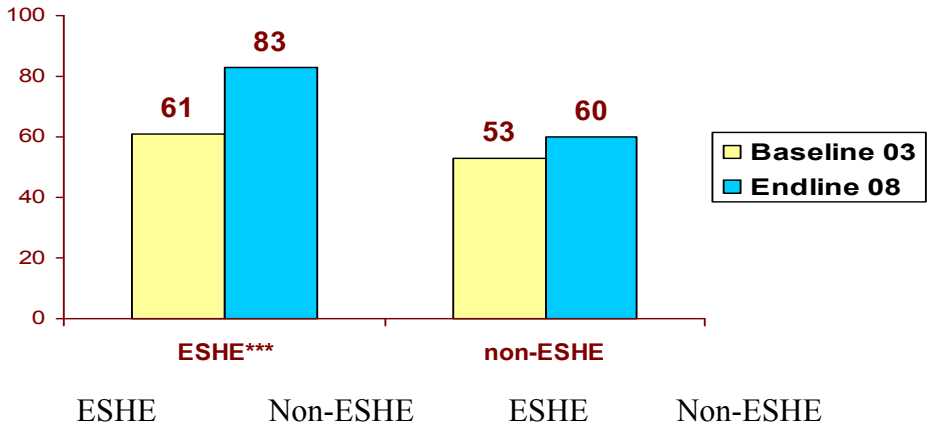
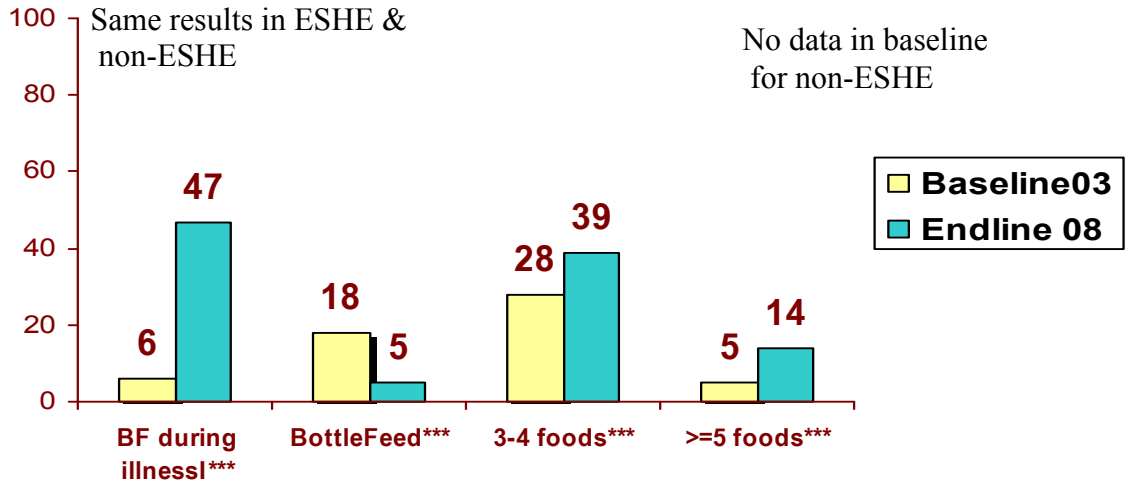


Fig. 33 Women 's Diet (during pregnancy and lactation) project vs. non-project areas



*** p<0.001*** p<0.001

Fig. 34 Timely complementary feeding 6-9 months project vs. non-project areas



*** p<0.001

Fig. 35 Infant Young Child Feeding (6-23 months)

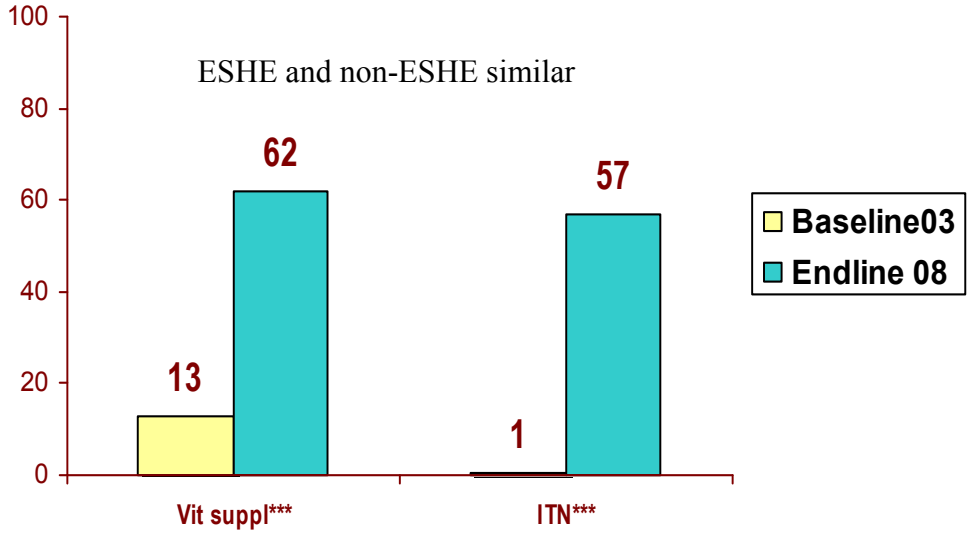


Fig. 36 Vitamin A (6-23 months) & insecticide-treated nets (0-23months), project vs. non-project areas

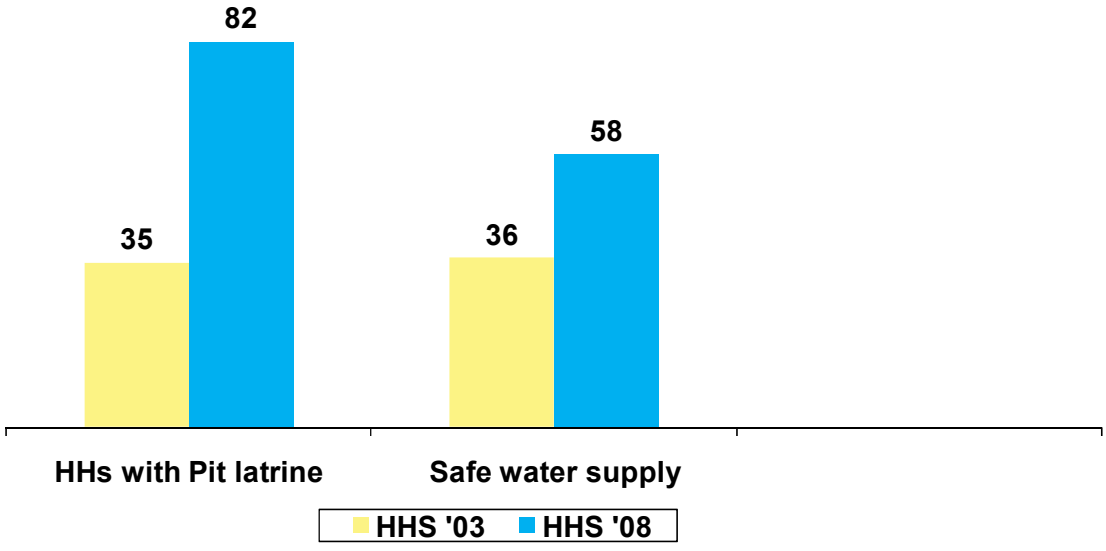


Fig. 37 Percentage of House Holds with pit latrine, and safe water supply ***SNNPR***

Table 13. Newly developed CF indicators results in project vs. non project areas, SNNPR

The CF indicators (WHO, 2008)	Project area	Non project
Introduction of soft, solid and semi-solid foods 6-8 ms	80***	55
Continuation of breastfeeding to 24 months - 12-15 months - 20-23 months	 99 84	 96 77
Minimum food frequency of 6-23 month olds (6-8 ms= 2 times; 9-23 ms= 3 times; non BF =4 times)	85**	75
Minimum dietary diversity (4 out of 7 groups for 6-23 ms) (Grains & roots, dairy, meats, eggs, Vit A, other fruits & veg. legumes)	24**	12
Minimum adequate diet (BF status, food frequency, dietary diversity)	21**	11

*** $p<0.001$, ** $p<0.01$

Summary of the findings

Child feeding practices including early initiation of BF, and exclusive breastfeeding, complementary feeding, sick child feeding (BF) and bottle feeding have significantly improved

Women's nutrition (IFA supplementation) and feeding practice during pregnancy has increased significantly

ITN and Sanitary Latrine ownership has increased significantly

Challenges

Harmonization of messages and BCC materials

Improve health providers negotiation skills for mothers and families to adopt new practices

Behavior change-results are not visible immediately and cannot be measured by routine health information system

The Way forward

ENA is a key component of the National Nutrition and IYCF strategies

IYCF/ENA is one of the foci of new USAID funded project Integrated Family Health Program /IFHP in 6 regions covering 75 million people

Continue strengthening partnerships to accelerate national impact

Tigist, a mother of twins from Wolayita, SNNPR, Ethiopia practiced optimal BF & Complementary feeding, Vitamin A, ITN use, Sanitation, Immunization,

After the panelists finalized their presentations, the moderator invited the participants to raise questions and comments participate in the discussion.
Then the following issues were raised by the participants to the panelists.

1. What is the reality with the universal iodations of salt in the country?
2. What is the effect of existence of Nutrition strategy on child mortality reduction?
3. What interventions are undertaken for mothers who are HIV positive but breast feed their children?
4. How do you coordinate or link various institutions in the research undertakings?
5. What is the role of health promoters in nutrition?
6. What is the breadth of Nutrition strategy?
7. Is there any mechanism devised for coordination starting from food production to consumption?
8. How is the utilization of operational research and undertakings of applied research with regard to nutrition?
9. Is there any plan in the production of human power in the field of nutrition?
10. Is there any linkage with Universities?

Responses given by the panelists

- Salt iodization program started five years back in Afar where salt is produced. However, the coverage in terms of accessibility is only 50%. Iodine capsules are distributed for 80 hot spot Woredas in the country. We have also public health proclamation on this issue.
- The Nutritional strategy effect has not been evaluated since the policy is young. But it will be evaluated in 2010 in DHS three.
- For mothers with HIV, if AFASS is fulfilled, she can feed on complementary feeding. If not AFASS, she has to breast feed like other mothers.
- Seventy three percent of Ethiopians, population live in iodine deficiency prone areas. Different organizations are involved to tackle the problem.

- Universities are encouraged and invited to undertake researches on nutritional issues?
- Both operational and applied researches are given special attention.
- There is also steering committee at national level from various sectors like Ministry of Water development, FMOH, Ministry of Agriculture and Ministry of Finance.
- Nutrition Professionals are also produced by different Universities like Hawassa, Jimma, Gondar and mekele.
- Exclusive breast feeding will reduce mortality by 30%. Early Breast feeding will reduce mortality by 23%.
- Health Promoters are selected and trained on communication skills of family planning, Malaria prevention and promote in collaboration with health extension program.

Finally, the moderator concluded the discussion by making the following remark:
The development of the National nutritional strategy is a remarkable achievement.

8. REPRODUCTIVE HEALTH SITUATIONS AT HIGHER LEARNING INSTITUTIONS

Moderators Dr. Zewditu Kebede
Dr. Yared Mekonnen

8.1. Policy Framework of Adolescent and YOUTH RH (AYRH)

(Solomon Emyu MD, MPH)

Introduction

Youth Related Policies

There were policies developed by different sectors addressing Adolescents and Youth namely:

National Population Policy (1993,under Prime Minister Office)
Education Policy
Health Policy (1993, PMO)
HIV/AIDS Policy (1998, MOH)

Social Security & Development Policy (MOLSA)
National Youth Policy (2004, MoYS)
National RH strategy, 2006 – 15 (2005, MOH)
National AYRH strategy, 2007 – 15 (2006, MOH)
Standards on Youth Friendly RH Services, (2007, MOH)

Definitions

Based on the AYRH strategy
Adolescents: ages 10-19 years old.
Young people or youth: 15 to 24 years old.
Adolescents & Youth: ages 10-24 years old.

RH Strategy

The development of the National RH Strategy builds on the existing health policy, HSDP, the HEP, targets of PASDEP and the Millennium Development Goals (MDGs).

RH Strategy - Priorities

Programmatically, this Strategy reflects three overriding priorities. the strategy also supports the nation's commitment to achieving the MDGs by 2015; responds to the socioeconomic and demographic realities that shape RH generally; and reflects the notable advances realized in the health sector, especially decentralization.

The priorities are described as follows:

The first is the nation's commitment to achieving the Millennium Development Goals (MDGs), a framework for measuring progress towards sustainable development and eliminating poverty. Of the eight goals, three – improving maternal health, promoting gender equality, and combating HIV/AIDS stand at the core of the present strategy document.

The second priority is the need to respond to the socioeconomic and demographic realities of Ethiopia today. The contents of this strategy, therefore, do not seek to exhaust the full range of activities theoretically subsumed under the rubric of reproductive and sexual health. It is, instead, a road map – one with a clear view of the journey's end; and one that reflects the cultural, socio-demographic, and political terrain that defines Ethiopia today.

The third priority is to build on the notable advances realized in the health sector over the past decade. As this document reveals, the last ten years have seen a decentralization of the health system.

The five main strategic approaches considered are:

1. Prioritizing the household and community as vehicles for change,
seeking more effective integration across the health sector,
2. Mainstreaming RH and ensuring its place in the national development agenda,
3. Capacity building and effective utilization of the scarce human resources, and
to confront head-on the diversity, that belies simple solutions or single approaches

The first approach prioritizes the household and community as vehicles for change. Whether the goal is to build local support for birth preparedness efforts, combat harmful traditional practices, or ensure educational and economic opportunities for all, family and community are key. They also lay at the heart of the new HEP, which seeks to deliver health services to where they are needed most. This focus on household and community, therefore, manifests itself at various levels: in the emphasis placed on awareness creation; on the importance of local ownership; and on the efforts to better articulate RH with the broader social, economic and legal system.

The second strategy employed in this document is to seek more effective integration across the health sector. One recurrent theme to emerge from the discussion is the inextricable link between RH and the health sector more broadly. Facilities are shared, staffs are shared, resources are shared, and opportunities (both realized and lost) are shared.

The third strategy guiding this document is to mainstream RH and ensure its place in the national development agenda. This is achieved through calls for advocacy and information - both to the community at large and to those authorities who can influence opinion, change behaviour, and often deliver scarce resources. The Strategy also seeks to institutionalize RH at all levels of society. The fifth and final strategy reflected in this document is to confront head-on the demographic, cultural, geographic diversity of Ethiopia – a diversity that belies simple solutions or single approaches. Throughout the present National RH Strategy, emphasis is placed on understanding factors that effectively differentiate society and their RH needs. This is

manifest in the segmentation of populations that, in the past, have often been treated as an undifferentiated group. The historic focus on facility-based services, for example, has in the past often excluded pastoral populations, urban migrants, displaced populations and those in conflict situations. Diversity is the hallmark of Ethiopian society and the present Strategy confronts this reality head-on.

Priority Areas

Six priority areas are identified

The social and cultural determinants of women's RH;

Fertility and family planning;

Maternal and newborn health;

HIV/AIDS;

RH of young people; and

Reproductive organ cancers.

RH of the Young People

Background

Few national programs or policies are specifically targeted towards addressing most pressing RH needs of the young, despite majority. A Few programs tend to serve primarily urban populations, many of whom are also enrolled in formal schooling.

The vast majority of young people (rural youth) remain underserved. Most programs for young people in Ethiopia tend to deliver generic, age- and gender-blind messages.

Moreover, this population has limited access to FP. the highest infection rates of HIV in the country are currently seen among young women between the ages of 15 to 24.

Therefore, priority issues considered because at System Level, The needs of young people are not adequately addressed within the health system, Government RH services are perceived by youth to be unfriendly and there is a lack of coordination between NGOs, the private sector and public providers of RH care for young people.

*At Policy Level t*here is no national strategic framework for addressing the RH needs of young people in a systemic and coherent manner and at the regional level, there is no institutional framework for adequately addressing RH issues for young people.

Goal

1. To enhance the reproductive health and well-being of the country's diverse populations of young people

2. To enhance the RH and well-being of the country's young people the strategies to be followed includes Segmenting the design and delivery, Address the immediate and long-term RH needs, Strengthening multi-sectored partnerships and Developing a comprehensive adolescent's reproductive health strategy

Strategies

Segment the design and delivery of all youth RH-related interventions and policies by gender, age cohort, marital status, and rural/urban residence.

Targets:

By 2006, develop a National Adolescent and Youth RH Strategy.

By 2007, develop regional implementation plans for the National Adolescent and Youth RH Strategy

Strategies

Address the immediate and long-term RH needs of young people, with priority given to married women between the ages of 15-19 and their partners, and young people generally between the ages of 10-14.

Targets:

Increase the median age of first intercourse for women in the age cohort 20-49, from 16.4 to 17 by 2010, and to 18 by 2015.

By the year 2015, decrease by 20 percent, HIV prevalence among women in the age cohort 15-2422.

Key Actions

Creating awareness of RH at the community level

Provide youth-friendly services through the public sector

Integration of RH and HIV/AIDS services

Increasing human resource capacity through appropriate training

Developing norms and standards for service provision

Enforce existing laws regarding the minimum age of marriage

Develop a National Adolescent and Youth RH Strategy
Expand multi-sectored coordination
National Adolescent and Youth Reproductive Health Strategy

Background

Young people are the largest group ever, makes up 30% of total population.
Young people are assets. It is a critical period to intervene.
"What happens between the ages of 10 and 19, whether for good or ill, shapes how girls and boys live out their lives as women and men—not only in the reproductive arena, but in the social and economic realm as well." Addressing the RH needs of young people is complex. Youth cannot be defined as a homogeneous group.
This National AYRH Strategy is grounded within the National RH Strategy 2006-2015.

AYRH in Ethiopia are Early Sexual Debut, [Early] Age at First Marriage, Early Child Bearing, Unwanted Pregnancy, Abortion, [Poor] Knowledge and Use of FP Methods, HIV/AIDS and STIs, Status of Adolescent Girls and Young Women, Female Genital Mutilation/Cutting (FGM/FGC) Abduction, Rape and Polygamy. Median age of sexual debut for girls is 16 and for boys is 20. Early sexual debut and limited use of contraceptive methods have been associated with increased risks of unwanted pregnancy, STI/HIV infection, and maternal health mortality and morbidity. In Ethiopia, trends in sexual initiation have changed little over the last five year. The median age of marriage for women age 25-49 in Ethiopia is 16.1 years, indicating that for most girls, marriage drives sexual debut. There are also large regional differences: the median age at first marriage is the lowest in the Amhara region with 14.1 years and highest in Addis Ababa with 21.9 years. Men tend to enter marriage later in life, with almost eight years later than women.

AYRH Services

Most of the youth RH programs served adolescents enrolled in school and those living in urban or per-urban centres. Limited provision of AYRH services in four major regions. Health providers' attitudes and community norms are a major barrier to the provision of youth friendly services. Youth preferred seeking services from the private sector or from the community traditional healer than visiting the public sector. Services tend to deliver generic, age- and gender-blind messages. In addition, very few youth programs deal with life skills, gender dynamics, and livelihoods.

Guiding Principles

Recognize the diversity of youth as a target population

Programs must be based on development-oriented and rights-affirming principles:

Address the needs of youth through a holistic approach:

The recognition that gender differences are fundamental in framing AYRH:

Look for opportunities to integrate and link RH services

Promote youth involvement and youth-adult partnerships:

Vision

To enhance RH and well-being among young people in Ethiopia ages 10-24 so that they may be productive and empowered to fully access and utilize quality reproductive health information and services, to make voluntary informed choices over their RH lives, and to participate fully in the development of the country.

Goals

1. To Increase access and quality of RH services

The AY Friendly RH services

2. To increase awareness and knowledge about RH issues.

3. To strengthen multi-sectored partnerships and create an enabling positive environment at all levels,

4. To design and implement innovative and evidence-based AYRH programs that are segmented and tailored to meet diverse needs of youth

Standards

Standards have been set on youth friendly reproductive health services and minimum service delivery packages. The purpose is setting clear standards and guidelines that would delineate which adolescent RH services would be provided, in which setting, by whom, and at what age.

Services intended as a package are:

1. Information and counseling on RH issues, and sexuality

2. Promotion of healthy sexual behaviours through various methods including peer education

3. FP information, counseling and methods including emergency contraceptive methods
4. Condom promotion and provision
5. Testing Services: Pregnancy, HCT
6. Management of STI
7. Antenatal care, Delivery Services, Postnatal Care and PMTCT
8. Abortion and Post Abortion Care

Appropriate referral linkage

Youth Friendly Service Standards are:

Appropriate health services that cater to the Reproductive and Sexual Health needs of the youth are available and accessible,

The service outlets provide the type of services supported by the existing national policies and processes that give due attention to the rights of the youth,

The service outlets have physical environment and are organized in a conducive way for the provision of youth friendly health services,

The service outlet has drugs, supplies and equipment necessary to provide the essentials service package of youth friendly health care,

Information, education and communication (IEC)/ Behavioural Change and Communication (BCC) consistent with minimum service package is provided.

The service providers in all service outlets have the required knowledge, skills and positive attitudes to effectively provide youth friendly RH services.

Youth receive an adequate psychosocial and physical assessment and individualized care based on the national standard case management guidelines/ protocols.

The service outlet has a system that ensures that the necessary referral linkage is made and ensures continuity of care for youth.

Youth participate in designing and implementing youth friendly services and mechanisms are created to enhance the participation of parents and members of the community to contribute towards a sustainable YFS services in their receptive localities.

Current initiatives to Improve the Reproductive Health Situation *in* Mekele, Adama & Hawassa Universities (*Worknesh Kereta Integrated Family Health Program*

Background:

Ethiopia is a nation of young people. One third of its population is estimated to be between 10 to 24 years of age. A nation whose youth have profound reproductive health needs because of their biological, psychological & social changes. High HIV/STI prevalence and unwanted pregnancy are rampant among adolescent and youths. Despite these, there are Limited access to RH information and services. Moreover the existing Health service is not Youth Friendly.

What is Youth friendly Reproductive Health service (YFS)?
These are Programs and/or services that:
Attract and meet the reproductive health needs
Respect and accommodate the unique psychological, social, cultural, and economic situations
Comfortable with appropriate environment,
Ensure confidentiality and privacy
Succeed in retaining these young clients for continuing care

Integrated Family Health program's response:
A joint venture with JSI and Pathfinder International
Tries to address the needs of a family as a whole.
(Continuum of care/ life cycle approach)
AYRH is one of the IFHP's priority program

Objectives:

To improve the ability of youth to make an informed RH decision by providing enhanced information, education, and behaviour change communication interventions.

To increase access & utilization of quality Youth friendly RH services within the public health facilities & university clinics

Program implementation Process:

Five university campuses were selected from our target areas: Mekele (Adihaki & Endayesus campuses), Adama University and Hawassa (Agriculture & main

campuses). Memorandum of understanding was signed. A consultative workshop was conducted. An In- depth assessment of the clinics/health facilities:

To determine the extent to which existing the services are youth-friendly
To identify the existing opportunities and areas that need improvement
To help a facility determine and address barriers to service and care for students

Major findings were:
No separate space to sit and wait for health service
Health care providers were not friendly and caring
health workers don't have the required knowledge, skills & positive attitude to handle adolescent & youth RH issues
No special training for health care providers
Compromised privacy, confidentiality and respect for the students
Students were not involved in their own health
No provision of information and education
Based on the in-depth assessment results:
Renovation/upgrading, furnishing & equipping of the Clinics (4/5 clinics)
Capacity building/training on:
YFS for all Health care providers from the clinic
STI, VCT, PAC and CAC for selected health care providers
Peer promoters
Training of proctors, guards, staffs from student cafeteria & supportive staff of the clinic
Creating linkage with their respective regional health bureaus to access to test kits for HIV, TT Vaccine & TB treatment
Availing continuous supply of consumables
(PT, ECP, FP methods.)
Sign posts fixed - to show the direction, types of services provided & indicating the service hours

Waiting areas organized with TV, DVD & educational films
Supported for bi- monthly coffee ceremonies for the girls clubs and organizing talk shows for all.
Prepared & distributed tailored messages on RH/FP/HIV/AIDS

Leaflets, Brochures, Posters

The referral linkage strengthened for further care

Monitoring tools were developed for:
clinics
peer educators to capture the service data.

Launching of the YFS service

A one day workshop was conducted for management team members, teaching staffs, gender offices, student council and anti AIDS, girls club members of the universities.
Annually, we organize an orientation sessions for newly enrolled students.
Quarterly review meetings were institutionalized to further improve the service in the clinic
Regular technical support provided

Achievements

Building the capacity of the health care providers and youths in each campuses

Introducing the importance of integrating RH service within the students clinics.

Making the health services youth friendly

advocate the need to integrate AYRH services within higher learning institutions

Availing FP, ECP, VCT, CAC/PAC,TB, TT services within the university clinics.

Waiting time for service improved
24/7 hours service started
The service became an excellent entry point for HIV interventions.
Essential drugs are made available in the clinic
Routine (Every three months) check up of food handlers (for all Kitchen workers)
Environmental sanitation services started by the clinic. (Adama)

Challenges:

High turnover of trained Health care providers

Denial/very low recognition the need for RH services in university clinics

Very low health seeking behavior of the students

The Way forward:

- ✓ Expanding the service to other universities in our target areas.
  . Medawelabu university
  . Jijiga university
  . Dilla (two campuses)
- ✓ Further improve the quality of RH information & services
- ✓ Create opportunities for the students to involve & be part of their health issues
- ✓ Close follow up of the health services through regular review meetings, supportive supervision, experience sharing.

8.2. Policy Environment to Promote Female Education in Ethiopia
Focus on Reproductive Health Situation in Higher Education

Asmaru Berihun (MoE)

Introduction

Policy Environment to Promote Female Education in Ethiopia

In the past female education in Ethiopia was not given attention due to this women in the country are still disadvantageous in all aspects of life (socially, economically, and politically) Hindrances of female education like Scio-cultural, Socio-economical, School related factors and Less attention was given to females.

The 1994 Education and Training Policy

The policy was designed to address the education main problems like Relevance, Quality, Accessibility and Equity (Gender, Rural/urban, Regional, Disabled etc). The policy objectives give attention to female education.

These are:

To gear education towards reorienting society's attitude and value pertaining to the role and contribution of women in development. Special attention will be given to the participation of women in the recruitment, training and assignment of teachers. Special attention will be given to women and those students who did not get educational opportunities in the preparation, distribution and use of educational support inputs. Educational management will be decentralized to create the necessary condition to expand, enrich and improve the relevance, quality. The government will give financial support to raise the participation of women in education. Ensure that the curriculum developed and textbooks prepared at central and regional…..giving due attention to concrete local condition and Gender issues.

To Implement the policy Education Sector Development Programs are being designed since 1996/1997 up to now

In the ESDPs (I,II,III) Gender is a cross cutting issue from primary to higher education in all programs Such as:
Teachers education, Curriculum, School building, management etc.
National girls education strategy developed 2004
Gender main streaming guideline also developed
Establishment of national women education forum since 2003 (members are Regional Education women affair bureau heads, regional women association chair persons regional and national teachers association women wing, higher education presidents and gender focal persons at university and regional education bureau the parliament women affairs standing committee, Ministry of Women affairs, and some local NGOs chaired by MoE
Gender department at MoE and Gender focal points at regional and teachers education
Gender offices at higher institutions are established
Gender clubs and girls female students associations are being operational in HLIs
To increase female teachers at all levels actions are being taken.

There is ongoing affirmative action lowering (GPAs) for girls at 10th and 12th grades examinations.
Tutorial support, counseling and other support for girls at all levels.
Incentives for high achiever girls at all levels to be a role model
Achievements have been registered since the policy implementation such as:

The number of both female and male students is increasing year to year at all levels. Especially at primary level a tremendous achievement is registered.

The number of graduate female and male students are increasing at higher education (female students with higher GPA are also increasing.)

The number of educational leaders at lower level seems increasing

The attitude of the community at large to words female education is increasing from time to time.

Achievements

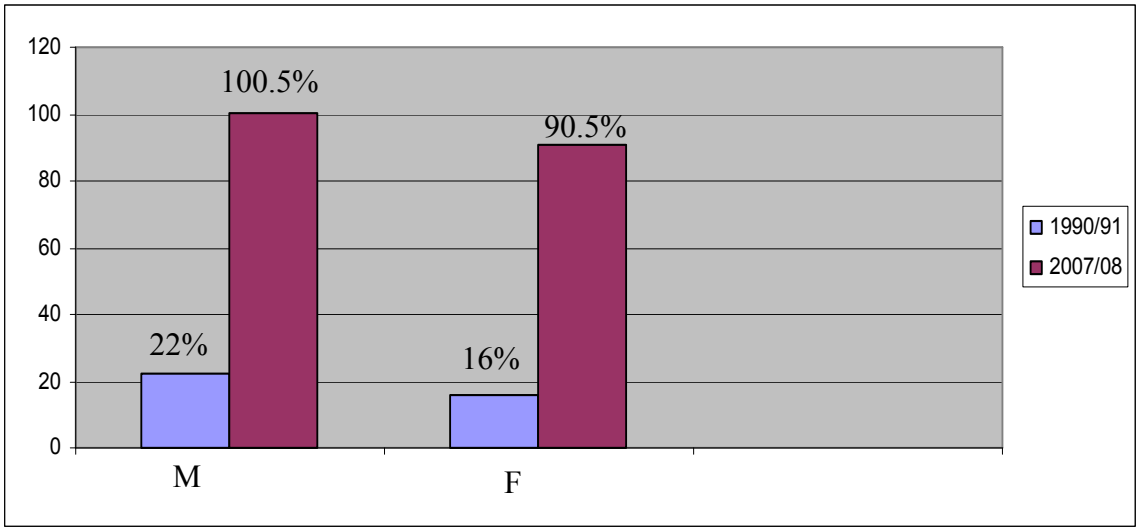


Fig. 38 Achievements of grades 1-8 1990/91-2007/08

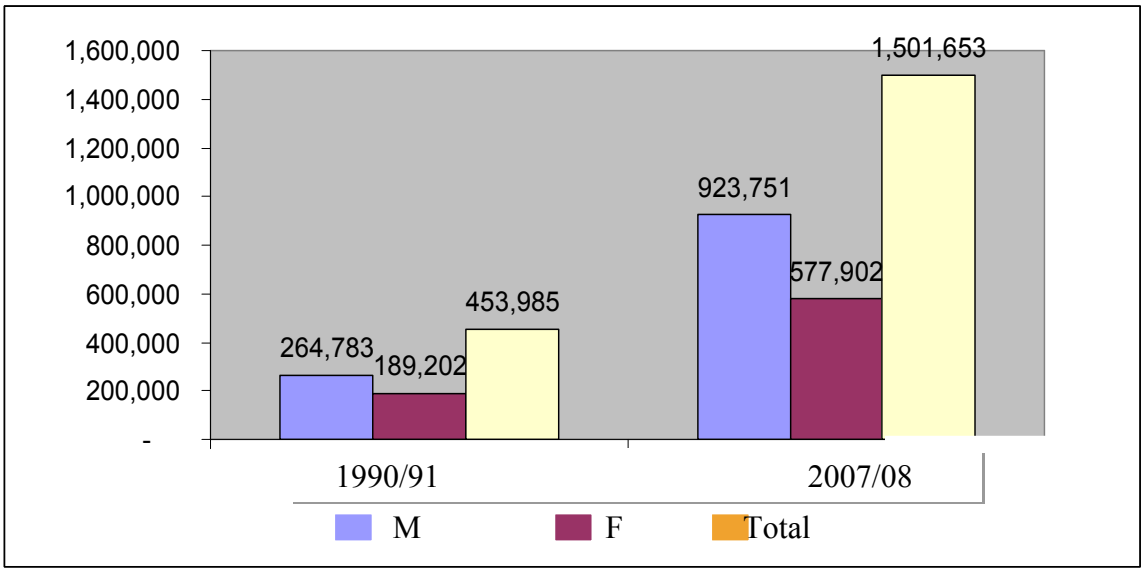


Fig. 39 Enrolment grade 9th-12th 1990/91 - 2007/08

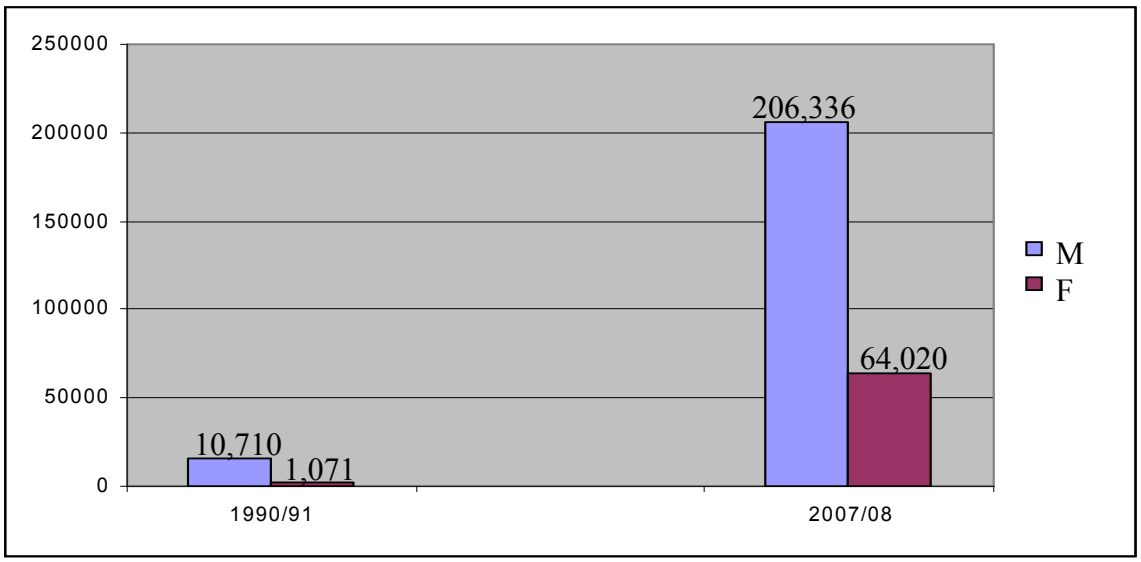


Fig. 40 Enrolment at Universities1990/91-2007/08

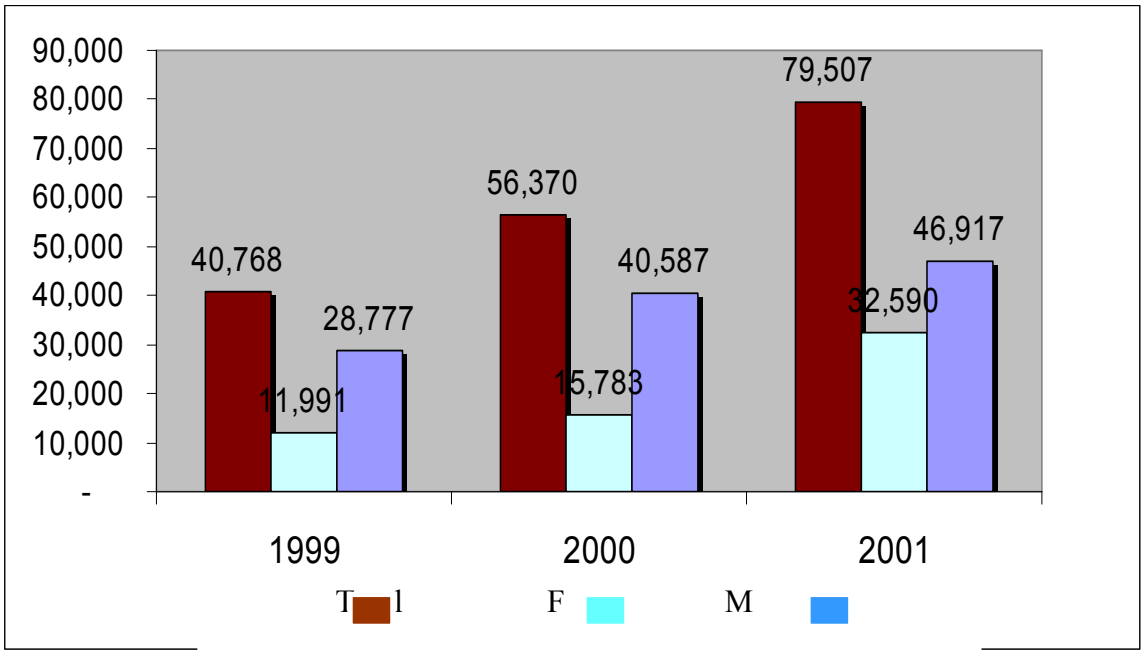


Fig. 41 Students Newly admitted to government Universities

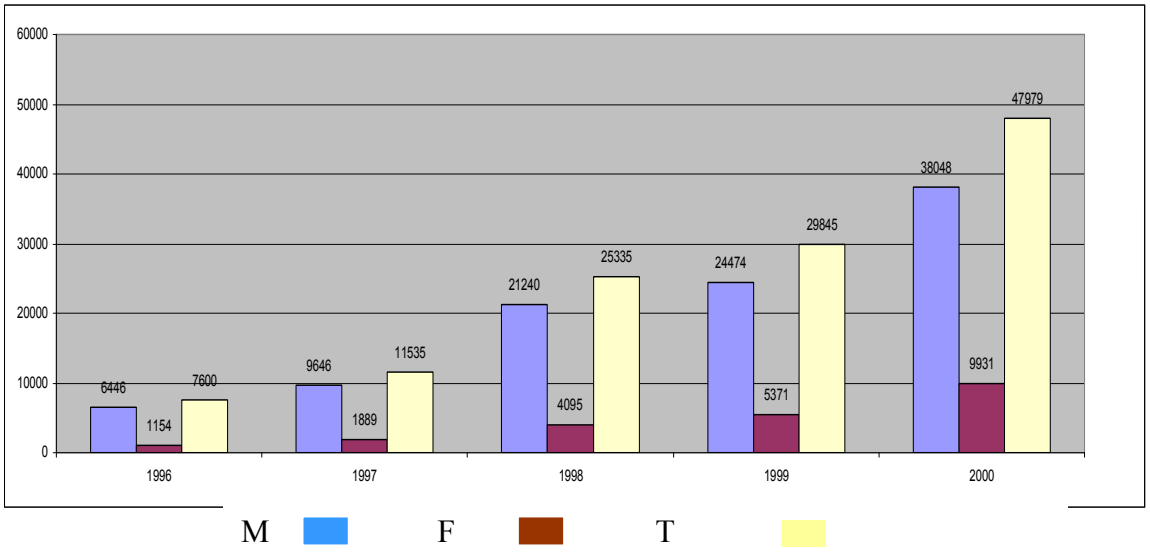


Fig. 42 BA/ BSC Graduates from All Programs 1996 – 2000 E.C

Challenges

Gender gap still persists at all levels the gap increases as the education level increases.

Performance of female students is less than male students

Gender based violence is affecting female education at all levels.

The number of female teachers is not as expected at all levels. The number decreases as the educational level increases (to be role model)

The number of female educational leaders is very few. (to be role model)

To overcome the challenges different interventions are being taken by the government.

Strengthening good practices

Give attention to equity in general education quality improvement program.

Civics and Ethical education

School improvement program etc

Conduct studies for action. Such as:

Regional peculiarities, violence against girls, attrition rate on higher education.

To fight against gender based violence inter ministerial committee is established one of is MoE.

Table 14. Problems Female Students Encounter in **Reproductive** Health

Rank	Problems in the University	Categories
1	fear of failure	Personal
2	Economic problem	Economic
3	Being placed in the department they were not interested	University environment
4	Influence from bad senior friends	University environment
5	lack of special support services	University environment
6	Adjustment problem	University environment
7	Presence of unfavorable attitude towards female	University environment
8	Verbal and physical harassment by male students	University environment
9	lack of concerned body to consult females	University environment
10	Shyness	Personal
11	Lack of assertiveness	Personal
12	Homesickness	Personal
13	Becoming easily desperate	Personal
14	Lack of facilities (separate reading places, medical, recreation, etc)	University environment
15	family imposition and control	Family
16	Verbal and physical harassment by male teachers	University environment
17	Lack of security in dormitories	University environment
18	Verbal and physical harassment by other staff members in the university and	University environment
19	Rape	University environment

Causes of Attrition

Poor academic performance

Health problem

Sexual harassment

Sexual harassments by senior male students and some instructors

Off campus factors

Disco houses and Traditional Music Houses (Azmari bet) in three towns, Bahir Dar, Awassa and Mekele.

Pregnancy is the major problem in the universities. At an average, 4-5 female students come to the clinics seeking help and advice due to pregnancy cases.

It is sever during immediately after freshman students are admitted to the university.

Measures taken in different universities

Organizing different programs to increase confidence of female students by Gender office, Female students association and Gender clubs (big sisters program to give awareness about reproductive health, tutorial support, peer counseling etc)

Economical support for the needy is started in some universities.

Separate library for female students. E.g. Haromeya University.

At federal level action plan is being prepared to address the problems at HLI such as developing rules or guideline against harassment and so on

It is believed that all problems will be addressed with BPR effective implementation at all levels.

Suggestions

Concerned government and non government organizations should organize a scheme to help female students such as:

Training on reproductive health, HIV/AIDS and other related issues

Supporting the economical problems

Financial, technical and material support for the ongoing tutorial and other gender issue programs give support to gender offices and gender clubs, etc in HLI.

8.3. Reproductive Health Situation in Higher learning Institutions (By Dr. Assefa Simie A.A.U)

Introduction

Adolescent is transitional period from childhood to adulthood, characterized by significant physiological, psychological and social changes. There are common features of students at higher learning institutions like, Young age group, away from families and being new to the environment as a result they will suffer from Physical health problems including SRH problems, social problems – poverty, school related

problems – studying skill, time management and psychological problems – mood changes, relationships.

Factors affecting SRH of young people in higher learning institutions are Lack of adequate awareness on RH issues, Geographical set up of the universities, Information and skills gaps, Quality and availability of services, Relations with lecturer, Peer pressure, Gender based violence, Lack of entertainment, and Absence of institutional support .

Studies conducted

Couple of studies (both quantitative and qualitative) was done across the institutions in the country namely; Addis Ababa, Jima, Bahir Dar, Mekele, Adama, and Hawassa Universities.

Table 15 Summary of study design, period, area and Study objectives

Year of study	Design	Study area	Objective
2005	Cross sectional: Qualitative	AA, Jima, Bahir Dar and Mekele	Assess experience in delivering/accessing information, education and services related to SRH
2008	**Cross sectional:** Quantitative & Qualitative	Addis Ababa University	Assess KAP , SRH services need and utilization, preference and types of SRH services provided
2009	Cross sectional: Qualitative	Mekele	Explore RH and related problems
2009	Cross sectional: Qualitative	Adama	Explore RH and Gender issues
2009	Cross sectional: Qualitative	Hawassa	Assess RH problems and pattern of RH service demand

Findings

Overall information and knowledge of the study subjects on SRH

Many of the students are not well aware of RH issues they think that it is the problem of female, delivery and Family Planning. Most students view RH as only concerned with sex and its outcome – pregnancy. Some have never heard about RH.

What is RH? I never heard of the word reproductive health" …20 years old second year student, Jimma University

I do not know what reproductive health mean'…many female students, Mekele University.

Some students have a misconception about RH issues particularly on condom effectiveness

" The brands of condom in our country and America are quite different. The condoms in our country are of poor quality and less effective. Hence someone shouldn't rely on condoms."

A female participant from Mekele

Source of information on Reproductive Health Issues are

Mass media (Radio, TV, Magazines) and University clinic – 12%

SRH problems of students in higher institutions

- ✓ Unsafe sex
- ✓ Unwanted pregnancy
- ✓ Abortion
- ✓ Sexually transmitted Infections (STIs) including HIV/AIDS
- ✓ Sexual harassment and rape in some universities both in and outside of the university campuses

Most sexual intercourses among couples in our campus are casual. They do it either in "Space" or under the tree where there is no adequate light either with out condom or with out correct use….."

A female FGD participant from Mekele

Groups that are at high risk of SRH problems
Fresh students
Female students

Female freshman students are the common victims of RH problems. They easily fall prey to the senior students'…male student, Bahir Dar University

Reasons are
Eagerness of the newly admitted students to get academic support from senior students
Low awareness of the risk associated with unprotected sex
Fresh students often need academic support and the senior students use this opportunity to trap them as their sexual partners'…male medical students, Jimma University

Health Care seeking behavior
There is limited health care seeking behavior among students. Among students with symptoms of STI, only 35% sought care (Addis Ababa University study).
The Reasons for this are Time and financial constraint, Unavailability of the service in the campus and Long process to get Diagnosis and treatment.

Despite the high prevalence of RH problems, absence of appropriate health care and other related interventions, **the tendency to keep the case secret or keeping the case limited to a small circle of friends** are the most important factors that aggravated the problem. Anything that happens to students related to RH would be heard immediately by the university community. Because of this, students keep their problem secret**' …male medical student, Mekele University**

RH services and its utilization in higher institutions

Generally the RH service delivery in higher institutions is non existent. There is no adequate specialty and No youth focused training for providers. Many students are not aware of the types of services provided in the university clinics and no SRH service delivery at all.

Most students support the establishment/availability of RH services in the campus such as

Emergency contraceptives, Condom, Post abortion care services, but there were Issues the worried them like Confidentiality and Quality of services.

"Students go to MSI clinics and other places when they face unwanted pregnancy"

A female FGD participant from Mekele

Factors exposing students to RH problems

Lack of awareness: inadequate or no information

Peer pressure

Low self esteem and lack of confidence

Economic reasons

Substance use (alcohol, khat, smoking)

Lack of conducive environment

Lack of recreation center

Absence of clear rules and regulations

Family, community and cultural factors

Lack of discussion on sexual matters

Stigma and discrimination

Consequences

Exposure unsafe sex, unwanted pregnancy which ends up in abortion (unsafe) and its complications

Dropout from school

Prostitutions

Drug addict

STIs including HIV/AIDS

It is not uncommon to hear that some female students get pregnant and abort while others drop from school due to pregnancy related problems'… female students, Jimma University

It is known by all that students have sex in the university compound. Since condoms are not readily available in and near the university compound, students will often have sex without a condom'…male medical student, Mekele University

Recommendations

Ensure availability of important RH services including the distribution of FP pills and condoms, and counseling on different psychosocial and health issues;
Promotion of healthy environment
Establishment of recreation centers
Appropriate measures to situations leading to risky sexual behaviors (pornography, violence, drugs)
Make the clinic environment non-threatening, which includes ensuring the confidentiality of the service rendered;
Increase student's awareness about HIV/AIDS and RH issues using various channels and methods;
Ensure the availability of adequate IEC/BCC materials on RH and HIV/AIDS issues

The moderators summarized the presentations and opened the floor for discussion. The following points were raised by the participants to the panelists.

1. What is the stand of Ministry of Education on Condom distribution for students?
2. there are encouraging initiatives on condom distribution for HLI students. Is there a plan to scale up the service?
3. it has been presented that clinics have been opened in the universities and named as RH clinics. Did you consider the issue of stigmatization in utilizing the clinics?
4. Is that not possible to make the mentorhip session to be facilitated by the students themselves?
5. Would you describe the terms segmentation vs integration?
6. Stakeholders should encourage researchers to conduct studies on this thematic area.

Responses made by the panelists

- Different collaborators are working aggrresively on Reproductive health problems among University students especially in newly opened Universities.

- Stigmatization is not problem that deters students from using the clinics.
- Orientation and reproductive health education have been given through mass-media like Radio Fana and other means.
- Universities are centers of excellence for research and education. They are not established to distribute condoms but they do promote RH services.
- The term integration refers to integrating RH sevices to other general health services. But segmentation refers to addressing the RH needs based on the age, sex and residential settings of the youth because there needs differences based on the aforementioned factors.
- Some encouraging results have been observed and scalling up will be done.

Finally the moderators appreciated both the presenters and the participants for the thorough discussions made. They also stated that task force has been established in collaboration with all 22 univesities in the country and interventions have been underway.

9. Tobacco Control Initiatives

Moderator: (Dr. Sintayehu Taddesse)

9. 1. Behavioral Aspects of Tobacco Smoking

(Ato Assefa Berihun, Addiction Psychologist)

Ato assefa commenced his presentation by forwarding the following question to the audience;

Do people use drugs or do drugs use people?

Addiction begins with use, but do all use lead to addiction?

What are possible factors for tobacco smoking/drug abuse?

Introduction

Global drug prevalence (of controlled drugs): 147.4 Million (cannabis), 40 Million (ATS), 13.4 Million (cocaine), 12.9 Million (Opiates) of social drugs, tobacco is number one killer

Tobacco kills about 4.9 million people per year (13,000 per day). Six Thousands billion cigarettes are smoked each year. The number of people smoking cigarettes is 1.3 billion worldwide: 41% of men and 21% women in developed countries, and 50% men and 8% women in developing countries.

Patterns of drug use

Use: using substances with no harm to health

Misuse: Non medical use of drugs

Abuse: sporadic excessive drug use, pathological pattern of use

Dependence: pathological state characterized by compulsion to take a drug on a continuous basis

Dependence/addiction

Tobacco is highly addictive; tolerance rapidly develops to the effect of nicotine

Nicotine is a chemical on which the taker becomes dependent. Tobacco dependence is a state where the person feels compelled to take tobacco. Dependence manifests itself along a continuum ranging from early problems without significance dependence to severe dependence with physical, mental, and socioeconomic consequences. Pin pointing exactly when a person becomes dependent on a substance is difficult.

People continue their addiction even though it may:

- ruin their health
- destroy family relationships
- wipeout the family's savings
- cause other serious problems in their lives jeopardize their job

How an addiction develops?

A person may:

Try a substance of curiosity, for "kicks", ….

Continue using the substance – makes the person feel good

Deny the substance is causing problems in life

Lose control – even after realizing the negative effects, the person can't stop

Phases of addiction development

Experimenting phase – to try a substance

Learning phase – get experience

Seeking phase – obsession, craving

Dependence phase – compulsive drug taking

Impact of smoking

An addiction causes a person to use a drug for short term gratification but there is a price to be paid

Psychic dependence:

A. Compulsive drug seeking (craving), and drug taking (abuse)
B. Tolerance
C. Anxiety, irritability, etc when stop/cut the amount
D. feeling of low self esteem due to bad breath, stained fingers, stained teeth, economic constraint, ill health, family discord

Physical illness

Extinction/quitting smoking

Stopping smoking takes time.

There are four stages:

1. Think about smoking (may take a few months, years)

make up the mind that one is going to stop

2. Prepare to stop (may take days or weeks):

Break the habit – smoking is a habit that is closely linked to certain times and places.

Get some help - try to get some help from friends, family, etc

Pick a day - decide when you are going to stop.

Make a day when you will not be under much stress

3. stopping

4. Working on staying stopped – take rest, high fluids, hot/steam bath, light foods (vegetables and fruits), exercising swimming and walking, etc

Measures

Addiction is a bio-psycho-social disease

Public health model: emphasize the interaction of Agent, Host and Environment

1. Supply reduction

2. Demand reduction

A. Primary prevention

B. Secondary prevention

C. Tertiary prevention

Rx modality: Substitutive

Symptomatic/supportive

9.2. WHO Framework Convention on Tobacco control
(By Addisalem Semma Drug Administration and Control Authority)

Introduction

Tobacco Control :

A range of supply ,demand and harm reduction strategy that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to smoke.

Convention adopted 56th World Health Assembly

Opened for signature on 28may/2003 for all members of WHO, UN &Regional Economic inter organization until 29 june2004.

Signatories to the WHO FCTC 168 country

Ethiopia sign in the year 2004 but Not Ratify till now

Objective of FCTC

Protect present and future generations from the devastating social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

Guiding principles

Inform the health consequence, addictive nature and mortal threat

Strong political commitment is necessary

International cooperation

Comprehensive multisectoral measurers

Financial assistance to aid tobacco grower & workers

Participation of civil society is essential in achieving the objective of the convention

General Obligations

Develop National tobacco control strategy

Adopt and implement effective legislative, Administrative measures

Formulation of proposed measures, procedure and guide lines

Measures related to the reduction of demand for tobacco

Price and tax measures

Increases taxation is effective control measure it reduce smoking initiation especially young

Non-price measures

Adopt and implement effective legislative and Administrative measure

Protection from exposure to tobacco smoke

- Recognize scientific evidences tobacco smoke cause death, disease and disability
- Adopt & implement in areas of existing national jurisdiction (indoor workplaces, public transport, indoor public places)

Regulation of content of tobacco products

-Testing and measuring the contents and emission of tobacco products

Regulatory provisions for tobacco control

Labeling provision

- Health warning
- Product constituent required on packages
- Size, placement, format and other detail of warning(50% or more of the display)
- Misleading descriptors(e.g. "mild" and "light") prohibited

Advertising, Sponsorship and promotion provision

Advertising Restrictions

- On design and content
- Health warning/ messages required
- Toxic Constituent disclosure required
- Restrictions by media type, audience type, location (e.g. no ads in school)

Ban on sponsorship

- No attribution to tobacco companies allowed during sponsored events
- No tobacco company or brand names, logos or identifying graphics or message
- Advertisements of sponsored events can not be attributed to or contain tobacco company or

brand name identity

Sponsorship Restrictions

- Health warning/ messages required during sponsored event
- Toxic Constituent disclosure required during sponsored event

Promotional Bans

- No brand stretching (even in tobacco products e.g. on clothing, bags, club name)
- No reverse brand stretching (e.g. Mercedes cigarettes)

Product Regulation Provisions

Authority to set maximum levels of toxic or harmful constituents (tar, nicotine, carbon monoxide and others

Authority to prescribe product testing methods

Authority to prescribe product design requirements

- Fire safety consideration
- " reduced harm" products
- Limits on flavorants and additives that make tobacco more appealing to youth
- limits on additives that enhance nicotine absorption

Smoke-free indoor air/protection from environmental tobacco smoke provision

Ban on smoking in all enclosed public places including modes of transport

Ban on smoking in certain identified places (e.g. workplaces, government facilities, school, health care facilities, public service facilities ,entertainment, shopping facilities and restaurants)

Smoking Restrictions

- Smoking allowed only in designed smoking areas (DSAs)
- DSAs required to be separately mechanically ventilated
- DSAs required to be in area that open to the outside
- DSAs signs required (signs additionally can be required to carry health message)

Sales and Distribution Provisions

Ban on sales to minors

- Verification of age required
- Signs required showing minimum age
- Restrictions on vending machines (placement of health messages, constituent disclosures and illegality of sales to minors age)

Ban on sales or distribution by minors

Ban on sales of single or unpacked cigarettes

Ban self-service displays

Ban on means of sale or distribution by which age can not be reliably verified (e.g. by mail, internet)

Ban on free sample or price for purchasing

Industry Reporting Provision

Routine reporting to the government on tobacco product

- Constituents and additives to tobacco products
- Functions of constituent and additives

Routine reporting to the government on company information

- Costs, revenues and profits
- Marketing expenditures and publication

National Tobacco Control Provision

Advertising ban; banned through legislation and regulation

Smoke- free indoor air restrictions

Public transportation and work places

by voluntary provision, not nationally legislated & regulated

Education, Communication, training and public awareness

Education and public awareness program on health risks & addictive character

Public access information on the convention and national law

Effective and appropriate training to health workers, community workers, social workers, media professionals, decision makers & administrators

Awareness and participation of public & private and NGOs

Treatment for tobacco dependence

Design and implement effective program

Include diagnosis & treatment of tobacco dependence in national plan and strategy

Establish health care facilities and rehabilitation centers

Collaborate with other parties to facilitate accessibility and affordability

Scientific and technical cooperation and communication

Promote and strengthen with the support of intergovernmental organization and other bodies

Cooperate with governmental and non governmental agencies in regional tobacco surveillance and exchange of information

Establish progressively a national system for the epidemiological severance of tobacco consumption related to social ,economical and health impact

Efforts made to implement FCTC in Ethiopia

9.3. Consequences of Tobacco smoking
(By Dr. Bogale Solomon)

Introduction

Tobacco is **the only** consumer product that **harms every person** exposed to it and **kills half** of its regular users!

TYPES OF TOBACCO USE

1. Smokeless tobacco (consumed without burning)
1.1. Snuff
1.2. Chewing
2. Smoking tobacco
    2.1. Cigarettes
    2.2. Cigars
    2.3. Pipes (Water pipes)

=> In any form tobacco is dangers!

DEADLY CHEMICALS

Tobacco smoke contains more than 1000 chemicals:

Fifty known or suspected carcinogens.

Many are potent irritants!

CIGARETTE CONSUMPTION

Unless some dramatic steps are taken to control tobacco: About 6.3 trillion cigarettes will be produced in 2010, **900** cigarettes for every man, woman and child.

Male Smoking

Smoking is marketed as a masculine habit linked to :

Health,

Wealth

Happiness,

Fitness etc

=> In reality smoking leads to:

Sickness

Premature deaths

Sexual impotence & infertility

Female Smoking

Tobacco industry markets cigarettes to women using false images of:

Vitality

Slimness

Emancipation

Sophistication

=> In reality smoking causes:

Reproductive damage

Disease

Death

BOYS & GIRLS TOBACCO USE

Global youth tobacco survey showed:

One quarter tried their 1st cigarette before 10 years of age.

PREVALENCE

The number of Smokers is about 1,250,000,000 globally. The prevalence in males is 80% (1,000,000,000). Female smokers account for (250,000,000) 20%.

Passive smokers

All the rest (including the unborn in the womb) are passive smokers.

TOBACCO PANDEMIC

Globally smoking is increasing since **James Bonsack** invented the first cigarette-rolling machine in **1881**

The rate is increasing rapidly in developing countries

=> The vector is the tobacco industry

HEALTH RISKS

To smokers:

All forms of tobacco are addictive and lethal.

- Increased risks of deaths from:
- Cancer
- Heart and respiratory diseases
- Stroke

Other fatal conditions

=> No safe level!

=> No safe type of tobacco!

Risks of adolescent tobacco addiction

=> Highest risks of contracting and succumbing to tobacco related diseases

- Cancer
- Emphysema
- Stoke
- Heart diseases
- Other fatal condtions

Secondhand smoke:

Adults	**Children**
Coronary heart disease	Middle ear disease
Lung cancer	Respiratory symptoms
Reproductive effects in women	Sudden infant death syndrome
	Impaired lung function
	Low birth weight
Stroke	Brain tumors
Nasal sinus cancer	Lymphoma
Breast cancer	Leukemia
Atherosclerosis	Asthma
COPD	
Preterm delivery	

Unborn

Still birth

Developmental malformation

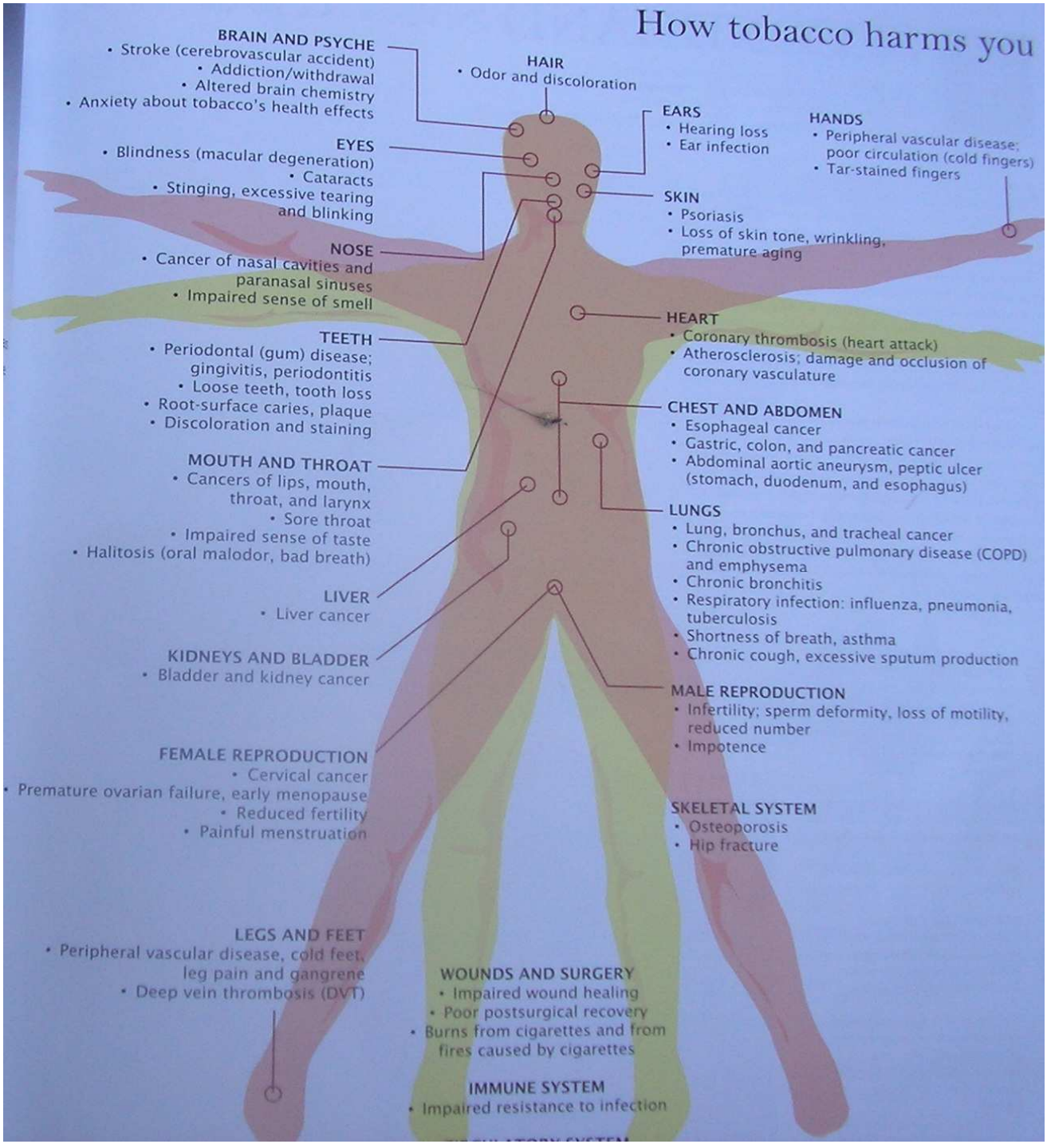


Fig. 43 Health problems of smoking on different Body system

Deaths

Tobacco use in any form is deadly. Smoking kills 1/2 of life time users. In 20th century killed 100 million people. In 2009 it will kill 5.5 million. If current trend continue it will kill:

7 million annually in 2020, 8 million annually in 2030. If the current trend continue tobacco will kill 1 billion people. Projected global tobacco attributable deaths 2015 is 6.4 million

Malignant neoplasm	34%
Cardiovascular diseases	29%
Respiratory diseases	29 %
Digestive diseases	3%
Lower respiratory infections	2%
Diabetics	2%
Tuberculosis	1%

COSTS TO THE ECONOMY

Tobacco imposes enormous economic costs on every country:

Lost productivity due to death or morbidity

Health care expenditure for smokers and passive smokers

Tobacco total economic costs reduce GDP of a country by 3.6%

=> Tobacco drain about $500 billion annually from world economy

COSTS TO THE SMOKERS

Smokers spend great sums of money that damages their health and financial security

=> Could have been used to cover basic human needs (food, shelter, education etc)

COSTS TO THE FAMILY

Exposed to tobacco smoke and its risks

Invest time and resource to care for sick and dying smoking relatives

Loss of income

HEALTH PROFESSIONALS

Essential in promoting tobacco free lifestyles and cultures

Unique opportunity to counsel individuals about why and how to stop smoking

Health professional who smoke are less likely to help their patients to quit smoking, lost their credibility.

SMOKING PREVALENCE AMONG HEALTH PROFESSIONALS

Health professionals smoking prevalence varies widely around the world.

There are countries with > 40% smoking prevalence.

Tobacco

It accounts for 1 out of every 10 deaths

It kills 1:2 of tobacco users. It Claims 5.5 million lives in 2009 and

Claims 8 million lives in 2020.

CONCLUSION

Tobacco is preventable and avoidable major cause of death and morbidity globally.

In 20th century there were 100 million deaths. In 21st century 1 billion deaths are expected. Therefore we have to act now! As it is a Global public health emergency !

Discussion

After the completion of the presentations, the moderator acknowledged the panelists and invited the participants to raise points of discussion on the papers presented. Accordingly, the following questions and comments were raised.

1.”Shisha” is currently distributed and used by many people. Is there any measure to be taken by the government to avert the problem?

2. what is the stand of the country on Tobacco and what is its economic impact?

3. who are the stakeholders in the campaign against Tobacco?

4.Is there any rehabilitation and counseling center for individuals affected by substance abuse?

5. What did DACA intervene so far to address the seriousness of the issue?

6. The DHS data revealed that the prevalence of Tobacco smoking is high. Is there any mitigating measure taken by the government?

7. Cigarretes are named by endemic animals but this has to be considered and measures have to be taken.

Responses made by the panelists

- Shisha is widely smoked by people of Arab countries and it is imported from these areas. But the problem is not only smoking the shisha, behind it there are other potential substances like Canabis imported together and used by different segments of the population.
- Proclamation on substance abuse has been practical to strengthen regulatory mechanisms. These are being implemented with stakeholders.
- Concerning the naming of cigarettes, The regulatory agency is working on the issue as to what has to be done.
- Studies showed that the prevalence of drug abuse including khat chewing is rising remarkably. Even cannabis has been started to be grown by some farmers in the country.
- There are no counseling centers for affected individuals so far. But there are initiatives.
- Religions are playing their roles to decrease the prevalence of cigarette smoking and other substance abuse. But this is not sufficient other stakeholders should be involved in the campaign.
- Cigarette smoking is practiced everywhere in public places or elsewhere. There are no proclamations to ban this. There is no one accountable for deaths caused by cigarette smoking. Even smokers corner are prohibited even in the airplanes. Therefore, concerned bodies should aggressively work to have the proclamation prohibiting this.
- Finally the moderator highlighted that every stakeholder should work aggressively to avert the current situation.

10. Business Meeting

The session was chaired by Dr. Mengistu Asnake, President of EPHA. He welcomed once again all the participants on behalf of the association. He highlighted the Agenda for discussion.

1. Annual Activity Report hearing and discussion
2. Annual Audit Report hearing and discussion
3. Annual chapters Report hearing
4. Draft strategic plan (2010-2014) Hearing and discussion
5. Identification of the chapter that hosts the 21st (2010) Annual EPHA

conference

6. Election of 4 board members to replace those who have served for two terms and who left the board membership

The chairman requested the house to endorse the Agenda for discussion. The House endorsed the listed agenda unanimously. The chairman called upon Dr. Solomon Worku to present the annual activity report performed by the association.

10.1. Annual Activity Report

Dr. Solomon worku acknowledged both the chairman and the participants and started his presentation.

As far as membership affairs are concerned, in the last one year 228 regular and six life time members were registered newly which totals 234 together. The total number of members of the association is currently 3163. Promotional activities were intervened to enroll more members. Online registration has been arranged using the website of the association (WWW.etpha.org). At present there are 14 chapters functioning at regional level. Working visits have been conducted to assist the chapters. In the last one year office materials like computers, printers, L- shape tables and secretary chairs fulfilled to 6 EPHA chapters.

Publications like Ethiopian Journal of Health development previous editions have been donated to the Universities like Meda Wolabu, Jimma, Gondar and Hawassa.

EPHA SECRETARIAT

A total of 44 full time employee and more than 500 temporary staffs available.

During the past one year, new posts have been developed. Monitoring and evaluation, Advocacy and public relations units were established. Legal advisor has been employed. Networking/Partnership was established with different stakeholders. Administrator was also hired.

EXCUTIVE BOARD

The Board members successfully accomplished tasks given both nationally and internationally. Three members served for two terms and one left the country.

Election of four board members is expected from this conference.

ADVISORY COUNCIL

This council is consisting of 30 people. Two meetings were conducted by the counsel during the last one year. Core committee has been established to host the 13th World Congress of Public Health.

Strategic plan development for 5 years (2010-2014) has been developed and members have participated in the development of the plan.

Members were included in EPHA delegation.

PUBLIC HEALTH RESEACH ETHICAL REVIEW COMMITTEE (PHRERC)

Public Health research and Ethical review committee have been established.

EPHA is one of the five nationally recognized institutions given mandate to establish IRB. The review committee reviewed a total of 58 proposals in the year.Income has been generated by the association. New Review committee members were elected.

Information Dissemination using EPHA Outlets

The association disseminates health information using its outlets and copies of the following materials were produced and distributed

- Ethiopian Journal of Health Development 6900 copies
- Felege Tena Newsletter: 6200 copies
- Public Health Digest/ HIV/AIDS/STI/TB Bulletin:6900 copies
- Masters Thesis Extract:6,000 copies
- EJHD Special issues= 1725 copies
- Annual Proceedings= 1725 copies
- Abstracts= 1725 copies
- Health extension news letter 2 issues 60,000 copies published.
- Special issue on Malaria control and prevention 30,000 copies published

EPHA Major project Activities

- Infection Prevention Project
- EPHA-CDC PROJECT Strategic Information component
- EPHA-CDC/CIII EPI PROJECT
- AIDS MORTALITY SURVEILLANCE

- SURVEY ON THE MAGNITUDE OF RISK FACTORS
- FIELED EPIDEMIOLOGY
- TOBACCO CONTROL CPHA/EPHA
- RH/FP REPOSITIONING PACKARD FOUNDATION/EPHA

Fund has been obtained from CDC for field Epidemiology and Laboratory training in masters program. In collaboation with Addis Ababa University School of Public Health and Federal Ministry of Health 13 residents have been enrolled and began their trainings.

MAJOR FOCUSES OF THE PROJECTS & COLLABORATORS

These are the activities and collaborators

- Researches & Evaluation
- Trainings
- Infection Prevention Advocacy with associations
- AIDS related mortality Surveillance: in collaboration with universities
- Expanding PMTCT Services in Private Health Sectors in Ethiopia in collaboration with ESOG
- Tobacco control policy project

TRAINING

Both long and short term trainings have been given for health professionals.

Short term trainings were given on the topics like SHORT TERM

- Research Methodology & Ethics training with all regions 5 trainings sessions were conducted and 96 professionals trained
- Monitoring & evaluation is given in collaboration with SPH/AAU – every year
- One session on Longitudinal Data Management and Analysis Using STATA given and 26 people were trained.
- Two hundred and twenty eight Health professionals were trained on different FP/RH topics
- In service training to 1566 health extension workers on FP/RH, gender

Long Term trainings are

- Support a one year Leadership in Strategic Information Training Program (LSITP) in collaboration with MOH, AAU and CDC.
- Support masters level Field Epidemiology and (Lab) Training Program (FELTP) in collaboration with MOH, SPH and CDC Launched on February 2, 2009.

Generation of information/ Researches

- Support AIDS Related Mortality Surveillance Surveys in Addis Ababa, Butajira, Gilgelgibe, Haremaya, Kersa in collaboration with the respected universities and Mekelle and Arbaminch joined the net work.
- Planned to increase its representativeness
- Supported 23 MPH theses of AA & Jimma university students –
- Undergoing to support 16 MPH Students from Haremaya University.

Researches Completed

- Evaluation of Alcohol/khat consumption in relation to HIV infection
- Formative Assessment of MSM
- Geographic Targeting of HIV Prevention Interventions to MARP's in High Prevalence Hotspot Areas in Amhara region
- Evaluation & screening for TB among patients attending ART clinics

Researches on process

- Survey on the Magnitude and Risk Factors for HIV Infection among MARP's in Ethiopia
- Pain Management Evaluation
- Assessment of Utilization and Quality of VCT in Ethiopia
- Evaluation of Effect of PEPFAR Interventions on the Health Sector
- EPHA Publications Evaluation Assessment

NATIONAL ROLE OF EPHA

- EPHA has also a national role. The association has been selected by the government representing all other association to participate and contribute on the National document for African Peer Review mechanism(APRM). EPHA is also closely working with sister associations EMA, ENA, ENMA, EPHLA and ESOG.

It was Representing African Public Health Associations at the WFPHA

EPHA is also a Member of the African Platform on Human Resources for Health

The association is also Closely working with Canadian PHA (CPHA), American PHA (APHA)and WFPHA.

Serno	Name of the chapter	New members registered 2009	Amount of money collected	Challenges	Recommendations
1	Tigray	25	-	- Transportation - Running cost to reach Woredas - Poor communication	- Allocation of running cost - Regular follow up - Regular communication
2	Bahir Dar	9	1,095	- Overloaded of work	-
3	Gondar University	-	2,665	- High turn over - Office materials without secretary - No core group	- To nominate new chapters - Establish members data - Open P.O.Box - Expand promotional work
4	South Wolllo	6	680	- Lack of P.O.Box - Some members are reluctant to pay - Difficult to collect fees who changed address	- Rent P.O.Box - Give training for core Group
5	North Wollo	14	1,100	- Turn over of staff - No office - No Telephone	- Give emphasis for the gap - Communicate Head office

6	Jimma Unniversity	102	5,200	- Overload of work - No space for office - No clear guidelines	- Allocation of resources - Secure office - Assign office person - Avail guidelines
7	SNNPR	16	6,180	- Difficult to develop annual plan - No access to communicate - No Fax, telephone and P.O.Box - Research proposal	- Need EPHA strategic plan - Finding Telephone numbers - Establish telephone, Fax and P.O.Box
8	Haramaya University	8	1,155	- Lack of office for chapter - Interruption of EPI project - High turn over - Not able to know the exact number	- Lobby for office
9	Benshangul	3	-	- Turn over	- Supportive supervision - Guideline
10	Dire Dawa	-	-	- Committed too many engagement	- Regular communication - Field visit by EPHA - Biannual report from chapters
11	Bale	11	800	- Difficult to collect fees - Not Receiving Research materials	- Office - Running cost - Office Furniture

12	Addis Ababa	257, of this 6 members are life	16,805		

Challenges

- Office premises – Still not successful
- Shortage of transportation facility
- Low budget utilization by partners
- Need Vs project mandate (rules & regulations)
- Slow ethical clearance of protocols
- Low diversity of budget sources (partially due to large scope of current projects)
- Regional chapters (need for regionalized structure

10.2. Annual Chapters Report

This report was summarized and presented in tabular form by Ato Ali Beyene who is the officer for membership affair at the association as follows.

10. 3. Audit Report by External Auditor (Awoke G/Sellassie)

አውቀ ገብረ ሥላሴ እና ኩባንያው - ሰርቲፋይድ የአዲት ድርጅት
AWEKE GEBRE SELASSIE & COMPANY
INTERNATIONAL ACCOUNTANTS (LONDON) & CERTIFIED PUBLIC AUDITORS
P.O. Box 3323
Addis Ababa
Ethiopia
E-mail:agsclassic@ethionet.et
+ 251 - 011 - 465 54 54
Tel./Fax. + 251 - 011 - 465 54 00
+ 251 - 011 - 661 48 29
+ 251 - 011 - 618 25 30

INDEPENDENT AUDITORS' REPORT
ETHIOPIAN PUBLIC HEALTH ASSOCIATION (EPHA)

We have audited the accompanying balance sheet of Ethiopian Public Health Association as at 31st July, 2009 and the related income and expenditure statement for the year then ended.

RESPECTIVE RESPONSIBILITIES OF MANAGEMENT AND AUDITORS

The preparation of the financial statements is the responsibility of the management of the Association. It is our responsibility, based on our audit, to express our independent opinion on these financial statements.

BASIS OF OPINION

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

OPINION

In our opinion, the financial statements referred to above together with the notes thereon, present fairly, in all material respects, the financial position of Ethiopian Public Health Association at 31st July, 2009 and the results of its operations for the year then ended.

AWEKE GEBRE SELASSIE AND COMPANY
CERTIFIED PUBLIC AUDITORS

October 16, 2009
Addis Ababa

ETHIOPIAN PUBLIC HEALTH ASSOCIATION (EPHA)

BALANCE SHEET

AS AT 31ST JULY, 2009

Currency: ETHIOPIAN BIRR

	Notes			2008
FIXED ASSETS	3(4)		361.00	307.00
CURRENT ASSETS				
Cash and bank	5	10,811,689.50		7,014,497.21
Debtors	6	317,721.24		2,318,565.77
		10,929,610.74		9,333,062.98
CURRENT LIABILITIES				
Creditors	7	1,795,176.83		1,650,815.17
NET CURRENT ASSETS			9,134,433.91	7,682,247.81
			9,134,794.91	7,682,554.81
REPRESENTED BY				
Fund balance as per the attached income and expenditure statement			9,134,794.91	7,682,554.81

ETHIOPIAN PUBLIC HEALTH ASSOCIATION (EPHA)
INCOME AND EXPENDITURE STATEMENT
FOR THE YEAR ENDED 31ST JULY, 2009

Currency: ETHIOPIAN BIRR

	Notes			2008
INCOME				
Project income - Grants	9.1		23,757,212.04	17,734,713.12
Administrative income (10% charge)			148,515.85	158,474.39
Membership fee	6.2		70,218.42	85,880.56
Interest income			102,629.19	88,704.15
Sundry income			260,070.96	498,493.56
			24,338,646.46	18,560,265.78
EXPENDITURE				
Personnel cost	9.1	3,327,636.43		2,307,340.20
Travel and per diem		1,204,142.96		1,132,659.82
Office supplies and printing		243,866.41		169,205.87
Occupancy cost	9.2	509,220.88		302,500.49
Communication	9.3	362,913.57		257,678.27
Repair and maintenance	9.5	166,103.68		38,148.38
Advertising expense		27,702.65		18,770.30
Consultancy fees		4,167,163.99		3,053,161.76
Insurance		19,104. 24		5,846.98
Workshop, meeting & training	9.4	2,948,579.12		2,282,814.09
Transferred to sub-recipients		7,455,963.88		4,692,051.82
EPHLA expense		357,248.31		148,079.79
Bank service charges		15,453.90		52,123.06
Fuel		94,046.44		47,046.52
Membership fee		-		2,469.80
Purchase of fixed assets	9.6	1,090,116.70		2,412,598.62
Audit fees		34,307.79		21,735.00
Administration cost/Others		100,307.34		46,203.01
Refreshment		9,467.74		5,456.99
Publication		631,239.43		417,238.06
Professional fee		122,000.92		-
			22,886,406.36	17,413,125.83
			1,452,240.10	1,147,139.96
Add: Fund balance on 01.08.08			7,682,554.81	6,535,414.86
Fund balance 31-07-09			9,134,794.91	7,682554.81
Fund balance transferred to balance sheet			(9,134,794.91)	(7,682,554.81)
			-	-

ETHIOPIAN PUBLIC HEALTH ASSOCIATION (EPHA)
NOTES FORMING PART OF THE ACCOUNTS
FOR THE YEAR ENDED 31ST JULY, 2009

Currency: ETHIOPIAN BIRR

1. ESTABLISHMENT

The Ethiopian Public Health Association is established in the month of August 1989 to be governed in accordance with the terms and conditions set forth in its Constitution.

2. OBJECTIVES

The objectives of EPHA are the advancement of public health measures for the promotion of health, prevention of diseases, timely treatment of the sick and rehabilitation of the disabled by:

2.1 Bringing together persons who are trained in, working in, or interested in public health or public health - related professions.

2.2 Participating in and making recommendations on health policy, planning, training, management and practice of public health.

2.3 Promoting the professional standard and interest of its members and other public health personnel.

2.4 Advancing research in public health.

2.5 Establishing a forum for promoting communication among members and the public on matters of health. Networking with similar associations and societies with similar professional aims within Africa as well as outside.

2.6 Publishing a scientific journal, a newsletter, etc., regularly to disseminate information to public health professionals and to the public.

2.7 Actively participating with other sister organizations in the country in the strengthening of professional associations as well as in the promotion of health.

2.8 Playing active advocacy roles on important national and international health issues.

3. ACCOUNTING POLICIES

The accounting policies adopted by the Association are indicated hereunder.

a. EPHA follows a modified cash basis of accounting.

b. Fixed assets are charged as expenses at the time of purchases against a nominal value of 1.00 Birr.

c. Donations in foreign currencies are stated in the accounts in Birr at the rate of exchange prevailing on the date the bank account of the association is credited.

4. FIXED ASSETS - NOMINAL VALUE OF ONE BIRR

	Balance 01.07.08	Addition	Adjustment	Balance 31.07.09
Fixed assets - EPHA	80.00	-	-	80.00
Fixed assets - EPHA/CDC	174.00	46.00	-	220.00
Fixed assets - EP/RH	53.00	8.00	-	61.00
	307.00	54.00	-	361.00

5. CASH AND BANK

		2008
Petty cash fund	5,293.62	1,050.72
CBE - Addis Ababa branch C/A - EPHA	2,731,035.72	1,850,124.44
CBE - " " " " - CDC	1,798,682.88	194,077.96
CBE - Addis Ababa branch S/A	2,777,980.52	2,675,351.33
CBE - " " " C/A - FP/RH	3,298,896.76	2,293,892.76
	10,611,889.50	7,014,497.21

6. WORK ADVANCES

		2008
Wondewossen Zenebu	4,788.00	4,788.00
Amsalu Feleke	500.00	-
Tensaea Tesfaye	5,350.00	-
Nega Bereki	-	53,012.32
Pramium plus printers	16,215.00	-
Moges G/Mariam	5,907.00	5,907.00
Zehara Suhali	2,000.00	5,869.61
Dr. Dawit Wolday	-	27,500.00
Hawa Seid - staff debtor	2,000.00	2,000.00
Asrat W/Meskel	-	490.21
Population Service International	-	1,027,785.32
Birtunet Deveopment and IT Solutions P.L.C.	-	445,333.24
Sisaynesh Bekele - staff debtor	132,742.29	527,902.50
	169,502.29	2,100,608.20

OTHER DEBTORS

Prepaid Insurance	6,697.17	-
Prepaid office rent	139,935.42	146,816.39
Sundry debtors	1,586.36	71,141.19
	148,218.95	217,957.57
	317,721.24	2,318,565.77

7. CREDITORS

EARMARKED FUND

		2009
WHO	215,152.69	-
Monitoring and evaluation	845,382.07	1,013,342.86
Visionary leadership program	1,843.17	1,843.17
Nat. Com. for Bln. Prev (NCPB)	149,768.97	156,368.97
Int. Conf. (organizing committee)	83,825.39	83,825.39
UPPSALA University	13,924.47	13,924.47
Professor Rada	359.19	359.19
UMEA University (Dr. Fikiru)	461.89	461.89
Mental health projects	300,097.73	252,118.68
	1,610,815.57	1,522,244.61

OTHER CREDITORS

		2008
Cash indemnity	8,500.00	5,600.00
Provident fund	332.46	546.24
Withholding tax	18,747.29	18,794.37
Income tax	92,705.89	41,736.17
Sundry creditors	2,524.59	5,506.39
	122,810.23	70,083.17

ACCRUALS

Nat. Comm. for Blin. Prev. (NCPB)	44,265.00	44,265.00
Audit fee - Aweke G/S and Company	9,000.00	9,000.00
Telephone charge	8,286.03	5,222.39
	61,551.03	58,487.39
	1,795,176.83	1,650,815.17

8. REVENUE

The details of revenue is shown as follows:-

8.1 PROJECT INCOME - GRANTS

Canadian Public Health Association (CPHA)	-	120,751.86
Center for Disease control (CDC)	20,787,271.44	14,449,541.26
Packard foundation	2,969,940.60	3,164,420.00
	23,757,212.04	17,734,713.12

8.2 MEMBERSHIP FEE

		2008
Membership fee – individuals	67,418.42	77,614.30
Membership fee – institutions	2,800.00	8,266.26
	70,218.42	85,880.56

9. EXPENDITURE

9.1 PERSONNEL COST

		2008
Basic salary –EPHA	49,974.00	81,243.45
Salary and Wages – EPHA/CDC	2,319,322.91	1,499,930.58
Salary and Wages – EP/R	429,421.92	332,500.16
Transport allowance – EPHA	18,500.00	25,030.35
Transport allowance – CDC	202,513.28	160,250.33
Transport allowance – EP/R	42,222.08	35,930.33
Provident fund – EPHA	4,976.01	8,202.29
Provident / fringe benefit- CDC	201,591.29	122,810.29
Provident fund – EP/R	42,918.58	33,375.42
Casual labour	18,196.36	6,067.00
	3,327,636.43	2,307,340.20

9.2 OCCUPANCY COST

Office rent and utility	424,340.69	293,839.30
Cleaning supplies	-	6,161.19
Office refurbishing	84,880.19	2,500.00
	509,220.88	302,500.49

9.3 COMMUNICATION

		2008
Telephone, internet, fax and Postage	362,913.57	257,676.27

9.4 WORKSHOP

Workshop, meeting and conference	2,949,679.12	2,282,814.09

9.5 REPAIR AND MAINTENANCE

Rep. and maint. CDC	20,127.50	-
Rep. and maint. vehicles	141,506.16	-
Rep. and maint. FP/RH	4,470.00	-
	166,103.66	39,149.39

9.6 PURCHASE OF FIXED ASSETS

		2008
EPHA - Office equipment	-	3,634.00
Computer and Accessories	-	10,500.00
CDC-office equipments	726,211.83	823,804.11
CDC-office furniture	153,032.89	166,973.13
CDC-computer and Accessories	-	153,788.43
EJHD - Office equipment	-	23,396.99
EJHD - Office furniture	-	6,332.13
FP/RH - Office furniture	2,529.00	2,959.15
Vehicle	139,500.00	1,221,205.68
Office equipment FP/RH	68,842.98	-
	1,090,116.70	2,412,595.62

9.7 COMPARATIVE FIGURES:

Are rearranged to facilitate comparison last year figures with current year ones.

10. CONCLUSION

10.1 We are most grateful to the management and employees of the Association for the assistance and co-operation extended to us duding the course of the audit.

10.2 Should there be any information required in respect of these accounts and report, we shall be pleased to supply it.

AWEKE GEBRE SELASSIE AND COMPANY
CERTIFIED PUBLIC AUDITORS

October 16, 2009
Addis Ababa

10.4. Draft strategic plan (2010-2014) by Ato Alemayehu Assefa (Strategic Plan consultant)

Introduction

Inorder to develop the the five years strategic plan of EPHA, Strategic plan consultant was hired. Questionnaire was developed and commented by responsible bodies. It was distributed to members, chapters, Board, Donors, gov't, advisory council, staffs and sister associations and response was obtained. Focus group discussions and key informant interview was conducted for staffs and management. Secondary data were also collected for external environment analysis and review of strategic plan II. Comments were also received on the draft strategic plan document from board and advisory council members.

Overview of implementation of Strategic plan II

The strategic plan II has enclosed the following objectives.

Objective 1 is to increase active members by 50 %. There were about 400 new registrations per year before. New registration increased from 918 to 3081. The number of life time members increased from 2 to 101. Out of the 3081, the number of active members is 1947. While the number of new registered members increased by 63%, that of active members increased by 27.76%.

Objective 2 is to meet 50% finance from own sources. The existing income from members comprises only 3%. The income from other related source is 1%. This objective was not realistic.

Objective 3 is to promote standards. This part was difficult to assess as data were not available. This indicated that there were poor documentation.

Objective 4 is to promote and protect the interest of its members. To materialize this advisory council has been established. The association has worked has worked to improve the salaries of public health professionals. It has also provided capacity building trainings in leadership, Field Epidemiology etc. Two books have been published. More than 2500 members attended conferences. Two hundred and fifty scientific papers were presented. Fifteen panel discussions were conducted and more than 60 panel discussants participated.

Objective 5 is to promote public health research. In this regard, commendable work has been done in HIV/AIDS and Field Epidemiology. MPH theses conducted in these

areas have been supported financially. So far more than 15 research projects have been implemented. The association is also providing technical, financial and administrative support to AIDS mortality surveillance projects. The challenges encountered in this regard are the activities are focusing mainly in Addis Ababa, lack of ownership by Universities and minimal dissemination of research findings.

Objective 6 is to establish working relationship with sister associations. In this regard, successful achievements have been obtained.

Objective 7 is to disseminate health information to members and public. In this aspect, 15 issues of EJHD with a print of 30,000 copies; 20 issues with a print of 40,000 copies of Felege-Tena news letter; 20 issues with a print of 80,000 copies of public health digest, and 6 MPH extracts were published in the form of booklet and 24,000 copies have been distributed.

Objective 8 is to carryout advocacy. This has been implemented by involving in family planning and reproductive health issues. The national laboratory policy development was initiated. The association has established public health ethics review committee. The association has also played a role in infection prevention advocacy with sister associations. It has also generated strategic information for better policy formulation.

Objective 9 is to strengthen EPHA's Capacity. The capacity of the association to administer projects has improved. The association has been involved in writing big proposals. It has recruited and hired different professionals. But the challenges are absence of own premises and clear organizational structure.

Vision of EPHA

EPHA envisions the attainment of an optimal standard of Health for the people of Ethiopia (Existing)

The vision of EPHA is to evolve into an association of proactive public health professionals that contribute to the attainment of optimal standard of health for the people of Ethiopia (proposed)

The vision of EPHA is to be a regional center of excellence in public health and aspires to see the attainment of an optimal standard of health for the people of Ethiopia (proposed)

Mission

The mission of EPHA is to promote better health services to the public and professional standards through advocacy, active involvement and networking **(existing)**

The mission of EPHA is to promote professional standards and better health services to the public through research, advocacy and active involvement in collaboration with public and private sections, NGOs, sister associations and all concerned stakeholders **(proposed)**

The mission of EPHA is to facilitate and enhance the contribution of members to the health sector development of the country through research, advocacy and capacity building services **(proposed)**

Values

- Frankness, transparency, honesty and integrity in our dealing with gov't and donors
- Equality in partnership
- Quality in every performance
- Commitment and involvement
- Striving for excellence in every activity
- Accountability for every performance
- Strict adherence to professional Ethics

Issues to be considered along with strategic planning II

- The legal environment
- Executive Board (focal point for membership dev't, role clarity)
- Advisory council (lack of program structure)
- Secretariat (Absence of committee work, frequent absence of leaders from office, structure, duties, and responsibilities
- Who should be a member? Or criteria for membership
- Danger of fragmentation Work Groups
- Research(inequality in providing opportunity)
- Regional chapters

- Organizational sustainability

Main Strategic/critical issues

- Organizational Identity
- Formation of Consortium society of Health professionals
- Weak membership drive
- Effective implementation of HEP
- Absence of Sub-specialized workgroups/Forums
- Weak Regional chapters
- Inability to construct its own premises
- Preparation for World Public Health Assembly 2012 and 25th Anniversary

Strategic Direction

- Re-registration of Ethiopian Resident's Societies
- Leading/coordinating or initiating the formation of a consortium
- Effective implementation of HEP focusing on:
    1. Policy and strategy revision
    2. Involving in Human Resource Development for health
    3. Health Information System
    4. Health care logistics (facilities, drugs, equipment)
    5. Research in Public Health and
    6. "Health care Reform" in general

- Strengthening membership
- Establishing EPHA Work Groups/Forums
- Establishing/strengthening Regional Chapters
- Constructing its own premises
- Using the World Public Health Assembly conference in 2012 and the 25th Anniversary in 2014 as a landmark to increase visibility and enhance status

Discussions

After the reports were presented, Dr. Mengistu Asnake, the chairperson, acknowledged the presenters and opened the floor for discussion. Based on this, the following questions and comments were raised.

- The way majority of the reports presented is fascinating. The performance of the secretariat and Board is also encouraging. Please keep it up as this will strengthen the association. But there is no female presenter/chairperson among you. Therefore something has to be done by EPHA in order to bring women to the leadership of the association. The other point I would like to ask is did you get equivalent Amharic version for the term "Chapter"? Are there future intententions to strengthen regional chapters? In the regional chapters' report made by Ato Ali Beyene, the recommendation part lacks clarity and in the same report there is no consistency b/n the number of members and the amount of money collected. Have you ever discussed with the regional health Bureaues and other stakeholders inorder to solve the shortage of offices for regional chapters? I have to be briefed on these points…

- I thank Mr. Chairperson. The association has accomplished wonderful achievements. It is clear that the association is sponsoring researches on various health issues particularly HIV/AIDS. But less attention has been given to Health Economics. Therefore I recommend the association to work on this issue proactively. Moreover, the association has to arrange a discussion session on this sensitive issue to attract researchers and other stakeholders. In the advisory council, there is lack of fairness in gender and generation mix, hence corrective measure has to be taken. By dealing with responsible body, the association has to secure its office premise and even generate its own income.

- Challenges encountered should have been well elaborated and appropriate recommendation should have been made in the reports made. The source of income is majorly from two organizations. This may challenge the survival of the association. Therefore solutions have to be sought inorder to secure other income sources. Election of new board members is to be made to replace board members including the president because they have served for two terms. But the preparation to host the 2012 WPHA is underway by these members. Is it not challenging for the new board members to familiarize themselves with the issue? Is the association registered like other civil society organizations as per the new proclamation?

- I thank the association because it has begun using the IT technology including for membership registration. But the association has to make sure that it is user friendly by developing a system so that members can use their own usernames and passwords in order to access and use the technology. In addition to the soft copies of Abstracts provided this year, it is better to distribute in hard copies as well for the next time.

- I have never come across such a wonderful and well organized annual conference. Moreover, the sessions are participatory; the issues are timely.I hope the association is addressing some issues not coverd by the government. I am very much delighted and acknowledge the organizers for this. What is the level of integration with government in addressing the various public health issues in the country?

- It was mentioned that the association is using IT technology for dissemination of information using its outlets and for other purposes. What is the association doing to facilitate online submission for publication in order to communicate with reviewers?

- In order to evaluate the audit report, the detail of the financial report should have been presented. Did the executve board evaluate the financial report?

- As to the future of EPHA in the strategic plan, is it proposed to be a professional association or labour union? Is there an intention to make it a business making organization? Please give a brief explanation on this issue. The association has to give due emphasis to research. As a professional association, are there initiatives to work on professional standards, quality assurance…..?

Responses Given

- Regional chapters are focal points that link members with their association. So far we did not get equivalent Amharic version for the term Chapter.
- The inconsistency between the number of members and the amount of money collected from some regional chapters is due to the sale of books namely the Epidemiology and Ecology of Health and disease in Ethiopia and Evolution of Public Health in Ethiopia.
- The working relation between EPHA and various levels of FMOH is promising. The ministry is our major stakeholder.But we need to restrengthen the relation furthermore. Even research findings and other information on different health issues are being disseminated through the outlets of the association to these partners.
- The office premises issue is raised by different participants. Still the board is working aggressively on this issue. We hope we will come up with good news in the near future. But members are expected to give their ideas to come up with better solutions.
- Concerning election of new board members, the idea raised is totally against the legislation of the association. Therefore we should not break the legislation ratified by the general assembly. But, the old board members have to contribute and support the

new ones especially for 13th WPHA to be held here in Addis Ababa in 2012. Because that is a membership duty as well.

- The association is not so far registered according to the new CSO proclamation. But it will be registered soon after the future direction of the association is set by the general assembly.
- Pertaining to the points raised on Information technology, the comments are relevant ones. Therefore, the association will work on it to come up with better access. And concerning the online submission, we will talk with the editorial board.
- The executive board has evaluated the financial report.
- The consortium of the health professionals is not established so far. But there are sister associations we are working with.
- In order to solve the problem of regional chapter offices, we have dealt with the universities and other concerned parties to solve it. But if the problem persists any more, we will seek for further solutions.
- EPHA has the mission to work on health professionals standards and quality assurance. In this regard we are developing a system to work jointly with the Regulatory Authority in the federal Ministry of Health on accreditation and licensing of health professionals.
- As to the 13th WPHA to be held in Ethiopia, we are making advocacy. Booz is to be undertaken for promotional purposes. Core committee has been established. Some preparations are underway with Global cynergies. Subcommittee will be established to undertake multidimensional preparations.

Finally Dr. Mengistu, the chairperson, acknowledged the participants for the wonderful discussions held and requested the general assembly to ratify the agenda presented and discussed. The assembly ratified the agendas presented unanimously.

10.5. Identification of the chapter that hosts the 21st (2010) Annual EPHA conference

This issue was raised by the president of the association to identify the chapter to host the 2010 (21st) annual conference. The focal person from Mekele University, Ato Araya raised his hand and requested the general assembly to give the opportunity to

Mekele University and Tigray Regional state Health Bureaue to host the upcoming Annual conference. He noted that there are remarkable improvements in the University particularly in the College of Health and Medical Sciences although the University is very young. There are also encouraging public health achievements in the Regional Health Bureaue. This is the best opportunity for these institutions to show their achievements to the concerned bodies. So this is the best time to host the event.

The chairperson envited the participants to comment on Ato Araya's request. But there were no comments forwarded. Finally the general assembly endorsed the request unanimously. Mekele University and the Tigray Regional state Health Bureaue were selected to host the conference in Tigray, Mekele.

10. 6. Election of 4 board members to replace those who have served for two terms and who left the board membership

Dr. Mengistu Asnake, President of EPHA, asked the general assembly to form a temporary electoral committee to coordinate and lead the voting process during the election process. Accordingly, two people namely Ato Tiruneh Sinishaw and Dr. Tesfaye Bulto were nominated as an electoral committee to lead the voting process. Then, the electoral committee started by asking the general assembly to nominate six potential candidates as per the legislation to elect executive board member for the association. So that 4 individuals will be elected out of the six. In addition to this, the committee also requested the general assembly to briefly present the academic background and work experience of each candidate so that the voting process will be facilitated smoothly. Accordingly, the following individuals were nominated:

1. Dr. Amha Kebede
2. Dr. Assefa Simie
3. Dr. Tibebu Alemayehu
4. Sr. Workinesh Kereta
5. Dr. Kunuz Abdella
6. Dr. Tewabech Bishaw

The academic background and work experience of the candidates were briefly presented.

The committee asked the general assembly to vote on each candidate. The committee also noted that each participant votes only for 4 candidates. Then, the voting process was conducted and the following individuals were elected as board members to serve for the coming two years.

1. Dr. Assefa Simie
2. Dr. Kunuz Abdella
3. Dr. Tewabech Bishaw
4. Sr. Worknesh Kereta

Following this, Dr. Mengistu Asnake acknowledged the committee and the general assembly and closed the Business meeting session. Finally Dr. Mengistu extended his heart felt appreciation to all participants for the active participation they make in the last three days of the conference. He also asked the participants to work closely with the newly elected board members and he closed the conference officially.

Annex I Speeches

1. Welcoming Address by Dr. Mengistu Asnake (President, EPHA)

His Excellency Dr. Tedros Adhanom, Minister of health for the Federal Democratic Republic of Ethiopia,
His Excellency Ato kassahun H/Mariam, Director for the Transport Authority
Honorable Members of the House of people Representatives
Dr. Carmella Green-Abate Representing CDC Ethiopia
Distinguished representatives of local and international organizations,
My fellow members of the Ethiopian Public Health Association,
Ladies and Gentlemen:

It gives me the greatest honor and pleasure to welcome you all to the 20th EPHA Annual conference. I am very pleased that our conference is held at a unique time when our association is in the process of finalizing its third five year strategic plan for the period of 2010 to 2014.

The theme of this year's conference is "**Road Traffic Accidents as a Major Public Health concern in Ethiopia**". We choose the theme based on the feedback from the 19th annual conference and through further discussion with the advisory council of EPHA on the Magnitude of the problem in Ethiopia.

As you are perhaps aware, road traffic accident is a global public health and development problem that occurs on all continents, in every country of the world. Every year 1.3 million people die on the world roads, and close to 50 million people sustain non-fatal injuries.

Excellencies, Ladies and Gentlemen,
The 2009 WHO global status report on road safety which is an assessment of the road safety situation in 178 countries, showed that, road traffic accidents remain a major public Health problem, particularly for low income countries.

In Ethiopia, although there is a lead agency and national strategy on road safety, the enforcement of speed limits from the national legislations are not effectively implemented. In addition, drink-driving law, motorcycle helmet law, seat-belt law, and child restraints law are not part of the national legislation. Some may wonder about motorcycle helmet and seat-belt laws in a country like Ethiopia? Well, my friends, my answer to that is each life is important, and each life lost, is a loss for families and the nation as a whole.

During the last Ethiopian fiscal year 2001, in Addis Ababa alone, 379 people died, 1564 people sustained major and minor injuries and over 31 million birr worth of property was damaged due to traffic accidents. Nationwide, every year over 400 million birr worth of property was damaged due to traffic accidents.

In the recent past, we have either witnessed or heard about many unforgettable tragic accident stories, some of them include:

- Eleven Children in one minibus taxi died around Debrezeit road due to care accident while they were returning back to home from school. Just think of the agony of their families not seeing the children back at home.
- A Bride died around the National palace one hour before her wedding ceremony. What do you tell people on the day you are supposed to start a new life?
- Several renowned persons have died due to care accident, including TV talk show host, University Professors, and not to mention even members of our own association.
- Weeks back 22 cars collided with each other on the ring road, around old airport.

Excellencies, Ladies and Gentlemen,

Beyond the enormous personal loss and suffering they cause, road traffic accidents can drive a family into poverty as survivors, and their families struggle to cope with the long term consequences, including the cost of medical care and rehabilitation, and all too often funeral expenses and the loss of the family breadwinner. They also place enormous strain on national health systems, taking away resources needed to address other health issues.

Through road safety education for drivers, pedestrians, cyclists, and motorcyclists, and enforcement of the corresponding legislation, we can prevent and substantially reduce the unnecessary death, injuries and disability of thousands of our citizens from road traffic incidents.

As a pre- conference panel held on October 24,2009, an awareness mass walk on October 25,2009 and today before this opening session, distinguished experts in the field including victim of traffic accident, presented and discussed their first hand account and experiences on the main theme of our conference and contributed to our efforts to outline the way forward.

In addition to the main theme, we have a number of panel discussion sessions on major public health issues, such as:

- "National Nutrition policy, Strategies and Implementation", looking at progresses made with experiences from the field.
- "Tobacco Control: International and National Initiatives", focusing on the impact and the need for concerted actions.
- "Reproductive health in Higher Learning Institutions", looking at the magnitude of the problem based on different assessments, current initiatives and future directions.
- "Multi- sectoral Response to HIV/ AIDS: Strategies to meet the Universal Access Target", focusing on Community Based HIV/ AIDS interventions and experiences.

You will hear experts in the field presenting and sharing their experiences from program implementation and research findings.

Excellencies, Ladies and Gentlemen,

The generation and dissemination of strategic information being one of the key objective of our association, we have made a number of strategic information materials available to all, so that the research findings and policies contained will help others to put them into practice.

In addition to the panel discussions, we have 63 papers (32 oral and 31 posters) which will be presented in concurrent sessions. These sessions will create opportunities to disseminate and use existing knowledge from different researches and program documentation.

In keeping with our tradition, specific time is also allocated for poster presentations to give the participants a one to one interaction with the individual presenters. This is a place the showcases what works in town, cities and communities around the country. Please do not miss it.

We will also have our business meeting for the association members during the conference and expected to discuss, examine and highlight achievement made by EPHA in reaching its targets within the framework of its strategic plan for the year 2005-2009 and propose recommendations for its third strategic plan for the period of 2010 to 2014.

I urge all members to attend, since the meeting is the venue to decide the future of our association related to its strategic plan and to put our vision to work. It will also discuss the issues of re- registration of the association based on the new CSO law.

Excellencies, Ladies and Gentlemen,

I would take this opportunity to share with you some of the tangible results and major achievements of our association in the past year ranging from training, capacity building, surveillance, and evaluation activities to networking, information exchange and dissemination. In particular:

- We held advisory council meetings twice to increase the involvement of members in supporting the executive board in making major decisions in between the annual conferences.
- Continued our activities on HIV/ AIDS prevention and control throughagreement with CDC- Ethiopia, in the areas of:
    1. Support in strategic information generation through capacity building support of 25 graduate students from Addis Ababa and Jimma universities to undertake operational research activities.

2. Continued Health Professional Associations Infection Prevention Partnership to protect members from HIV infection at workplace by involving three sister associations.
3. Initiated PMTCT Services in Private Health facilities in Ethiopia in collaboration with ESOG.
4. Evaluated the one year training program for regional HAPCO and regional laboratory coordinators on leadership in strategic information in collaboration with CDC- Atlanta, the School of Public Health, AAU and trained 13 health program mangers in a similar program.
5. Initiated the field Epidemiology and laboratory Masters Training program in collaboration with FMOH, AAU and CDC, with an initial entry of 13 graduate students from 8 regions.
6. Strengthened AIDS and related mortality surveillance in collaboration with AAU, Haromaya, Jimma, Arbaminch, Mekele and Gondar Universities.
7. Finalized the targeted evaluation four major public health issues and is in the process of undertaking 5 other evaluations and formative assessments.

- We continued the implementation of "Repositioning Reproductive Health and Family Planning" Project through the support of the David and Lucile Packard Foundation by:
  1. Providing TOT and a cascaded training for 1556 HEWs
  2. Provided RH/FP leadership training for 111 HEP coordinators and supervisors.

We collaborated with the Canadian Public Health Association (CPHA) in tobacco control project under the FTCP. We have taken different initiatives to increase the membership base and to date the association has over 3100 members (over 100 life members) and established 14 chapters. EPHA has continued its global collaboration with the World Federation of Public Health Association (WFPHA) by representing the African region in the executive board of WFPHA and contributing to global initiatives. EPHA through its 6 delegates attended the 12th World Congress on Public Health in Istanbul, Turkey from April 27 to May 1, 2009 and was given the official responsibility of hosting the 2012 World Congress on Public Health in Addis Ababa, Ethiopia. Other

routine activities such as disseminating health information messages and research findings to members and the larger public health community using official publications and has increased the representation of professional associations in different initiatives of the Ethiopian government and other stakeholders.

This year the Ethiopian Journal of Health Development (EJHD) will celebrate its 25th year- silvery jubilee of publication. With your continued support and contribution, the EJHD is being produced and distributed regularly while providing our readers with an insightful coverage of public health issues in Ethiopia and being a platform for discussions and debates, and a medium for dissemination of research and program findings.

As per our yearly tradition, we have managed to select the 2009 a ward winners in four different categories using an independent committee and based on our guidelines and will be announced at the close of the opening session.

I must say we have done quite a lot and we should be proud of what we have done.

Excellencies, Distinguished Guests, Ladies and Gentlemen,
None of the achievements listed above would have been possible without the support of so many of you. And on behalf of the Executive board, I want to take this opportunity to extend my deepest appreciation to those who stood alongside EPHA in all its efforts to discharge its responsibility as a professional public health association.

I take great pride in recognizing the Federal Ministry of Health for the unconditional support given to our association, in particular, the very able leadership of His Excellency Dr. Tedros Adhanom. Thank you for your committed service to your country and for ensuring health is one of the top priorities of our national development agenda, as well as your international service and contribution in the effort to accelerate action on the health- related targets of the Millennium Development Goals (MDGs). You make us all proud as a citizen and as our member.

On behave of EPHA Excutive Board; I need to thank The HIV/ AIDS Prevention and Control Office (HAPCO), The Health promotion and disease prevention General Directorate, CDC and the US Government, USAID, AIDS Resource Center- JHU, WHO,

The David and Lucile Packard Foundation, Canadian Public Health Association, American Public Health Association, WFPHA, EPHA regional chapters, Federal Police, AA Police Commission and AA traffic Police, Road Transport Authority, NIB insurance Company, Abyssinia automobile Assistance and Tebeta Ambulance Service

My heart felt appreciation to the staff of EPHA, who made the preparation of the 20th annual conference a success. Without your day- to – day tireless work we would not be here today. I would kindly ask all staff members of EPHA to please stand up and be recognized. Thank you and please be seated.

Excellencies, Ladies and Gentlemen,
As per our constitution, today marks the last time I am addressing you as the President of the EPHA. I have been truly honored and privileged to serve as President. I wish to thank all EPHA members and our supporters for the strong and continued support you have extended to me and our association during the past four years. Thanks to you, we have grown stronger and matured in many ways, and received several recognitions by many development partners.

Although I bid farewell as the President, I will continue to do whatever is possible in my capacity to support our association. I will continue to be your voice and the voice of Africa as an Executive Board member of the world Federation of Public Health associations and Chair of the WFPHA nomination committee. We have the privilege and honor of hosting the 2012 World Congress on Public Health. This honor will also come with lots of responsibilities, and you can count on my support and full engagement to make it a success.

As I said earlier, in the past few years, together, we have done some extraordinary things and let us build on that foundation and commit ourselves to serve our fellow citizens. As health professionals, we have been trained, none other than to save lives, to attend to the birth of a new life, to take care of the sick, the weak, the injured, the disabled, to develop and implement health policies and guidelines.

It is a true privilege to be a custodian of such a responsibility. We have literally millions of people who are in constant need of our help, who look up on us, waiting for

our help and assistance. Let us just do what we are trained to do. Let us make the best out of it. Let us be courageous to do more, and be an inspiration and a true example for others to follow, and even to do more.

Today, Currently, EPHA stands over 3000 strong and we still have very serious and important work ahead of us. We still need to engage more people in our work. It is not enough to talk about the health problems we are faced with; we have to move from being aware of the problem to engaging everyone. It is only then we can collectively mobilize our knowledge, expertise and resources to do something about it. Act on it.

Excellencies, Ladies and gentlemen,
I would like to end by sharing with you a real story, a story that has become a life changing experience for me. I am sure, we all have stories to tell, and this happened in one of my field trips to the country side where I met a little girl aged four, very intelligent and thoughtful for her age. She was an orphan. She lost both her parents to AIDS, but by the Grace of god she was not infected. But, here is the most remarkable story about her: just like all of us dreamt to be something or somewhere when we grow up, her dream was to be a doctor that will discover the medicine that would cure AIDS. I must confess, I was struggling to hide the tears in my eyes.

But it was the tears of joy just looking into the eyes of this four year old girl and her determination not to let the tragedy that has taken the lives of her parents would not happen to another family. This makes you strong in your heart, strong in your belief to help others no matter what the situation may be. If she can have that degree of determination and wisdom at that age, then we could do a lot more with the experience we have acquired over the years.

It is with that spirit that I urge all of us to join hands for the better future of public health and our people who expect so much from us.

Once again, welcome to the 20th EPHA annual conference and let us be reminded that Public Health is not only a concern of health professionals, but it is Everybody's business and concern.
I thank you.

2. Keynote Addresses by Dr. Carmela Green- Abate, PEPFAR Coordinator, Guest of Honour Speech

Your Excellency Dr Tedros Adhanom, Minister of Health,
Dr. Mengistu Asnake, President of the EPHA,
Distinguished guests and colleagues

It is with great pleasure that I am making these few remarks on the occasion of the 20th Annual Conference. I remember when this Association was formed and I am delighted that it has grown into such a vibrant and important association supporting the health sector in Ethiopia.

The EPHA is an important partner for the US government's president's Emergency plan for AIDS Relief- PEPFAR. Ethiopia has made remarkable progress over the last 5 years in addressing HIV and AIDS. Fears that the HIV epidemic would spiral out of control and reach prevalence similar to southern Africa have not materialized. Current point prevalence is estimated at 2.3%. However, this still means that there are over 1 million who are HIV infected and that there are still more new infections occurring than the number of people that are being put on antiretroviral treatment. There are also almost 900,000 children from and estimated 5.4 million orphans who have been orphaned through HIV. However, from a few thousand people who were on antiretroviral treatment in 2003, there are now over 152,000 currently receiving ARVs.

Behind each person receiving ARVs there is a family who is now in a better position as mothers and fathers regain their health.

The EPHA has been a key partner in a number of basic research activities which provide an evidence base to expanding and strengthening HIV prevention, care and treatment programs. These include:- Amhara MARPS study, The on- going National MARPS survey with EHRNI, and Alcohol and Chat studies are evidence points to a mixed type of HIV epidemic in Ethiopia, primarily urban and peri- urban based with most at risk groups driving the epidemic. Thus these studies provide important epidemiology information that will translate into targeted interventions for these at risk groups.

Other studies include AIDS Mortality surveillance is vital in improving HIV/STI/TB related public health practice & service delivery. A key factor in strengthening health service delivery is its work force. Supporting pre and in- service training and working on strategies for health worker retention are of essential importance. The Association is already playing a role in this through the Masters level field Epidemiology & Laboratory Training program which it is carrying out in conjunction with AAU and Jimma University it also provides public health leadership training for a multi- sectoral response addressing the youth.

However, retention of physicians within the health sector has proved challenging. The government is addressing increasing health workers in a number of ways. There is a draft human resources of health strategy which I hope the Association will also be able to provide input. The rapid expansion of training institutions for training all cadres of health workers will help to address the problem but these also require the availability of teachers. The deployment of health extension workers has the potential to play a pivotal role in improving public health at community level.

However; it is also important that a proper mix of health workers and available top support these front line workers. A group that may be forgotten but are crucial are the health management and support staff at all levels of the health system. The government has considered incentives to retain health workers. One of these includes access to continuing medical education. It would seem to me that the EPHA may have an important role to play here through its journal and other means.

I would like to conclude by stressing the importance of an association such as the EPHA, working in partnership with the government at this crucial time within the health sector. I am delighted that there are so many people attending this conference and hope that through the presentations and networking, each and every one of you goes away enriched.

3. Keynote Addresses By Ato Kassahun Ayele, Director of Road Traffic Authority, Guest of Honour Speech

ትራንስፓርት ባለሥልጣን ዋና ዳይሬክተር
ጥቅምት 16 **ቀን** 2002 **ዓ.ም በኢትዮጵያ የጤና አጠባበቅ ማህበር**
በሀገራችን የትራፊክ አደጋን አስመልክቶ በአዘጋጀው 20**ኛ ጉባዔ ላይ የአቶ ካሳሁን የመክፈቻ ንግግር፣**

ክቡር ዶክተር ቴዎድሮስ አድሃኖም የጤና ጥበቃ ሚኒስቴር
ክቡር ዶክተር መንግሥቱ አስናቀ የኢትዮጵያ ጤና አጠባበቅ ማህበር ፕሬዝዳንት
ክቡራን ጥሪ የተደረገላችሁ የፕሮግራሙ ተሳታፊዎች

ክቡራትና ክቡራን
የኢትዮጵያ ጤና አጠባባቅ ማህበር " Road Traffic Accident As Major Public Health Concern in Ethiopia" **በሚል ርዕስ ያዘጋጀው ጉባዔ ላይ በመገኘቴ የክብር ምስጋና አቀርባለሁ።**

በየዓመቱ ከ2000 **በላይ ሰዎች ህይወታቸውን ያጣሉ።** ከ8000 **በላይ የአካል ጉዳት ይደረስባቸዋል።** ከነዚህም ውስጥ 55 **የሞት አደጋ የሚደርስበት በእግረኛው ነው።** በየ10ሺ000 **ተሽከርካሪ በሀገራችን** 80 **ሰው ለሞት ይዳረጋል።** ይህ አሀዝ **በሀገራችን የእያንዳንዱ ተሽከርካሪ የአደገኝነት ሚዛን ከፍ ያለ መሆኑን ያሳየናል።** በአሁኑ ጊዜ **ያሉን የተሽከርካሪዎች ብዛት አነስተኛ በመሆኑ ይህ አጠቃለይ የውድመት አሃዝ ዝቅተኛ ቢመስልም በዚህ ግዝፈት መሠረት ከቀጠለ ግን ወደፊት የተሽከርካሪዎች ቁጥር እየጨመረ ሲሄድ**

በህብረተሰቡና በሀገር ኢኮኖሚ ላይ ከፍተኛ ጉዳት የሚያደርስ እንደሚሆን ያስገነዝበናል። ለማንዛቤ ያህል በሰለጠኑ ሀገሮች ያለውን በ10,000 ተሽከርካሪ የሞት አደጋ እስከ 3 ዝቅ ያለ መሆኑን ስናይ በጣም ብዙ መሥራት እንደለብን ያሳያል።

የመንገድ አደጋ መንስኤዎች በጥቅሉ ሲታይ በመንገድና አካባቢው፣ በመንገድ ተጠቃሚውና በተሽከረካሪው በተናጠል ወይም በጣምራ ስህተት ወይም ጉድለት ምክንያት የሚደርስ ነው። የመንገድ አደጋ በሰው ህይወትና አካል ላይ እንዲሁም በንብረት ላይ ከፍተኛ ጉዳይ ያደርሳል። የሰው ጉዳት አደጋው በእግረኛው፣ በተሳፋሪው፣ በአሽከርካሪው፣ እድሜ ፣ ጾታና የትምህርት ደረጃ ሳይለይ ይደርሳል። በከተማም በገጠርም ይከሰታል። ባጭሩ ሁሉም የህብረተሰቡ አካል ለመንገድ አደጋ የተጋለጠ ነው በንብረትም ላይ የሚደርሰው ውድመት የትራንስፖርት አገልግሎት ሰጪው፣ የትራንስፖርት አገልግሎት ተጠቃሚው ሁሉም ተጠቂዎች ናቸው። በሀገራችን በየዓመቱ ከ500 ሚሊዮን ብር በላይ የሚገመት ውድመት በኢኮኖሚው ላይ እንደሚደርስ ጥናቶች ያመለክታሉ። ይህ በአደጋ ምክንያት የሚደርሰው ውድመት በትራንስፖርት ዋጋ ላይ የሚደመርና ወደ ትራንስፖርት ተጠቃሚውና ሸማቹ የሚተላለፍ እዳ ነው። ስለሆነም የመንገድ አደጋ ጉዳት እያንዳንዱ የህብረተሰብ ክፍል የሚነካ ጉዳይ ነው። የትራንስፖርትን ዋጋ ስለሚያንርና ይህም ወጪ ወደሸማቹ ይሸጋገራል።

የመንገድ አደጋ ትክክለኛ የመፍትሔ ጥረት ከተደረገበት ሊገታ የሚችል ክስተት ነው። የመንገድ አደጋ ሁሉንም የህብረተሰብ ክፍል ለጉዳት የሚዳርግ እንደመሆኑ የመንገድ ደህንነት ጉዳይም ዘላቂ መፍትሔ እንዲያገኝ ሁሉንም የህብረተሰብ ክፍል የሚያሳትፍ መሆን አለበት።

የመንገድ አደጋ በአለም ደረጃ ሲታይ በሰው ላይ ከፍተኛ አደጋ እያደረሰ ነው። ይህም ከአመት ወደ አመት እየጨመረ የመጣ በመሆኑ ይህ ገዝፈቱ ካልተገታ እ.እ.አ በ20020 በየአመቱ በአለም ላይ እስከ 1,900.000 የሚሆኑ ለሞት ሊዳረጉ እንደሚችሉ የዓለም ጤና ድርጅት ጥናት ያሳያል። በመሆኑም በሰው ላይ እየደረሰ ያለውን ጉዳት ለመቀነስ በአለም ደረጃ ትኩረት አግኝቶ ሀገራት ሁሉ ድርሻቸውን ተወጥተው ይህን ይደርሳል ተበሎ የተተመነውን በግማሽ ዝቅ ለማድረግ በአለም ጤና ደርጅት መሪነት የሚቀጥለው 10 አመት በመንገድ ደህንነት የተግባር 10 ዓመት ተብሎ የተባበሩት መንግሥታት የሚሰየም እንደሚሆን ይጠበቃል ። በሀገራችንም ይህ ጉዳይ ትኩረት አግኝቶ ህብረተሰቡን ያሳተፈ እንቅስቃሴ ተጀምሯል። ለዚህም ጉዳዩ የሚመለከታቸው መንግሥታዊና መንግሥታዊ ያልሆነ ድርጅቶችና ህብረተሰቡን ለማሳተፍ በሀገር አቀፍና በክልል ደረጃ የመንገድ ደህንነት አስተባባሪ ኮሚቴዎች ተቋቁመዋል። በተዋረድም እስከ ቀበሌ የደረሰ ኮሚቴዎች ተቋቁመው የበኩላቸውን ድርሻ እየተወጡ ነው።

የመገናኛ ብዙሀንም የህብረተሰቡን ግንዛቤ ለማዳበር በተለያዩ የመንገድ ደህንነት ርዕሶች በተለያዩ የአገሪቱ ቋንቋዎች በማስተላለፍ ያለው ከፍተኛ ተነሳሽነት በጣም ሊበረታታ የሚገባ ጉዳይ የትራፊክ ደህንነትን ለማረጋገጥ የሚችሉ የአሽከርካሪ ብቃት ማረጋገጫ የተሽከርካሪ ብቃት ማረጋገጫና እንዲሁም የመንገድ ትራፊክ መቆጣጠሪያ አዋጆች ወዘተ . . . የመሳሰሉትን ህጎችን በተደረገው የመሠረታዊ አሠራር ሂደት ለውጥ በጥልቀት ታይተው በመንግሥት እየወጡ ሲሆን

አንዳንዶች ወደ ትግበራ የተሸጋገረ በመሆኑ በሂደት የአሸከርካሪ ብቃት ለማሻሻል አልፎ ብቁ ያልሆኑትን ከመንገድ የማስወጣት ሥራዎች በሰፊው መሥራት ይጠይቃል::

በጤና ጥበቃ ሚኒስቴር ትኩረት አግኝቶ የአደጋን አስከፊነት ለመቀነስ የድንገተኛ ህክምና አገልግሎት ለማጠናከር እንቅስቃሴ የተጀመረ መሆኑ አበረታች ነው :: ይህን እርምጃ ለማጠናከር ጉልህ አስተዋጽኦ የሚኖረው የሶስተኛ ወገን የተሸከረካሪ አስገዳጅ ዋስትና አዋጅ ወጥቷል:: ስራም ለመጀመር እንቅስቃሴ ላይ ነው በዚህም የትራፊክ አደጋ የደረሰባቸው ተጎጅዎች በየትኛውም የህክምና ተቋም ያለምንም ቀድመ ሁኔታ 1000 ብር የሚደርስ ህክምና ይደረግላቸዋል:: ሙያተኛ አሽከርካሪዎችም የመንጃ ፈቃድ ለማግኘት የመጀመሪያ እርዳታ አሰጣጥ ትምህርት እንዲወስዱ አስፈላጊ ሆኖ በስርዓተ ትምህርቱ ውስጥ እንዲካተት ተደርጓል::

ክቡራንና ክቡራት
የኢትዮጵያ የጤና አጠባበቅ ማህበር የማህበሩን 20ኛ ጉባዔ የመንገድ ትራፊክ አደጋ በኢትዮጵያ አሳሳቢ የህዝብ ጤና ችግር በሚል ርዕሰ አደጋን ለመቀነስ ያዘጋጀው ፕሮግራም የአደጋውን እስከፊነት ለመቀነስ ቀጥተኛ አስተዋጽኦ ያለቸው የህክምና ባለሙያዎችና ተቋማትን ተሳትፎ የሚያጠናክር ከመሆኑም ባሻገር አደጋንም ለመቀነስ የህብረተሰቡንም ግንዛቤ በማዳበር እንቅስቃሴ ውስጥ ከፍተኛ ፋይዳ ያለው ነው:: በመሆኑም ማህበሩ ይህን ወቅታዊ ትኩረት የሚሻ አርዕስት መርጦ ይህን ፕሮግራም በማዘጋጀቱ ያለኝን አክብሮትና አድናቆት ለመግለጽ እወዳለሁ:: ይህ ያቀዳችሁት ዘርፈ ብዙ ፕሮግራም የተሳካ እንዲሆን ምኞቴ ነው::

አመሰግናለሁ::

4. Opening speech by His Excellency Dr, Tedros Adhanom, Minister of FMoH and Guest of Honour and Opening Speech

በ20ኛው የኢትዮጵያ ጤና አጠባበቅ ማህበር ዓመታዊ ጉባኤ
የጤና ጥበቃ ሚ/ርና የዕለቱ የክብር እንግዳ
ዶ/ር ቴዎድሮስ አድሃኖም ያደረጉት የመክፈቻ ንግግር፣

ክቡር አቶ ካሳሁን ሀ/ማሪያም–የመንገድ ትራንስፖርት ባለሥልጣን ዋና ዳይሬክተር
ክቡር ዶ/ር መንግስቱ አስናቀ–የኢትዮጵያ ጤና አጠባበቅ ማህበር ፕሬዝዳንት
ክብርት ዶ/ር ካረሜላ ግሪን - yPEPFAR, Ethiopia ተጠሪ
ጥሪ የተደረገላችሁ እንግዶችና የማህበሩ አባላት
ክቡራትና ክቡራን

በመጀመሪያ እንኳን ለ20ኛው የማህበራችን አመታዊ ጉባኤ አደረሳችሁ እያልኩ ለጉባኤው ወቅታዊ አጀንዳ የሆነውን የመንገድ ትራፊክ አደጋ በማህበሩ በመመረጡ ማህበሩን ለማመስገን እወዳለሁ::

ከዚህ በመቀጠል ከማህበሩ በተሠጠኝ አስተያየት መሠረት በጤና ጥበቃ ሚ/ር ውስጥ እየተተገበረ ያለውን መሠረታዊ የሥራ ሂደት ለውጥ /Reform/ ለማህበሩ አባላት ለመግለጽ እሞክራለሁ።

በዚሁ መሠረት በአለም አቀፍ ደረጃ የሚታወቁ እየተተገበሩ የሉ ስድስት የጤና አገልገሎት አሠጣጥ ሥርዓቶች /Building blacks/ አሉ። የሚኒስቴር መ/ቤታችን ግን የሀገሪቱን ነባራዊ ሁኔታ ከግምት ውስጥ በማስገባት ሥርዓቱን ከስድስት ወደ ስምንት አሣድጓል።

አንደኛው ሥርዓት መሠረታዊ የጤና አገልግሎት አሠጣጥ ሽፋን ማሻሻል ሲሆን በ2003 ዓ/ም ይህ ሥርዓት ግቡን እንዲመታ ጥረት እየተደረገ ይገኛል። ለዚህ ተብሎ 30ሽ190 የገጠር ጤና ኤክስቴንሽን ሠራተኞች ሠልጥነው በየገጠር ቀበሌ እንዲሠማሩ ተደርጓል ። የጤና ኬላ ግንባታ ሽፋንም 83% ደርሷል። ምክንያቱም ጤና ኬላ በተለይም በገጠሩ የጤና አገልግሎት አሠጣጥ መሠረት ነውና። ከዚህ ጋር ተያይዞ የእናቶችንና የህፃናት ሞት ለመቀነስ የቤተሰብ ምጣኔ አገልግሎት እየተስፋፋ ሲሆን Contraceptive acceptance rate 56% ደርሷል። ስለዚህ መርህ ግብሩን በዚሁ መልክ ማጠናከር አስፈላጊ ሆኖ ተገኝቷል።

በሌላ በኩል በ$_{U}$ገር አቀፍ ደረጃ 3200 የጤና ጣቢያዎች ለመገንባት ታቅዶ እንቅስቃሴ እየተደረገ ሲሆን እስካሁን የ1492 ጤና ጣቢያዎች ግንባታ ተጠናቆ ሲሆን ቀሪዎቹ በመገንባት ላይ ይገኛሉ። ይህ ደግሞ መሠረታዊና ፈርጀ ብዙ የሆነ የጤና አገልግሎትን ለህብረተሰቡ ለማዳረስ ያስችለናል። አገልግሎቱን ከማስፋፋት አኳያም ጥሩ ጅምር ነው ።
የጤና ጣቢያዎች ግንባታ በ2003 ዓ/ም የሚጠናቀቅ ሲሆን በቀሪው 5 ዓመታት የምዕተ አመቱን የልማት ግቦች ለማሳካት ሌሎች ቀሪ ሥራዎች ይተገበራሉ።

በሠው ሃይል አቅም ግንባታ ረገድ የጤና ባለሙያዎች በተለያዩ ዘርፎች ሠልጥነው እየወጡ ይገኛሉ። በተለይም የተፋጠና የጤና መኮንኖች ስልጠና በተሣካ ሁኔታ እየተካሄደ ሲሆን ባለሙያዎቹ ሲመረቁ በጠ$_{ኃ}$ና ጣቢያዎች በሆስፒታሎችና በየደረጃው ባሉት የጤና አመራር ቦታዎች ላይ በመመደብ እየሠሩ ይገኛሉ።

የሆስፒታል ግንባታን በሚመለከት ከዚህ በፊት TYPE A የሚባሉ ለ100,000 ህዝብ አገልግሎት ይሰጡ የነበሩት ወደ ወረዳ /District/ ሆስፒታል እንዲያድጉ እየታሰበ ነው። ይህ ደግሞ በ100,000 ህዝብ አንድ የወረዳ ሆስፒታል ለማቋቋም ያስችለናል። ስለሆነም ድንገተኛ የቀዶ ህክምና / Emergency surgery / አገልግሎት ለመስጠት ይረዳናል። ይኸውም የዓለም ጤና ድርጅት / World Health Organization / አንድ የድንገተኛ የቀዶ ህክምና ማዕከል ለ500,000 ህዝብ የተቀመጠውን ከግብ እንድናደርስ ይረዳናል። ለዚሁም bEmergency surgery በማስተርስ ደረጃ ባለሙያዎች በሦስት ዩኒቨርሲቲዎች ማለትም **በሀዋሳ ፣ ጂማ** እና **መቀሌ** ሥልጠና እየተሠጣቸው ይገኛል።

ሌላው የቅድመ ሆስፒታል የህክምና አገልግሎት¼ Pre-Hospital Medical Service/ ማስፋፋት ያስፈልጋል ። ምክንያቱም በዚህ ረገድ እየተሠጠ ያለው ህክምና እጅግ ደካማ በመሆኑ የብዙ ዜጎች

ህይወት እየተቀጠፈ ይገኛል። በተለይም ድንገተኛ አደጋ ከሚከሰትበት ቦታ ጀምሮ የሚሠጠው ክህሎት ያለው ህክምና በጣም ደካማ ነውና ይህንን ሁኔታ ለመቀየር ነርሶች በድንገተኛ የጤና አገልግሎት ዙሪያ ክህሎት ኖሮአቸው አገልግሎት እንዲሠጡ ለሁለት አመታት እንዲሠለጥኑ ታቅዶ ከውጭና ከሀገር ውስጥ ዩኒቪርሲቲዎች ጋር ስለ አፈፃፀሙ ጥናት እየተደረገ ሲሆን ሥልጠናውን የሚሠጡ መምህራንም ተዘጋጅተዋል።

ሁለተኛ የጤና አገልግሎት አሠጣጥ ሥርዓት የመድሃኒት አቅርቦትና ስርጭትን ለማሻሻል የተዘረጋ ሥርዓት ሲሆን ይኸው በአንድ ማዕከል እንዲተዳደር የተፈለገ ሲሆን በኤጀንሲ እንዲተዳደር ተደርጓል። ስለዚህ የመድሃኒት ግዥው የተማከለ /Pool procurement /እንዲሆን የታቀደ ሲሆን ይህም ጥሩ መድሃኒቶችን በተመጣጣኝ ዋጋ ለማግኘት ያስችላል። በሀገራቱ 12 ማዕከላት ሐ ሀጭበሰ ሐ እንዲኖሩ የታሰበ ሲሆን ተፈላጊ መድሃኒቶች በነዚህ ማዕከላት እንዲገኙ ይደረጋል ከነዚህ ማዕከላት መድሃኒቶቹ ወደ ጤና ድርጅቶች እንዲሠራጩ ነው የታቀደው ይኸውም በሚቀጥለው ዓመት ለመተግበር ታቅዷል።

ክቡራትና ክቡራን

ሦስተኛው የጤና አገልግሎት አሠጣጥ ሥርዓት የጤና አገልግሎት ኢንሹራንስ ሲሆን የጤና ድርጅቶቹ የራሳቸውን ገቢ እንዲያዳብሩና እራሳቸውን ችለው እንዲንቀሳቀሱ ታቅዷል። በዚሁ መሠረት የጤና አገልግሎት ክፍያ / premium/ ከተቀጣሪ 3% ከቀጣሪም 3% ተዋጥቶ 6% እንዲቀመጥና ዜጎች የህክምና አገልግሎቱን የሚያገኙበት ስልት ተነድፎ ረቂቁ ለህዝብ ተወካዮች ቀርቦ እንዲፀድቅ ተደርጎ ውጤቱን በመጠባበቅ ላይ እንገኛለን። ይህም በጤና አገልገሎት ውስጥ ለውጥ ለማምጣት ከፍተኛ ድርሻ ይኖረዋል ተብሎ ይታመናል።

አራተኛው የጤና አገልግሎት አሠጣጥ ሥርዓት የጤና መረጃ አያያዝ ስርዓትን ማሻሻል ሲሆን ይህንኑ ለማሳካት 18,000 family folders/ የቤተሰብ ፋይሎች/ የተዘጋጁ ሲሆን እነዚህ ቅፆች በጤና ኤክስቴንሽን ባለሙያዎች እንዲሞሉ ይደረጋል። የቅብብሎሽ / Referral / ሥራ ጭምር ይመዘገባል። የሙከራ ትግበራ በድሬደዋ አስተዳደር ተደርጎ አበረታች ውጤት ተገኝቶበታል።

አምስተኛው የድንገተኛ ህክምና አገልግሎት ሲሆን ይህም እስከ ቅርብ ጊዜ ድርስ በሚ/ር መ/ቤታችን በኩል ትኩረት ሳይሰጠው ባለቤት አጥቶ የቆየ ነው። በዚህ ምክንያት ብዙ ችግሮች ሲፈጠሩ ቆይተዋል። ይህም ሥርዓት በአዲስ መስክ ተደራጅቶ በሽታንና ሌሎች የጤና ችግሮችን የመከላከል የማከምና እንዲሁም የማገገሚያ አገልግሎት እንዲሠጥ ያስችላል። ይህንኑ ለማሳካት ባለሙያዎች በተለያዩ ወረዳዎች በመሠልጠን ላይ ይገኛሉ። ለአብነት ያህል / ፍፀጽለደ ፕፀደጽመፀጸለጸገየ ሐባለሙያዎች ከኢትዮጵያ ጤና አጠባበቅ ማህበርና ከአ. አ. ዩ ጋር በመተባበር በማስተርስ ደረጃ በመሠልጠን ላይ ይገኛሉ።

ስድስተኛው ችግር ፈቺ የሆኑ ምርምሮችና የቴክኖሎጂ ሽግግር /Research & Technology Transfer/ ሲሆን በዚህም መስክ ምርምሮች በስፋት እንዲካሄዱ ለዚሁም ምቹ ሁኔታዎች እንዲፈጠሩ እየተደረገ

ይገኛል **ለምሣሌ** ክትባትን ማምረት/Vaccine production በሀገር ውስጥ እንዲከናወን ጥረቶች እየተደረጉ ይገኛሉ::

ሰባተኛው ሥርዓት የቁጥጥር / ርጽገጭለፎተጸረየ/ አካል የማቋቋም ሥራ ሲሆን ይህም ለጤና አገልግሎት የሚሆኑ መድሃኒቶችንና ሌሎች የህክምና መገልገያ መሣሪያዎች በሚፈለገው ጥራትና መጠን እንዲመረት የራሱን ድርሻ የሚወጣ ነው:: ከዚህም በተጨማሪ ይህ አካል የአገልግሎት አሠጣጥ ጥራትን የመቆጣጠርና የመከታተል የሠው ሃይል ብቃትና ጥራት የመቆጣጠርና የመከታተል እንዲሁም ደረጃ የመስጠት የጤና አገልግሎት መስጫ ማዕከላት አደረጃጀቶችን የመገምገምና ደረጃ የመስጠት የማስተካከል ተግባራትን ያከናውናል:: በመሆኑም የጤና አገልገሎት ሥርዓቱ ደረጃውን የጠበቀ እንዲሆን የራሱን ድርሻ እንደሚያበረክት ይታመናል::

ስምንተኛው የሠው ሃይል አቅም ግንባታ ሲሆን እንደሚታወቀው በዘርፉ የሠለጠነ የሰው ሃይል እጥረት እንዳለ ይታወቃል :: በተያያዥነት ደግሞ ፍላጎቱ ነው :: ስለዚህ ይህንን ከግንዛቤ ውስጥ በማስገባት ከ30,000 በላይ የሚሆኑ የጤና ኤክስቴንሽን ባለሙያዎች ሠልጥነው ተሠማርተዋል:: በሐኪሞች ሥልጠና በአመት 250 ብቻ የነበረው የቅበላ አቅም ወደ 1500 እንዲያደግ ተደርጓል:: ወደፊት በዓመት በዩኒቨርሲቲዎች ላይ የቅበላ አቅምን እስከ 4000 ድረስ ለማድረስ ታስቧል:: ይህንኑ እውን ለማድረግ በጠ ፣ና ጥበቃ ሚ/ር ውስጥ የጤና ሳይንስ ኮሌጆችን ለማስፋፋት ጥረት እየተደረገ ነው::ይህ ደግሞ በህኪሞችና በአዋላጅ ነርሶች ሥልጠና ላይ ይበልጥ ያተኩራል:: በዚሁ መሠረት በቅዱስ ጳውሎስ ሆስፒታል ሥርዓተ ትምህርት ተቀርፆ ሥልጠናው ተጀምሯል:: በተጨማሪም በተለያዩ መስኮች ማለትም፣ bHealth Care and Hospital Administration bHealth Monitoring and Evaluation እና bEmergency surgery ዙሪያ በማስተርስ ድግሪ ሥልጠናዎች እየተሠጡ ይገኛሉ::

ክቡራትና ክቡራን

በአጠቃላይ የጤና ሥርዓቱን ስናየው በሦስት ክፍሎች ከፍሎ ማየት ይቻላል፣

አገልግሎት ሰጪ

አገልግሎት ተቀባይ

የቁጥጥር /Regulatory¼ አካል ናቸው

የጤና ስርዓቱን ለማሻሻል ከአጋሮች ጋር በአንድ ላይ እየሠራን ሲሆን ይህም ለ/Harmonization /ማለትም አንድ ዕቅድ፣ አንድ በጀትና አንድ ሪፓርት የሚለውን ለመተግበር ይረዳናል በዚህ ዙሪያ ጥሩ ተሞክሮዎች አሉን::

በ Referral system /ቅብብሎሽ ሥርዓት/ ዙሪያ መጓተት እንዳይኖር የአምቡላንስ አገልግሎት እንዲስፋፋ ከመንገድ ትራንስፖርት ጋር በመተባበር የባጃጅ ተሽከርካሪዎችን በማሻሻል ለመጠቀም እየተሞከረ ነው::

የእናቶችን ህመምና ሞት ለመቀነስ 3,000,000 / implanon ለማሠራጨት ታቅዷል::

የአጎበር ሥርጭትም ወባን ለመከላከልና ለመቆጣጠር በከፍተኛ ደረጃ እየተሰራ ይገኛል። በተጨማሪም የድድት ርጭት በDeltamethrine እየተተካ የሚገኝ ሲሆን ይህም ኬሚካል በሀገር ውስጥ ስለሚመረት አዋጭ ነው።

የኤች.አይ.ቪ. ቁጥጥር ለማሣካት በዓመት ለ6,000,000 ሰዎች ምርመራ ተደርጓል። በ2003 ዓ/ም ደግሞ ሁሉም ከቫይረሱ ጋር የሚኖሩ ሰዎች የፀረ ኤድስ መድሃኒት ተደራሽ እንዲሆኑ ለማድረግ ታቅዷል።

በቲቢ በሽታ ቁጥጥር ዙሪያም ጥናቶች እየተደረጉ ይገኛሉ። ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ የPMTCT አገልግሎት መጠናከር አለበት። ምክንያቱም አገልግሎቱን ማግኘት ካለባቸው ውስጥ ተጠቃሚ የሆኑት 15% ብቻ ናቸውና።

በተጨማሪ በወረርሽኝ መልክ የሚከሰቱ እንደ አጣዳፊ ተቅማጥና ትውከት ያሉ ችግሮች በ2001/2002 ዓ/ም በአዲስ አበባና በሀገሪቱ እንዳንድ ቦታዎች የታዩ ሲሆን የችግሮቹ ምንጮች ተለይተው መፍትሄ ተሠጥቷቸዋል።

ለማጠቃለል እነዚህ Building Blocks/ የጤና አገልገሎት ሥርዓቶችን ለመተግበር ፈታኝ ሲሆኑ የሚያስገኙት ውጤት ግን ከፍተኛ ነው። ስለዚህ እያንዳንዱ የማህበሩ አባል በነዚህ ሥርዓቶች ላይ ሀሳብ እንዲያቀርብ እንፈልጋለን። በተጨማሪም እነዚህን ሥርዓቶች ለመተግበር ሁሉም የማህበሩ አባል የድርሻውን እንዲወጣ አደራ እላለሁ። የኢትዮጵያ ጤና አጠባበቅ ማህበርም በ2012 ዓ/ም yWorld Public Health Congress 13ኛውን ጉባኤ በሀገራችን እንዲዘጋጅ በማድረጉ ለማህበሩ ምስጋናዬን እያቀረብኩ ይህ ጉባኤ በይፋ መከፈቱን አበስራለሁ።

አመሰግናለሁ

Annex II-Pre-conference Minuet

የቅድመ ኮንፈረንስ የፓናል ውይይት

ቀን፡- ጥቅምት 14፣ 2002 ዓ.ም
ቦታ፡- ትራንስፖርት ባለስልጣን መሰብሰቢያ አዳራሽ
ሰዓት፡- ጠዋት 2፡30-6፡30
ከሰዓት 7፡30-11፡30
ርዕስ፡- "የመንገድ ትራፊክ አደጋ አበይት የማህበረሰብ የጤና ችግር"
ተወያዮች፡- የኢትዮጵያ ጤና አጠባበቅ ማህበር አባላት፣ ጉዳዩ የሚመለከታቸው ድርጅቶች
ተወካዮችና የመገናኛ ብዙሃን ባለሙያዎች

የእለቱ ፕሮግራም የተጀመረው በዶ/ር መንግስቱ አስናቀ የኢትዮጵያ ጤና አጠባበቅ ማህበር ፕሬዚዳንት ሲሆን የፕሮግራም ማስተዋወቅ ተግባር ከፈጸሙ በኋላ የመክፈቻ ንግግር እንዲያደርጉ የሚከተሉትን ግለሰቦች በየተራ የጋበዙ ሲሆን እግረ መንገዳቸውንም ለፕሮግራሙ መሳካት አስተዋጽኦ ያደረጉትን የተለያዩ ድርጅቶች አመስግነዋል፡፡

1. የመክፈቻ ንግግሮች

1.1 አቶ ዳኜ ታደሰ በጤና ጥበቃ ሚኒስቴር የጤና ማበልፀግና የበሽታ መከላከል ጄኔራል ዳይሬክተር የመክፈቻ ንግግር ሙሉ ቃል፤

ክቡር አቶ ካሳሁን ኃ/ማርያም የትራንስፖርት ባለስልጣን ዋና ዳይሬክተር
የተከበሩ የኢትዮጵያ ጤና አጠባበቅ ማህበር ፕሬዝዳንት
የተከበራችሁ የኢትዮጵያ ጤና አጠባበቅ ማህበር አባላት
ጥሪ የተደረገላችሁ እንግዶች
ክቡራትና ክቡራን

መንግሥት የመሠረተ ጤና አገልግሎት በአገሪቱ የገጠርና ከተማ አካባቢዎች በማስፋፋት ሁሉም ዜጋ ጤናማና አምራች እንዲሆን ያላሳለሰ ጥረት በማድረግ ላይ ይገኛል። ይህን ራዕይ ከግብ ለማድረስ የኢትዮጵያ ጤና አጠባበቅ ማህበር የህብረተሰቡን ጤና ለማሻሻልና ለመለወጥ መንግሥት የሚያደርገውን ጥረት በጥናትና ምርምር የፖሊሲ ሀሳቦችን በማመንጨት፣ ፕሮግራሞችንና ፕሮጀክቶችን ተግባራዊ በማድረግ የተለያዩ ዘርፈብዙ ጥረቶችን በማድረግ ላይ ይገኛል።

ማህበሩ ከአጋር አካላትና ከአባላቱ ጋር በመተባበር በተለያዩ የጤናነክ ጉዳዮች ላይ የተሰሩ የምርምርና የጥናት ውጤቶች የሚቀርቡበት ዓመታዊ ጉባኤ ሲያካሄድ መቆየቱ የሚታወስ ነው።

በያዝነው አመት ማህበሩ 20ኛውን ጉባኤ Road Traffic Accidents as A Major Health Concern in Ethiopian በሚል መሪ ሃሣብ የሀገራችን የትራፊክ አደጋ እጅግ አሣሣቢ የጤና ችግር መሆኑን በማመን ይህን የፓናል ውይይት ማዘጋጀቱ ማህበሩ የህብረተሰቡን ጉልህ የጤና ችግሮች ትኩረት ሰጥቶ የሚሰራ መሆኑና ችግሮች በውይይት በጋራ የሚፈቱበትን መድረክ ማመቻቸቱ ጤና ጥበቃ ጤናማና አምራች ዜጋን ለማፍራት ያስቀመጠውን ራዕይ ከግብ ለማድረስ ማህበሩ በቁርጠኝነት የጤና ልማት አጋርነቱን የሚያመለክት በመሆኑ በጤና ጥበቃ ሚ/ር ስም ምስጋናዬን እንዳቀርብ ይፈቀድልኝ።

እንደሚታወቀው የመንገድ ትራፊክ አደጋ አስከፊነት በዓለም ዓቀፍ ደረጃና በኢትዮጵያ በሰው ህይወትና በአካል እንዲሁም በንብረት ላይ ከፍተኛ ጉዳት እያደረሰ ነው። የሰው ጉዳት አደጋው በእግረኛው፣ በተሳፋሪው፣ በአሽከርካሪው ዕድሜ፣ ፆታና የትምህርት ደረጃ ሳይለይ በሁሉም ሰዎች ላይ ጉዳት እየደረሰ ነው። አደጋዎቹ በከተማና ገጠር ይከሰታሉ፣ በአጠቃላይ ሁሉም የህብረተሰቡ አካል በተመሣሣይ ሁኔታ ለመንገድ አደጋ የተጋለጠ ነው።

በንብረት ላይ ለሚደርሰው ውድመት የትራንስፖርት አገልግሎት ሰጪው፣ ባለንብረቱ፣ የትራንስፖርት ተጠቃሚ ሁሉም በአደጋዎቹ ተጠቂዎች ናቸው።

በዓለም አቀፍ ደረጃ

- በመላው ዓለም በመንገድ ትራፊክ አደጋ ብቻ በትንሹ በየዓመቱ በአማካይ 1.2 ሚሊዮን ሰዎች ህይወታቸውን ያጣሉ
- ከ50 ሚሊዮን ያላነሱ ለአካል ጉዳተኛነት ይዳረጋሉ
- ከ600 ቢሊዮን የአሜሪካን ዶላር በላይ የሚገመት የንብረት ጉዳት እንደሚደርስ መረጃዎች ይጠቀማሉ
- 70% - 90% የሚሆነው አደጋ የሚከሰተው በታዳጊ አገሮች ውስጥ ነው

በኢትዮጵያ የመንገድ ትራፊክ አደጋ በሃገራችን አሣሣቢ ደረጃ ላይ የደረሰ ነው።

- በየዓመቱ 2,300 በላይ የሚሆኑ ሰዎች ህይወታቸውን በትራፊክ አደጋ ያጣሉ
- ከ8,696 ሰዎች በላይ የአካል ጎዶሎነት አደጋ ይደርስባቸዋል

በመንገድ አደጋ ከሚሞቱት ሰዎች ውስጥ

- 44% እግረኞች
- 48% ተሣፋሪዎች
- 8% አሽከርካሪዎች ናቸው

በ10,000 ተሽከርካሪ የሰው ሞት በአገራችን የሚደርሰው በ80 ሰዎች ነው። እንደፌዴራል ፖሊስ ዘገባ ከ1996 - 2000 ዓ.ም. የደረሰው የትራፊክ አደጋና በአደጋው ሳቢያ የተጎጂዎች ብዛት በተመለከተ 85,842 የትራፊክ አደጋ የደረሰ ሲሆን በ11,499 ሰዎች ላይ የሞት አደጋ ደርሷል። ይህም አደጋ በአዲስ አበባ 49,142 አደጋዎች ተከስተው 1,829 ሰዎች ሞተዋል። በኦሮሚያ 15,086 አደጋዎች ተከስተው 4,010 ሰዎች ሞተዋል፣ በአማራ 8,984 አደጋዎች ተከስተው 2,483 ሰዎች ሞተዋል፣ በደቡብ ህዝቦች 4,720 አደጋዎች ተከስተው 1,360 ሰዎች ሞተዋል፣ በትግራይ 3,377 አደጋዎች ተከስተው 1,091 ሰዎች ሞተዋል። በሌሎች ክልሎች በተዋረድ አደጋዎች የደረሱ ሲሆን የመጨረሻ ዝቅተኛ አደጋ የደረሰው በሶማሌ ክልል ሲሆን 226 አደጋዎች የደረሱ ሲሆን 143 ሰዎች ላይ የሞት አደጋ ደርሷል።

እንዲሁም በንብረት ላይ የደረሱ ጉዳቶች እንደ ፌዴራል ፖሊስ ግምት በ1996 ዓ.ም (81,090,494.00)፣ በ1997 ዓ.ም (84,529,936.00)፣ በ1998 ዓ.ም (101,802,182.00)፣ በ1999 ዓ.ም (123,513,562.28)፣ በ2000 ዓ.ም (81,766,533.00) በድምሩ ብር 472,702,707.00 የሚገመት ንብረት ወድሟል።

የተከበራችሁ የፕሮግራሙ ተሳታፊዎች
ክቡራትና ክቡራን

እንደ ብሔራዊ የመንገድ ደህንነት ጽ/ቤት በሃገራችን ለሚከሰተው የመንገድ አደጋ ዋና ዋና መሰረታዊ መንስኤዎች

1. በአሽከርካሪዎች ብቃት ማነስ ወይም የስነ-ምግባርና የግንዛቤ ችግር
    - ለእግረኞች ቅድሚያ ያለመስጠት
    - የፍጥነት ወሰንን አለማክበር
    - ደህንነቱ ባለተጠበቀ የጭነት ተሽከርካሪ ሰዎችን ማጓጓዝ
    - የትራፊክ ደንብን ያለማክበር
    - ከልክ በላይ መጫን ወይም በጥንቃቄ አለመጫን
    - ረጅም ርቀትና ያለበቂ ዕረፍት ማሽከርከር
2. የተሽከርካሪዎችን የቴክኒክ ብቃት ያለመፈተሽና ያለማረጋገጥ
3. የእግረኞች የመንገድ አጠቃቀም ግንዛቤ አናሳ መሆን
4. የትራፊክ ቁጥጥር በአደጋ መንስኤዎች ላይ ትኩረት ያለመስጠት
5. እንስሳትና ጋሪዎች በዋና መንገድ ላይ ስርዓት ሳይከተሉ መጓዝ
6. የመንገድ ስራዎች የመንገድ ደህንነትን በበቂ አለማካተት
7. የአስቸኳይ ህክምና አገልግሎት አለመጠናከር

ለአደጋው መከሰት አስተዋፅኦ የሚያደርጉ ምክንያቶች መሆናቸው ተገልፆል፡፡

የተከበራችሁ የፕሮግራሙ ተሳታፊዎች
ጥሪ የተደረገላችሁ እንግዶች
ክቡራትና ክቡራን

ይህን በሰው ህይወትና ንብረት ላይ ያነጣጠረ ከፍተኛ አደጋ ለመቀነስ ሁሉም አጋር ድርጅቶች ያቀረቡት የመፍትሔ ሃሳቦች

1. የእግረኞችን ለመንገድ አደጋ ተጋላጭነት ለመቀነስ እስከ ቀበሌ የዘለቀ የመንገድ ደህንነት ግንዛቤን በማስፈን በአማራ ክልል በአዊና ጎጃም ዞኖች የታየውን መልካም ተሞክሮ ወደ ሌሎች ክልሎች ማስፋፋት
2. የህብረተሰቡን የመንገድ ደህንነት ግንዛቤ በስፋት ለማዳበር ሁሉም የጤና ሙያተኞች፣ የመገናኛ ብዙሐን ድርጅቶች መደበኛ የስርጭት ጊዜ ሰጥተው የህብተሰቡን ግንዛቤ እንዲዳብር አጠናክረው እንዲቀጥሉ ማድረግ
3. በትምህርት ቤቶች ውስጥ በመደበኛና በተጓዳኝ ትምህርት የመንገድ ደህንነት ግንዛቤ ለማዳበር የተጀመረውን ጥረት ማጠናከር
4. የአሽከርካሪዎችንና የተሽከርካሪን የቴክኒክ ብቃት ለማጠናከር የመንገድ ደህንነትን ለማስፈን የወጡ የትራፊክ ደንቦችን መመሪያዎችን በትራንስፖርት አገልግሎት ሰጪ ማህበራትና ድርጅቶች ውስጥ በተሟላ ሁኔታ ለማስከበር የፌዴራልና የክልል የመንገድ ትራንስፖርት ተቆጣጣሪ መ/ቤቶች የተቀነባበረ የቁጥጥር ስልት እንዲቀይሱ ማድረግ
5. በመረጃ ላይ በተመሰረተ ስልት አደጋን ለመቀነስ ያስቻሉትን በተግባር የታዩትን አሰራሮች መደበኛ የአሰራር ስልት አድርጎ የትራፊክ ፖሊስ ማደራጀትና ከስራው ጋር የተመጣጠነ የሰው ሃይል ስልጠና ፋሲሊቲና መሣሪያ ማሟላት
6. የአደገኛ ቦታዎችንና የአደጋ መከሰት ምክንያቶችን የመለየት ጥናትና የመንገድ ደህንነት ምህንድስና አዲት ስራን ማጠናከር፣ የፍጥነት መቀነሻ የምህንድስና ስራዎችን መተግበር
7. በርካታ አደጋዎች በደረሱባቸው ክልሎች ልዩ ትኩረት ሰጥቶ በመስራት ችግሩ የሚወገድበትን መፍትሔዎች መፈለግ እንዲሁም ከፍተኛ አደጋ በማድረስ ላይ ባሉ አሽከርካሪዎች የታክሲ 6,5581፣ የጭነት ተሽከርካሪ 5,948፣ አውቶሞቢል 3,837፣ የህዝብ ማመላለሻ አውቶሞቢል 2,640 ለአደጋ ተጋላጭ የሆኑ ተሽከርካሪዎች ላይ ጤናማ የባህሪ ለውጥ እንዲያመጡ ትኩረት ሰጥቶ መስራት
8. የአስቸኳይ ህክምና አገልግሎት እንዲጠናከር በጤና ጥበቃ የተጀመረውን የረጅም ጊዜ ማሻሻያ ስልት ተግባራዊ ማድረግ ችግሩን እንደሚቀንስ ይታመናል፡፡

ስለዚህ የኢትዮጵያ ጤና አጠባበቅ ማህበር ከአጋር አካላት ጋር በመተባበር ለእግረኛው፣ ለተሣፋሪው፣ ለአሽከርካሪውና ለባለንብረቱ የመንገድ ትራፊክ አደጋን ለመቀነስ የአመለካከትና የአስተሣሰብ ለውጥ በምልአተ ህዝቡ ውስጥ በማስረፅና ጤናማነትን የማጎልበት የተጠናከረ ጥረቱን አጠናክሮ እንዲቀጥል እያሣሰብኩ የጤና ጥበቃ ሚኒስቴር የመንገድ ትራፊክ አደጋን ችግር ጉልህ የጤና ችግር መሆኑን በመገንዘብ የጤና ኤክስቴንሽን ፕሮግራም ከተዘጋጁት 16 የጤና ፓኬጆች መካከል የመንገድ ትራፊክ አደጋ የመጀመሪያ ህክምና እርዳታ ፓኬጅ አንዱ በመሆኑና እስከ ቀበሌ በተዘረጋውን የጤና ኤክስቴንሽን ፕሮግራም በመጠቀም በትምህርት ቤት፣ በወጣት ማዕከላት፣ ቤት ለቤትና በማህበረሰብ

ደረጃዎች የህብረተሰቡን ተፈላጊውን እውቀትና ክህሎት ለማዳረስ መርሃ ግብርን አጠናክሮ እንደሚቀጥል እያረጋገጥኩ የመንገድ ትራፊክ አደጋ የኢትዮጵያውያን ዋነኛ የህዝብ የጤና ችግራች መሆኑን በሚያስረዳ የቀረበውን መሪ ሃሳብ ለመተግበር በንቃት እንድንነሳሳ በጤና ጥበቃ ሚኒስቴር ስም ጥሪዬን አስተላልፋለሁ።

አመሰግናለሁ።

1.2 ኮማንደር ደምሳሽ ሀይሉ የፌደራል ፖሊስ ሕዝብ ግንኙነት የመክፈቻ ንግግር፤

ኮማንደር ደምሳሽ ሀይሉ የፓናል ተሰብሳቢዎችን እንኳን ደህና መጣችሁ በማለት ንግግራቸውን የጀመሩ ሲሆን የትራፊክ አደጋ የተማሩ ዜጎችን እያሳጣን መሆኑ ለሃገራችን ልማት መፋጠን አሉታዊ ተጽእኖ እንዳለው ገልጸዋል። ከጊዜ ወደ ጊዜም የትራፊክ አደጋ አሳሳቢነቱ እየጨመረ መምጣቱን ገልጸው አደጋው የግድ በራሳችን ላይ ባይደርስም በቤተሰባችን፣ በጓደኞችን፣ በስራ ባልደረባችን እንዲሁም በቅርብ በምናውቃቸው ሰዎች ላይ እደረሰ ያለ ችግር በመሆኑ የሁላችንንም ቤት እያንኳኳ ነው ብለዋል።

ኮማንደር ደምሳሽ ይህንኑ ሃሳባቸውን በግል በደረሱባቸውና ባስተዋሏቸው የትራፊክ አደጋ ገጠመኞች ያዳበሩ ሲሆን በአጠቃላይ ከቤታችን ወጥተን እስክንመለስ ድረስ በእያንዳንዷ ደቂቃ የትራፊክ አደጋ እንደማይደርስብን እርግጠኛ አለመሆናችንንና የራሳችን የግል ጥንቃቄ ብቻውን ከአደጋ እንደማያድነን ገልጸዋል። ስለሆነም እያንዳንዳችን እጅ ለእጅ ተያይዘን እንዳንችን ለአንዳንችን መተሳሰብ አለብን ያሉ ሲሆን ይህንን በትራፊክ አደጋ ላይ ያተኮረ የፓናል ውይይት የኢትዮጵያ ጤና አጠባበቅ ማህበር ማዘጋጀቱን አመስግነው ውይይቱ የፌዴራል ፖሊስ የትራፊክ አደጋን ለመከላከል ለሚያደርገው ጥረት ግብዓት በመሆን እንደሚያገለግል እምነቱ ነው በማለት ንግግራቸውን አጠቃለዋል።

1.3 አቶ ካሳሁን ኃ/ማርያም የትራንስፖርት ባለስልጣን ዋና ዳይሬክተር የመክፈቻ ንግግር ሙሉ ቃል፤

አቶ ዳኜ ታደሰ የጤና ማበልፀግ የበሽታ መከላከል ጄኔራል ዳይሬክተር
ክቡር ዶክተር ከሰተብርሃን አድማሱ በጤና ጥበቃ ሚኒስቴር ዋና ዳይሬክተር
ኮማንደር ደምሳሽ ሀይሉ የፌደራል ፖሊስ ሕዝብ ግንኙነት
ክቡር ዶክተር መንግስቱ አስናቀ የኢትዮጵያ የጤና አጠባበቅ ማህበር ፕሬዚዳንት ክቡራን ጥሪ
የተደረገላችሁ የፕሮግራሙ ተሳታፊዎች
ክቡራትና ክቡራን

የመንገድ ትራፊክ አደጋ በሀገራችን አሳሳቢ ደረጃ ላይ የደረሰ ነው። በየዓመቱ ከ2,000 በላይ ሰዎች ህይወታቸውን ያጣሉ። ከ8,000 ከላይ የአካል ጉዳት ይደርስባቸዋል። ከነዚህም ውስጥ 55% የሞት አደጋ የሚደርስበት እግረኛው ነው። በየ10,000 ተሽከርካሪ በሃገራችን 80 ሰው ለሞት ይዳርጋል። ይህ አሃዝ በሃገራችን የእያንዳንዱ ተሽከርካሪ የአደገኝነት ሚዛን ከፍ ያለ መሆኑን ያሳየናል። በአሁኑ ጊዜ ያሉን የተሽከርካሪዎች ብዛት አነስተኛ በመሆኑ ይህ አጠቃላይ የውድመት አሃዝ ዝቅተኛ ቢመስልም በዚህ ግዘፈት መሰረት ከቀጠለ ግን ወደፊት የተሽከርካሪዎች ቁጥር እየጨመረ ሲሄድ በህብረተሰብና በሃገር ኢኮኖሚ ላይ ከፍተኛ ጉዳት የሚያደርስ እንዲሆን ያስገነዝበናል።

የመንገድ አደጋ መንስኤዎች በጥቅሉ ሲታይ በመንገድና አካባቢው፣ በመንገድ ተጠቃሚውና በተሽከርካሪው በተናጠል ወይም በጣምራ ስህተት ወይም ጉድለት ምክንያት የሚደርስ ነው። የመንገድ አደጋ በሰው ህይወትና አካል ላይ እንዲሁም በንብረት ላይ ከፍተኛ ጉዳት ያደርሳል። የሰው ጉዳት አደጋ በእግረኛው፣ በተሳፋሪው፣ በአሽከርካሪው፣ እድሜ፣ ጾታና የትምህርት ደረጃ ሳይለይ ይደርሳል። በከተማም በገጠርም ይከሰታል። በአጭሩ ሁሉም የህብረተሰቡ አካል ለመንገድ አደጋ የተጋለጠ ነው። በንብረትም ላይ የሚደርሰው ውድመት ትራንስፖርት አገልግሎት ሰጪው፣ የትራንስፖርት አገልግሎት ተጠቃሚው ሁሉም ተጠቂዎች ናቸው። በሃገራችን በየዓመቱ ከ500 ሚሊዮን ብር በላይ የሚገመት ውድመት በኢኮኖሚው ላይ እንደሚደርስ ጥናቶች ያመለክታሉ። ይህ በአደጋ ምክንያት የሚደርሰው ውድመት በትራንስፖርት ዋጋ ላይ የሚደመርና ወደ ትራንስፖርት ተጠቃሚውና ሸማቹ የሚተላለፍ እዳ ነው። ስለሆነም የመንገድ አደጋ ጉዳት እያንዳንዱን የህብረተሰብ ክፍል የሚነካ ጉዳይ ነው። የትራንስፖርትን ዋጋ ስለሚያንርና ይህም ወጪ ወደሸማቹ ስለሚሸጋገር የመንገድ አደጋ ትክክለኛ የመፍትሄ ጥረት ከተደረገበት ሊገታ የሚችል ክስተት ነው። የመንገድ አደጋ ሁሉንም የህብረተሰብ ክፍል ለጉዳት የሚዳርግ እንደመሆኑ የመንገድ ደህንነት ጉዳይም ዘላቂ መፍትሄ እንዲያገኝ ሁሉንም የህብረተሰብ ክፍል የሚያሳትፍ መሆን አለበት።

የመንገድ አደጋ በአለም ደረጃ ሲታይ በሰው ላይ ከፍተኛ ጉዳት እያደረሰ ነው። ይህም ከአመት ወደ አመት እየጨመረ የመጣ በመሆኑ ይህ ግዘፈቱ ካልተገታ እ.ኤ.አ በ2020 በየአመቱ በአለም ላይ እስከ

1,900,000 የሚሆኑ ለሞት ሊዳረጉ እንደሚችሉ የአለም ጤና ድርጅት ጥናት ያሳያል፡፡ በመሆኑም በሰው ላይ እየደረሰ ያለውን ጉዳት ለመቀነስ በአለም ደረጃ ትኩረት አግኝቶ ሀገራት ሁሉ ድርሻቸውን ተወጥተው ይህን ይደርሳል ተብሎ የተተመተወን በግማሽ ዝቅ ለማድረግ በአለም ጤና ድርጅት መሪነት የሚቀጥለው 10 አመት በመንገድ ደህንነት የተግባር 10 ዓመት ተብሎ በተባበሩት መንግስት የሚሰየም እንደሚሆን ይጠበቃል፡፡ በሃገራችንም ይህ ጉዳይ ትኩረት አግኝቶ ህብረተሰቡን ያሳተፈ እንቅስቃሴ ተጀምሯል፡፡ ለዚህም ጉዳዩ የሚመለከታቸው መንግስታዊና መንግስታዊ ያልሆኑ ድርጅቶችንና ህብተሰቡን ለማሳተፍ በሃገር አቀፍና በክልል ደረጃ የመንገድ ደህንነት አስተባባሪ ኮሚቴዎች ተቋቁመዋል፡፡ በተዋረድም እስከቀበሌ የደረሰ ኮሚቴዎች ተቋቁመው የበኩላቸውን ድርሻ የተወጡ ነው፡፡

በጤና ጥበቃ ሚኒስቴር ትኩረት አግኝቶ የአደጋን አስከፊነት ለመቀነስ የድንገተኛ ህክምና አገልግሎትን ለማጠናከር እንቅስቃሴ የተጀመረ መሆኑ አበረታች ነው፡፡ ይህን እርምጃ ለማጠናከር ጉልህ አስተዋጽኦ የሚኖረው የሶስተኛ ወገን የተሽከርካሪ አስገዳጅ ዋስትና አዋጅ ወጥቷል፣ ስራም ለመጀመር በእንቅስቃሴ ላይ ነው፡፡ ሙያተኛ አሽከርካሪዎችም የመንጃ ፈቃድ ለማግኘት መጀመሪያ እርዳታ አሰጣጥ ትምህርት እንዲወስዱ አስፈላጊ ሆኖ በስርዓተ ትምህርቱ ውስጥ እንዲካተት ተደርጓል፡፡

ክቡራንና ክቡራት

የኢትዮጵያ የጤና አጠባበቅ ማህበር የማህበሩን ሃያኛ ጉባኤ "የመንገድ ትራፊክ አደጋ በኢትዮጵያ አሳሳቢ የህዝብ ጤና ችግር" በሚል ርዕስ አደጋን ለመቀነስ ያዘጋጀው ፕሮግራም የአደጋውን አስከፊነት ለመቀነስ ቀጥተኛ አስተዋጽኦ ያላቸውን የህክምና ባለሙያዎችንና ተቋማትን ተሳትፎ የሚያጠናክር ከመሆኑም ባሻገር አደጋንም ለመቀነስ የህብረተሰቡንም ግንዛቤ በማዳበር እንቅስቃሴ ውስጥ ከፍተኛ ፋይዳ ያለው ነው፡፡ በመሆኑም ማህበሩ ይህን ወቅታዊ ትኩረት የሚሻ አርእስት መርጦ ይህን ፕሮግራም በማዘጋጀቱ ያለኝን አክብሮትና አድናቆት ለመግለጽ እወዳለሁ፡፡ ይህ ያቀዳችሁት ዘርፈብዙ ፕሮግራም የተሳካ እንዲሆን ምኞቴ ነው፡፡

አመሰግናለሁ

2. የጥናታዊ ጽሁፎች አቀርቦት

የእለቱ የፕሮግራም መሪ ጥናታዊ ጽሁፎች የሚቀርቡበት ሰዓት መድረሱን በመግለጽ መድረኩን እንዲመሩና አቅራቢዎቹን እንዲጋብዙ አቶ/ዶ/ር... በመጠየቅ ሁሉም ጥናታዊ ጽሁፍ አቅራቢዎች ቦታቸውን እንዲይዙ ተደረገ፡፡ በዚህም መሰረት ቀጥሎ የተዘረዘሩት ጽሁፎች ለፓናሉ ተወያይ ተራ በተራ ቀረበ፡፡

2.1 የመንገድ ትራፊክ አደጋ ስፋትና የሚያስከትላቸውን ጉዳቶች በመቀነስ ረገድ የማህበረሰብ ጤና ያለው ሚና

(The Magnitude of Traffic Injury and the Role of Public Health in Reducing the Consequences)

አቶ ዳኜ ታደሰ በጤና ጥበቃ ሚ/ር የጤና ማበልፀግ የበሽታ መከላከል ጃኔራል ዳይሬክተር

አቶ ዳኜ ታደሰ ጥናታዊ ጽሁፍ የመንገድ ትራፊክ አደጋ ስፋት አለምአቀፋዊና ሃገራዊ ገጽታ፣ የመኪና አደጋ መንስኤዎች፣ የመኪና አደጋ ማህበረሰባዊ ጤና ተጽዕኖዎች፣ የማህበረሰብ ጤና ሚና፣ በፌዴራል ጤና ጥበቃ ሚ/ር የተወሰዱ እርምጃዎችና የመፍትሄ አቅጣጫዎች የሚሉ ክፍሎች አሉት፡፡

በመንገድ ትራፊክ አደጋ ምክንያት በአለም ላይ 1.2 ሚሊዮን ሰዎች በየአመቱ እንደሚሞቱና ከ20-50 ሚሊዮን የሚጠጉ ሰዎች ለህልፈት የማይዳርግ የአካል ጉዳት ለሰባዎች ይሆናሉ፡፡ በአለም ላይ ከሚከሰተው የመንገድ ትራፊክ አደጋ ሞት ውስጥ 90% የሚሆነው በአለም ላይ ካለው የተሽከርካሪ ቁጥር ውስጥ 48% ያህሉን ብቻ በሚሸፍኑት በኤኮኖሚ መካከለኛና ዝቅተኛ የእድገት ደረጃ ላይ ባሉ ሀገሮች ውስጥ ነው፡፡ በሀገራችን በ10,000 ተሽከርካሪ ሰማንያ ሰዎች ሲሞቱ በአሜሪካ ግን በ100,000 ተሽከርካሪ 21 ሰዎች ብቻ ለህልፈት እንደሚዳረጉ አቶ ዳኜ አስረድተዋል፡፡

የመኪና አደጋ መንስኤዎችን በተመለከተም የተለያዩ ሁኔታዎች በዋነኝነት የሚጠቀሱ ሲሆን አካባቢያዊ ተጽእኖዎችን በተመለከተ ከመንገድ ጥበት፣ ከጎማ መፈንዳት፣ ከመኪኖች ቁጥር መብዛት፣ ከትራፊክ መጨናነቅ፤ ሳይኮሶሻል የሚባሉት ደግሞ ከደካማ የቁጥጥር፣ የማናጅመንትና የአመራር ስርዓት ጋር የሚያያዙ፤ ለአደጋ መከሰት የተመቻቹ ቅድመ ሁኔታ በሚል ደግሞ የመስማትና የማየት ችሎታ እክል፣ ጡንቻ-አጥንትና ነርቭ ነክ እክሎች፣ ዝቅተኛ የአእምሮ ንቃት ደረጃ፣ የማሽከርከር ልምድ ማነስ፣ ከፍተኛ ፍጥነት መጠቀም እንዲሁም የመንገድ ስነስርዓት ደንቦች ግንዛቤ ማነስና ቸልተኝነት ሲጠቀሱ በአጠቃላይ በዋና የትራፊክ አደጋ መንስኤነት አቶ ዳኜ የዘረዘሯቸው ከልክ ያለፈ ፍጥነት፣ አልኮል ጠጥቶ

ማሽከርከር፣ አደንዛዥ እጽ መጠቀም፣ ሄልሜት አለማድረግ፣ የደህንነት ቀበቶ አለማሰር፣ የሕጻናት አደጋ መከላከያዎችን አለመጠቀም፣ እያሽከረከሩ ሞባይል ስልክ ማናገርና የአሽከርካሪው እድሜ ደረጃ ናቸው።

በመቀጠልም አቶ ዳኜ የመኪና አደጋ በማህበረሰብ ጤና ላይ ያለውን ተጽዕኖ አስመልክተው ሲያረዱ የአካል ጉዳት፣ አካላ ጎዶሎነት፣ ሞት፣ ስነልቦናዊ ችግሮች፣ በሰዎችና በንብረት ላይ የሚደርስ ውድመት እንዲሁም ኤኮኖሚያዊ ክስረት ተጠቃሽ መሆናቸውን ገልጸዋል። በመንገድ ትራፊክ አደጋ ውስጥ የማህበረሰብ ጤና ያለውን ሚና በተመለከተ አቶ ዳኜ ያስረዱ ሲሆን የማህበረሰብ ትምህርት፣ የማህበረሰብን ጤናነክ ፍላጎቶች መከታተልና መገምገም፣ በማህበረሰቡ ውስጥ ያሉትን ጤነኛ ድርጊቶችና ባህርያትን ማበረታታት፣ ቅድመ ሆስፒታል እንክብካቤን ማሻሻል፣ የሆስፒታል እንክብካቤን ማሻሻል እንዲሁም የማገገሚያ አገልግሎቶችን ማሻሻል እንደሚገባ ያስረዱ ሲሆን ከዚሁ ጋር አያይዘው የማህበረሰብ ጤና ሊያበረክታቸው የሚገቡ አገልግሎቶችንም የጠቀሱ ሲሆን ከእነዚህም ውስጥ ጤናን በማስፋፋትና በሽታን በመከላከል ስራዎቻቸው ውስጥ የመንገድ ደህንነትን ማካተት፣ የመከላከያ ዘዴዎች አቅርቦትን ማረጋገጥ ለምሳሌ የህጻናት ደህንነት ቀበቶ እና የሳይክል ጋላቢዎች ሄልሜት እንዲሁም ለመንገድ ትራፊክ ተጎጂዎች የሚሰጡ የቅድመ-ሆስፒታልና የሆስፒታል ውስጥ እንክብካቤ መስጠት የሚሉት ይገኙበታል።

አቶ ዳኜ በመቀጠል በፌዴራል ጤና ጥበቃ ሚ/ር የተወሰዱ እርምጃዎችን የዘረዘሩ ሲሆን ከእነዚህም ውስጥ የአደጋ መከላከል ጽንሰ ሃሳብ በፖሊሲ ዶክመንት ውስጥ መካተት፣ የመንገድ ደህንነት ስትራቴጂዎች ንድፍ መዘጋጀት፣ የአደጋ መከላከል፣ የመጀመሪያ የህክምና እርዳታ አሰጣጥና የሪፈራል ፓኬጅ መዘጋጀት፣ በስተማና በገጠር አካባቢዎች የማህበረሰብ መንገድ ደህንነት ዘመቻ ማካሄድና የመንገድ ደህንነት መቆጣጠሪያ መዘርጋት በሁሉም ሆስፒታሎችና የጤና ተቋማት የድንገተኛ ህክምና አገልግሎት መስጫ ክፍሎችን ማዘጋጀት ተጠቅሰዋል።

አቶ ዳኜ የመንገድ ትራፊክ አደጋን ለመከላከል መወሰድ አለባቸው ያሏቸውን የመፍትሄ አቅጣጫዎች ለፓናሉ ተሳታፊዎች ያቀረቡ ሲሆን ከእነዚህም ውስጥ በችግሩ ላይ ጥናት ማካሄድ፣ በዚሁ ጥናት ላይ ተመስርቶ ስትራቴጂያዊ ፕላን ማዘጋጀት፣ የመንገድ ትራፊክ አደጋን ለመከላከል ዘርፈብዙ ምላሽ ማስተባበር፣ የአድቮከሲ አውደ ጥናቶችን ማዘጋጀት፣ በብዙሃን መገናኛና በአውደ ጥናቶች ማህበረሰባዊ ንቅናቄዎችን ማቀጣጠል፣ ለአሽከርካሪዎች በተወሰነ የጊዜ ልዩነት መደበኛ የጤና ምርመራ መስጠት፣ አሽከርካሪዎች አደጋን ስለመከላከል ያላቸውን ግንዛቤ ማሳደግ፣ የደህንነት ቀበቶ አጠቃቀምን ማሳደግ፣ ፍጥነትን መቆጣጠር፣ የመንገዶችና መንገድ ዳር ዲዛይን ደህንነትን ያገናዘበ ማድረግ፣ የመንገድ ዳር አደጋ መከላከያዎችን ማዘጋጀት (crash barriers) እንዲሁም ጠጥቶና ጫት ቅሞ ማሽከርከርን ማስወገድ የሚሉት ይገኙበታል። (አቶ ዳኜ ለፓናል ተሳታፊው በእለቱ ያቀረቡት ጥናታዊ ጽሁፍ በአባሪነት ስለተካተተ ሙሉ ጽሁፉን ማንበብ ይቻላል።)

የመንገድ ደህንነት በኢትዮጵያ

(አቶ አበበ አስራት ከብሔራዊ የመንገድ ደህንነት ማስተባበሪያ ጽ/ቤት)

አቶ አበበ አስራት ለፓናሉ ተሰብሳቢ ያቀረቡት ጥናታዊ ጽሁፍ የሚጀምረው በኢትዮጵያ እየተከሰተ ያለው የመንገድ አደጋ አጠቃላይ ገጽታ አስመልክተው በ2002 ዓ.ም 2,160 ሰዎች በመኪና አደጋ መሞታቸውን፣ 8,958 መቁሰላቸውን፣ 55% ያህሉ ተጎጂዎች እግረኞች መሆናቸውንና የሞት መጠን 10,000 ተሽከርካሪዎች 80 ሰው መሆኑንና ይህም በአለም አቀፍ ደረጃ ከፍተኛ ምድብ ውስጥ የሚካተት መሆኑን አስረድተዋል።

አቶ አበበ በኢትዮጵያ ለሚደርሱ የመኪና አደጋዎች አጋላጭ ሁኔታዎች ነሶስት እንደሚከፈሉና ሰብአዊ-ነክ የሚባሉት ከአሽከርካሪ እውቀትና የህግ ተገዢነት ጋር የሚያያዙ፣ ተሽከርካራ-ነክ የሚባሉት ደግሞ ከመኪናው አካላዊና የቴክኒክ ብቃት ጋር የሚያያዙ ሲሆን አካባቢያዊ በሚባሉት ደግሞ የመንገድ ዲዛይንን የሚመለከቱ ናቸው ብለዋል።

በመቀጠልም አቶ አበበ በኢትዮጵያ ለሚደርሱ የመኪና አደጋዎች መንስኤዎችን በተመለከተ የአሽከርካሪዎች ባህሪና ዝቅተኛ የማሽከርከር ብቃት፣ የተሽከርካሪ ደካማ ቴክኒካዊ ብቃት፣ የእንስሳትና የጋሪዎች ዋና መንገድ መጠቀም፣ የእግረኛ ጥንቃቄ ጉድለት፣ ደካማ የትራፊክ ህግ አፈጻጸም/አተገባበር፣ ደካማ የድንገተኛ ህክምና አገልግሎትና በመንገድ ግንባታ ወቅት በቂ ጥንቃቄ አለማድረግ ይገኙበታል ብለዋል።

አቶ አበበ ለፓናሉ ተሰብሳቢ ያቀረቡት ሌላው አቢይ ጉዳይ በኢትዮጵያ የተወሰዱ ዋነኛ እርምጃዎችን የሚመለከት ሲሆን በዚህም መሰረት ከብሔራዊ መንገድ ደህንነት ማስተባበሪያ ጽ/ቤት ጀምሮ እስከ ቀበሌ ድረስ አስተባባሪ ኮሚቴ መዋቀሩ፣ ከህግ አንጻርም የተለያዩ ህግና ደምቦች መውጣታቸው፣ በትራንስፖርት ዘርፍም በፌዴራልና በክልል ደረጃ የመንገድ ደህንነት መዋቅሮች መጠናከርና የተሽከርካሪ የቴክኒክ ምርመራና አሽከርካሪ ብቃት ማረጋገጫ ስልቶች መዘርጋት፣ በማስተማሩ ረገድም በዋና ዋና

የመገናኛ ብዙሃን የግንዛቤ መፍጠሪያ ስራዎች መከናወንና የመንገድ ደህንነት ሳምንት መከበር፣ ለልጆች የመንገድ ደህንነት ትምህርት መስጠት፣ በተለያዩ ክልሎች የማህበረሰብ ዘመቻዎች ማካሄድ፣ የትራፊክ ህግ አፈጻጸምን በተመለከተም በተለያዩ ክልሎች የትራፊክ ፖሊስ አደረጃጀቶችን ማጠናከርና የፍጥነት መቆጣጠሪያ ራዳር መተከል፣ የመንገድ ኢንጂነሪንግን በተመለከተም አደገኛ መንገዶችን የሚለይ ጥናትና ተያያዥ ጉዳዮች ይገኙበታል፡፡

አቶ አበበ ለፓናሉ ተሰብሳቢ ያቀረቡት ሌላው አቢይ ጉዳይ በድንገተኛ የህክምና እርዳታ አሰጣጥ ሁኔታ ላይ የሚያተኩር ሲሆን በዚህም መሰረት የሃገራችን ገጽታ እንደሌሎቹ ታዳጊ ሀገሮች የድንገተኛ የህክምና እርዳታ አገልግሎትና የሰለጠን የሰው ሃይል እጥረት መኖሩን፣ አደጋ ከደረሰበት ቦታ እስከ ህክምና ተቋም ድረስ የሚያጋጥመው ከፍተኛ መጓተት የሚስተዋሉ መሆናቸውን አስረድተዋል፡፡ ሌላው አቶ አበበ ያነሱት ተያያዥ ጉዳይ ለመኪና አደጋ ሰለባዎች የህክምና አገልግሎት ለመስጠት የሚያስገድድ የሶስተኛ ወገን ኢንሹራንስ ህግ መውጣቱን ነው፡፡

በመጨረሻም አቶ አበበ የመንገድ ትራፊክ አደጋን ለመከላከል ወደፊት መወሰድ ስለሚገባቸው የመፍትሄ እርምጃዎች የተወሰኑ ሃሳቦችን ለፓናሉ ተሳታፊ ያቀረቡ ሲሆን ከእነዚህ ውስጥም የትራንስፖርት ማናጅመንትና ደህንነት ተቋም እንዲቋቋም ማገዝ፣ የትራፊክ ህግ አፈጻጸም አቅምን ማጠናከር፣ የአደጋ መረጃ አሰባሰብ ስርዓትን ማሻሻል፣ የመንገድ ደህንነት ቁጥጥርና የደህንነት ኢንጂነሪንግ እርምጃዎችን ማጠናከር፣ የልጆች የመንገድ ደህንነት ትምህርትን ማጠናከርና የጤና ጥበቃ ሚኒስቴር የሚያካሂደውን የድንገተኛ አደጋ ህክምና አገልግሎት ጥረቶችን ማገዝ የሚሉት ይገኙበታል፡፡ (አቶ አበበ ለፓናል ተሳታፊው በእለቱ ያቀረቡት ጥናታዊ ጽሁፍ በአባሪነት ስለተካተተ ሙሉ ጽሁፉን ማንበብ ይቻላል፡፡)

2.2 የመንገድ ትራፊክ አደጋ አለም አቀፋዊ ገጽታ

(Global Perspective of Road Traffic Injuries)

በዶ/ር ኩኑዝ አብደላ የአለም አቀፉ የጤና ድርጅት የኢትዮጵያ ቢሮ ተወካይ

ዶ/ር ኩኑዝ አብደላ ያቀረቡት ጥናታዊ ጽሁፍ ርእስ የመንገድ ትራፊክ አደጋ አለም አቀፋዊ ገጽታ የሚል ነበር፡፡ ጽሁፉ ሶስት ዋነኛ ክፍሎች ያሉት ሲሆን የመንገድ ትራፊክ አደጋ በአለም አቀፍ ደረጃ እያደረሰ ስላለው ጫና፣ የመንገድ ትራፊክ አደጋን ለመከላከል ስለተነደፈው አዲስ የአቀራረብ ስልት እንዲሁም የመንገድ ትራፊክ አደጋን ለመከላከል እየተሰጠ ያለው አለም አቀፋዊ ምላሽ በሚል የተከፈለ ነው፡፡

በዚህም መሰረት በመንገድ ትራፊክ አደጋ ምክንያት በአለም ላይ 1.2 ሚሊዮን ሰዎች በየአመቱ እንደሚሞቱና በየቀኑም በአደጋ ምክንያት ህይወታቸውን ከሚያጡ 16,000 ሰዎች ውስጥ እሩብ ያህሉን እጅ የሚሸፍነው የመንገድ ትራፊክ አደጋ መሆኑን ገልጸዋል፡፡ ዶ/ር ኩኑዝ አያይዘውም የመንገድ ትራፊክ አደጋ በሁሉም የእድሜ እርከን ላይ ለሚገኙ ሰዎች ህልፈት መንስኤ በመሆን ረገድ 9ኛ ደረጃ መያዙን ገልጸዋል፡፡ የመንገድ ትራፊክ አደጋ በመካከለኛና ዝቅተኛ የኤኮኖሚ እድገት ደረጃ ላይ በሚገኙ ሃገሮች ውስጥ በስፋት የተንሰራፋ ችግር ሲሆን ለዚህም ማሳያ የሚሆነው ይህ አደጋ ከሚያስከትለው ሞት ውስጥ 85% የሚሆነው የሚከሰተው በእነዚሁ ሀገሮች ውስጥ መሆኑ ነው ብለዋል፡፡

የመንገድ ትራፊክ አደጋን ለመከላከልና ለመቆጣጠር የሚያስችሉ አቅጣጫዎችን በተመለከተም የመንገድ ትራፊክ አደጋ ሊከሰት እንደሚችል አስቀድሞ መገመት (PREDICTABLE) እና ለመከላከልም የሚቻል (PREVENTABLE) መሆኑ ለአመክንዮአዊ ትንተና ምቹ መሆኑን፤ ከዚህም በተጨማሪ ዘርፈብዙና የማህበረሰብ ጤና ችግር በመሆኑ የጋራ ሃላፊነት፣ እርምጃና አድቮከሲ እንደሚሻ፤ ተራ የአነዳድና የእግረኛ ስህተቶች ለሞት እንደማይዳርጉ፤ የቴክኖሎጂ ሽግግሮች ከተጨባጭ አካባቢያዊ ሁኔታዎች ጋር መጣጣም እንደሚገባቸው፤ አካባቢያዊ ፍላጎቶችም በጥናት ላይ መመስረት እንደሚገባቸው፤ የመኪና አደጋ የማህበራዊ ፍትህ ጉዳይ መሆኑን፤ ለሁሉም የመንገድ ተጠቃሚዎች እኩል ጥበቃ መደረግ እንደሚገባ፤አካባቢያዊ እውቀት የአካባቢያዊ መፍትሄ ምንጭ መሆን አለበት የሚሉ መሰረት ሃሳቦችን ዶ/ር ኩኑዝ ጠቅሰዋል፡፡

የመንገድ ትራፊክ አደጋን ለመከላከል እየተሰጠ ስላለው አለም አቀፋዊ ምላሽ በተመለከተ አለም አቀፍ የጤና ድርጅት ለአራት አሰርት አመታት ሲያሳስበው የቆየ ጉዳይ ነው፡፡ ለዚህም ማሳያ የሚሆነው ስለመንገድ ትራፊክ አደጋ ባህርይ እና አጠቃላይ ገጽታ የሚተነትን ሪፖርት እ.ኤ.አ በ1962 በድርጅቱ ተዘጋቶ ወጥቷል፡፡ ከዚህም በተጨማሪ የተባበሩት መንግስታት አጠቃላይ ጉባኤ እ.ኤ.አ በ1974 "የመንገድ ትራፊክ አደጋ የማህበረሰብ የጤና ችግር መሆኑን እና አባል ሀገራትም አስፈላጊውን እርምጃ እንዲወስዱ" በአዋጅ ጠይቋል፡፡ ወርልድ ባንክም በበኩሉ ለአለፉት ሁለት አሰርት አመታት ተበዳሪዎቹ በሚያቀርቧቸው የትራንስፖርት ፕሮጀክቶቻቸው ውስጥ የመንገድ ደህንነትን እንዲያካትቱ ሲጠይቅ መቆየቱን ዶ/ር ኩኑዝ

አስረድተዋል፡፡ ከዚህም ሌላ ዶ/ር ኩኑዝ በጥናታዊ ጽሁፋቸው ላይ ለወደፊት መወሰድ የሚገባቸውን የመፍትሄ አቅጣጫዎችንና ያጋጠሙ ችግሮችን አስመልክተው ሃሳቦችን በመሰንዘር ሃሳባቸውን አጠቃለዋል፡፡ (ዶ/ር ኩኑዝ ለፓናል ተሳታፊው በእለቱ ያቀረቡት ጥናታዊ ጽሁፍ በአባሪነት ስለተካተተ ሙሉ ጽሁፉን ማንበብ ይቻላል፡፡)

2.3 የመንገድ ትራፊክ አደጋ አሳሳቢነት በአለም አቀፍ ደረጃና በኢትዮጵያ

(ኮማንደር አክሊሉ ሐይሉ የፌዴራል ፖሊስ ተወካይ)

ኮማንደር አክሊሉ "መንገድ ትራፊክ አደጋ አሳሳቢነት በአለም አቀፍ ደረጃና በኢትዮጵያ" በሚል ርእስ ጥናታዊ ጽሁፋቸውን ለፓናል ተሳታፊዎች ያቀረቡ ሲሆን ሃሳባቸውን የጀመሩት "የመንገድ አደጋ በሰው ህይወትና በአካል እንዲሁም በንብረት ላይ ከፍተኛ ጉዳት ያደርሳል፣ የሰው ጉዳት አደጋው በእግረኛው በተሳፋሪው፣ በአሽከርካሪው ዕድሜ ጾታና የትምህርት ደረጃ ሳይለይ በሁሉም ሰዎች ላይ ጉዳቱ ይደርሳል" በሚል ነው፡፡ የመንገድ አደጋ በአለም ደረጃ የሚያደርሰውን ጉዳት ከዳሰሱ በኋላ በሃገራችን ያለውን ገጽታ በተመለከተ በየዓመቱ 2,300 በላይ የሚሆኑ ሰዎች ሕይወታቸውን እንደሚያጡ፣ ከ8,696 በላይ የአካለ ጎዶሎነት አደጋ እንደሚደርስባቸው፣ 44% ያህሉ ሟቾች እግረኞች መሆናቸውንና ከእነዚህም ውስጥ 48% ተሳፋሪዎች፣ 8% አሽከርካሪዎች መሆናቸውን አስረድተዋል፡፡

ኮማንደር አክሊሉ በመቀጠል ከ1996 - 2000 በአገር አቀፍ ደረጃ ከፍተኛ የትራፊክ አደጋ የተከሰተባቸውን የክልል መስተዳድሮች አስመልክተው አዲስ አበባ በ49,142፣ ኦሮሚያ በ15,086 አማራ በ8,984 ከአንደኛ እስከ ሶስተኛ ደረጃ መያዛቸውን የገለጹ ሲሆን ዝቅተኛ የትራፊክ አደጋ የተከሰተባቸውን በተመለከተም ሶማሌ 226፣ ቢንሻንጉል 384 እንዲሁም ሀረሪ 559 አደጋዎችን ማስመዝገባቸውን አስረድተዋል፡፡ በእነዚህ አመታት በደረሰው የትራፊክ አደጋ የተጎጂዎችን አይነት በተመለከተም ተሳፋሪዎች 48%፣ እግረኞች 8% እንዲሁም አሽከርካሪዎች 8% ይሸፍናሉ ብለዋል፡፡ በአጠቃላይም ከ1996 - 2000 ዓመት በ54,975 ሰዎች ላይ ከሞት እስከ ቀላል የአካል ጉዳት ደርሷል፡፡

ሌላው ኮማንደሩ ያነሱት ጉዳይ አደጋዎች የደረሱባቸውን የመንገድ ንጣፍ ዓይነት የሚመለከት ሲሆን በዚህም መሰረት 83% የሚሆነው አደጋ የደረሰው በጥሩ አስፋልት በመቀጠልም 12% የሚሆነው በጠጠር መንገድ ላይ ነው ብለዋል፡፡ ከ1996 - 2000 ዓመት በንብረት ላይ የደረሱት ጉዳቶች በገንዘብ ሲተመኑ በ1996 - 81,090,494፣ በ1997 - 84,529,936፣ በ1998 - 101,802,182፣ በ1999 - 123,513,562.28 እንዲሁም በ2000 81,766,533 ብር መሆናቸውን ኮማንደሩ አስረድተዋል፡፡

በመቀጠልም ዋና ዋና የመንገድ አደጋ ምክንያቶች ውስጥ የአሽከርካሪ ስህተት፣ የተሽከርካሪ የቴክኒክ ብቃት ማነስ፣ የመንገድ አካባቢና የእግረኛ ስህተት ተጠቃሽ መሆናቸውን ኮማንደሩ አስረድተዋል፡፡ ከዚሁ ጋር አያይዘውም የትራፊክ ጥፋቶች በዓይነትም ሆነ በብዛት ቁጥራቸው ብዙ መሆናቸውንና በተለያዩ ዘዴዎች ጥፋትን መከፍፈልና መመደብ ለትራፊክ ደንብ ማስከበርና ደህንነትን ለማስፈን ጠቃሚ መሆኑን አስረድተው በአጠቃላይ የትራፊክ ጥፋቶች ከጥንቃቄ ጋር የሚዛመዱ ጥፋቶች፣ ከትራፊክ ፍሰት ጋር የሚዛመዱ፣ ከተሽከርካሪው ሁኔታ ጋርና ከአስተዳደር ጋር የተያያዙ ተብለው ይከፈላሉ፡፡

በመጨረሻም ኮማንደር አክሊሉ በ2000 በመንገድ ትራንስፖርት ባለሥልጣን በተደረገው የተሽከርካሪ ምዝገባ መሠረት ከ260,000 በላይ ተሽከርካሪዎች መኖራቸውን አስረድተው በየዓመቱም በ13% የተሽከርካሪ ቁጥር ይጨምራል ብለዋል፡፡ ወደ አገሪቱ ከገቡት ተሽከርካሪዎች መካከል የ2000 የትራፊክ አደጋ በዋናነት ለአደጋዎች ተጋላጭ የሆኑ ተሽከርካሪዎች መካከል ከፍተኛውን ደረጃ የያዙት ታክሲ - **61,581**፣ የጭነት ተሽከርካሪ - **5,948**፣ አውቶሞቢል - **3,837**፣ የሕዝብ ማመላለሻ አውቶሞቢል - 2,640 ከብዙዎቹ በጥቂቱ የሚጠቀሱ ናቸው መሆናቸውን ገልጸዋል፡፡

በሃገራችን እየተከሰተ ያለውን ከፍተኛ የመንገድ ትራፊክ አደጋ ለማስወገድ ምን መደረግ አለበት ለሚለውም በማጠቃለያ የመፍትሔ ሀሳብነት የመንገድ አቅርቦትን ማሻሻል፣ የአሽከርካሪውን ክህሎትና ሥነ ምግባር የሚያሻሽሉ ሥልጠናዎችን መስጠት፣ ጠጥተው በሚያሽከረክሩ አሽከርካሪዎች ላይ ጠበቅ ያለ ሕግ ማውጣት፣ ተሽከርካሪዎች የደህንነት ሁኔታ በየጊዜው ቋሚ ምርመራን ማካሄድ፣ በአደጋው ሳቢያ ለሚጎዱ ሰዎች ኢንሹራንስ የሚያገኙበትን ሁኔታ ማመቻቸት፣ የፍጥነት ህግን በስራ ላይ ማዋል፣ የደህንነት ቀበቶ አሽከርካሪው እንዲያስር የሚያስገድድ ህግ ማውጣት፣መንገዶች ሲበላሹ በወቅቱ መጠገን፣ ህብረተሰቡን ስለመንገድ አጠቃቀም ትምህርት በስፋት የሚያገኝበትን ምቹ ሁኔታዎች መፍጠር፣ የእግረኞች መሄጃ

መንገዶችን በብዛት ማስፋፋት፣ ዘመኑ ባፈራቸው ልዩ ልዩ የቴክኒክ መሳሪያዎች በመታገዝ የቁጥጥሩን ሁኔታ ማጠናከር፣ የትራፊክ ህጉን ማሻሻል፣ የተሽከርካሪ የትራፊክ ብቃት የመጫን አቅምና የአገልግሎት ጊዜን በህግ መወሰን የሚሉት ተጠቅሰዋል። (ኮማንደር አክሊሉ ለፓናል ተሳታፊው በእለቱ ያቀረቡት ጥናታዊ ጽሁፍ በአባሪነት ስለተካተተ ሙሉ ጽሁፉን ማንበብ ይቻላል።)

2.4 የትራፊክ ደህንነት ትምህርት አጀማመር በአዲስ አበባ ት/ቢሮ

(አቶ ሐይሌ ድንቁ የአዲስ አበባ ትምህርት ቢሮ ተወካይ)

አቶ ሐይሌ ድንቁ ለፓናል ተሰብሳቢው ያቀረቡት ጥናታዊ ጽሁፍ የመንገድ ትራንስፖርት አገልግሎት፣ አጠቃላይ የትራፊክ አደጋ ሁኔታ በአዲስ አበባ ከተማ፣ የትራፊክ አደጋ መንስኤዎች ተብለው የሚጠቀሱ ችግሮች፣ በት/ቢሮ በኩል የተሠሩ ሥራዎች፣ የተገኙ ልምዶች፣ የተገኙ ውጤቶች፣ ወደ ፊት ምን መደረግ አለበት በሚሉ ርእሰ ጉዳዮች ላይ ያተኮሩ ናቸው።

አቶ ሐይሌ የመንገድ ትራንስፖርት አገልግሎትን በተመለከለተ ለአንድ ሃገር ያለውን ኤኮኖሚያዊ ጠቀሜታ የዳሰሱ ሲሆን የትራፊክ አደጋ ሁኔታ በአዲስ አበባ ከተማ ያለውን ገጽታ አስመልክተውም የመንገድ ትራፊክ አደጋ በአዲስ አበባ ከጊዜ ወደ ጊዜ እየጨመረ መምጣቱን በአሃዝ አስደግፈው ለተሰብሳቢው አስረድተዋል።

በመቀጠልም አቶ ሐይሌ የትራፊክ አደጋ መንስኤዎችን በተመለከለተ በሶስት ዋና ዋና ክፍሎች የመደቧቸው ሲሆን አንደኛው በተሽከርካሪ በኩል ያለውን የሚመለከት ሲሆን ለእግረኛ ቅድሚያ ያለመስጠት፣ ርቀት ጠብቆ ያለመንዳት፣ ለተሽከርካሪ ቅድሚያ ያለመስጠት፣ ከተወሰነለት ፍጥነት በላይ መንዳት፣ ጠጥቶ መንዳት፣ ጫት እየቃሙና ሞባይል እያናገሩ መንዳት ተጠቅሰዋል። በእግረኛ በኩል ያለውንም ችግር በተመለከተ የትራፊክ ሕግና ደንብ ተከትሎ ያለመንቀሳቀስ፣ ግራና ቀኝ አይቶ መንገድ ያለመቋረጥና የእግረኛ ማቋረጫ ያለመጠቀም፣ ከፊት ለፊት የሚመጣን ተሽከርካሪ ለማየት በሚያስችል አቅጣጫ የመንገድ ዳር ይዞ አለመንቀሳቀስና በስካር መንፈስ መሃል መንገድ ውስጥ መንቀሳቀስ የሚጠቀሱ ናቸው ብለዋል። የመንገድ አካባቢ ችግሮች ከሚባሉት ውስጥም የእግረኛ መሄጃና ማቋረጫ መንገዶች ካለው የሕዝብና የተሽከርካሪ ብዛት አንፃር በቂ ያለመሆን፣ አማራጭና መጋቢ መንገዶች ያለመስፋፋት፣ የትራፊክ ምልክቶችና ማመልከቻዎች የተጣሉ አለመሆናቸው ተጠቅሰዋል።

የመንገድ ትራፊክ አደጋን በተመለከተ በት/ቢሮ በኩል የተሠሩ ሥራዎች ካልዋቸው ውስጥ በት/ቢሮው ከአዲስ አበባ ፖሊሲ ኮሚሽን ጋር ለመሠራት መስማማቱና በደቡብ አፍሪካ የልምድ ልውውጥ መደረና ጠቅሰዋል። ከዚህ የልምድ ልውውጥም የሕፃናት ትራፊክ ደህንነት የትምህርት ቤቶች ደህንነት እንደአንድ ዋና አካል ተደርጎ የሚወሰድ መሆኑን፣ የትራፊክ ደህንነት ትምህርት የሥርዓተ ትምህርቱ አካል ተደርጎ መዘጋጀቱን፣ የተማሪ ትራፊኮች ሥልጠናና ተሳትፎ በሰፊው የሚሠራበት መሆኑን፣ የሕፃናት ትራፊክ ደህንነት ትምህርትን እንደአንዱ አንገብጋቢ ጉዳይ ወስዶ በመንቀሳቀስ፣ ለአፀደ ሕፃናት፣ ከ1ኛ-4ኛ ክፍል፣ ከ5ኛ-8ኛ ክፍሎች ለሚያስተምሩ መምህራን ከአዲስ አበባ ትራፊክ ምርመራ ጋር በመሆን ከኖርዌይና ስዊድን መንግሥታዊ ያልሆኑ ድርጅቶች በተገኘ የገንዘብ ድጋፍ ማኑዋል ተዘጋጅቶ ከ15,000 በላይ ኮፒዎች መሰራጨታቸውን፣ በመደበኛውና መደበኛ ባልሆነው ሥርዓተ ትምህርት ውስጥ ተቀናጅቶ እንዲገባ መደረጉ ከብዙዎቹ በጥቂቱ የሚጠቀሱ ልምዶች መሆናቸውን ጠቅሰዋል።

አቶ ሐይሌ የመንገድ ትራፊክ ደህንነትን በተመለከተ በት/ቢሮ በኩል ከተሠሩ ሥራዎች የተገኙ ውጤቶችን አስመልክተው የትራፊክ ደህንነት ትምህርት የመደበኛው ሥርዓተ ትምህርት አካል መደረጉ፣ የተማሪ ትራፊክ ሥልጠናና የተግባር ተሳትፎ በት/ቤቶች መጀመሩ፣ የማስተማሪያ ማኑዋሎች እንደየተማሪዎቹ የዕድሜ ደረጃ መዘጋጀታቸውና መሠራጨታቸው፣ ተማሪዎች ስለትራፊክ ደህንነት መጠነኛ ዕውቀት በሚኒሚዲያዎች አመካኝነት እንዲያገኙ መደረጉ፣ ከትራፊክ ፖሊሶችና ከአዲስ አበባ መንገድ ትራንስፖርት ጋር አብሮ መሥራት መጀመሩንና የትራፊክ ክበባት በየት/ቤቶች መቋቋማቸውን አስረድተዋል።

በመጨረሻም ወደፊት ምን መደረግ አለበት የሚለውንም ሃሳብ በተመለከተ የተጀመረውን እንቅስቃሴ አጠናክሮ መቀጠል፣ ከአዲስ አበባ ትራፊክ መ/ቤትና ከአዲስ አበባ መንገድ ትራንስፖርት ጋር በመሆን በቅንጅት ለመሥራት የጋራ ኮሚቴ ማቋቋም፣ ቀደም ብለው የተዘጋጁትን ማኑዋሎች የሕይወት ክህሎቶችን በማካተት እንደገና ማዘጋጀት፣ መምህራንንና ተማሪዎችን በትራፊክ ደህንነት ትምህርት በሰፊው ማሰልጠን፣ ለትራፊክ ደህንነት እንቅስቃሴ ሊውሉ የሚችሉ የገንዘብና የቁሳቁስ ሐብት በጋራ ማፈላለግ፣ ለሱፐርቫይዘሮች ሥልጠና በመስጠት የተጠናከረ ክትትልና ድጋፍ እንዲያደርጉ ማድረግ፣ ለ2ኛ ደረጃ ተማሪዎች ፕላዝማ በመጠቀም የትራፊክ መልዕክቶችን ለማስተላለፍ እንዲቻል ከት/ሚኒስቴር ጋር

መነጋገርና የትራፊክ ክበባትን ማጠናከር አስፈላጊ መሆኑን አስረድተዋል፡፡ (አቶ ሐይሌ ለፓናል ተሳታፊው በእለቱ ያቀረቡት ጥናታዊ ጽሁፍ በአባሪነት ስለተካተተ ሙሉ ጽሁፉን ማንበብ ይቻላል፡፡)

2.5 የትራፊክ ደንብ አፈጻጸም ጥረቶች
(Efforts on Law Enforcement)
አቶ ምትኩ መዳ የአዲስ አበባ ፍትህ ቢሮ ተወካይ

አቶ ምትኩ መዳ እስካሁን የነበረው የትራፊክ ደንብ በሰውና በንብረት ላይ እየደረሰ ያለውን ጉዳት ለማስቀረት የማያችል በመሆኑ አዲስ የትራፊክ ደንብ ረቂቅ ማዘጋጀት አስፈላጊ ሆኖ መገኘቱን ገልጸዋል፡፡ በዚህም መሰረት የበፊቱንና አሁን ሊወጣ በገፃጅት ላይ የሚገኘውን ደንብ አስመልክተው አንዳንድ ነጥቦች ለፓናሉ ተሳታፊዎች ገልጸዋል፡፡

እንደአቶ ምትኩ ገለጻ በአዲስ አበባ ደረጃ በ1990 ዓ.ም ደንብ ቁጥር 5 ላይ የትራፊክ ደንብ መተላለፍ ምን ምን እንደሆኑ ሊደርሱ ከሚችሉ ተገቢ ቅጣቶች ጋር ተዘርዝሮ ቀርቧል፡፡ በ1992 ዓ.ም ደንብ ቁጥር 5 የተወሰነ ማሻሻያ የተደረገበት ሲሆን በ1995 ዓ.ም የከተማው የትራፊክ አደጋ ከጊዜ ወደ ጊዜ እየጨመረ ስለመጣ ይህንን ችግር ለመቆጣጠርና ለመከላከል ከተለያዩ የመንግስትና የንግድ ተቋማት የትራፊክ ደህንነት ምክር ቤት የተቋቋመ ሲሆን ስራውን በአግባቡ እየተወጣ ነው ለማለት አያስደፍርም በማለት አቶ ምትኩ አስረድተዋል፡፡

በ1996 ዓ.ም ደንብ ቁጥር 23/92 ተሻሽሎ በደንብ 24/96 የተተካ ሲሆን ይህም ቢሆን ከሌሎቹ ደንቦች ጋር ተባብሮ በከተማዋ የሚደርሰውን የትራፊክ አደጋ ለማስቆም አላስቻለም፡፡ በዚህም መሰረት በአሁኑ ወቅት አዲስ ረቂቅ ደንብ የተዘጋጀ ሲሆን ይህ ደንብ በአዲስ አበባ ለሚከሰቱ የትራፊክ አደጋዎች ምንስኤው ሙሉ በሙሉም ባይሆን በዋናነት ከአሽከርካሪዎች ድርጊትና ባህሪያት ጋር ስለሚያያዝ ይህንኑ ሁኔታ ለማስተካከል በሚያስችል መልኩ የተረቀቀ መሆኑን አቶ ምትኩ አስረድተዋል፡፡

በአዲስ አበባ እየተስፋፋ ከመጣው ቴክኖሎጂ ጋር በተያያዘ በአዲሱ ረቂቅ ደንብ ውስጥ ትኩረት የተሰጣቸው ጉዳዮች መኖራቸውን አቶ ምትኩ ጠቅሰው ከእነዚህም ውስጥ ሞባይል እያናገሩ መኪና ማሽከርከር እንዲሁም በአንዳንድ ተሽከርካሪዎች ላይ የሚገጠሙ የቴሌቪዥን እስክሪኖች ከአሽከርካሪው ጆርባ መሆን ደሲገባቸው ከዘሽከርካሪው ፊት የሚቀመጡበት አግባብነት የጎደለው ሁኔታ በረቂቅ ደንቡ ትኩረት የተሰጠው ሌላው ጉዳይ ነው መሆኑን አቶ ምትኩ ለፓናሉ ተሳታፊ አስረድተዋል፡፡

2.6 የተሽከርካሪ አደጋ የሦስተኛ ወገን መድን ዋስትና ጠቀሜታና ትኩረት የሚሹ ጉዳዮች
አቶ... የንብ ኢንሹራንስ ኩባንያ ተወካይ

አቶ... በሀገራችን በሰው ሕይወት፣ አካልና ንብረት ላይ ጉዳት ከሚያደርሱ ክስተቶች አንዱና ዋነኛው የተሽከርካሪ አደጋ መሆኑንና የአደጋውን ከጊዜ ወደ ጊዜ እየጨመረ መሄዱን በአጽንኦት በመግለጽ ነበር ንግግራቸውን የጀመሩት፡፡ በማስከተልም ከተሽከርካሪ አደጋ ጋር በተያያዘ ለኢንሹራንስ ኩባንያዎች ከሚቀርቡ የካሣ ክፍያ ጥያቄዎችና በኢንዱስትሪው ከተፈፀመ የካሣ ክፍያ አንፃር ሲታይ አደጋው ከጊዜ ወደ ጊዜ እየከፋ መሄዱን ያመለክታል ብለዋል፡፡ ለዚህ ሃሳባቸው በማስረጃነትም የሚከተለውን የንብ ኢንሹራንስ ኩባንያ የካሣ ክፍያ መረጃ ለፓናሉ ተሰብሳቢ አቅርበዋል፡፡

እ.ኤ.አ በ2006/07 ⟶ ሪፖርት የተደረገ የካሣ ጥያቄ በቁጥር 1142 የተከፈለ ካሣ ብር 26,236,000.00

እ.ኤ.አ በ2007/08 ⟶ ሪፖርት የተደረገ የካሣ ጥያቄ በቁጥር 1320 የተከፈለ ካሣ ብር 36,028,000.00

እ.ኤ.አ በ2008/09 ⟶ ሪፖርት የተደረገ የካሣ ጥያቄ በቁጥር 1882 የተከፈለ ካሣ ብር 46,361,000.00

በተመሣሣይ ሁኔታ ከኢትዮጵያ ብሔራዊ ባንክ በተገኘ መረጃ መሠረት በኢንሹራንስ ኢንዱስትሪው ባሉት ኩባንያዎች በአጠቃላይ ከመኪና አደጋ ጋር በተያያዘ ለቀረቡ የካሣ ጥያቄዎች የተከፈለውን የካሣ ክፍያ ስንመለከት

እ.ኤ.አ በ2007/08 ⟶ የተከፈለ ካሣ ብር 507,565.000.00

እ.ኤ.አ በ2008/09 ⟶ የተከፈለ ካሣ ብር 581,641.000.00 መሆኑን አቶ.... አስረድተዋል፡፡

እነዚህ አሀዞች የሚያሳዩት ኢንሹራንስ ኖሯቸው አደጋ ባደረሱና አደጋውን ለኢንሹራንስ ኩባንያዎች ሪፖርት አድርገው ካሣ ክፍያ የተፈመባቸውን አደጋዎች ብቻ መሆኑንና የተጠቀሰው የካሣ ክፍያ መጠንም በሂደት ላይ ያሉ የካሣ ጥያቄዎችንና ኢሹንራንስ በሌላቸው ተሽከርካሪዎች ምክንያት የደረሱ አደጋዎችን እንዲሁም ወደ ኢንሹራንስ ኩባንያዎች ሳይቀርቡ አደጋ የደረሰባቸው ወገኖች

በስምምነት የጨረሏቸውን የካሣ ክፍያ የሚያስከትሉ አደጋዎችን የማያካትት መሆኑን መግለጽ ይህን ከግምት ውስጥ አስገብተን ስናየው በየጊዜው እየደረሰ ያለው አደጋና አደጋው የሚያስከትለው ውድመት እጅግ ከፍተኛ መሆኑን ያሳያል ብለዋል፡፡

አቶ... በማስከተልም የመንገድ ትራፊክ አደጋዎች እንዳይከሰቱና ጉዳት እንዳያስከትሉ ተገቢውን ጥንቃቄ ማድረግ፣ ከአቅም በላይ በሆነ ሁኔታ የሚከሰቱ ከሆነ ደግሞ የሚያስከትሉትን ሰብአዊ ቁሳዊና ኢኮኖሚያዊ ጉዳት ለመቋቋም የሚያስችሉ መፍትሄዎችን መፈለግ የግድ ይሆናል ብለዋል፡፡ ከዚህ አንፃርም ከቅርብ ዓመታት ወዲህ የህብረተሰቡን ግንዛቤ የማዳበር ኘሮግራሞች፣ በትምህርት ቤቶች አካባቢ የተማሪ ትራፊኮችን ማስልጠን፣ የአሽከርካሪ ብቃት ማረጋገጫ ፈቃድ አሰጣጥን በሚመለከት እና ጥፋት በሚፈፅሙ አሽከራካሪዎች ላይ ስለተጣለ ቅጣት በአዋጅ ቁጥር 600/2000 (Proclamation No. 600/2008) ሐምሌ 19 ቀን 2000 ዓ.ም፣ ስለተሽከርካሪ አደጋ የሦስተኛ ወገን መድን ዋስትና ደግሞ በአዋጅ ቁጥር 599/2000 (Proclamation No. 599/2008) ታህሳስ 30 ቀን 2000 ዓ.ም አዋጆች ማውጣታቸው፣ የጉዳዩን አሳሳቢነት በመረዳት በሚመለከታቸው ክፍሎች ከተወሰዱ ተጨባጭ እርምጃዎች ውስጥ ዋና ዋናዎቹ ናቸው መሆናቸውን አስረድተዋል፡፡

ከአቅም በላይ በሆኑ አጋጣሚዎች በሚከሰቱ የተሽከርካሪ አደጋዎች ምክንያት ለደረሰው አደጋ ተጠያቂ በሆኑት ወገኖችም ሆነ የጉዳቱ ሰለባ በሆኑት ዜጎች ላይ የሚደርሰውን ጫና ከመቀነስ አንፃር በአዋጅ ቁጥር 599/2000 የተደነገገው የተሽከርካሪ አደጋ የሦስተኛ ወገን መድን ዋስትና ከፍተኛ ጠቀሜታ አለው ብለዋል፡፡ በአዋጁ መግቢያ ላይ በግልፅ እንደተቀመጠው የተሽከርካሪ አደጋ የሦስተኛ ወገን መድን ዋስትና አስፈላጊ እንዲሆን ያስገደዱት ምክንያቶች፤

1ኛ/ በተሽከርካሪ ምክንያት እየደረሰ ያለው አደጋ በየጊዜው መጨመሩ

2ኛ/ በተሽከርካሪ አደጋ ምክንያት የሚደርሰው የሞት የአካል ጉዳትና የንብረት ኪሣራ ማህበራዊ ችግር የሚያስከትል በመሆኑ

3ኛ/ የተሽከርካሪ አደጋ ተጎጂዎች አስቸኳይ የህክምና አገልግሎት የሚያገኙበትን ሁኔታ ማመቻቸትና የተሽከርካሪ ባለንብረቶች የተሽከርካሪ አደጋ የሦስተኛ ወገን መድን ሽፋን እንዲኖራቸው ማድረግ አስፈላጊ መሆኑ የሚሉት ናቸው፡፡

በአዋጁ ክፍል 2 አንቀፅ 4 ተራ ቁጥር 1 እና 2 የኢንሹራንስ ፖሊሲው ሊሰጥ የሚችለው በኢንሹራንስ ኩባንያዎች ብቻ መሆኑንና ውሉ የሚሰጠው ሽፋን መድን የተገባለት ተሽከርካሪ ከሚያደርሰው የሰው ሞት የአካል ጉዳትና የንብረት ኪሣራ መክፈል የሚገባውን ካሣና የአስቸኳይ ሕክምና ወጪን የሚሸፍን መሆን እንዳለበት ያስረዳል፡፡ የአስገዳጅነቱ ባህሪ የመነጨውም ሁሉም የተሽከርካሪ ባለንብረት እስከአሁን በተግባር እንደታየው በራሱ ተነሳሽነትና መልካም ፈቃድ የኢሹንራንስ ዋስትና ይገባል ወይም ይኖረዋል ብሎ መገመት አስቸጋሪ ከመሆኑም በላይ ኢንሹራንስ ባልተገባላቸው ተሽከርካሪዎች ለሚፈጠሩ አደጋዎችና አደጋዎቹ ለሚያደርሷቸው ጉዳቶች የተሽከርካሪዎቹ ባለንብረቶች ለተጎጂዎች ተገቢውን አፋጣኝ እርዳታ ለመስጠትና ካሣ ለመፈፀም የሚኖርባቸው የኢኮኖሚ አቅም ውስኑነትና አንዳንዱም ለደረሰው ጉዳት ሃላፊነትን በመቀበልና ባለመቀበል መካከል በሚፈጠሩ ክፍቶተች በሰው ህይወት ላይ የሚደርሰውን ጉዳት ለማስቀረት መሆኑን መረዳት ይቻላል፡፡

አቶ... ንግግራቸውን ሲያጠቃልሉም የአስቸኳይ ሕክምና አገልግሎት በተመለከተ በአዋጁ የሰፈሩት ድንጋጌዎችንና **የኃላፊነት መጠን**፣ የተሽከርካሪ አደጋ የሦስተኛ ወገን ኢንሹራንስ ሽፋን የዋስትና ገደብ፣ የመንገድ ተጠቃሚዎችም መወጣት ስለሚገባቸው ሃላፊነት ወዘተ የተለያዩ ድንጋጌዎችን ያሰፈረ በመሆኑ ማንኛውም ግለሰብ አሽከርካሪም ሆነ እግረኛ ስለአዋጁ በደንብ ለማወቅ ጥረት ማድረግ ይገባዋል በማለት ሃሳባቸውን አጠቃለዋል፡፡

2.7 **የትራፊክ አደጋ ተጽዕኖ በግለሰቦች ላይ**

(ሲስተር ጽጌ ከበደ - የትራፊክ አደጋ ተጠቂ)

ወደምሰራበት የካቲት 12 ሆስፒታል/ዘውዲቱ ጠዋት በስራ ሰዓት ለመድረስ ከቤተተ ወጣሁ፡፡ ካዛንቺስ ግብርና ቢሮ ፊት ለፊት ያለውነረ ዜብራ መሻገሪያ ተጠቅሜ ለመሻገር መዳመድ እንደጀመርኩ ከኋላዬ አንድ መኪና ገጨኝ፤ ወደቅሁ፡፡ ከተኛሁበት አስፓልት ላይ ቀና ማለት አቃተኝ፡፡ መላ ሰውነቴ ደነዘዘ፡፡ ተገጭቼ ስወድቅ ያዩኝ ሰዎች መጥጠው ከበቡኝ፡፡ ነገር ግን አጠገቤ ደርሰው ባዩት ሁኔታ ብዙም አልተደናገጡም፡፡ አልተሳሳጥኩ፣ አልደማሁ፣ አጥንቴ አልወለቀ፣ ላመል እንኳን ሰምበር አልወጣብኝ ወይም ደግሞ በህመም ስሜት አልጮኽኩ፤ ታዲያ ሰዎቹ ምን በወጣቸው ይደነግጣሉ? ዙሪያዬን ከበው የከንፈር መጠጣ እርዳታ ማድረጋቸውም ተመስገን ነው፡፡ እኔ ግን ከወደቅሁበት ለመነሳት ጥረት ባደርግም ሰውነቴ ጨርሶውኑ አልታዘዝ ብሎኝ እታገላለሁ፡፡

እንዳጋጣሚ ከከበቡኝ ሰዎች ውስጥ አንደኛው ሆስፒታል የምሰራ ነርስ መሆኔን ያውቅ ኖሮ "እቺንማ አውቃታለሁ፡፡ የካቲት 12 ሆስፒታል/ዘውዲቱ የምትሰራ ሀኪም ናት፡፡ እባካችሁ ተባብረን እዛው ሆስፒታል እናድርሳትና ባልደረቦቿዋ የሚያድርጉላትን ያድርጉላት" አለ፡፡ ከዚያም ተረባርበው ከተኛሁበት አስፓልት ላይ አነሱኝ፡፡ መኪና አስመጥተውም የካቲት 12 ሆስፒታል/ዘውዲቱ አደረሱኝ፡፡ በማክሞበት ሆስፒታል ታካሚ ሆኜ አልጋ ያዝኩኝ፡፡ የሆስፒታሉ ሀኪሞች ተረባርበው ህክምና ሊያደርጉልኝ ቢሞክሩም የደረሰብኝ ጉዳት በግልጽ አካሌ ላይ የማይታይ በመሆኑ ግራ ተጋቡ፡፡

በወቅቱ የአጥንት መመርመሪያ መሳሪያ ያለውና በመስኩም አንድ ለእናቱ ወደ ነበረው ጥቁር አንበሳ ሆስፒታል ወሰዱኝ፡፡ እዛም ምርመራ ሲደረግልኝ የደረሰብኝ ጉዳት ... ሆኖ ተገኘ፡፡ ጉዳቱ በሃገር ውስጥ ህክምና ለመስጠት የሚያዳግት በመሆኑና ወደ ቤቱም መሄድ ስለማልችል አልጋ ይገፍ መጨረሻዬ ምን ይሆን በሚል መጠባበቅ ጀመርኩኝ፡፡

እኔ በተኛሁበት ክፍል ውስጥ ወደ አስር የሚጠጉ ህመማን የነበሩ ሲሆን ከእነዚህ ውስጥ በግምት ስምንት ያህሉ የመኪና አደጋ የደረሰባቸው ነበሩ፡፡ በጣም የገረመኝ ደግሞ ወደ ስድስት ያህል የሚሆኑት አደጋው የደረሰባቸው ካዛንችስ አካባቢ መሆኑ ነው፡፡ ለተወሰኑ ወራት/ሳምንታት/ቀናት ሀኪሞቹ የአቅማቸውን ያህል ሲንከባከቡኝ ቆይተው ጉዳቱ ከባድ ስለነበር ወደ ውጪ ሀገር ሄጄ እንድታከም የዶክተሮች ቦርድ ወሰነና ህንድ ሃገር ሄጅ ለሶስት ወራት ያህል ስታከም ቆየሁኝ፡፡

ከጥቁር አንበሳ ሆስፒታል ጀምሮ እስከ ህንድ ሃገር የሶስት ወራት ቆይታዬ ድረስ ከተጋደምኩበት አልጋ/ስትሬቸር ላይ አልተነሳሁም ነበር፡፡ በስተመጨረሻም ከዱዳቱ ድኜ ወደ ሃገሬ ተመልሼ የህክምና አገልግሎት መስጠቴን ቀጠልኩኝ፡፡

ከእኔ የመኪና አደጋ ገጠመኝ የታዘብኩትን አንድ ሁኔታ ሰዎች እንዲገነዘቡልኝ እፈልጋለሁ፡፡ ይኸውም አንድ ሰው በመኪና ተገጭቶ ሲወድቅ የጉዳቱን መጠን በግልጽ በሚታየው በሚፈሰው ደም ወይም በተሰበረው አጥንቱ አልያም በህመም ስሜቱ አስጨናቂነት መለካት የለብንም፡፡ ጉዳቱ በግልጽ የማይታና ለተጎጂውም ብዙም ስሜት የማይሰጥ ቀላል ሊመስል ስለሚችል መጠንቀቅ አለብን፡፡ ስለዚህም ማንኛውም የመኪና አደጋ በሰው ላይ ሲከሰት የመጀመሪያው ተግባራችን ለተጎጂው የመጀመሪያ እርዳታ ሰጥቶ ወዲያውኑ ወደ ህክምና ተቋም ማድረስ መሆን ይገባናል፡፡

ከላይ የተጠቀሱት የጥናት ጽሁፎች ከቀረቡ በኋላ የፕሮግራሙ መሪ የምሳ ሰዓት መድረሱን በመግለጽ ተወያዮቹን አሰናብተዋል፡፡ ከምሳ መልስ የነበረው ፕሮግራም ከምሳ በፊት የቀረቡትን ጥናታዊ ጽሁፎች መሰረት አድርጎ በሶስት ምድብ የተከፈለ የቡድን ውይይት ማካሄድ ነበር፡፡ በዚህም መሰረት የመንገድ ትራፊክ አደጋ ከትራንስፖርትና የመንገድ ደህንነት አንጻር፣ ከማህበረሰብ ጤና/ፐብሊክ ኸልዝ አንጻር እንዲሁም ከህግ አተገባበር/አፈጻጸም አንጻር የሚሉ የተናጠል የመወያያ ርእሶች ላይ በየዘርፉ ያሉ ችግሮችን መለየት፣ እየተወሰዱ ያሉ ጥረቶችን ማውጣትና ለወደፊት መወሰድ የሚገባቸውን እርምጃዎች ማስቀመጥ በሚሉ አቅጣጫዎች ሶስቱም ቡድኖች ውይይት አካሄዱ፡፡

ከውይይታቸውም በኋላ የየቡድናቸውን የጋራ አቋም በተወካዮቻቸው አማካይነት ያቀረቡ ሲሆን በተወያዮቹ ተጨማሪ ሃሳብ ከዳበረ በኋላ የአጠቃላዩ የፓናል ተወያይ ሀሳብ ሆኖ የሚከተለው አቋም ወጥቷል፡፡

Position Paper on Road Traffic Injuries
October, 24, 2009

As part of the 20th Annual conference of the EPHA a pre-conference panel with a theme of "Multisectoral Response to Road Traffic Injuries in Ethiopia" was held at the conference hall of the Ethiopian Road Transport Authority on October 24, 2009, which was attended by over 200 participants. The panel discussion was organized jointly by EPHA, WHO, FMoH, Road Transport Authority and Federal and Addis Ababa Police Commissions with support from NIB Insurance Company and Abyssinia Automotive Association.

After a one day long deliberation on the magnitude of Road Traffic Injuries, current efforts and the way forward, the meeting participants considered Road Traffic Accidents as a concern of individuals, government, non-government and private institutions and forwarded the following points as their positions in improving the situation of Road Traffic Injuries in Ethiopia.

1. Road traffic accidents needs to be considered as a major public health problem and the necessary public health actions need to be taken through the

leadership of the MoH within the framework of a multisectoral response to Road Traffic Injuries.
2. Policies and strategies to be formulated in improving road safety need always to focus on education, engineering and enforcement in an integrated way.
3. Increase public awareness on the magnitude of Road Traffic Injuries, their prevention and existing laws and regulations using harmonized messages on a regular and continuous basis through available media channels including traditional institutions such as Idir and religious institutions.
4. Conduct and use operational researches to generate enough evidence on road safety, behaviors of individuals involved in RTI and institutional responses to road traffic accidents, in order to implement evidence based sustainable actions.
5. Strengthen coordinated capacity building activities aimed at decreasing RTI for drivers, traffic police and others involved in road safety activities. Insurance companies must also be involved in such preventive capacity building activities.
6. Life of vehicles on the road and an exit system for old vehicles which are prone to RTI needs a clear regulation from the transport authority. In addition, revision on the high level of tax on new vehicles and discouraging old vehicles beyond certain age needs to be considered by the concerned authorities.
7. Annual vehicle inspections need to be done strictly with inclusion of mandatory regulations in avoiding RTIs including first aid kits.
8. Strict medical check ups for drivers beyond new licensing needs must be instituted during regular renewal of driving licenses.
9. FMoH needs to establish a national multisectoral committee on road traffic injury. In addition it should take a leadership role in improving emergency care for victims of road traffic accidents by scaling up pre-hospital care, improving hospital care and strengthening emergency networks.
10. Transport authorities' need to work in coordination with other responsible government and non-governmental organizations to improve road networks, outlet designs, and increase the number and functionality of road traffic lights.
11. Road safety education should be included in schools curriculums to increase the awareness of the youth.
12. Establish monitoring and evaluation systems to ensure the implementation of law enforcement and other road safety measures.
13. The EPHA needs to continue its current effort on Road Traffic Accidents in the implementation and follow-up of the recommendations forwarded in the panel discussion.

Addis Ababa, October 24, 2009.

ፕሬስ ኮንፈረንስ

ጥያቄ፡- የዛሬው የፓናል ውይይት ውጤት ወዴት ያመራል? ማህበሩስ በጉዳዩ ላይ እስከምን ድረስ ይገፋበታል?

መልስ በዶ/ር መንግስቱ አስናቀ፡- ከዛሬው ውይይት የአቋም መግለጫ እናወጣለን፡፡ ይህም ለአባላቶቻችን በሙሉ የሚደርስበት ሁኔታ አንዱ ነው፡፡ አንዳንድ ከመንገድ ደህንነት ጋር በተያያዘ የተነሱ ሃሳቦችን የኢትዮጵያ ጤና አጠባበቅ ማህበር በባለሙያዎቹ አማካይነት ይበልጥ ማብራራት የሚያስፈልጋቸውን አንዳንድ ሃሳቦች በቀጣይነት ያከናውናል፡፡ ከዛ ባሻገር ግን አቅማችን በፈቀደ መጠን የተለያዩ አነስተኛ ፕሮግራሞችን በመቅረጽ ስራ ላይ እናውላለን፡፡ ከእነዚህም በተጨማሪ የአቋም መግለጫችን ለተለያዩ ለሚመለከታቸው የመንግስት አካላት እንዲደርስ እናደርጋለን፡፡ ይህንንም የምናደርገው የመንገድ ደህንነት ህጎች ተፈጻሚነት እንደሚጎላቸው በፓናል ውይይቱ ላይ በስፋት የተነሳ ሃሳብ በመሆኑ ህጎቹ ተፈጻሚነት እንዲኖራቸው ግፊት እናደርጋለን፡፡ ሌላው በ20ኛው አመታዊ ጉባኤያችን ላይ የህዝብ ተወካዮች ምክርቤት

ቋሚ አባላት እንዲገኙ ስለለጋበዝን ህግ በሚወጣበት ጊዜ የመንገድ ደህንነት ትልቅ ትኩረት እንዲሰጠው ለማድረግ አስበናል፡፡ ከዚህም ሌላ በምናገኛቸው የተለያዩ አጋጣሚዎች በመጠቀምና ባለንባቸው ብሔራዊ ግብረሃይሎች ውስጥ በመንገድ ደህንነት ርእስ ጉዳይ ዙሪያ ግፊት እናደርጋለን፡፡

ጥያቄ፡- በቅርቡ ይወጣል በተባለው የመንገድ ደህንነት በደንብ ውስጥ ከተካተቱት ውስጥ የደህንነት ቀበቶ (ሴፍቲ ቤልት) በግዴታ ስለመጠቀም የሚያወሳ አለና ከዚሁ ጋር ተያይዞ ሄልሜት ስለመጠቀምስ ምን ሃሳብ አለ?

መልስ በአቶ አበበ አስራት፡- የደህንነት ቀበቶን በተመለከተ በብሄራዊ ደረጃ አዋጅ ተቀርጿል፡፡ አዋጁ የደህንነት ቀበቶን ብቻ ሳይሆን በአለም የጤና ደህንነት ማኑዋሎች ላይ የተጠቀሙ የተለያዩ እርምጃዎችንም ያካተተ ነው፡፡ እናም በአጭር ጊዜ ውስጥ ተግባራዊ እንደሚሆን እምነቱ አለኝ፡፡ ሄልሜትን በተመለከተ አዋጁ ብስኪሌት ጋላቢዎችም ሳይቀሩ ሄልሜት እንዲያደርጉ የሚያስገድድ ነው፡፡

ጥያቄ፡- ብዙ ጊዜ ስለተከሰተ የመንገድ ትራፊክ አደጋ ሲገለጽ ምክንያቱ ለእግረኛ ቅድሚያ በመከልከል ነው ይባላልና እግረኛው በሰራው ስህተት ምክንያት አደጋ ቢደርስ ተጠያቂው ለምን ሹፌሩ ብቻ ይሆናል?

መልስ በሳጅን አሰፋ መዝገቡ፡- ለዚህ ጥያቄ መልሱ በእኔ አቅም ሊሰጥ የሚችል አይደለም፡፡ ምክንያቱም ጥያቄው የህግ ይዘት ያለው ስለሆነ ነው፡፡ ሆኖም ግን በሃገራችን የምንጠቀምበት የ1956 ዓ.ም የወጣው ትራንስፖርት አዋጅ እግረኞች ሊከተሏቸው የሚገባቸውን የተለያዩ ህጎች ያካተተ ነው፡፡ አዲስ አበባ ውስጥ የምንጠቀምበት ደንብ ቁጥር 1990 አሽከርካሪዎችን ብቻ የሚመለከት ነው የወጣው፡፡ እግረኞችን የሚመለከት ደንብ ግን እግረኞችን ተንተርሶ አልወጣም፡፡ በዚህም የተነሳ እግረኞች ያለአግባብ ሲጓዙ ደንብ ተላልፋችኋል ብሎ ለመቅጣት የሚያስችል ሁኔታ የለም፡፡ ይህም ሆኖ በፌዴራልና በአዲስ አበባ ደረጃ እግረኞች ተጠያቂ የሚሆኑበትን ሁኔታ ያካተተ ረቂቅ በመጠናት ላይ ነው፡፡

እስካሁን ባለው ሁኔታ ግን የትራፊክ ህግ እውቀቱ ያለው አሽከርካሪዎች ጋር እንደመሆኑ መጠንና አደጋን መቀነስ አለበት ብለን ስለምናምንም እግረኞች ከተገጨ በኋላ ተጠያቂ ይሆናሉ ተብሎ በህግ ያልተቀመጠውን ነገር ብንናገር አሽከርካሪዎችን ያበረታታል ብለን ስለምናምን በዚህ ምክንያት አሽከርካሪዎች ጥፋተኛ የሚሆኑበትን ሁኔታ ነው ለህብረተሰቡ እየገለጽን ያለነው፡፡ ምናልባት አዲስ ከሚወጣው ህግ ጋር ተካቶ እግረኞችም ተጠያቂ የሚሆኑበት የህግ አግባብ ይኖራል ብዬ አስባለሁ፡፡

ጥያቄ፡- በኢትዮጵያ እየደረሰ ያለውን የትራፊክ አደጋ አለምአቀፉ የጤና ድርጅት እንዴት ይመለከተዋል?

መልስ በዶ/ር ኩኑዝ አብደላ፡- በሃገራችን ያለው የመኪና ብዛትና እየደረሰ ያለው የመንገድ ትራፊክ አደጋ በእጅጉ የማይመጣጠን ሲሆን በአለም አቀፍ ደረጃም ከፍተኛ የአደጋ መጠም በመከሰት ላይ ነው፡፡ ይህ ሁኔታ በአለም አቀፍ የጤና ድርጅት አይን አንድ ትልቅ የጤና ችግር ተደርጎ ነው የሚወሰደው፡፡ ለዚህ ደግሞ ምክንያቱ ያሉን ውስን የጤና ድርጅቶች በዚህ አደጋ ሰለባ መሆናቸው ነው፡፡ ሌሎች ከባድ የጤና ችግሮችን ልናስወግድበት የምንችለውን የመድሃኒትና የቁሳቁስ አቅርቦት እንዲሁም የህክምና ባለሙያዎች አቅም በዚህ ልንከላከለው በምንችል ችግር ላይ እያዋልነው ነው ያለነው፡፡

Annex III: List of panelists

No	Name	e-mail	Tel.
	Main theme presenters		
1	Sr. Sosina (FMOH)	sessenab@yahoo.com	0911656022
2	Dr. Kunuz Abdela	kunuza@et.afro.who.int	0911405763
3	Com. Aklilu Seifu	-	0913120386
	Sub-theme _One_ presenters		
4	Hailemariam Leggesse	hailemariaml@yahoo.com	0916828156
5	Belaynesh Yifru	ybmulugeta@yahoo.com	0911712412
6	Cherinet Abuye	Cherinetabuye1@yahoo.com	0911136948
	Sub-theme _Two_ presenters		
7	Dr. Solomon Emyu	solomone@et.afro.who.int	0911401551
8	Dr.Assefa Semie	assefaseme@gmail.com	0911228193
9	s/r Workenesh	wkerefa@pathfind.org	0911304727
10	W/r Asemaru	elaluberihanu@yahoo.com	0911683241
	Sub-theme _Three_ presenters		
11	Meskele Lera	meskelel@etharc.org	0912068712
12	Feleke Dana	flktanga@yahoo.com	0911199123
13	Zelalem Gizaw	zgizaw@path.org	0910977835
14	Chrly Fontaine	fontaine@unaids.org	0911502225
	Sub-theme _Four_ presenters		
15	Addisalem Semma	Aladdis2000@yahoo.com	0911661601
16	Bogale Solomon	bsolomon@ethionet.et	0911228553
17	Assefa Berihun	assefaberihun@yahoo.com	0911467022
	Proceeding producers		
	Alemayehu Bekele	alemayehubekele2002@yahoo.com	0911179205
	Mihret Teclemariam	teclemariamm@yahoo.com	0911480386
	Zewdie Teferra	zewdtt@yahoo.com	0913457676

Annex IV List of Presenters

List of Oral Presenters

1. Dr. Omar Ahmed
2. Nodla Prata
3. Dr. Amanuel Gessesew
4. Bisrat H/Mariam
5. Dejene Tilahun
6. Sultan Abajebel
7. Lense Gobu
8. Nasir Tajure
9. Markos Tesfaye
10. Tenaw Andualem
11. Hiwot Teka
12. Birke Abate
13. Birhanu Cheneke
14. Amare Eshetu
15. Samuel Kinde
16. Tekebash Araya
17. Tolcha Kebebew
18. Daniel S. Telake
19. Filimona Bisrat
20. Surafel Fantaw
21. Feyissa Challa
22. Tsehaynesh Lemma
23. Mulu Abraha

24. Abdu Bedru
25. Tamirat Gebru
26. Bezatu Mengiste
27. Wondimu Shanko
28. Tadesse Alemu
29. Ashenafi Assefa
30. Heven Sime
31. Belete Tafesse
32. Muluneh Yigzaw

List of Poster Presenters

1. Memberu Getachew
2. Hagos Godefay
3. Nega Assefa
4. Sibhatu Biadgilign
5. Bisrat H/mariam
6. Amare Deribew
7. Berhane Haileselassie
8. Dawit Seyoum
9. Tenaw Andualem
10. Tseganesh Amsalu
11. Gudian Egata
12. Wondwossen Melaku
13. Solomon Abera
14. Biruk Tensou
15. Tadesse Liqidi
16. Chalachew Teshale
17. Yisahak Abraham
18. Surafel Fantaw
19. Tewabech Bishaw
20. Tibebe Akalu
21. Tilahun Negate

22. Addisu Gize
23. Shirega Minuye
24. Tegbar Yigzaw
25. Diriba Yadesa
26. Araya Abrha
27. Tadesse Alemu
28. Anemaw Asrat
29. N. Indra Senam
30. Mulugeta Tarekegn
31. Belay Bezabeh

Annex V Conference Program

Monday, October 26, 2009		
7:30-8:30	Registration	
8:30-10:30	Opening Ceremony	Dr. Solomon Worku V/President, EPHA
	Master of the Ceremony	
	Welcome Address	Dr. Mengistu Asnake, President, EPHA
	Keynote Address	
	Opening Address	
	EPHA Award	Dr. Mengistu Asnake, President of EPHA
10:30-11-00	Morning Break	
11:00-11:45	Road Traffic Accidents as a Major Public Health Concern in Ethiopia Position paper	Moderator: Dr. Mengistu Asnake Panelist: Dr. Kunuz Abdela, WHO Sr. Tsige Kebede(survivor) Ato Samuel Hailu, FMoH Ato Abebe Asrat, NRSCO - Dr. Mengistu Asnake (EPHA)
11:45-12:30	Discussion	
12:30-14:00	Lunch Break	
14:00-14:45	Nutrition	Moderator: Dr. Zewdie Woldegebriel Panelist: Dr. Belaynesh Yifru, MoH Dr. Iqbal, UNICEF Dr. Cherinet Abuye, EHNRI Dr. H/mariam Legesse, ESHE
14:45-15:30	Discussion	
15:30-16:00	Afternoon Break	
16:00-17:30	Poster Presentation and Exhibition	
Tuesday, October 27, 2009		
8:30-9:30	Adolescent and Youth Reproductive Health	Moderator: Panelist: Dr. Solomon Emeyu, FMoH Dr. Michael Dejenie S/r. Worknesh Kereta, Pathfinder MoE (TBA)
9:30-10:00	Discussion	
10:00-10:30	Morning Break	
10:30-12:30	Concurrent Session **Room A**: Health Service	Moderators: Dr. Hailu Yeneneh

	Room B: Child Health	Ato Tiruneh Sineshaw
12:30-14:00	Lunch Break	
14:00-15:30	Concurrent Session **Room A**: RH **Room B:** HIV/AIDS and TB	Moderators: Dr. Mesganaw Fantahun Dr. Tesfaye Bulto
15:30-16:00	Afternoon Break	
16:00-17:30	Business Meeting	Moderator:
18:00-22:00	Social Evening Dinner at Shalla Park	
Wednesday, October 28, 2009		
9:30-10:20	HIV/AIDS	Moderator: Dr. Betru Tekle Panelist: Dr. Zelalem Gizaw Dr. Afework Kassa, FHAPCO Kris/Alti
10:20-11:00	Discussion	
11:00-11:30	Morning Break	
11:30-12:30	Concurrent Session **Room A:** Biomedical **Room B:** Malaria and Environmental Health **Room C:** Road Traffic Accidents and Mental Health	Moderator: Dr. Amha Kebede Dr. Agonafer Tekalegn Dr. Abera Kume Dr. Bahiru Bezabeh Dr. Mesfin Araya
12:30-14:00	Lunch Break	
14:00-14:50	Tobacco	Moderator: Laureate Prof. Tirusew Teferra Panelist: Dr. Solomon Bogale, AAU Ato Addisalem Sema, DACA Ato Bekele Tefera, WHO Assefa Berihun, DU
14:50-15:20	Discussion	
15:20-15:50	Afternoon Break	

Oral Presentation

Tuesday October 27, 2009

Time: 10:30-12 Rooms: A

Health Service

Promoting Cochrane collaboration activity in Ethiopia through an African Cochrane Network
Dr. Omar Ahmed Abdulwadud

Utilization of Health Information System at district level in Jimma zone Oromia Regional State, South West Ethiopia
Sultan Abajebel

Assessment of information use in patients referral system at Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia
Biruk Abate

Trend in cancer deaths in Addis Ababa from 2001 to 2008
Tolcha Kebebew

Modeling trends of health and health related indicators in Ethiopia (1987-2000EC): A Time series study
Mulu Abraha

Health seeking behavior of households and determining factors in Kersa woreda, Eastern Hararge, Eastern Ethiopia
Tamirat Gebru

Epidemic dropsy in Addis Ababa
Ashenafi Assefa

Child Health

Room: B

Interventions in the workplace to support breastfeeding for women to support breastfeeding for women in employment (Cochrane systematic relieve)
Dr. Omar Ahmed Abdulwadud

Cereal and its production in Ethiopia: how safe are they?
Bisrat H/Mariam

Factors affecting adherence to executive breastfeeding practices in Ambo Town and Ambo Woreda
Lense Gobu

Oral Presentation

Time: 10:30-12

Room:B

Assessment of knowledge and practice of polloi vaccination in Gambella Region
Filimona Bisrat

Birth spacing and risk of child mortality at kalu district, South Wollo zone of Amhara regional state, Ethiopia
Muluneh Yigzaw

Time: 14:00-15:30 **Room: A**

Reproductive Health

Bringing their method of choice to rural women community based distribution of inject able contraceptive in Tigray, Ethiopia
Nodla Prata, Amanuel Gessessew

Emergency obstetric intervention by non-physician clinicians experience of task shifting to improve materials health Tigray Region
Amanuel Gessesew

Emergency Contraceptives utilization and influencing factors among Adama University female under graduate students, South East Ethiopia
Dejene Tilahun

Domestic Violence against women (DVM in Kersa District Eastern Hararge, Oromia, Eastern Ethiopia
Wondimu Shanko

Prevalence of unwanted pregnancy Abortion and preference for health care usage among women of Reproductive age in Kersa District Eastern Hararge Oromia, Eastern Ethiopia
Wondimu Shanko

Oral Presentation

[illegible], Oromia, Eastern Ethiopia
Wondimu Shanko

Factors Associated with indused abortion in Bahir-dar city: A case control study
Belete Tafesse

Oral Presentation

Time: 14:00-15:30

Tuberculosis **Room: B**

Ethiopia prevalence of common possible bacterial pathogens among pulmonary TB suspected sear negative patients
Bisrat H/Mariam
Time: 14:00-15:30

HIV/AIDS **Room: B**

In vitro susceptibility of Canada isolates from oral cavities of HIV/AIDS patients to the commonly used antifungal agents in Jimma University
Nasir Tajure

Selected micronutrients and response to highly active antiretroviral therapy (HAART) among HIV/AIDS patients attending St. Paul's General Specialized Hospital, Addis Ababa, Ethiopia
Amare Eshetu

Adult AIDS mortality trends in Addis Ababa
Daniel S. Telake

Assessment of predictors of survival inpatient living with HIV/AIDS after advent of HAART, Addis Ababa
Abdu Bedru

Assessment of the status, shortcomings and prospects of care and support service provide to PLWHAS by care and support providing firms in Arbaminch Town and nearby areas
Tadesse Alemu

Oral Presentation

Wednesday October 28, 2009

Time: 10:30-12:30 Room: A

Biomedical

Antimicrobials use resistance and containment baseline survey: Anti microbial use, resistance and containment practices in health facilities in Ethiopia
Tenaw Andualem

Establishment of biochemical reference values of commonly requested liver function tests for apparently health adult Ethiopian Medical Students
Samuel Kinde

Performance assessment of clinical microbiology laboratories in Ethiopia: bacterial identification and antibiotic susceptibility testing
Surafel Fantaw

Reference values of serum urea and creatinine in apparently healthy

Feyissa Challa

Bacteriological analysis of infected leprosy ulcers in alert, kuyera and Gambo hospitals, Ethiopia
Tsehaynesh Lema

Time: 10:30-12:30 **Room: B**

Malaria

Chlorogquine-resistant plasmodium vivax malaria in Debre-zeit Ethiopia
Hiwot Teka

Therapeutic Efficacy of Artemether, Lumefantrine (Coartem) against plasmodium falciparium in Kersa, South West Ethiopia
Ashenafi Assefa

The prevalence of HIV/Malaria Co-infection during pregnancy in Adama Hospital and Awash Sebat kilo Health Center, Ethiopia
Heven Sime

Oral Presentation

Time: 10:30-12:30 **Room: B**

Environmental Health

Knowledge, Attitude & practice of KOKA flower farm spray workers towards agro chemical handling, application and safety measure in KOKA town, East Shoa, Oromia Region
Birhanu Cheneke

Community based survey on household management of waste in Kersa Demographic surveillance and health research center (kds-HRG) field site
Bezatu Mengiste

Time: 10:30-12:30 **Room: C**

Road Traffic Accidents

Road Traffic accidents in Addis Ababa (2001-2008)
Tekebash Araya

Mental Health

Common mental disorders among HIV infected adults in Ethiopia
Markos Tesfaye

Poster Presentation

Date

Time: Room:

Factors affecting fertility decisions of married men and women living with HIV in South Wollo zone, Northeast Ethiopia
Memberu Getachew

The importance of ANC risk scoring in predicting delivery out comes in Tigray Region, A cohort Study
Hagos Godefay

Role of husbands on contraceptive usage in Kersa District, Eastern Hararge zone, East Ethiopia
Nega Assefa

Epidemiological analysis in treatment outcome of tuberculosis in rural South West Ethiopia: A retrospective cohort study
Sibhatu Biadgilign

Antimicrobial resistance of Bacterial isolated from seam negative pulmonary TB suspected patients visiting St. Peter TB specialized
Bisrat H/Mariam

Malaria & anemia in vulnerable groups, baseline result of cluster randomized trial
Amare Deribew

Assessment of malaria control interventions in pastoralist community of Afar people, Northeast Ethiopia
Berhane Haileselassie

Paying from poverty impoverishing health care expenditure
Dawit Syoum

Anti-microbial use, resistance and containment baseline survey: course content reviles on antimicrobials resistance prevention and containment of health professionals training
Tenaw Andualem

Poster Presentation

Date

Time: Room:

Anti-microbial use, resistance and containment baseline survey: bacteriological culture and sensitivity retrospective records review
Tenaw Andualem

Assessment of caregivers child feeding behaviors in Derashe special woreda, Southern Ethiopia
Tseganesh Amsalu

Determinants of acute malnutrition among children under five years of age: A case study in Haranya woreda, East Haraghe Zone, East Ethiopia
Gudian Egata, Haji Kedir

Lipid profiles of HIV/AIDS patients and the effect of combination anti-retroviral therapy cross-sectional study in Jimma University specialized hospital
Wondwosen Melaku

Bacteriological quality of drinking water sources, cross sectional study in serbo town Jimma Zone, South –West Ethiopia
Solomon Abera

Differentials of AIDS mortality evidence form, Addis Ababa, Ethiopia
Biruk Tensou

Prevalence of human immune deficiency virus-1 (HIV-1) infection in newly diagnosed TB patients in Adama Hospital, Ethiopia
Tadesse Liqidi

Antimicrobial effects of the extract of some: selected Aromatic Medicinal Plants
Chalachew Teshale

Bacteriology of compound (open) fracture wounds in Tikur Anbessa University Hospital, Addis Ababa, Ethiopia
Yisahak Abraham

Poster Presentation

Date	
Time:	Room:

Prevalence of bacterial otitis infection, isolates and anti-microbial susceptibility pattern
Surafel Fantaw, EHNRI

Strategies to enhance diaspora participation in national development
Tewabech Bishaw

Economic burden of health care at household level examination of out of pocket expenditure on sexual and reproductive health care
Tibebe Akalu

Cost effectiveness analysis of clinical specialist outreach in Ethiopia: an economic evaluation

Tilahun Negate

Assessment of patient satisfaction on the laboratory services in Jimma University specialized Hospital and Jimma Health Center
Addisu Gize

Assessment of utilization of community participatory mapping in HIV/AIDS interventions in Ethiopia
Shirega Minuye

Strengthening the education of health care providers to improve public health in Ethiopia
Tegbar Yigzaw

Knowledge of Adolescent Reproductive Health and related reproductive behavior of among adolescents in Kersa
Nega Assefa, Gudina Egata

Cosmetics utilization pattern and common cosmetics related adverse reactions among female students of Mekelle University, Northern Ethiopia
Diriba Yadesa

Poster Presentation

Date

Time: Room:

Acceptability of provider-initiated HIV counseling and testing (PIHCT) among adult out patient department clients visiting hospitals in Tigray Region, Ethiopia
Araya Abrha

Effects of social stigma and discrimination on care seeking behavior of PLWHAS, in Arbaminch town and surrounding areas, Southern Ethiopia
Tadesse Alemu

Assessment of sexual risk behavior of in-school youth: effect of living arrangement of students, west Gojam zone, Amhara Regional state, Ethiopia
Anemaw Asrat

Road accidents in Ethiopia-A common cause of worry for all concerned
N. Indra Senam

Attitude and Practice of Medical Faculty students Jimma University on Self Medication
Mulugeta Tarekegn

A field investigation of safety belt usage, Addis Ababa, Ethiopia-2009

Belay Bezabeh

Annex VI
Conference Evaluation Feedback and Result

As part of the conference activity the conference evaluation form were prepared and distributed to be filled by volunteer members at the end of the conference day. Accordingly 150 members filled the form and submitted to EPHA. The results of the evaluation after it is analysed is summarized below.

Out of 150 participants who fill the EPHA evaluation form 122 were males and 28 were males. Most of (81.3%) the participants were coming from Addis Ababa and the rest 18.7 % were from other regions. 40% of the participants work in governmental organizations which primarily engaged in health and health related activities; 20% of the participants work in non-governmental organizations working in health and health related activities; 20% of the participants were students who were studying health and health related subjects; the rest of 20% of the participants were other professionals working in private health and health related activities and no health related activities. Profession wise as expected majority of them (98.6%) have health and health related profession (Table 1).

Table 1: Distribution of Participants by background characteristics

Background characteristics	N	%
Sex		
Male	122	81.3
Female	28	18.7
Region		
In Addis Ababa	122	81.3
Out of Addis Ababa	28	18.7
Type of Work		
NGO health	22.0	14.7
NGO health related	8.0	5.3
NGO non-health	2.0	1.3
Gov't health	52.0	34.7
Government health related	8.0	5.3
Private health	10.0	6.7
Private health related	2.0	1.3
Student health	26.0	17.3
Student health related	4.0	2.7
Other	14.0	9.3
Profession		
Health	140	93.3
Health related	8	5.3
Non-health	2	1.3
Ever participated		
Yes	80	53
No	66	44
Missing	4	3
Total	150	100%

The 19th EPHA's Annual conference was one of the conferences which have a relatively higher number of new participants. From the participants 44% of them were new comers and 53% have already experiences EPHA conferences at least once (Table 1).

Figure 1 describes the medium through which the participants got information about the EPHA annual conference. Accordingly majority (50.7%) of them got information through

their or related postal addresses. Other means including friend's information and phone contribute to 22.7%. The rest 14.7 % of them got information about the conference through their Email (Fig.1).
It was also observed that, 33.3% of the participants were regular participants of the EPHA conference however 28% of the participants were either rarely or sometimes attending the previous EPHA conferences (Fig.2).

Fig 1. Medium through which participants got information about the Conference

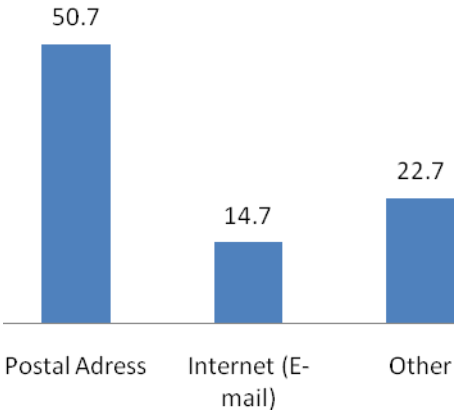
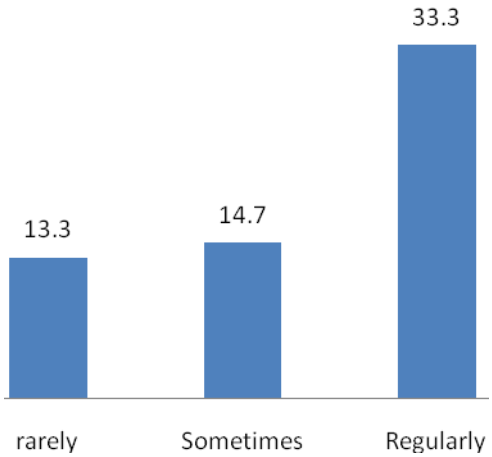
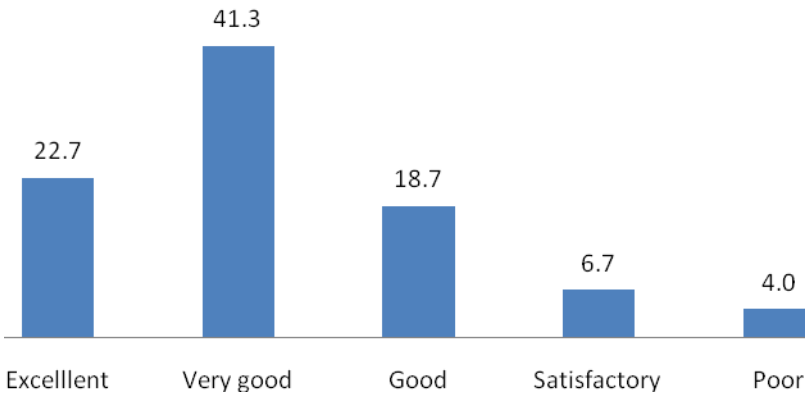


Fig 2. How Often do you Participate in the EPHA Conference



Most of them (95%) of the participants were very happy with the venue of the 19th EPHA conference however the rest 5% of the participants were unhappy by the venue of the conference that was held in Hilton Hotel, Addis Ababa. They would rather prefer other regions out side Addis Ababa to hold the conference.
Regarding the timing of the invitation to paper presenters and participants, majority (64%) of them responded that the timing was very good or excellent. But 10.7 % of them responded that the timing of invitation to paper presenters was either satisfactory or poor (fig 3).

Fig 3. Timing of invitation to paper presenters and participants



The quality of papers and presentations of the 19th EPHA conference was also another important element for conference evaluation. Accordingly, even though most of (70.7 %) the participants responded as the quality of the papers were very good or excellent; there are still some participants (22.7%) who have some reservations on the quality of the papers presented. Similar distribution was also observed about the quality of presentations i.e. except 25.3% of the participants, 70.7% of them rate the quality of presentations as very good or excellent. Moreover, 88% of the participants believe that the discussions made after each presentation were well achieved (Table 2).

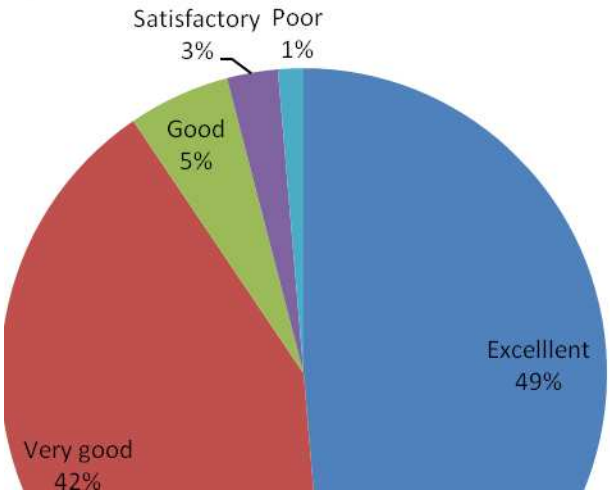
Table 2: Quality of papers and presentations of the 19th EPHA conference

	N	%
Quality of Papers		
Excellent	24	16.0
Very good	82	54.7
Good	30	20.0
Satisfactory	4	2.7
Quality of Presentations		
Excellent	24	16.0
Very good	82	54.7
Good	30	20.0
Satisfactory	8	5.3
Achieved with discussion?		
Yes	132	88.0
No	10	6.7
Were you happy with the topics of each session		
Yes	138	92
No	6	4
Total	150	100.0

Overall Assessment the EPHA evaluation

Finally the participants have been requested to rate how successful the 19th EPHA conference was? In response to this question almost half of the participants responded that the organization process of the 19th EPHA conference was excellent; 42% of the participant's rate it as it was organized in a very good way; 5% rate it as good. Only 4% of the participants rate it as satisfactory or poor (Fig 4). This implies that the 19th EPHA conference has been was very well achieved.

Fig 4. How sucessful was the 19th EPHA conference



Recommendations of the 19th EPHA Conference Evaluation

After coming across with the evaluation of the conference the following basic recommendations were forwarded:

1. The conference benefited several related governmental and nongovernmental organizations, researchers, students and other collaborating bodies;
2. Quality of papers to be presented in EPHA conference has to be a little bit improved. In this regard better selection mechanisms for the papers to be presented has to be made to improve the quality of the papers;
3. The EPHA website should be improved in a way that it could alert every member about EPHA conference and other related issues through their emails;
4. As part of the package EPHA shall better work in providing travel awards for selected poster and paper presenters to encourage researchers in the area;
5. Special promotion has to be made to recruit new member from other regions and to participate the already existing members in EPHA conferences. Since most of the members and/or conference participants from other regions (outside Addis Ababa) were rare and have been rarely participating in EPHA's annual conferences.