DOWNLOAD PDF HEALTH SERVICE COVERAGE IN ETHIOPIA

Chapter 1 : WHO | World Health Organization

Health in Ethiopia has improved markedly since the early s, with government leadership playing a key role in mobilizing resources and ensuring that they are used effectively.

It envisions reaching universal health coverage by The prioritized initiatives are mobilizing adequate resources mainly from domestic sources, reducing out-of-pocket spending at the point of service use, enhancing efficiency and effectiveness , strengthening public private partnership and capacity development for improved health care financing. To operationalize the strategy, various reform measures were implemented. Purchasing of services[edit] While mobilizing sufficient public resources and organizing pooling to maximize re-distributive capacity are essential for achieving equitable and affordable health care access for all, it is of equal importance that collected resources be efficiently used in order to maximize and sustain the provision of benefits for the population. Strategic use of the purchasing function is the key health financing instrument for this purpose. The main purchasers of health service in Ethiopia are: There is fee waiver system to covers Indigents but with various challenges in implementation. The number of fee waiver beneficiaries has reached two million. History[edit] Throughout the s, the government, as part of its reconstruction program, devoted ever-increasing amounts of funding to the social and health sectors, which brought corresponding improvements in school enrollments, adult literacy , and infant mortality rates. These expenditures stagnated or declined during the â€" war with Eritrea , but since outlays for health have grown steadily. In the country counted one hospital bed per 4, population and more than 27, people per primary health care facility. The physician to population ratio was 1: Overall, there were 20 trained health providers per , inhabitants. Health care is disproportionately available in urban centers; in rural areas where the vast majority of the population resides, access to health care varied from limited to nonexistent. Its major themes focussed on: Democratization and decentralization of health system; Expanding the primary health care system and emphasizing preventive, promotional, and basic curative health services; and Encouraging partnerships and the participation of the community and nongovernmental actors. A polio vaccination campaign for 14 million children was carried out. In the government launched the Health Extension Program intended to provide universal primary health care coverage by This included placing two government-salaried female Health Extension Workers in every kebele , with the aim of shifting the emphasis of health care to prevention. About 2, completed their training by the end of at 11 technical and vocational education centers, while 7, were still in training in , and over 30, were expected to complete their training by However, these trainees encountered a lack of adequate facilities, including classrooms, libraries, water, and latrines. The selection of trainees was flawed, with most being urban inhabitants and not from the rural villages they would be working in. Reimbursement was haphazard as trainees in some regions did not receive stipends while those in other regions did. There were hospitals 12 in Addis Ababa alone and health centers in Ethiopia in These problems are exacerbated by the shortage of trained manpower and health facilities. It is a community-based intervention designed to make basic health services accessible to the rural and underserved segments of the population. Services are organized along geographic lines with construction of a comprehensive network of primary health care units throughout the country with one health post in every rural kebele of people linked to a referral health center. A health post is a two-room structure of most peripheral health care unit and the first level for the provision of healthcare for the community, emphasizing preventive and promotive care. Model households who have been trained and graduated have reached a cumulative total of 4,, from an eligible total of 15,, households. Equipping Health posts with medical kits remained a major challenge. Supportive supervision technical, reference books for rural HEP and manuals for school health program were prepared. An implementation Manual for Pastoralist and semi-pastoralist areas was finalized and distributed to respective regions. The focus is disease prevention and health promotion, with limited curative care. It is the healthcare service delivery mechanism of the people, by the people, and for the people by involving the community in the whole process of healthcare delivery and by encouraging them to maintain their own health. The program involves women in decision-making processes and promotes community ownership,

empowerment, autonomy and self-reliance. Ethiopia has come a long way in improving the health status of its people as evidenced by the achievement of most health related Millennium Development Goals. The second generation rural plan will include: In cities and urban areas, the Family Health Team approach will be introduced. The team will be composed of clinicians, public health professionals, environmental technicians, other health professional, social workers and health extension professionals to provide services for urban dwellers. Following a deeper and systematic analysis of the "as is" situation at all levels of the health system, including health facilities, the sector has brought in innovative approaches including, benchmarking best practices, redesign new processes, revising organizational structures and a selection of 8 core process and 5 support processes.

Chapter 2 : Healthcare in Ethiopia - Wikipedia

The graphic above depicts the three-tier structure of the Ethiopian health system. The secondary and tertiary levels are comprised of general and specialized hospitals, and the coverage of each extends to larger portions of the population.

By Abebe Alebachew Proper health care service helps citizens enjoy their constitutional rights The World Health Organization defines universal health coverage UHC as a situation in which all people who need health services receive them, without incurring financial hardship. UHC is currently perceived as a crucial component of sustainable development and listed as one of the possible goals of the post development agenda. It aims at informing the Ethiopian government as it develops its own UHC strategy and eventually implements such policies. Ethiopia has not yet promulgated an official definition of UHC, although numerous strategies, policies, and guidelines are being implemented to achieve universal access to primary health care and reduce impoverishment due to health spending. Existing strategies remain fragmented across health care services and financing mechanisms. Among the 61 proposed indicators that were explored in this article to measure UHC, our review indicated that 28 are collected in Ethiopia through surveys and 14 are recorded and reported through the health management information system HMIS or other administrative sources. Ethiopia measures most of the major service coverage indicators related to reproductive, maternal, and child health and key infectious disease services using routine information systems and population-based surveys. Yes, the country has shown significant progress in reducing under-five, infant, and neonatal mortality rates over the last decade. According to the latest United Nations report, Ethiopia has achieved the Millennium Development Goal MDG goal of reducing child mortality well ahead of its deadline. Trends in childhood mortality rates deaths per 1, live births. Immunization rates and the delivery of other child health services have improved substantially since However, coverage trends have been mixed for maternal and reproductive health services; the maternal mortality ratio has registered no significant change since the Demographic and Health Survey DHS. Trends in maternal mortality ratios maternal deaths per , live births. The total number of health care facilities, particularly primary care centers, has increased nearly fold since and distribution on a per capita basis is largely equitable; on the other hand, secondary and tertiary level service capacity has not improved significantly. This shortage has been one factor leading to socioeconomic disparities in the access to and utilization of hospital level health services; other factors include costs and geographical barriers. The largest improvements in service coverage between and occurred among the wealthiest households. Ethiopia is moving to expand financial protection through various financing initiatives. A social health insurance law was recently passed and a national health insurance agency established. Pilot community-based health insurance schemes have also been initiated. Local stakeholders expressed a preference for indicators that are more programmatically relevant to their context and less resource-intensive to collect. Countries like Ethiopia should be assisted in defining and developing UHC strategies; technical support should also be given to build their capacity to collect, analyze, and use routine and survey-based information. Such capacity in Ethiopia is growing but still limited, and this has negatively impacted the quality and availability of data. As learnt from studies, contracts for complex healthcare services are being increasingly promoted and adopted in low- and middle-income countries LMICs. Many governments, along with some development agencies and international financial institutions, are promoting the use of a specific form of public-private partnership PPP in which the responsibility to provide health care assets and services is contracted out to a private consortium in a single transaction. Because of the complex and capital-intensive nature of such contracts, as well as their multi-decade duration, they are likely to pose particular challenges for LMIC governments with limited fiscal and institutional capacity. To contact the copyright holder directly for corrections â€" or for permission to republish or make other authorized use of this material, click here. AllAfrica publishes around reports a day from more than news organizations and over other institutions and individuals , representing a diversity of positions on every topic. We publish news and views ranging from vigorous opponents of governments to government publications and spokespersons. Publishers named above each report are responsible for their own content, which AllAfrica does not have the legal right to edit or correct. Articles and commentaries that

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Chapter 3 : Ethiopian Health System - Health Care in Ethiopia Health Care in Ethiopia

The financing of health care services in Ethiopia is made by government and donors/ partners (grants), user fees, insurance and community contributions. The government contributes approximately 55% of the annual health budget, while donors contribute % and user fees amounts to %.

The total land area of the country is 1,, square kilometers. The capital city of Ethiopia is Addis Ababa, which is situated near the center of the country. Ethiopia is located very close to the equator, weather is generally tropical; however, temperatures vary according to the altitude. The lowlands are generally hot and humid while the temperatures in the Ethiopian Highlands are cooler. The dry season runs from October to May, while the rainy season lasts from mid-June to mid-September. Ethiopia is the only African country that had never been fully colonised, because of this, the country has managed to retain its unique culture. It has its own script and language and maintains a strong sense of national identity. The country is full of beautiful mountains and landscapes. It is accountable for preparing, publishing and distributing the national standards for health posts, health centers and district hospitals in the country. Ethiopia is a poor country and the infrastructure of the healthcare system is weak. The Government is the main healthcare service provider but the coverage and distribution of the healthcare facilities among regions are uneven. There is a lack of access to basic healthcare facilities in rural areas. Primary healthcare in Ethiopia is provided by facilities including health centers and health posts. In terms of hospitals, both public and private hospitals are available in Ethiopia. The total expenditure that the Government spent on healthcare in Ethiopia is around 4. Widespread diseases in Ethiopia include malaria, tuberculosis, syphilis, gonorrhea, leprosy, dysentery, and schistosomiasis. The health status in Ethiopia is poor; this is mainly due to the circulation of communicable diseases caused by poor sanitation and nutritional deficiencies. On top of that, there is a shortage of trained medical personnel in the healthcare system. It is advised that travellers to obtain appropriate vaccinations and medications prior to travelling to Ethiopia. Medical personnel in Ethiopia receive low wages, for this reason, the majority of them often seek out second jobs to make ends meet. This has resulted to frequent absenteeism in medical staff. The management is reluctant to challenge the physicians over their frequent absences from work as well as their tendencies to take long breaks and arrive late at work. Lower level workers have followed the same behaviour as the physicians, leading to high absenteeism and low productivity at all levels. Corruption exists in the healthcare sector in Ethiopia, which involves procurement, services and supply of goods and medicines. The lack of medical staff and the corruption that often diverts investments that should be going into building a more robust medical system has a knock on effect on the healthcare system, increasing the probability of unsatisfactory healthcare outcomes. The standard of the healthcare system in Ethiopia is far below the standards generally set in western countries. For visitors and expatriates who prefer to have a sense of security and to ensure that medical costs will be covered in the event of an accident or illness while travelling to Ethiopia, purchasing a comprehensive travel insurance policy or an expat medical insurance plan will be the best solution for you. A global medical insurance policy that covers for medical evacuation to a healthcare facility that can provide the necessary medical care would be recommended. Ethiopia International Health Insurance Globalsurance is a one-stop insurance brokerage service provider for you when travelling to the Ethiopia. We offer a wide range of policies to meet your individual needs, including benefits such as dental, maternity, inpatient, outpatient, specialist consultations, and many others. We offer a large variety of international health insurance plans as well as travellers insurance plans. Contact our professional advisers today to enjoy full insurance protection such as an Expat Health Insurance Plan for yourself and your family.

Chapter 4 : Essential Health Services: Ethiopia - HFG

Ethiopia - Universal health coverage for inclusive and sustainable development: country summary report (English) Abstract. A low-income country, Ethiopia has made impressive progress in improving health outcomes.

However, there has been encouraging improvements in the coverage and utilization of the health service over the periods of implementation of Health Sector Development Plan, the health chapter of the national poverty reduction strategy, which aims to increase immunization coverage and decrease under-five mortality at large. The HEP is designed to deliver health promotion, immunization and other disease prevention measures along with a limited number of high-impact curative interventions. Ethiopia had the lowest level of expected human capital among the 20 largest countries with less than 5 health, education, and learning-adjusted expected years lived between age 20 and 64 years. This put it in th place, an improvement over its position in when it was th. The effort to control tuberculosis began in the early 60s with the establishment of TB centers and sanatoria in three major urban areas in the country. From the very beginning the CO had serious problems in securing sufficient budget and skilled human resource. In , a well-organized TB program incorporating standardized directly observed short course treatment DOTS was implemented in a few pilot areas of the country. An organized leprosy control program was established within the Ministry of Health in , with a detailed policy in This vertical program was well funded and has scored notable achievements in reducing the prevalence of leprosy, especially after the introduction of Multiple Drug Therapy MDT in This has encouraged Ethiopia to consider integration of the vertical leprosy control program with in the general health services. This finding indicates that the actual TB prevalence and incidence rates in Ethiopia are lower than the WHO estimates. Additionally, the survey showed a higher prevalence rates for smear positive and bacteriologically confirmed TB in pastoralist communities. However, pertaining to its methodology, the survey did not produce further disaggregated sub-national estimates. Maternal and child health[edit] Maternal and child health program is a priority agenda of the government of Ethiopia and this has been clearly indicated on the currently being implemented strategic plan of the FDRE Ministry of health. Though Maternal and child health program is still one of the target area which needs much organized, systematic and focused effort, clear progress has been witnessed over years as per the Demographic health survey report of the country. The recent DHS [1] in the country shows these steady changes. Maternal health status could be assessed with many indicators of which Modern contraceptive use, skilled delivery and maternal mortality are some of the majors. Modern contraceptive use by currently married Ethiopian women has increased over 15years prior to the DHS. The total fertility is declining but the changes are not that significant. The pregnancy related mortality has also dropped over the last three surveys and this could be attributed to the improvement on skilled delivery and family planning. The fact that Ethiopia is on the verge of eradicating polio could be a good evidence for that. Childhood mortality has declined substantially since However, the change in neonatal mortality is not significant compared to post neonatal and child mortality. Reducing child mortality MDG 3 has been achieved previously and if the effort is maintained the target of decreasing the under-five mortality to 25 could be met by the end of the target. Traditional medicine[edit] The low availability of health care professionals with modern medical training, together with lack of funds for medical services, leads to the preponderancy of less reliable traditional healers that use home-based therapies to heal common ailments. High rates of unemployment leave many Ethiopian citizens unable to support their families. In Ethiopia an increasing number of "false healers" using home-based medicines have grown with the rising population. However, only about ten percent of practicing healers are true Ethiopian healers. Much of the false practice can be attributed to commercialization of medicine and the high demand for healing. Both men and women are known to practice medicine from their homes. It is most commonly the men that dispense herbal medicine similar to an out of home pharmacy. Before the onset of Christian missionaries and Medical Revolution sciences, traditional medicine was the only form of treatment available. Traditional healers extract healing ingredients from wild plants, animals and rare minerals. AIDS, malaria, tuberculosis and dysentery are the leading causes of disease-related death. Largely because of the costs, traditional medicine continues to be the most common

form of medicine practiced. Many Ethiopians are unemployed which makes it difficult to pay for most medicinal treatments. Many physical ailments are believed to be caused by the spiritual realm which is the reason healers are most likely to integrate spiritual and magical healing techniques. Traditional medicinal practice is strongly related to the rich cultural beliefs of Ethiopia, which explains the emphasis of its use. The first is attributed to God or other supernatural forces, while the other is attributed to external factors such as unclean drinking water and unsanitary food. Most genetic diseases or deaths are viewed as the will of God. Miscarriages are thought to be the result of demonic spirits. Nearly four out of five Ethiopian women are circumcised. There are three levels of circumcision that involve different degrees of cutting the clitoris and vaginal area. Many of these practices are done with an unsanitary blade with little or no anesthetics. It can result in heavy bleeding, high pain, and sometimes death. Today there are three medical schools in Ethiopia that began training students in two of which are linked to Addis Ababa University. Although there have been huge leaps and bounds in medical technology there is still a large problem in the distribution of medicine and doctors in Ethiopia.

Chapter 5 : Home | Universal Health Care

The major components of the Essential Health Services Package for Ethiopia are classified building on the Health Service Extension Program, which was launched in as an essential health services package at the community level, in recognition of the failure of essential services to reach remote communities in the country.

Health profile General health indicators The health status of Ethiopia is poor, even when related to other low-income countries including those in sub-Saharan Africa. The population suffers from a huge burden of potentially preventable diseases such as HIV, malaria, tuberculosis, intestinal parasites, acute respiratory infections and diarrhoeal diseases. The health indicators are generally poor, though there are improvements observed. Statistics on hospital admissions are not readily available. Other conditions responsible for admission include tuberculosis, malaria, respiratory infections, trauma, pregnancy-related conditions and complications of measles. Determinants of ill health Poverty: Lack of access to safe drinking water: Bacillary dysentery water borne disease affected 63, people in the same year with deaths same source. Lack of sanitation facilities: Disposal of waste is a particular challenge to the authorities at all levels and is not sufficiently addressed. High rate of migration: Large segments of the population are migrating for climatic, economic and social reasons and sometimes because of social unrest. According to the National Labour Force Survey, The health system is unable to provide health care for more than half the population. Much of the rural population has no access to any type of modern health care service. However, when there is physical access to the facility, it is reported that some facilities are staffed with health workers of low qualifications and drugs and clinical supplies are not available at many health facilities all of the time. There seems to be gross inequalities when it comes to access to health services amongst different regions of the country. Low agricultural productivity and recurring droughts contribute to nutritional deficiencies. The same survey found 3. These strategies served as a basis to elaborate implementation programs jointly with the regional owners and international partners. After presentation of these programs to a Consultative Meeting in , constructive advice was obtained and a plan of action was elaborated, creating favourable conditions for enhanced cooperation and joint implementation with technical assistance from a number of partners. These two documents define the objectives, the strategies, activities and the responsibilities of all actors at various levels. This is the sector-wide approach in action! The main objectives of the HSDP for the period are: Improve service quality through training and an improved supply of necessary inputs. Strengthen management of health services at federal and regional level. Encourage participation of the private sector and the NGO sector by creating an enabling environment for participation, coordination and mobilisation of funds. The five-year health program is designed to emphasize the preventive aspects of care and to develop comprehensive and integrated primary health care services. The focus is on communicable diseases, common nutritional disorders and environmental health and hygiene. In particular this program aims to support activities for improvement in reproductive health care, family planning, immunisation, control of epidemic diseases such as malaria and tuberculosis, and control of sexually transmitted diseases. The current vertical programs will be gradually phased out as capacity at woreda level increases. The proportion of health expenditure attributable to the utilization of the private health services both modern and traditional is not fully documented, but is believed to be considerable. The overall budget includes categories for capital development and recurrent costs. The per capita expenditure on health in Ethiopia is about USD 1. Health sector expenditures in Ethiopia have tended to emphasize on urban-based, curative services rather than rural-based, preventive primary health care services. The regions whose populations predominantly live in urban areas tend to have more budget allocation per capita than the predominantly rural counterparts. The budget allocated by the government to the health sector is highly inadequate and there is a considerable dependence on donors and other partners to supplement the resources of the MoH. However, there has been a corresponding increase in health expenditure on drugs and other non-salary items. The decrease in the proportion of health budget allocated to salaries may have led to the stagnation of salaries, leading to high attrition of staff. Health delivery system In , there existed a total of hospitals all denominations , health centres HC , 2, health stations HS , health posts HP and 1, private clinics in Ethiopia. There is no data

on the number of traditional healers available in the country, whose services many Ethiopian households use for various health problems. The population per primary health care facility is 27,, which is three times higher than in the rest of sub-Saharan Africa. The total number of hospital beds is 11,, which means that there is only one bed for a population of 4,, which is about five times lower than the average for sub-Saharan Africa. Currently as part of HSDP, the existing six-tier health care management system is being transformed into a four-tier system characterized by a PHC-unit 1 HC and 5 satellite HPs , the district hospital, zonal hospital and specialized hospital. The limited number of health institutions, the poor distribution of medical supplies among regions and the disparity between urban and rural areas are all responsible for the inaccessibility of health care services to the population. In Ethiopia, drugs that are required to reduce morbidity and mortality from common illnesses are mostly in short supply, the majority of which are imported and expensive. According to the mid-term review of the Health Sector Development Program, , problems related to essential drugs utilization include inadequate budget, weak drug supply system, poor logistic support for distribution and irrational drug use. The HCs are on average staffed by at least one medical officer, several nurses and health assistants who have 18 months basic health training , one laboratory technician and one pharmacy technician. At the average health station, there are three health assistant staff. The physician per population ratio is one per 48, and the nurse per population ratio is one per 12, one third and one sixth, respectively, of the average of the rest of sub-Saharan Africa. Overall there are 20 trained HWs per ,, a very low ratio even for sub-Saharan standards. There are presently 14 nursing schools in the country with an annual output of nurses. Based on the present number of trained health workers, a population growth rate of 2. The medical and nursing schools and training institutions for paramedical professionals are available in the country and do make attempts to increase the annual output of trained personnel to meet the demands. However, the quality of some trained manpower is believed to be unsatisfactory. An evaluation of the human resource system has been recommended by the mid-term review of the HSDP.

Chapter 6 : Health in Ethiopia - Wikipedia

Ethiopia is Africa's oldest independent country. It is the tenth largest country in Africa, covering 1,, square kilometres (with 1 million sq km land area and.

Received Mar 26; Accepted Sep This article has been cited by other articles in PMC. Abstract Reproductive health services are crucial for maternal and child health, but universal health coverage is still not within reach in most societies. When moving towards universal health coverage, health plans and policies require contextualized knowledge about baseline indicators and their distributions. To understand more about the factors that explain coverage, we study the relationship between socioeconomic and geographic factors and the use of reproductive health services in Ethiopia, and further explore inequalities in reproductive health coverage. Based on these findings, we discuss the normative implications of these findings for health policy. Using population-level data from the Ethiopian Demographic and Health Survey in a multivariate logistic model, we find that family planning and use of antenatal care are associated with higher wealth, higher education and being employed. Skilled attendance at birth is associated with higher wealth, higher education, and urban location. There is large variation between Addis Ababa the capital and other administrative regions. Concentration indices show substantial inequalities in the use of reproductive health services. Decomposition of the concentration indices indicates that difference in wealth is the most important explanatory factor for inequality in reproductive health coverage, but other factors, such as urban setting and previous health care use, are also associated with inequalities. When aiming for universal health coverage, this study shows that different socioeconomic factors as well as health-sector factors should be addressed. Our study re-confirms the importance of a broader approach to reproductive health, and in particular the importance of inequality in wealth and geography. Poor, non-educated, non-employed women in rural areas are multidimensionally worse off. The needs of these women should be addressed through elimination of out-of-pocket costs and revision of the formula for resource allocation between regions as Ethiopia moves towards universal health coverage. Electronic supplementary material The online version of this article doi: Reproductive health, Universal health coverage, Inequity, Concentration index, Ethiopia Introduction Although ethical, economic and democratic arguments highlight the importance of health and health investment, not everyone has access to the health services they need [1 â€” 3]. Universal health coverage UHC has recently been identified as crucial when seeking to improve health and strengthen health systems worldwide. Given resource constraints, this does not entail all possible services, but a comprehensive range of key services that is well aligned with other social goals [6]. A range of socioeconomic, geographic, and cultural factors influence health coverage, but which factors that contribute most differ between settings [7 , 8]. This information is necessary when making value judgements about whether the inequalities are unjust inequities, and relevant in academic and policy discussions about provision of health services and non-health services [5 , 9 â€” 11]. Ethiopia is a country with a very unequal distribution of health services [1]. Ethiopia is a low-income country in rapid transition, with high economic growth, positive improvement in development parameters, and impressive reductions in child mortality [13 , 14]. Reproductive health in Ethiopia The Ethiopian Demographic and Health Surveys of , , and showed that reproductive health coverage in general is very low in Ethiopia, but increasing [19 â€” 23]. Table 1 Coverage of reproductive health services Family Planninga.

DOWNLOAD PDF HEALTH SERVICE COVERAGE IN ETHIOPIA

Chapter 7 : Maternal, Neonatal and Child Health | Ethiopia | U.S. Agency for International Development

Ethiopia measures most of the major service coverage indicators related to reproductive, maternal, and child health and key infectious disease services using routine information systems and.

There are many reasons why women do not use health services in Ethiopia. Although the government just approved and promised to implement a national insurance plan, citizens have to pay out-of-pocket until the plan is established. Finding transport, a lack of money, and the distance to a health center are stated as the greatest barriers in accessing health services. Many are also concerned about arriving at a health center only to find there is no health worker or no drugs that they need. After spending the time and money, and taking off work, this is a legitimate concern that would deter anyone form seeking health care. Twenty-nine percent of women also worried about receiving permission to seek health The table below displays the statistics regarding barriers to health that women in Ethiopia cited DHS, , p. Employment and wealth contribute significantly to level of autonomy. Three out of ten women received no pay for their work, nothing And, although education is important as well, it is most valuable when it opens doors for employment for women. Women with the highest educational attainment and best reading abilities belong to the highest wealth quintile In the Demographic Health Survey, women with more than secondary education and women in the highest quintile reported the least barriers to accessing health care. Not only is policy in Ethiopia not gender-forward refer to the page on this blog for more information , but there is also a gap in the awareness of policies that do protect women. Furthermore, there is no feminist movement or ideological progression that speaks for gender equality in Ethiopia. In order for women to belive they have agency and power to make their own decision regarding health, they need to be empowered in addition to being economically dependent and educated. Women who believe that their husbands are justified in beating them for fewer reasons are also more likely to use contraception depicted in the table below, taken from the Dempographic Health Survery Women who are more empowered have more decision-making power and believe their husbands are less justified in beating them utilize other reproductive health services more often than women who are less empowered. The table below, taken from the Demographic Health Survey , represents this data p. Ethiopia demographic and health survey Ethiopia demographic health survey Federal Democratic Republic of Ethiopia. The criminal code of the federal democratic republic of Ethiopia, proclamation no. Retrieved November 14, , from http: The revised family code [Ethiopia], proclamation no. Venture Strategies Innovations, Inc. Accessed 5 December

Chapter 8 : Ethiopia Health Insurance | Globalsurance

health service delivery strategies of significant scale, namely: (1) provider-based strategies with a particular focus on various types of decentralization including fiscal decentralization and devolution of authority to subnational levels; (2) public oversight.

Chapter 9 : Global Health | Ethiopia | U.S. Agency for International Development

Coverage for reproductive health services is very low in Ethiopia. The majority of Ethiopian women do not make use of essential reproductive health care services. Coverage for family planning is 22 %; for antenatal care 22 %, and for skilled birth attendance 14 %.