

ETHIOPIA: THE COUNTRY, THE PEOPLE AND THEIR HEALTH

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Abstract

One of the oldest independent countries in the world, Ethiopia has remained a poor country due to repeated invasions by different phases of colonialism and cultural influence, with some successfully staved off but others succumbed to. Its own expansionist ambitions and colonial tendencies have brought it to war with her neighbours. A combination of war, poor management of the state, natural calamities, imbalanced international trade etc has left the country with poor indicators of health funding, health system performance, health status and gross inequality in resource distribution. At the end of 2004, only 36.5% of infants were fully immunised by 1 year, attendance of one visit of Ante Natal Care (ANC) services was 40.8%, assisted deliveries were 9.45%, Tetanus Toxoid immunization coverage for pregnant women was 31.9% and out-patient visits were 0.36 per person per year. There was one hospital bed per 5,300 people and yet the average Bed Occupancy Rate was 28.2%. Only 6% of the deliveries were attended by skilled workers and life expectancy at birth was 46 years. With increasing internally generated and externally generated tension, coupled with draconian response by the government, the author warns of a likelihood of worsening of the indicators.

Introduction

Ethiopia is one of the oldest independent states in the world. Her first inhabitants were Afro-Asiatic Cushitic and Omotic-speaking, thought to be in this land around 7,000 years BC. During the second century BC Semitic populations migrated from the Arabic Peninsula to the northern highlands of what is now Ethiopia and set the foundations of what became, at the beginning of the Christian era, the Kingdom of Aksum. Towards the end of the IV century AD the Christian religion was introduced in the Aksumite kingdom in its Byzantine Orthodox form. After overcoming an initial resistance, it took root and became an extremely important factor of social and political cohesion and identity. The spread of Islam, in the VI and VII century, threatened the survival of the Christian religion and of the kingdom. The kingdom reacted by isolating itself. In the famous words of the British historian Edward Gibbon, “... encompassed on all sides by the enemies of their religion, the Ethiopians slept nearly a thousand years, forgetful of the world by whom they were forgotten” (Gibbon, 1778).

Eventually, the Aksumite kingdom collapsed and was replaced by several smaller kingdoms that succeeded one to another. Some fundamental characteristics, however, remained unchanged: the importance of Christianity, the dominance of Semitic languages and a feudal system of ruling based on three castes: the warriors/rulers, the priests and the peasants.

Tewodoros and the making of modern Ethiopia

The XVII and XVIII centuries saw a sort of cultural and political renaissance but it was only in the mid XIX century that Tewodoros II succeeded in reuniting the kingdom and restoring the power of the monarchy. It is with Tewodoros that the modern history of Ethiopia starts. In 1896 the then Emperor Menelik II defeated the Italians who tried to invade Ethiopia. They managed to retain the territory of the present day Eritrea. Menelik went on to conquer more and more land in the south creating the present-day nation state of Ethiopia with its capital set in Addis Ababa (the New Flower) in 1889.

Haile Selassie

After having served as regent, a cousin of Menelik, Ras Tafari Makonnen, became Emperor and took the name of Haile Selassie I. He started an intense programme of western-inspired reforms that was stopped, in 1936, by a new invasion by the Italians, this time under the fascist rule of Benito Mussolini. Ethiopia being a member of the League of Nations, the Emperor appealed several times for protection and help but his appeals fell on deaf ears. Italy never controlled vast parts of the Ethiopian territory and her rule was short lived. In 1941 British and Commonwealth troops, together with militants of the Ethiopian resistance, defeated the Italians. Haile Selassie was reinstated as Emperor. The British ruled Eritrea until 1952, when it was joined to Ethiopia in the framework of a federal state. Ten years later, in 1962, Haile Selassie annexed Eritrea. The Eritreans had started their war for independence a year earlier, in 1961.

The Emperor put in place a much centralised system of government. Widespread poverty and the slow pace of reforms led to an attempted coup d'état. The coup was ferociously repressed by the army. Between 1973 and 1974 more than 200,000 people died of starvation in one of the most serious of the famines that periodically affect the country. A violent wave of discontent exploded in the main towns. The army stepped in.

Menghistu Haile Mariam

A group of young officers took power on September 12th 1974, deposing Haile Selassie, who died a few months later in circumstances never made clear. The country was ruled by a *Derg* (*Committee* in Amharic). In 1977 Colonel Menghistu Hailé Mariam took power as the head of the Derg. The Derg ruled in the name of Marxism. In reality, it was an extremely harsh military dictatorship. In the following years more than 2,500 opponents (or suspected opponents) of the regime, were imprisoned and killed in what became known as "*the red terror*". The Eritrean independence war went on against the Menghistu regime. Several liberation movements, mostly formed on a regional basis, sprang up and started a long civil war against the Derg. Between the end of 1977 and March 1978, Ethiopia was at war with Somalia which had invaded parts of the south east. She won the war thanks to the massive military help of the then Soviet Union and Cuba.

Between 1984 and 1985 Ethiopia was, once again, on the front pages of the world newspapers for yet another extremely serious famine. The western public

opinion was mobilised and huge amounts of international aid were sent to the country. To many observers it was perfectly clear that the government was making the famine worse and was using international aid to achieve internal political aims. Tens of thousands of people were forcibly moved, from Eritrea and Tigray, to desolated southern lands. Eritrea had been fighting her independence war for more than 20 years. Tigray was home to one of the most important and powerful guerrilla groups fighting the regime, the "*Tigray People's Liberation Front*" (TPLF). The political aims of the forced migration were, therefore, clear. Tens of thousands of people died, but the majority of the "humanitarian" organizations and foreign governments remained silent.

The fall of Menghistu

After the fall of the Soviet Union and the disappearance of its economic and military support, the Derg, too, collapsed. In May 1991 the troops of a coalition of several guerrilla groups, calling itself "Ethiopian People's Revolutionary Democratic Front" (EPRDF) captured Addis Ababa. It was headed by Meles Zenawi, the leader of the TPLF. Menghistu managed to flee the country. To date, he lives in a very comfortable exile in Zimbabwe. Eritrea put in place a provisional government waiting for a referendum on independence agreed upon with the EPRDF leadership. The referendum took place on May 24th 1993 and the independence option was opted for by virtually all the voters.

In December 1994 Ethiopia introduced a new Constitution. On its basis, the country became a Federal State divided into nine Regions formed on the basis of ethnicity and, at least theoretically, entitled to opt for secession if their people so wish. Negasso Gidada was named President and, Meles Zenawi, Prime Minister. The current President, Girma Wolde-Giorgis, replaced Gidada in 2001. The President is a mainly ceremonial role. Executive power lies in the hands of the Prime Minister.

In 1998, a disagreement over the correct position of their national borders led to a disastrous and bloody border war between Ethiopia and Eritrea. It lasted two years and cost at least 100,000 lives (about 70,000 of them Ethiopians) started. The disputed land being arid and non-arable, the war was aptly described by analysts as "two bald men fighting for a comb" (which none of them will use anyway). In June 2000, the two countries signed a truce followed, in December of the same year, by an agreement providing for: the withdrawal of Ethiopian troops from Eritrea, the

deployment of a United Nations peace keeping force and the formation of a United Nations Commission charged with studying and solving the border issue. Despite international arbitration, the two countries have not yet settled the border disagreement and the relations between them remain dangerously tense, threatening to continue through proxy unstable situations as that in Somalia.

May 15th 2005: the third multiparty elections

On May 15th 2005 about 26 million voters cast their votes to elect the 547 members of the Federal Parliament. After those of 1995 and 2000, these were the third multiparty democratic elections. Not everything went well. The opposition made huge gains, obtaining, according to the provisional results, 189 seats against the 12 it had in the previous legislature. Notwithstanding these gains, the opposition cried foul and filed legal complaints citing fraud in 299 of the 547 constituencies. There were riots in the capital, mainly by university students, and in other major towns. The repression was harsh and 36 people were reportedly killed. When the Electoral Commission made public the results of its investigations, on August 9th, the EPRDF remained with an overall majority in Parliament. The opposition rejected the verdict and the official results. On August 25th Ana Gomes, the Head of the European Union group of election observers, said that “*The EU Observation Mission regrets [that the election process] did not live up to the international standards and to the aspirations of Ethiopians for democracy*”. This was a blow to the reputation of the Ethiopian Government and cast a shadow on the stability of the country.

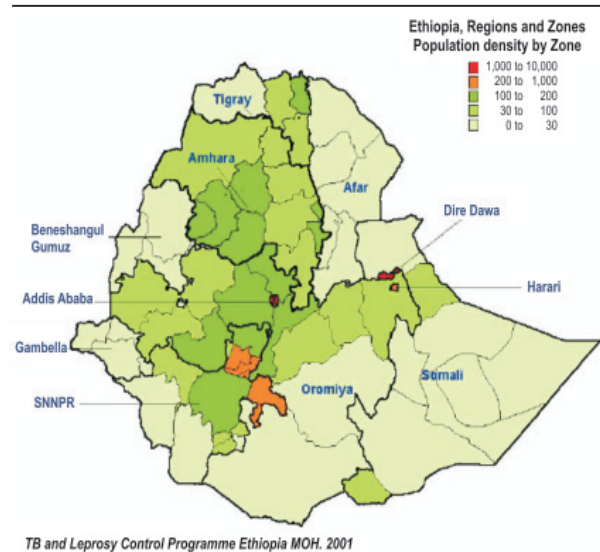
Population and demography

With an estimated population of about 72.4 million people (EIU, 2005) Ethiopia is the second most populous country in Africa after Nigeria. The last National Census was carried out in 1994. Current estimates put the total fertility rate at about 6.1 children per woman and the annual population growth rate at about 2.8% (UNICEF 2004). The population structure is the typical one of poor countries: about 19% is below age 5, about 43.5% is below age 15, about 51.9% is between 15 and 59 and about 4.6% is above 60 years of age. About 24% of the women are in their reproductive age (15-45) and, at any given time, pregnant women represent about 4.6% of the total population (Ministry of Health 2005). The crude birth rate is about 49 / 1000, the crude death rate about 18 / 1000 and the life expectancy at birth about 46 years (UNICEF 2004). With an urban population estimated at about 15% of the total, Ethiopia is one of the least urbanized countries in the world but the urban

population growth rate is estimated at about 4.1% per year (Ministry of Health 2005).

The country is one of the largest in Africa (1,127,127 square Km). This would give a population density of about 64.2 people / Km². In reality, as the map in next page shows, the population is very unequally distributed on the national territory with about 23.2% of it occupying just 9% of the land (Ministry of Health 2005).

The majority of the population lives in the northern and southern highlands. The western and eastern lowlands are scarcely and sparsely populated. It is estimated that only about 20 % of the land area is currently used for agriculture, even if the amount of arable land is estimated to be larger. This puts an enormous pressure on the cultivable land and leads to accelerated and unchecked land degradation. Due to rapid deforestation, only between 10% and 15% of the land is covered by forests. Vast areas are unfit for agriculture or any other use.



In 2005, the government relocated about two million people from the northern highlands to other areas. The exercise was carried out without proper preparation and the “relocated” people were, often, left to themselves in areas without shelter and any other infrastructure.

The Ethiopian population is very varied, with more than 80 different ethnic groups and about 70 different languages. The biggest ethnic groups have up to 18 million people while the smallest have about 100 people (Ministry of Health, 2005). Most of the languages belong to the Semitic, Cushitic, or Omotic families of the larger Afro-Asiatic super-language family. A small number belong to the Nilo-Saharan family of languages.

The largest Semitic speaking groups are the Amhara, who speak Amharic. The Amhara people held power for centuries and Amharic was the country official language. It is still used by about 25% of the population. The Tigray, who speak Tigrinya, account for perhaps 14 percent of Ethiopia's people. The Amhara occupy the centre of the northern highlands, the Tigray, the far north. Both are agriculturalists. Cushitic-speakers include a large number of groups, most of who live in the southern highlands. Among them are the Oromo, probably the largest of the Ethiopian ethnic groups, who live in the centre-west and in the central southern highlands. Orthodox Christianity and Islam are the main religions accounting, each, for about 45% of the total population. Catholics, estimated to be about 500,000, are less than 1% of the total population. Some people follow "traditional religions".

Administrative structure

The EPRDF which took power after the fall of the Derg regime, on May 28th 1991, is a coalition of four main parties: the TPLF (Tigray's People Liberation Front), the ANDM (Amhara National Democratic Movement), the OPDO (Oromo People's Democratic Organization) and the SEPDM (Southern Ethiopia People's Democratic Movement). According to the Constitution introduced in December 1994, the official name of the country is "Federal Democratic Republic of Ethiopia". The federal state is made of nine Regional States: Afar, Amhara, Benishangul-Gumuz, Gambella, Harari, Oromia, Somali, Tigray, Southern Nations Nationalities and Peoples Region (SNNPR) and two city Administrations: Addis Ababa and Dire Dawa. Each Region is divided into Zones, in turn divided in Woredas (Districts), themselves divided into Kebeles. The number of Woredas is not clear, even to the same ministry: 560 (Ministry of Health 2005) or 580 (Ministry of Health 2004). There are about 15,000 Kebeles: 5,000 urban and 10,000 rural.

The Federal State has a bicameral Parliament made of the lower house, the Council of Peoples' Representatives, made of 547 members directly elected by the people and the upper house, the Council of the Federation, whose 108 members are nominated by the respective Regional Councils. Each region has its own parliament, the Regional Council, whose members are elected and whose President is nominated by the party holding the majority of seats.

In line with the decentralization policy, the basic decentralized local government and decentralized administrative unit is the Woreda. The Woreda (similar to the administrative units called "Districts" in other

countries, for instance, Uganda) is led by an Administrative Council whose members are elected. The highest administrative authority in a Woreda is the Administrator, assisted by the Heads of the different Desks under his authority such as Agriculture, Capacity Building, Education, Health, etc.

The calendar

The Ethiopian Calendar (EC) differs from the Gregorian Calendar (GC) used in many other countries. The Ethiopian calendar year has 13 months, of which 12 have 30 days each and a short thirteenth month which has five days (six in the leap years). On the GC, the Ethiopian year begins on September 11 and ends on September 10th. In addition, the Ethiopian Calendar is eight years behind the GC. For instance, the Ethiopian year 1999 started on September 11th 2006 and will end on September 10th 2007 of the Gregorian Calendar.

The Economy

With a Gross National Income (GNI) per capita estimated at 90 US\$ per person per year, Ethiopia is one of the poorest countries in the world (UNICEF 2004). Agriculture accounts for about 44.1% of GNI, industry for about 10.4 % and services for about 45.5% (EIU 2005). The recent growth in the services sector is mainly due to the government commitment to the SDPRP (Sustainable Development Poverty Reduction Programme) providing for significant investment in education and health and in other social sectors (OECD 2005). Ethiopia has one of the most developed and successful airlines in the whole continent.

Conditions of life are heavily affected by the availability of resources and by the way they are used. According to the United Nations Development Programme, the Human Development Index of Ethiopia is 0.359, which makes her ranking 170 out of a total of 177 countries studied (UNDP 2004). Coffee is, by far, the most important earner of foreign exchange: in 2003 it earned about US\$ 184 million; chat earned US\$ 116 million, oilseeds US\$ 48 million and pulses US\$ 11 million (EIU 2005). Textile production, although still small, increased sharply since 2001. In 2004 the sales to the US (by far the most important customer, thanks to the "Africa Growth and Opportunity Act" –AGOA-) raised to a record US\$ 3.3 million.

In recent years, the economic performance has been reasonably good. The real Gross Domestic Product growth was 5.4% in 2000, 7.7% in 2001, it fell to 1.2% in 2002. In 2003 the GDP growth rate decreased to -3.8%. In 2004 there was a remarkable rebound with a record growth of 11.6%. The Economist

Intelligence Unit forecasts a growth of about 6.5% in 2005 and 5.6% in 2006 (EIU 2005). Given the importance of agriculture in the Ethiopian economy and its extreme vulnerability to the weather, these forecasts assume normal rainfall.

Even under favourable weather condition, however, about five million people are constantly in need of food aid and 10 more million are at high risk of food insecurity (OECD, 2005). According to the World Bank, in 2000, 23% of the population lived on less than one dollar a day and 77.8% lived on less than two dollars a day (World Bank 2005). Ethiopia has a foreign debt of about US\$ 6 billion and servicing it absorbs about 8% of the export earnings (EIU 2005). Foreign aid accounts for about 7.8% of GDP (EIU 2005) but, when calculated in relation to the total population, it amounts to about US \$ 13 per person per year, about half the average for Sub Saharan Africa (OECD 2005).

Education and Communication

Illiteracy is still one of the major problems. In 1990, the adult literacy rate stood at 37% for men and 20% for women; in 2000 it stood at 47% and 31% respectively. The net primary school enrolment ratio, between 1998 and 2002, was 52% for boys and 41% for women. The actual net primary school attendance, between 1996 and 2003, was 33% for boys and 28% for girls. Between 1998 and 2002, 23% of the eligible males and 15 % of the eligible women enrolled in secondary schools (UNICEF 2004). These estimates suggest not only an overall poor performance of the education sector, but, also, a high degree of discrimination against women and girls. According to the United Nations Development Programme, the Ethiopian budget for education amounted to 3.4% of GDP in 1990 and 4.8% between 1999 and 2001. As a percentage of government spending the budget for education was 9.4% in 1990 and 13.4% between 1999 and 2001 (UNDP 2004).

In 2002 (the last year for which reliable figures are available) the estimated access to telephones was 1 per 100 people and the internet usage was 0 for 100 people (UNICEF 2004).

The Health Sector

Organization and infrastructure

The Ethiopian Health Sector is particularly underdeveloped in infrastructure and manpower. Table 1, below, gives a picture of the health infrastructure by type and number:

Table 1: Health facilities by type and number

Type of Health Facility	Number
Hospital	126
Health Centre	519
Health Stations	1.797
Health Posts	2.899
Private Clinics	1.299
Pharmacies	275
Drug Shops	375
Rural Drug Vendors	1.783

Source: Health and Health Related Indicators, Ministry of Health, 2004

Human Resources for Health

According to a new policy and strategy, the National Health System should be structured in four tiers. The first tier should be constituted by a Standard Health Centre with five satellite Community Health Posts (CHP). CHP should deliver mainly promotive and preventive services and treat minor ailments. Their unit of reference would be the Health Centre, with ten beds for in-patients and capable of providing outpatient services, MCH services, assist deliveries and take care of emergencies on a 24 hours basis.

The Health Centre and its five satellite CHP would refer complicated cases to Woreda (District) Hospital, next tiers being the Zonal Hospitals and, finally, the so called Speciality Hospitals.

According to a new policy, the “Health Stations” will be either downgraded to “Community Health Posts” (the new denomination of Health Posts) or upgraded to Health Centres or closed down. According to the same policy, there should be a Community Health Post (CHP) for every 5.000 people and it should be run by a female health worker called “Health Extension Worker”. In reality, the majority of existing CHP are managed by the so called “Frontline Health Workers”, with no formal and little practical health training. The currently available Human Resources for Health (HRH) are inadequate in number, type of training, knowledge and experience. Table 2 shows the number of the most important health cadres and their ratio to the estimated population of about 72 million.

Table 2: Type and number of the main health cadres and their ratio to the total population

Type of Health Cadre	Number in 2004	Ratio to the estimated population of 72.000.000
Physician	2,679	26,876
Nurse (all type)	15,544	4,632
Health Assistants	6,628	10,863
Environmental Health Worker	1,169	61,591

Source: Ministry of Health 2004: Health and Health Related Indicators (modified)

A new plan for the health sector, the “*Health Sector Development Programme III*”, currently being developed, takes this major problem into serious consideration. One of the main strategies to expand health services coverage and population access to health services is the so called “*Accelerated Expansion of Primary Health Care Coverage in Ethiopia*”, officially launched in November 2004. This strategy aims at increasing the number of health units, mainly Community Health Posts (CHP). The increased staffing requirements created by the increased health units pose a great challenge to the Government and its Development Partners.

It is the Ethiopian Government’s intention to triple the health workforce between 2005 and 2009. About 7,200 Health Extension Workers (HEW) were trained in 2004. They are all female and are supposed to run the CHP. The official plans are to train 32,200 new HEW by 2009. About 6,000 Health Assistants should be given additional training and upgraded to Diploma in Nursing level. In order to increase the intake of students for the three year Diploma Course for Nurse Midwives, many school dormitories will be converted into classrooms. Additional efforts are planned to increase and accelerate the output of an important health cadre: the Health Officer. Health Officers will manage Health Centres and some of them will lead the Health Desk at the Woreda level. The government plans to train at least 5,000 Health Officers by 2009. This huge effort is commendable but, given its magnitude and ambition, some worries about the feasibility and the quality of the training seem to be legitimate.

There are four Faculties of Medicine in Ethiopia (in Addis Ababa, Gondar, Jimma and Mekelle). In 2004 they produced 289 new doctors (31 of whom were female). There are 25 nursing schools in the country. The output of these and the other schools of various cadres is also disproportionately low when compared to the growing population needs. In 2004 the total

number of graduates from Public Higher Education (including the above mentioned doctors) was 2,374. Other Senior Training Schools, of various types, graduated 651 health workers of various cadres (MOH 2004).

As in many other African countries, brain drain of health workers is a serious problem. It seems to concern mainly doctors. According to the International Organization of Migration (IOM), quoted by *The Economist*, “... more Ethiopian doctors are practicing in Chicago than in Ethiopia” (The Economist, August 13th 2005).

Utilization and coverage indicators

The utilization and coverage indicators, although not very reliable, indicate a dire situation and are among the worst in Sub Saharan Africa. According to the Ministry of Health, in 2004 the coverage of fully immunised children was 36.5% , attendance of one visit of Ante Natal Care (ANC) services was 40.8%, assisted deliveries are 9.45%, Tetanus Toxoid immunization coverage for pregnant women was 31.9%, coverage for non-pregnant women 17.1%, the number of out-patient visits was 0.36 per person per year. In 2004 the hospital beds were, in total, 13,502 (one hospital bed per 5,300 people). The average Bed Occupancy Rate was 28.2% (MOH 2004). Deliveries attended by skilled workers were about 6% of the total (UNICEF 2004).

Health services and coverage disparities

The few indicators mentioned above suggest low coverage and low utilization of health services. As all aggregated figures and averages, they hide significant differences between and within regions. For instance, the coverage for fully immunised children is reported to be 64.9 % in Tigray and 3.69% in Somali; attended deliveries are reported to be 34.84% in Tigray and 2.10 % in Afar; out-patients visits are reported to be 0.77 per person per year in Tigray against 0.09 per person per year in Somali; average bed occupancy rate is reported to be 46.6% in Tigray and 9.4% in Somali. The list could go on.

Epidemiological profile

As in all poor countries, the bulk of the disease burden is made by parasitic and infectious diseases. According to the available data, Malaria is the number one disease for both, morbidity and mortality. In 2003, it accounted for about 15.5% of all outpatient visits, about 20.4% of all admissions and for 27% of all hospital deaths in all age groups (MOH 2004). According to the World Health Organization, the overall malaria mortality rate, in Ethiopia, is 80/100,000 (WHO 2004).

Other leading causes of outpatient's visits, for the same year, were acute respiratory infections (11.3%), intestinal parasites (7.2%) and diarrhoeal diseases (4.8%). Other leading causes of admissions were uncomplicated deliveries (9.5%), acute respiratory infections (6.6%) and Tuberculosis (4.3%). Other leading causes of hospital deaths were acute respiratory infections (12.6%) and Tuberculosis (11.5%) (MOH 2004).

In 2003 the prevalence of HIV among the adult population was estimated at about 4.4% (26 % in rural and 12.6% in urban areas). About 1.5 million people are estimated to be living with AIDS, 96,000 of them being children below the age of 15. People estimated to need Anti-Retroviral Treatment (ART) are about 245,000. Data from 29 rural and 37 sentinel surveillance sites show that in 2003, there were an estimated 539,000 AIDS orphans in Ethiopia (MOH 2004b).

According to WHO the Tuberculosis prevalence in Ethiopia is 440/100.000 and the estimated Tuberculosis mortality rate is 52/100.0000 (WHO 2004). According to the Ministry of Health, about 38% of TB cases are associated with HIV/AIDS (MOH 2004b).

Health Indicators

As expected, the most commonly used health indicators testify to a very poor general population health status. The Crude Birth Rate is 39.9/1,000 and the Crude Death Rate is 12.6/1,000; the Infant Mortality Rate is 96.8/1,000 and the under-five mortality rate is 136/1,000, (MOH 2004). The overall Life Expectancy at Birth is 54 (53.4 for men and 55.4 for men); the Maternal Mortality Ratio is estimated at 871/100.000 live births (MOH 2005).

UNICEF gives different values to the above statistics: it puts the Crude Birth Rate at 49/1000, the Crude Death Rate at 18/1000, Infant Mortality Rate at 112/

1000, under-five mortality rate at 169/1,000; overall Life Expectancy at Birth is put at 46 years. The Maternal Mortality Ratio is virtually the same (870/100,000 live births).

The nutritional status of the general population is poor. In particular, the *2000 Ethiopia Demographic and Health Survey* (quoted in MOH 2005) found that 52% of under-five children were stunted while 26.3 % were severely stunted; 11% were wasted and 1% severely wasted; 47% were underweight and 16% were severely underweight. About 15% of babies are born with a low birth weight (less than 1,500 grams) which is a sign of poor nutritional status of mothers (UNICEF 2004).

Only 22% of the population was using improved drinking water sources in 2002 with huge discrepancies between urban and rural population: 81% and 11% respectively (UNICEF 2004). According to the same source, still in 2002, about 6% of the population was using adequate sanitation facilities: 19% in urban areas and 4% in rural areas (UNICEF 2004).

Health Financing

Although precise figures are hard to come by, it is currently estimated that the overall expenditure for health in Ethiopia is about US\$ 5 per person per year. This includes government, donors, employers and out-of-pocket expenditure. The Ministry of Health estimates that the total government public health expenditure, in 2004, was 910,588,000 Birr, which makes about 12, 8 Birr (about US \$ 1) per person per year. The following table, elaborated from data extracted from the 2004 World Health Report gives an idea of the health expenditure in Ethiopia, its very low level and the very heavy burden on the people. The data also, somehow, explain the very low level of utilization of health services even where they are available.

Table 3: Health expenditure in Ethiopia between 1997 and 2001

Expenditure	1997	1998	1999	2000	2001
Health expenditure as % of GDP	3.4	3.6	3.5	3.2	3.6
Government expenditure on health as % of its total expenditure	5.8	5.9	4.3	3.2	4.9
Government expenditure on health as % of total health expenditure	37.9	39.3	37.7	34.5	40.5
External resources for health (included in the government ones)	9.3	23.5	27.6	29.6	34.3
Private expenditure on health as % of total health expenditure	62.1	60.7	62.3	65.5	59.5
Social Security expenditure on health as % of total expenditure on health	0.7	0.7	0.8	1	0.8
Out of pocket payments as % of total expenditure on health	86.2	85.7	85.4	84.6	84.7
Private pre-paid health plans as % of total expenditure on health *	0	0	0	0	0
Per capita expenditure on health at average US \$ exchange rate	4	4	3	3	3
Gvt per capita expenditure on health at average US\$ exchange rate	1	1	1	1	1

Source: *World Health Report 2004: Changing History (modified)*

* A few experimental pre-paid schemes are currently being tried out around the country but their importance and relevance is still very limited (Damen Haile Mariam, 2003)

This already extremely low level of expenditure does not tell the whole story. The bulk of the expenditure for health care is paid by the households as out-of-pocket payments. Patients are expected to pay fees in all government and non-government health units at all levels. The structure of the fees varies from one region to the other. There are flat rate fees and fee-for-service arrangements where the total bill depends on the amount of care and consumables that patients get. Very often, patients are required to buy medicines, syringes, gauzes, bandages and other consumables in private pharmacies or drug shops.

In some regions, the fees collected remain at health unit level and are used directly to purchase medicines, execute minor structural repairs, reward the personnel, etc. In other regions the money collected by the health units is sent to the central level and is not necessarily reallocated to the health sector. The few existing community based health insurance schemes are small and of no real significance (Haile Mariam, 2003).

Conclusion

With the poor indicators of health care funding, health system performance, health status and glaring inequalities, increasing social unrest is inevitable. The relations with Eritrea are dangerously tense again, coupled with threats from Somalia and the government is adopting a harder stance to political opposition than before. It is hard to predict a better future for health care in Ethiopia.

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