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Health and Education Issues in Ethiopia

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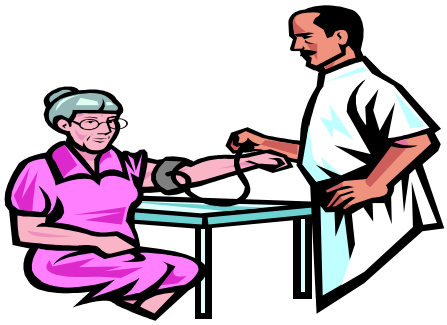

Paper to be Presented in the
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by
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1. Introduction

This paper is written for use in the International Conference on Contemporary Development Issues in Ethiopia that will be held, at Western Michigan University, from August 16-18, 2001. It is written for participants of the conference who are interested to know about the current situation of health and education sectors in Ethiopia, in the overall framework of the country's economy. In the paper, the earlier and existing policies and their impact on the development of the sectors is touched up on.

The levels of the health care system, number of facilities, health personnel vis- a vis the population of the country is discussed in detail. The government's effort to improve the situation by establishing funding organizations, collaboration with NGOs and private sectors is also discussed in detail.

The current situation of the education sector and the extent of enrolment at all levels are discussed in depth. Gender disparity in enrolment, quality, efficiency and equity in education are dealt with. Problems of each sector are addressed.

Furthermore, the contribution of Ethiopian Social Rehabilitation & Development Fund (one of the biggest poverty alleviation program in the country), Non-Governmental Organizations (NGOs) and private investment in health and education is discussed. Finally, conclusion and recommendation on the existing situation is presented.

2. Background

Ethiopia is one of the least developed countries in the world whose economy is mainly dependent on small-holder rain-fed agriculture. The weather condition, backward technology, inadequate infrastructure and support services, degradation and erosion of fertile soil have contributed to the low productivity in the agricultural sector. Though much effort have been exerted to the growth of the sector, it has not been developed up to the required standard. The Gross National Product (GNP) per capita is USD100 while the annual GNP rate is only 3.3%. Due to these reasons, there is high unemployment and low work expectancy. Even those who are employed earn low income. The low level of income led to food shortages, necessitating increased amounts of food aid and imports. According to the Human Development Report, UNDP 2000, Ethiopia's cereal food aid and imports account for 589,000 metric tons every year. The total population as mentioned in the Ministry of Health (MOH) 1999/00 report was 63.5 million, the average growth rate being 2.7%. There is low contraceptive prevalence rate; leading to higher rate of population and sexually transmitted diseases. Based on the Welfare Monitoring report of Ethiopia 1999, 50% of the population live below poverty line. There is ill health, malise, illiteracy and hopelessness. Life expectancy at birth is only 43.4 years. These problems coupled with shortage of resources contributed to the under-development of both the economic and social infrastructures.

Concerning health, most people in the country depended on traditional medicines and healers before and early 20th century. This was mainly because of poverty, ignorance, the undeveloped health care system and absence of a clear cut policy. In the early 1950's, a comprehensive health policy was formulated, though it was not put into action. In the 1970's this policy was further developed, however it was not properly adopted due to the change in government. Later on, the military government formulated a policy that gave priority to the rural areas where the main emphasis was prevention and control, but due to resources that were geared to military expenditure it was not implemented as expected. Furthermore, the limited number of health facilities, professionals and the less attention given to the sector kept it under developed.

Similarly, modern education was introduced in Ethiopia at the beginning of the 2oth century. The education policy initially focused on limited communication skills that assisted the government bureaucracy. Afterwards, a number of schools; primary, secondary, tertiary, teacher training and professional training centers were opened. This has assisted in producing the necessary professionals. As time passed the main aim became increase in the number of students. However, owing to the fewer number of schools compared with the students enrolled, lack of educational materials, quality of teaching, the lower government expenditure and the low moral and mass exodus of teachers from the teaching service to other sectors affected the quality of education. These problems led to haphazard attendance, high attrition and repetition rates.

3. Overview of Health and Education Policies

To overcome the above mentioned problems, a new health and education policies are adopted in 1994. This policies have considered health and education sectors as the foremost sectors for eradication of poverty. Furthermore, to strengthen the policies Ministry of Health (MOH) and Ministry of Education have adopted a countrywide health and education development programs in 1998.

The overall goals of the Health policy and the sectoral development Programs are to improve the health of the people and to establish a firm institutional base. These goals include provision of training to health workers and medical doctors and expansion of primary health care service coverage. The policy focuses on eradication of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions. The promotion and the participation of the private sector and NGOs in the provision of health care services is included in the policy.

On the other hand, the general objective of the education policy and its strategies of implementation, indicates provision of basic education for all its citizens. Through this policy, it would expand education by building the capacity of individuals to solve problems, wise utilization of resources and respect of human rights.

4. Contemporary Situation of Health and Education in Ethiopia

As shown in the background section of this paper, poverty is the main cause for the low level of health and education situation in the country. There is a vicious circle of poverty in every angle. Income poverty led to illiteracy and ill health, and illiteracy and ill health

led to income poverty. With this state of poverty, it was not possible to improve the quality of education and health care facilities. Though the development of health & education systems are important to lay the background for development, the importance of the other sectors should not be underestimated since development is multi-dimensional.

4.1 The Health Sector

Based on the Human Development Report, UNDP 2000, 81% of the population don't have access to adequate sanitary facilities and only 2% have access to solid waste disposal facilities. The new five year Health Sector Investment Program is based on the basic strategy of improving access to primary health care. There are 4 health delivery systems in the country. These are, Primary Health Care Unit, District Rural Hospital, Zonal Hospital and Referral Hospital. Eventhough the structure is set, the status of health services in the country is very low in relation with the population of 63,495,000. There is skewed distribution of health facilities and professionals. Most of the doctors, nurses and hospital beds are located in urban areas.

In addition, the health budget as % of national budget is very low to cover the requirement of the health sector. As shown in table 1 below, the total budget is at a decreasing trend, particularly in 1999/00 it decreased more than the preceding years.

Table 1: Health Budget as percent of National Budget

	1995/96	**1996/97**	**1997/98**	**1999/2000**
Recurrent	6.00	5.50	5.60	3.51
Capital	5.90	6.60	4.90	7.93
Total	**6.00**	**5.60**	**5.30**	**4.75**

Source: Ministry of Health 1999/2000 report

Due to the low expenditure in health, the number of health professionals and facilities are not developed; only 45% of the total population have health service coverage. Tables 2, 3 and 4 show the number of health facilities, health facilities to population ratio and health personnel to population ratio, respectively.

Table 2: Number of Health Facilities

Facilities	**Years**			
	1995/96	**1996/97**	**1997/98**	**1999/2000**
Hospitals	87	96	100	103
Health Centers	257	282	304	356
Health Stations	2451	2331	2268	2330
Health Posts	N.A	802	1012	833*
Private Clinics	541	712	966	1119
Pharmacies	N.A	197	292	272*
Drug Shops	N.A	148	222	243
Rural drug Vendors	1460	1659	1858	1950

*Source, Ministry of Health, **1999/2000** report.*
*the number decreased due to being out of standard and are currently non-functional

Though the number of health infrastructures have improved over the years, much remains to be done owing to the growing rate of population.

Table 3: Health Facility to Population Ratio

Facilities	Number of health facilities (1999/2000)	Standard Set by MOH	Actual Coverage Ratio
Hospitals	103	1:250,000	1:616456
Health Centers	356	1:25,000	1:178357
Health Stations	2330	1:10,000	1:27251
Health Posts	833	1:5,000	1 76

According to the standard set by the MOH, one hospital is supposed to give service to 250,000 patients, however the actual coverage as indicated in the above table is 1:616,456. The crowdedness of patients affected the quality of the delivery services. As shown in table 4 below, the health personnel to population ratio is also unthinkable by the standards of even other Sub-Saharan African countries. In addition to the low number of health facilities and personnel, most hospitals are not well equipped by modern medical equipment and drugs. It is mainly due to these reasons that many people are dying of potentially preventable infectious diseases and nutritional deficiencies, particularly in the rural areas. Even the major diseases, like tuberculosis and malaria, respiratory infections, skin infections, diarrhea and intestinal parasitic infections could have been prevented if the necessary infrastructures, drugs and qualified professionals were put in place.

Table 4: Health Personnel to Population Ratio

Health Professionals	Year	Ratio of health personnel to population
	1992	
Physicians	1263	1:50273
Health Officers	201	1:315895
Nurses	6713	1:9458
Health Assistants	8330	1:7622

*Source: Ministry of Health**1999/2000** report.*

The other problem of the day is the infection of HIV/AIDS. It is becoming the major killer of the sexually active population. HIV prevalence was very low at the beginning of the 1980's, however now, it is increasing rapidly. In 1989, it was 2.7% of the adult population, in 2000 it increased to 7.3%. Initially it was rampant in cities, at present it is spreading even in the remotest rural areas. According to the MOH, Nov, 2000 report on HIV/AIDs, 2.6 million people out of the adult population were infected. Of these, 16.8% were in Addis Abeba, 13.4% in other cities and 5% in rural areas. Most of the AIDS

cases indicate that the productive forces, ages between 15 and 49, are the most affected. To arrest this epidemic, the government has adopted an HIV/AIDs policy in 1998 and a five year strategic plan for the period covering 2000 - 2004. The major focus is on prevention, care and support

4.1.1 Gender disparity in health

Though the low level of income is affecting the health of the poor in general, women's health is particularly affected by poverty than men. Men are the first to go to the health care system than women, since they are expected to be the breadwinners for the family, particularly in rural areas. It is known that women's work at home is not accounted for, though they carry the burden of work both at home and in the farm field. Women in the rural areas are housewives and don't have their own income. From experience, women's income is more important to the family than men. If a woman has an income she takes care of her family's health. However, being dependent on men's income, women don't do whatever they want. They don't eat balanced diet even during pregnancy. Nutritional deficiencies such as iron, iodine and vitamin A are highly prevalent. The health care systems are located very far from most communities. It is due to these reasons that most women are dying together with their babies during delivery; trained health personnel attend only 9% of births. Infant mortality is 110/1000 live births and maternal mortality rate is between 500 and 700/1000. Mother & child immunization rate is very low, 173/1000 is dying due to lack of vaccination.

4.1.2 Non-Governmental Organizations

There are about 921 NGOs working in Ethiopia. Of these, 182 are registered under the umbrella of Christian Relief and Development Association (CRDA). From the NGOs registered with CRDA, 119 are working on health. They supplement the government in providing primary health education, provision of essential drugs, Mother and Child Health (MCH) care & family planning, nutrition, primary health care services, prevention and control of locally endemic diseases, strengthening health infrastructures and equipment, training community health attendants and traditional birth attendants and giving counseling to HIV/AIDS patients. They develop information, education, and communication materials, fund projects, support and care for people with AIDS & AIDS orphans.

4.1.3 Private Sector Investment in health

According to the Ethiopian Investment Authority 1999 report, 156 health facilities were constructed by both local and foreign investors amounting to Birr 1.4 billion or USD166,211,564 (@1USD to 8.423 Birr) and provided employment for 10,500 people.

4.2 Education

4.2.1 System of Education

The Ethiopian educational system has been changed a number of times when governments changed. During the Imperial period, the school structure was 4-4-4

(4 years of elementary, 4 years of junior secondary and 4 years of senior secondary). During the Derg period, it was 6-2-4. At present, the schooling setup is changed to 8 years of primary, 2 years of general secondary and 2 years of preparatory senior secondary education. Students in grade 10 take general education examination prepared by Ministry of Education (MOE). Those who pass grade 10 examination go to senior secondary school i.e. preparation to go to university and those who fail go to vocational training for which some preparations are being done, though, the system has already started this year. Then from grade 11 onwards, expenditure sharing is taken as one of the strategies to increase the expenditures of the government. However, it doesn't seem feasible owing to the poverty of parents.

4.2.2 Education Expenditure

Educational expenditures are useful indicators of the sectors development. As shown in table 5 below, education expenditure has been increasing from 1995/96 to 1999/00, However, it is too low to cover the requirements of the sector.

Table 5: Education expenditure

in '000 birr

Type	**Years**			
	1995/96	**1996/97**	**1997/98**	**1999/2000**
Recurrent	1,034	1,123	1,239	1,393
Capital	429	370	824	910
Total	**1,463**	**1,493**	**2,063**	**2,403**

*Source: Ministry of Eeducation**1999/2000** report.*

4.2.3 Infrastructures

Educational facilities have impact on access, quality, efficiency and equity. As is indicated in table 6 below, the number of schools have increased through time, though it did not keep pace with the number of school children that have been enrolled every year.

Table 6: Education Infrastructures

Year	**Primary**	**Secondary**	**College***	**University**	**Technical/ Vocational schools**	**Teachers Training Institute**
	Number		**Number**	**Number**	**Number**	**Number**
1989	10,144	427	10	3	17	13
1990	10,587	382	16	3	15	10
1991	10,918	386	16	3	16	11
1992	11,361	410	15	6	47	12

*Colleges under universities are not included here

4.2.4 Levels of Education

As shown in tables 7, 8 and 9 below total enrolment has increased at all levels. Though this is an encouraging trend, in the 1999/00 report of MOE, it is indicated that 49% of the school age children are out of school. Even more worrying is girls enrolment that far below than boys enrolment.

Table 7: Primary school enrolment ratio (1-8)

Year	Girls	Girls enrolment as % of total	Boys	Boys enrolment as % of total	Total
1995/96	1,625,903	0.36	2,842,391	0.64	4,468,294
1996/97	1,866,605	0.37	3,224,065	0.63	5,090,670
1996/97	2,157,910	0.38	3,544,323	0.62	5,702,233
1996/97	2,535,233	0.39	3,927,270	0.61	6,462,503
Total	8,185,651	0.38	13,538,049	0.62	21,723,700

*Source: Ministry of Eeducation**1999/2000** report.*

As can be seen from the table below, the enrollment decreased in secondary schools compared with primary school enrolment. This is due to the higher repetition rate at grade 8 level. Besides, as the level gets higher, the capacity to continue education due to poverty decreases.

Table 8: Secondary School enrolment (9-12)

Year	Girls	Girls as % of total	Boys	Boys as % of total	Total
1995/96	176,886	41	249,609	59	426,495
1996/97	191,090	41	276,579	59	467,669
1996/97	211,614	41	310,114	59	521,728
1996/97	233,192	41	338,527	59	571,719
Total	812,782	41	1,174,829	59	1,987,611

*Source: Ministry of Education**1999/2000** report.*

In the policy, it is indicated that tertiary education would be expanded by opening new training programs and that active participation of the private sector, community and parents in financing and managing education would be supported. However, very few progresses have been seen in the areas of opening schools by private investors and parents.

Table 9: Tertiary enrolment (Diploma, under-graduate and post-graduate)

Year	Girls	girls as % of total	Boys	Boys as % of total	Total
1995/96	8,554	20	33,618	80	42,132
1997/98	8,702	19	36,852	81	45,554

1998/99	9,769	19	53,035	81	52,305
1999/2000	1,4647	22	166,041	78	67,682
Total	41,672	20	179,221	80	207,673

*Source: Ministry of Education**1999/2000** report.*

As shown in table 9 below, the total number of students enrolled at the tertiary level have increased over the years. However, girls enrolment in the 4 years was at a maximum of only 20% of the total enrolment, requiring special attention by both the government and parents. The effort made by MOE to increase girls enrolment at the tertiary level is discussed under 4.2.6 below.

4.2.5 Other Educational Institutions

4.2.5.1 Technical and vocational schools

There are a number of technical and vocational training schools and institutions below university level, see table 6 above. Most of the students are secondary school graduates who have not been able to join higher educational institutions. In addition, there are technical and vocational institutions that are under the management and supervision of MOE These are specialized training courses, for three years, for those who are eligible and have completed grade 10.

4.2.5.2 Teacher Training Institutions

There are Teacher Training Institutions (TTI) for primary and secondary schools teachers. For the first-cycle (1-6), teachers are recruited after completion of high school and for second-cycle (grades 7-8), they are recruited from graduates of junior colleges or higher education institutions. Teachers for the Secondary schools (grades 9-12) are recruited from different higher education institutions awarding Bachelor degrees.

4.2.6 Gender Disparity in Schools

The United Nations Universal Declaration of Human Rights declared access to all school age children by year 2015. In the declaration, primary education is taken as a prime factor to eradicate poverty. However, girls with less than half of 6-12 year olds are estimated to be in school (UNESCO 1995). In UNICEF 2000 also it is indicated that by the age of 18 girls have received on average 4.4 years less education than boys worldwide and women's illiteracy exceeds men's nearly by 25 percent. Girls enrolment in general and particularly in Ethiopia is affected due to insecurity and cultural beliefs, sexual harassment by male colleagues and teachers. In addition, the long distance that they travel from home to schools creates serious problems to girls. As a result, they become vulnerable to rape, early pregnancy and sexually transmitted diseases. As shown in the above tables, gender disparity in enrolment is very high. It should be noted that more than 50% of the population in Ethiopia are women. One should however bear in mind that investment in girls' education reduces women's fertility rate as women with formal education are more likely to use family planning and educate their family.

To improve this situation much needs to be done in the area of awareness creation to teachers, parents and the community at large. In fact, to overcome the disparity in girls education, MOE is trying its best to increase the enrolment in the number of girls at each level through different means. At tertiary level for example, the entrance exam result for girls have been lowered by 2 points. To join departments, there is a quota for girls. However, sexual harassment, insecurity, cultural beliefs are still affecting the girls.

4.2.7 Quality, Efficiency and equity in education

Quality, efficiency and equity are inter-related. To achieve quality in education, efficient mode of delivery, commitment and capacity of teachers and frequent student-teacher contact is important. In Ethiopia, there are many students in a classroom whereby the teachers have no time to go around and check students' assignments. This is one of the factors that led students to repeat classes. Repeating a grade means utilization of resources allocated to other students. On the other hand, the number of schools, teachers and school facilities in rural and urban areas are not equitably distributed. This affect both the efficiency and quality of education. To over come the problems of quality, efficiency and equity in education, MOE set a list of indicators by giving a time frame (2001/02) for its achievement.

Quality Indicators	Base year 1995/96	Status of 1999/2000	2001/2002
• Share of lower primary (grades 1-4) teachers who are qualified	85%	80.6%	95%
• Total number of upper primary (grades 5-8) teachers	27,381	39,145	36,777
• Number of qualified upper primary teachers	5,729	7,205	20,000
• Total number of Secondary teachers	12,143	13,154	17,463
• Number of qualified Secondary teachers	4,910	4,858	10,760
• Number of core primary textbooks in school	2,273,000	1,643,000	51,000,000
• Grade 8 examination pass rate	61.7%	82.39%	80.0%

Efficiency Indicators	Base-Year 1995/96	Status of 1999/2000	2001/02
• Primary school student to section ratio	52	66.4	50
• Secondary school student to section ratio	63	74.9	50
• Grade 1 dropout rate	28.5%	30.3%	14.2%
• Total Primary school dropout	8.4%	18.9%	4.2%
• Average grade 4 to 8 repetition rate	12.8%	12.9%	6.4%
• Average grade 4 to 8 repetition rate for girls	16.2%	9.5%	8.1%
• Coefficient of primary school efficiency	60%	36.6%	80.0%

Equity Indicators	Base-Year 1995/96	Status of 1999/2000	2001/02
• Gross primary enrollment ratio in the under-served areas	16.2%	8.53%	25%
• Share of girls in primary school enrollment (grades 1-6)	38%	39.2%	45%

4.2.8 Non-Governmental Organizations

There are 119 international & local NGOs that are assisting the government in providing non-formal schooling, rehabilitation and refurbishing of old schools and adult non-formal education, in general. These NGOs are functioning under the umbrella of Christian Relief and Rehabilitation Association.

4.2.9 Private Sector Investment in Education

According to the Ethiopian Investment Authority, 175 schools were constructed all over the country from July 1992 - July 2000. Of these, 1 school was terminated. The total

amount approved for the construction of these schools was Birr 1.8 billion or USD213,700,582 (@1USD to 8.423 Birr). The investment has provided employment for 12, 289 people.

5. Ethiopian Social Rehabilitation and Development Fund (ESRDF)

To improve access to education and health and other social sectors, the Ethiopian Social Rehabilitation and Development Fund was established on 13 February 1996 as one of the biggest government's poverty reduction programs.

The main objective of the Fund is to promote and practice a bottom up approach in the planning, design, implementation, monitoring and evaluation of projects. By so doing, it is expected that the living conditions of the poor communities would be improved and enhancement of their income generating capacities would be achieved. Towards this end, the Fund renders technical and financial assistance to grassroots in order to increase their technical and managerial capabilities. The financial support goes to communities who initiate projects and are able to carry out responsibilities for management and subsequent maintenance of the projects that they initiate, plan and implement. The communities are expected to contribute at least 10% of the total cost of the project either in the form of cash, labor, local materials or a combination these. The contribution of a community is believed to help in inculcating sense of ownership and ensuring sustainability of projects and to change the belief that the government is the sole provider of services. Since the Fund is based on a demand-driven approach, it does not identify projects by itself, but appraises and selects from among those proposed by the communities or other organizations working on their behalf. However, given the enormous need and the wide range of potential, the Fund focuses in certain broad project areas that are high priorities in the overall development strategy of the country. Five major areas of intervention have been identified as being instrumental in contributing to the Fund's overall objective of poverty alleviation. These are construction of small-scale irrigation dams, rural water supply, primary education, basic health, capacity building and other projects like environment, gender and income generation. ESRDF is working in collaboration with line ministries and sector bureaus to ensure sustainability of the projects after handing over to the communities.

To realize its objectives, the Fund has organized a Central Office (CO), and Regional Offices (ROs) in almost all the administrative regions of the country, in line with the democratization and decentralization policy of the government. The ESRDF Board, which guides and supervises the overall administration and operations of the Fund at its highest policy level structure has been constituted. Likewise, Regional Steering Committees have been established in all the regions that approve project proposals, guide and oversee the overall performances of the ROs.

The Fund is envisaged to operate for five years with the support of the Ethiopian government(15%) a credit from the international Development Association (IDA) (45%), grants from other donors (30%) and community contribution (10%).

The ESRDF is now in its 5th year of operation. Since then, it has constructed and completed 521 primary schools, 441 primary health infrastructures (health posts and health centers), 1,250 rural water supply schemes, 43 small scale irrigation dams and 148 other projects that include soil & water conservation, input store construction, bee keeping, income generating projects like micro finance and grinding mill. Furthermore, it has implemented 416 training & capacity building projects that trained 196,150 people. The operation of the fund covers 100% of the zones and 94% of the woredas in the country with the aim of reaching the un-reached. For details on completed projects, training and areas covered by ESRDF refer to attached Annexes. After having presented the overall project implementation, I now indicate the specific contributions it had made to the education and health sectors.

5.1 Health

In addition to constructing health centers and health posts, the Fund also supplied medical equipment to 257 Health Posts, 58 health centers and 50 veterinary clinics. Furthermore MOH assigned trained personnel to most of the facilities as agreed before construction. The health infrastructures that ESRDF constructed assisted in increasing nearby access to health facilities, thereby decreasing transport costs and saving lives that were caused by travelling long distances, particularly during delivery and children's immunization. Besides, the construction of health facilities, the Fund also gave training to community project committees and built the capacity of the communities and partner organizations.

5.2 Education

Besides the construction of primary schools, it also assisted in the provision of furniture to the schools that it has constructed. According NEK international consultants that have done impact assessment of ESRDF in July 2000, the classrooms built by ESRDF are well ventilated and allow enough lighting compared with other schools. The schools have gender separated latrines which most government schools lack, head teacher' office, staff rooms, storeroom, pedagogical centers and libraries /reading rooms. Based on the impact assessment interview, 98.7% of the households confirmed that the school projects that ESRDF constructed are assisting them a lot. Parents have also indicated that the schools have contributed in the following ways:

- The home-school distance is reduced i.e. the service is taken nearer to the community. Therefore children are safer now going and coming from school.
- The crowdedness of the classrooms have subsided.
- The participation of female students has increased.
- The rate of dropouts and repetition has decreased.
- The classroom facilities are in a better situation.
- The awareness and interest of community members in education has increased
- Adult literacy education in rural areas has been made possible since some of these schools are serving as literacy centers too and
- The increase in school infrastructure decreased the operation of some of the schools on double shifts.

While performing all the above mentioned projects, it has encountered some problems. The major ones being, lack of implementing capacity at both the community level and other partner institutions and delays created by contractors in fulfilling their obligations.

5.3 Special Contributions of ESRDF

- It implemented projects where government and NGO's have not reached. The Fund's projects are implemented 50 kms. away from the main road while other projects are only 4 kms. away from the main roads
- Projects implemented by the ESRDF took less time (15%) and less cost (6%) compared with other implementers
- Transparency in selecting contractors and putting project fund in the accounts of the community representatives are better than the other funding organizations
- Packaging of projects are being practiced by ESRDF's implementing agencies.

5.4 Future Plans of ESRDF

In the future, the Fund is planning to work more on soft ware aspect i.e. building the capacity of rural communities and partner organizations while in the mean time continue working on the hard ware aspect/construction of social infrastructures. Furthermore, it is planning to include other economic activities during its 2nd phase.

6. Conclusion and Recommendation

6.1 Conclusion

The Ethiopian educational level is one of the least developed in the world. This is mainly attributed to the low budget allocation to the sector. Though the enrolment increased over time, 49% of the school age children are out of school. Even for those enrolled, there is lower student-teacher ratio and higher student-class ratio that negatively affected the efficiency and quality of education. Absence of required number of textbooks, incentives and other necessary facilities frustrates teachers. Equity in education, rural/ urban and gender disparity is yet not met.

The health sector also shares almost all problems of the education sector. The lower expenditure, the fewer number of health delivery systems, backward medical equipment, limited number of hospitals and health professionals led to lesser quality and inefficient services being provided to patients. The inequitable distribution of health professionals and infrastructure needs to be addressed.

The problems that exist in education and health sectors, as mentioned earlier, are affecting its development in particular and the development of the country in general. For a country to reach a level of sustainable development, it needs educated and able-bodied people. However, in Ethiopia, to achieve this goal there is a long way to go.

6.2 Recommendation

- Sectoral collaboration between different ministries should be strengthened so that schools and health delivery systems can have the required facilities.
- The government should continue supporting the construction of new primary schools, expansion and rehabilitation of old schools, provision of furniture and equipment, books and other educational materials in order to be able to meet the year 2015 universal declaration of access to primary education for all.
- Quality inputs; like reasonably qualified teachers, adequate operational budget, required quantities of text books and school radios should catch up with expansion. Special attention should be given to pastorals so that education will assist in poverty reduction.
- Income generating projects, for parents, in both sectors should be considered. This will assist parents to send their children to schools, particularly girls, and stop using child labor for domestic consumption and at the same time keeping them healthy.
- Partnership with donors, NGOs and other institutions should be welcomed to overcome shortage of resources and to attract new methods and skills.
- Capacity strengthening for teachers and health professionals should be seen from the point of view of improving quality and efficiency.
- Mass campaign should be done through radio, newspaper and television against harassment of girls.

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