

EDITORIAL

WHY IS THE MEDICAL SUPPLY IN CRISIS?

In the past years, the number of both public and private health care providers has increased significantly. Similarly, companies that either produce or import and distribute medical equipments, drugs and supplies became numerous in number. However, there was big discrepancy both in quality and quantity between the health care providers demand and the market supply causing chronic medical equipment, drugs and supplies problem. This unmet drugs and supplies gap has created unmet health care services gap.

The problem became worse in the past few months affecting the day to day health care services. Most hospitals stopped radiologic service due to lack of film fixer; delivery services, surgeries and wound care are compromised since there are no gauze and antiseptics like alcohol and iodine; routine laboratory services are compromised due to lack of items like slides and capillary tubes on market. The case of Jimma University Specialized Hospital is even worse due to the load and the fact that it is the only referral hospital in Southwest Ethiopia. The condition forced the hospital to limit available drugs and supplies only to emergency services. As a result of this, the health care service is being affected significantly and avoidable complications and deaths are becoming inevitable. The lack of supplies for routine medical care made me call the current situation 'CRISIS'.

Similar problem affecting mainly reproductive health drugs, was reported in Uganda in 2009 which was attributed to theft and limited funding. In February 2011 acute shortage of drugs and essential medical supplies in public hospitals has been registered, in Kenya. According to a study commissioned by Transparency International-Kenya, the shortage has created a trail of misery for patients across the country.

This short communication is not intended to define what 'crisis' is or investigate the cause rather trying to show what we are experiencing on our day to day practice and the widening avoidable unmet health services gap. Unless responsible government bodies, specifically Food, Medicine and Health Care Administration and Control Authority of Ethiopia (FMHACA) take practical measures, the problem could get worse.

The current issue of EJHS contains seven original articles including three articles on unmet gap and quality of health care services, one on surgical wound infection, one on burden of human schistosomiasis, another one on risk factor of active tuberculosis on HIV/AIDS patients and the other one on bacterial uropathogens.

Of the three articles which investigated health care services at various levels, a study done on factors affecting unmet need for family planning in SNNPR state showed that the unmet need for contraception increased from 35.1% in 2000 to 37.4% in 2005. A study done on clients' satisfaction with health service deliveries at Jimma University specialized hospital showed that an overall client satisfaction level of 77%. The other study conducted to assess the quality of care provided to patients with chronic Non-communicable diseases showed that the recommended care components were actually provided to patients in 35.1%, 38.5% and 60.1% of patients with Diabetes, Hypertension and Epilepsy, respectively.

The study done on burden and risk factor of surgical site infections showed an overall surgical site infection rate of 11.4%. Chorioamnionitis, presence of meconium, large intraoperative blood loss and Perioperative blood transfusion were associated with increased severity of SSIs.

A study done on the magnitude of human intestinal schistosomiasis in Jimma Town showed a prevalence of 26.3%. Participants in the age group 10-19 years and those living near the Awetu River had higher risk of infection.

A study done to assess risk factors of active tuberculosis in people living with HIV/AIDS revealed a body mass index less than 18.5 kg/m², hemoglobin level less than 10.0 g/dl, CD4 lymphocyte count less than 200 cells/ μ L, WHO clinical stage IV, not taking antiretroviral treatment and history of contact with a tuberculosis patient in the family among others were independently associated with the development of active tuberculosis.

Another study done to identify bacterial pathogens in urinary tract infection showed that *Escherichia coli*, *Klebsiella pneumoniae* and *S. saprophyticus* were the commonly isolated organisms. All *E. coli* and *Klebsiella pneumoniae* isolates were resistant to ampicillin and amoxicillin but were susceptible to ciprofloxacin.

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