

**The Last Ten Kilometers Project  
(L10K)**

**Rapid Appraisal of Health Extension Program:  
Ethiopia Country Report**



**Research & Training Institute, Inc.**

# **L10K Project Ethiopia**

## **Rapid Appraisal of Health Extension Program: Ethiopia Country Report**

### **Final Report**

The L10k Project of JSI  
Miz-Hasab Research Center  
Addis Ababa  
Ethiopia

Hailom Banteyerga (Principal Investigator)  
Aklilu Kidanu (Project Coordinator)

September 10, 2008

## Table of Contents

	<i>Page</i>
<i>List of acronyms</i>	<i>i</i>
<i>Acknowledgements</i>	<i>ii</i>
<i>Executive summary</i>	<i>1</i>
1. Background	10
2. The Research methodology	12
2.1 Type of study and data	12
2.2 Data sources	12
2.3 Key questions	13
2.4 Data management, analysis and quality assurance	13
2.5 Limitation of the study	14
3. Findings	15
3.1 What is HEP?	15
3.2 What has HEP done so far? Impacts	16
3.2.1 Community awareness of disease prevention	16
3.2.2 Family Health	17
3.2.3 Hygiene and environmental sanitation	17
3.2.4 Health education and communication	18
3.2.5 Participation: community and local government	18
3.2.6 Development partners	24
3.3 HEP study thematic areas	27
3.3.1 Access and demand	27
3.3.2 Quality of health care service delivery	30
3.3.3 HEP systems	31
3.3.4 Referrals	32
3.3.5 Partnership/collaboration/coordination	33
4 Discussions: RMNCH and curative services	36
5. Recommendations and conclusion	39
Annexes	45
Annex A: Study site by region, woreda and kebele	45
Annex B: Source of data by stakeholders, key informants and FGDs	46
Annex C: Development partners by region	47
Annex D: Documents consulted	51

## List of Acronyms

ADA= Amhara Development Association  
CBRHA= community based reproductive health agent  
CBO=Community Based Organization  
ESHE= Essential Health Services for Ethiopia  
FGD=Focus Group Discussion  
FMOH=Federal Ministry of Health  
HC=Health center  
HEEC=Health Extension and Education Center  
HEP= Health Extension Program  
HEWs Health Extension Workers  
HIMS= Health Information Management system  
HP=Health Post  
IMNCI= Integrated Management of Newborn Illnesses  
IRT= Integrated Refresher Training  
JSI =John Snows International  
KI= Key Informant  
L10k= Lat 10 kilometers  
MCH=Maternity and Child Health  
MNCH= Maternity, Neonatal and child Health  
ODA= Oromo Development Association  
REST= Relief Society of Tigray  
RMNCH= Reproductive Maternity Neonatal and Child Health  
TDA= Tigray Development Association  
UNICEF= United Nations Children Fund  
USAID= United States Agency for International Development  
vCHWs = Voluntary Community Health Workers

## **Acknowledgement**

The Miz-Hasab Research Center acknowledges the support it received from the L10k the ESHE project staff. It duly recognizes the input it received from the local and international consultants that participated in the inception workshop.

The Center also gratefully acknowledges the whole-hearted support it received from the following offices:

Regional health bureau of Amhara, the woreda administration and health offices of Arthuma Farsi and the Kutaber and the leadership and HEWs in the study village sites.

Regional health bureau of Oromia, the woreda administration and health offices of Boset and the Dodota and the leadership and HEWs in the study village sites.

Regional health bureau of SNNPR, the woreda administration and health offices of Merab Azerenet Berbere and Limu and the local leadership and HEWs in the study village sites.

Regional health bureau of Tigray, the woreda administration and health offices of Kelte Awlalo and Enderta and the local leadership and HEWs in the study village sites.

# **Executive Summary**

## **I. Introduction**

The Health Extension Program (HEP) was launched in 2004 with the objective of making health services accessible to the rural communities of Ethiopia. The program has covered about 80% of the country. This study is a rapid appraisal of the HEP focusing on the four major regions of the country: Oromia, Amhara, Tigray and SNNPR.

### **1. Aim**

The aim of the study is to identify evidences that help strengthen the bridge between families, communities, governments, development partners and the HEP to achieve sustainable rural maternal and child health improvements. The Miz-Hasab Research Center, in collaboration with the Last 10 Kilometers (L10K) project of John Snow International (JSI), conducted the appraisal with a field work that took place between April and May of 2008.

### **2. Methodology**

The rapid appraisal methodology began with an inception workshop followed by qualitative data gathering with 88 key informant interviews (KIs) and 32 focus group discussions (FGDs). A total of 4 regions, 8 werdas and 16 kebeds were covered in the appraisal.

## **II. Findings**

The HEP has made significant impacts on the health outcomes of the target communities in the villages where implementation is taking place. The study has also identified gaps that stakeholders have to address to speed up the implementation process.

### **1. Impacts**

HEP is proving to be an effective approach in community health delivery service. HEP is enabling rural communities to access health services.

#### **(i) Disease prevention**

Interviews and discussions conducted at the community level and observational assessments made by the researchers show that HEP has already started making an impact in the reduction of disease burden in the areas studied. Malaria is no more an epidemic; diarrhea and eye infections are decreasing; the number of people suffering from water born infections is declining. Community and household attitude towards HIV/AIDS and community members living with HIV/AIDS is changing. They are observed openly discussing HIV/AIDS and caring for those living with the virus. Knowledge and behavioral practices towards prevention of sexually transmitted diseases has improved.

## **(ii) Family health**

The appraisal revealed that there is a significant change in attitude and behavioral practices in the preventive aspects of maternal and child health. Mothers and children are getting attention in households; antenatal and postnatal care is being practiced; proper feeding habits (such as breast feeding, supplements for babies, and proper meals for mothers) are being promoted; child and mother immunization is increasing, and practices in reporting sick children to health extension workers have shown a significant improvement, as health post charts show.

## **(iii) Environmental hygiene and sanitation**

Communities have shown significant improvements in this package. Most households use pit latrines; separate animal shed from the human residence; use improved cooking practices; keep drinking water free from contamination; and manage their household goods in a hygienic and systematic manner.

## **(iv) Health education and communication**

HEWs and voluntary community health workers (vCHWs) spend most of the time teaching families and communities. The training of model families is being implemented. Some HEWs have already graduated two batches; some are starting. The defusing strategy of using model families and vCHWs is functioning, but not as quickly as predicted in the HEP implementation guide.

## **(v) Participation of community and local government**

Community participation is improving although the participation of local government leadership, including woreda administrations, happens intermittently such as during vaccination campaigns.

## **(vi) Development partners**

Development partners are appreciative of HEP. They seem to be enthusiastic about it and would like to be involved. Those already involved see it as the best way forward to reach the communities regarding health.

## **(vii) Political leadership**

The political leadership at the regional and the federal levels see HEP as a major government program. The government is encouraging partners in health to work at the village level with the motto: "All roads lead to the health extension program!"

## **2. Gaps**

On the other hand, the HEP has a number of gaps that have to be addressed by stakeholders. The main ones are as follows:

### **(a) Access and demand**

(i) Model families and Voluntary Community Health Workers (vCHWs)

The graduation of model families is not happening at the rate expected, partially because the number of vCHWs in most sites is low. The major reasons are lack of training abilities on the side of HEWs and limited assistance from woreda and village leaders in mobilizing the communities to involve more model families and vCHWs.

It is thus recommended that the number and abilities of model families and vCHWs be increased by:

- improving the skills of HEWs through giving regular integrated refresher trainings
- improving communication and pedagogic skills of HEWs
- involving the community leaders and local government officials to value vCHWs' role and look for non financial incentives that make voluntary community services attractive.

(ii) Communication and negotiation skills for the mobilization of community for promotive and preventive services

HEP has had significant impacts on promotion and preventive services. However, this intervention needs to develop further in communication and negotiation skills. The study revealed that in woredas where HEWs and woreda and village leaders received additional training in communication and negotiation skills, they were able to mobilize the community to do more work in disease prevention. They also involved more vCHWs and graduated more model families.

It is thus recommended that:

- HEWs as well as vCHWs be given training in communication and negotiation skills
- Community leaders and local government administration members should also be targeted in the training in community mobilization skills.

(iii) Motivation and volunteerism of vCHWs

The roles that vCHWs play in HEP are critical. vCHWs are volunteers, but have to be motivated to keep on doing the preventive and promotive activities in health - including treatment services in malaria, diarrhea and community DOTs. Some vCHWs are traditional birth attendants and assist in safe and clean home delivery. HEWs reported that vCHWs are important in HEP, but due to lack of clearly defined roles and incentives of vCHWs, it is difficult to make their services sustainable.

It is thus recommended that incentives and voluntarism of community health workers be defined. Moreover, roles of vCHWs in the HEP should be defined. Some call them promoters, reproductive health agents, community health agents, traditional birth attendants. It is suggested that the use of vCHWs in HEP should be consistent with the understanding of the government. It is thus suggested that vCHWs be given reward for their services in the forms of social recognition, award of certificates of merit, invitation to attend workshops, and further training.

(iv) Task shifting

The study revealed that all the intervention packages in a community cannot be covered by two HEWs in a community. All informants agree that the sixteen packages make HEP too broad to be implemented by two HEWs. Size of villages and distance among sub villages and households is a problem, too. There are some



tasks in HEP that vCHWs have successfully implemented as has been seen in Tigray under the Millennium village project. These are activities in

- Environmental hygiene and sanitation
- Data collection on births and deaths in the community
- Treatment of malaria with coartuum; TB with community DOTs; diarrhea with ORS and assisting women in home delivery.

It is thus recommended that at least the tasks above could be shifted to vVHWs with some training.

## **(b) Quality**

### **(i) Skills**

HEP has a vast curriculum but a short training period for HEWs who are assigned with the responsibility of implementing all the sixteen packages. HEWs and vCHWs need more skills and focused training in key areas that help them to work appreciably. These include:

- Communication and negotiation skills
- Safe and clean delivery
- Data analysis and use of health information gathered at community for planning intervention activities

### **(ii) Supportive supervision**

HEWs exhibited some weaknesses in training and supervising model families and vCHWs.

They need educational skills in:

- Training and mentoring vCHWs - they need pedagogical skills on transferring knowledge and skills, considering that most of their work is educational.
- Supervisory capacity with the aim of developing skills of HEWs - they have to learn how to identify key points for discussion and reflection from actions observed.
- Use of monitoring and observational methods to identify household behaviors that should be enhanced and those that need focus for change.

## **(c) Systems**

### **(i) Logistics and supply**

Health posts lack the basic equipments and supplies and drugs to deliver health post based services. Many health posts are not operational because of lack of supplies and equipments.

### **(ii) Community based health information management system (HIMS) including using data for decision making**

The HEP requires HEWs to compile village population profiles and to collect vital statistical information on births and deaths; such information is essential to plan activities. HEWs have been observed doing this, but

the village HIMS lacks essential variables on possible cause of death, sequence of pregnancy in relation to number of live births

It is recommended that the form for village statistics be expanded by adding key variables on causes of mortality and sequence of pregnancies and age of mothers. HEWs need to be equipped with knowledge and skills in data interpretation for decision making and planning subsequent interventions.

#### (iii) Participatory planning

The HEP requires the participation of community stakeholders in the planning of intervention activities. However, it is observed that this practice is not satisfactory. ESHE woredas have done better in practicing participatory planning where stakeholders, especially HEWs and vCHWs, worked and planned together.

Therefore, it is recommended that HEP uses participatory planning of village interventions by:

- Forming a village HEP structure/committee involving all stakeholders including sectors in charge of planning, programming and monitoring and evaluating implementation processes and outcomes. The HEP village committee should be inclusive of the village leadership, community leaders, HEWs, representatives of vCHWs, and sectors. The creation of such a committee is essential to use the available potential in the villages and speed up implementation by creating synergy.
- Involving the broader community by using community dialogue to identify interventions that have to be prioritized.

#### (iv) Transportation

All villages visited are geographically vast with households scattered all over the place. HEP is very much based on home visits and households training. HEWs say they walk up to six hours a day and, hence, unsustainable.

It is recommended that the transport needs of HEWs need to be addressed fully and immediately by considering the village context. Some may need mules, other bicycles, etc.

### **(d) Referral linkage**

The referral linkage between health posts and health centers is very weak. The following gaps in the referral system are observed:

#### (i) Communication and feedback

There is no formal way that HEWs could communicate to the health centers; there is no formal referral slip. There is no way that referral facilities could communicate to the HEWs either.

Therefore, it is recommended that there be a formal standardized process of sending patients from health posts to referral facilities, and vice versa.

#### (ii) Unavailability of services at referral facility

The health centers are supposed to give curative services to patients referred from health posts and from the catchments areas. However, this is not happening as expected because some health centers lack the necessary human resources. Some do not have basic supplies, and patients have to buy drugs.

Therefore, referral facilities have to be strengthened to meet their duties and responsibilities.

(iii) Barriers for referrals at health post

Transportation is often difficult and expensive for families accompanying a patient to a health facility. Communities report that they have problems of transportation and finance to travel to the referral facilities since they are far from their villages. Some villages are not linked to referral facilities by road.

Hence, one feasible way to resolve the problem of finance is to introduce community insurance system where *idirs* could be strengthened to also include funding of patients that need referral treatments.

**(e) Partnership with government and community leadership**

(i) The role of kebel/woreda administrations

The woreda and village administrations have not been able to deliver support to HEP as required in the HEP guide. The major focus of the administrations is the selection of candidates to be trained as HEWs and the constructing of health posts. As HEP is a community based intervention, it requires the mobilization of the community by the administration and political leadership. Some efforts are exerted by the woreda administration, but not as much as expected.

The ESHE experience of working with woreda administrations could be of help. It seems appropriate to involve woreda and village administrators in training programs so they could understand the program better and, as a result, show better commitment in program implementation..

(ii) The role of the community leaders in support of HEP

The participation of community leaders especially those that lead influential associations like the *idir*, *equib* has not been satisfactory and needs to be re-examined. These influential stakeholders have to be targeted and invited in the process of HEP implementation. One way forward is to make them active participants in the suggested Village HEP committee.

(iii) The role of development partners and sectors

The role of development partners is limited. ESHE is the most committed development partner in HEP. Other partners in health should take ESHE as an example.

Inter-sectoral coordination and integration of activities is weak. There should be closer interaction among health, education, agriculture and infrastructure. Sector units in villages should work together. Development agents, schools, and other government units in the village have to be involved in the implementation of HEP. There should be away of sharing experience and coordinating activities among themselves. In some village schools, students and teachers are involved as vCHWs and development agents

are working closely with HEWs in community conversation and the prevention of HIV/AIDS. The suggested village HEP committee could be a way forward to help engage every stakeholder in contributing to the implementation of HEP.

### **III. Conclusion**

The HEP in Ethiopia has shown significant positive impacts on the health of communities, in disease prevention, family health, environmental hygiene and sanitation. Local government and community participation, the role and interest of development partners is also on the increase. This represents a big leap in health delivery services in the country.

There are also gaps that need be addressed in order to support and strengthen the implementation of the HEP. Lack of communication and negotiation skills among HEWs, equipments and drugs in health posts, inadequate means of transportation for HEWs and patients on referral and slow or weak involvement of stakeholders remain obstacles for the realization of HEP--improved health outcomes of the rural communities.

It is concluded that development partners, in partnership with local administrations, have to play a major role in addressing these gaps and help communities realize their innovations and capabilities to assume ownership of their health. This may come as a result of providing occasional refresher trainings for HEWs and vCHWs, establishing a formal referral system, assuring a sustainable supply of drugs and equipments at local facilities, increasing the involvement of local and community leadership.

## 1. Background

Ethiopia is one of the countries with high disease burden. Mortality and morbidity of mothers and children is said to be one of the highest in Africa.

Ethiopia introduced a health policy and health development program that targets disease prevention. Both the health policy and program give due emphasis to mother and child healthcare (MCH). The Federal ministry of Health has introduced a four tier system: the federal specialized referral hospitals, the regional specialized referral hospitals, the district hospital and the primary health care with a health center and satellite health posts. The four tier system is designed to make health service delivery at each level accessible.

The major target of the health policy and program is disease prevention. The primary health care system focuses mainly on disease prevention and health promotion. Curative services are given at nucleus health centers.

The health extension program is a strategy on disease prevention and health promotion implemented at village level. It was launched in 2004 with 16 packages to be implemented in rural Ethiopia. It has four major health categories: disease prevention, family health, environmental hygiene and sanitation and health education and communication. Its main approach is transferring skills and knowledge in health to households and communities as a mechanism of improving community and household health outcomes.

Two female Health Extension Workers (HEWs) are assigned at each health post and each village. They are regular employees and salaried. Health extension workers are selected from the villages that they are supposed to serve. They have to be grade ten complete and speak the language of the communities they would be serving. They are trained for a year in the sixteen packages.

The HEP requires all government sectors, local leaders and communities to collaborate in the implementation of the packages. The communities and local leadership participate in many ways to make the implementation smooth especially in the construction of the health post, the selection of Voluntary Community Health Workers (vCHWs) and model families. HEP takes vCHWs and model families as key components in the transfer of skills and knowledge in health to households and communities.

HEP is a household and community based health intervention. It believes that communities can take care of their health if they are helped to build their capacities and skills in disease prevention and health management. According to HEP, the communities and households have to own health. Every household should be producer and multiplier of health. HEP takes access, equity, quality and safety of mothers and children as indicators of effective community health care.

The implantation of HEP is based on Karl Rogers's diffusion model. HEWs train vCHWs and supervise their activities. Both HEWs and vCHWs work in collaboration in the training and graduation of model families. HEWs take the responsibility of training model families in the sixteen packages whereas vCHWs facilitate the process and assist HEWs. It is believed that vCHWs have better opportunity to reinforce health behavior since they live close to the community members and interact more.

The assumption behind the idea of model families is that such families would influence their next door households and friends to promote practices and positive attitude towards disease prevention and better quality of life.

The whole idea of voluntarism in health and model families is to make every household a volunteer and model in health. At the initial stage of implementation, it is assumed that there would be one vCHW for 10-20 households.

The HEP recognizes the potential roles that community structures could play in the implementation process. Community structures are social capital with a lot of influence on households. Thus, HEP has a community package that HEWs implement. HEP also recognizes the roles that could be played by sector structures such as schools, agriculture extension agents. According to the health extension guide (FMOH,2007):

‘ Structures such as *idir*, *equib*, religious institutions, and government structure at community such as schools, community based associations (CBOs) such as women association, youth association, and farmers association... are expected to be active in health promotion and enabling the community to own health and produce and multiply health.’

HEP is open and participatory. It requires all stakeholders including development partners to invest in HEP that:

- (i) There is adequate input in material and human resource;
- (ii) There is capacity building by strengthening training centers for HEWs, and offering quality pre and in service training HEW, vCHWs, model families;
- (iii) The linkage between communities, vCHWs, HEWs is strengthened to make the benefits of the community in health vivid;
- (iv) The linkage among health posts, health centers and woreda health bureaus is strengthened to ensure flow of support in supervision, technical training and health commodities and drugs and referrals
- (v) The linkage between community structures, government institutions, and civil associations in the community is strengthened to speed up implementation by creating synergy.
- (vi) The political leadership at woreda actively supports the implementation process. The kebele leadership plays active role in the planning, monitoring and evaluation process.
- (vii) The health information management system is improved to ensure the regular collection of vital health statistics.
- (viii) Mechanisms for use of participatory supervision that is forward looking is in place
- (ix) Practices in monitoring and evaluation including external evaluation for improvement are strengthened and carried out on regular basis

## 2. The Research Methodology

This study was initiated by L10k project of JSI. *The purpose of the study is to identify evidences that help strengthen the bridge between Ethiopian families, communities and HEP to achieve sustainable RMNCH improvements in scale*

In order to answer this basic research question, L10k recommended a rapid appraisal of HEP in four regions: Oromia, Amhara, SNNPR and Tigray. It is hoped that findings in these four major regions would give a fair picture of HEP. Miz-Hasab research center was subcontracted to do the study.

### 2.1 Type of study and data

Qualitative study involving 80 key informant interviews and 32 focuses discussion groups of communities and vCHWs was recommended in an inception workshop held on April 17-19 at Global hotel. The inception workshop did a number of activities:

- Identified the key questions to be asked,
- selected the woredas and villages to be included in the study for each region
- decided on the type of informants to be interviewed: HEWs, village leaders, community leaders, woreda administration, health office, regional and federal informants;
- decided on the number of village FGDs and identified the type of participants of the FGDs for each study site: FGD of community members all women involving model and non model families and FGD of vCHWs.

Data was supplemented by analysis of documents at health posts to see whether HEWs are implementing the HIMS of the HEP packages or not; random visits of households and observations on household conditions and remarks made by field researchers.

Available information on partners working in health was documented for identifying partners in HEP. However, the information made available to researcher does not exhaust the partners in the regions visited.

### 2.2 Data sources

The sources of the data are the stakeholders involved directly in HEP: the communities in the study sites, the health extension workers, the voluntary community health workers, the model families, the local government (the village and the woreda), the woreda health bureau and health center, regional and federal informants and the non-governmental partners that are involved in one way or the other in HEP.

The regions included in the study namely Amhara, Oromia, SNNPR and Tigray were selected by the client. In the three regions with the exception of Tigray, ESHE is involved. The selection of woredas in the three regions involved ESHE and Non-ESHE woredas. ESHE has been involved in capacity building in HEP through its BCC activities and training programs in RMNCH. The idea of including ESHE woredas is to get insight as to what development partners could do to strengthen HEP. From each region two woredas and from each woreda two villages were selected for the rapid appraisal (see annex for woredas selected). 32 FGDs and 88 key informant interviews at village, district, region and federal level were conducted (see annexes A and B.)

The review is based on the information drawn from (i) government structures: federal, regional, district and village levels; (ii) beneficiary communities and households; (iii) health workers at health posts; (iv) woreda administration and health office; (v) health centers and (vi) the development partners.

### **2.3 Key questions**

The key questions asked to stakeholders during the review are the following:

1. What does the level of knowledge; attitude and practice look among all the stakeholders? This question is asked to see:
  - the level of shared HEP discourse among stakeholders;
  - the attitude and commitment stakeholders have towards the realization of HEP objectives.
2. What capacity has been utilized and what remains to be done by stakeholders to ensure the realization of HEP objectives? This question looks into:
  - current practices in HEP,
  - level of collaboration,
  - linkage among stakeholders (government, community and development partners)
  - Identification of gaps and ways of bridging them,
  - Existing potential and social capital in communities
  - Roles of development partners
3. What are the successes and challenges in HEP? This question assess:
  - the appropriateness of the strategies used to implement HEP—the HEWs, vCHWs, model families;
  - the focus on prevention and promotion on health;
  - the differing of curative services;
  - the roles assigned to the nucleus health center, the woreda health bureau—logistics and supply, training and supervision, and referrals;
  - Improvement of health outcomes and challenges in meeting MDG 4 and 5.
4. What stakeholders need to do to move forward towards the realization of HEP objectives? This question looks into
  - the transfer of health ownership to households and communities,
  - the making of community based health care reliable, equitable, accessible and sustainable
  - the way forward to meeting MDG 4 and 5.

### **2.4 Data management, analysis and quality assurance**

Key informant interviews were transcribed in local languages and translated into English. FGDs were conducted by a facilitator and note taker including tape recording. Notes taken were transcribed and translated into English.

Data analysis is done thematically. Themes identified were grounded through triangulation of data generated at different levels from different informants and by probing more discussion questions with informants at all levels.



To ensure a fair degree of quality, although rapid assessment, an inception workshop was organized involving the researchers, ESHE program people, consultants (local and international). The participants deliberated on HEP and the challenges in implementation. The guides were jointly developed and tested. The researchers used the data to develop draft instruments which were commented and piloted before use for the rapid appraisal. The selection of sites was done by the client.

Training was given to data collectors by the lead researcher and the staff from ESHE. Data collectors were recruited from the permanent staff of Miz-Hasab research center and outside on the basis of experience in qualitative data. All had their first degree from Addis Ababa University and other national universities.

Respondents were asked for their consent to give answers to the questions in the guide.

## **2.5 Limitation of the study**

The study is a rapid assessment and is based on eight woredas and sixteen kebeles. The HEP is still at its initial stage of implementation and has not fully settled down. The observations made may not be representative, although the uniform way of implementing HEP makes it possible to make generalizations from studies conducted on fewer sites.

### 3. Findings

#### 3.1 What is HEP?

HEP is a community based health care delivery service package. The goal of the HEP is ‘to create a healthy society and reduce rates of maternal and child morbidity and mortality.’ HEP focuses on ‘essential promotive, preventive and selected high impact curative health service targeting household.’ (HEEC, FMOH, 2007)

HEP is designed as a community based health care delivery service. It assumes the full participation of households and communities including the use of ‘local technologies and the community skills and wisdom.’ HEP’s fundamental assumption is, ‘if the right knowledge and skill is transferred to households they can take responsibility for producing and maintaining their own health.’ HEP aims at:

- Improving access and equity to preventive essential health interventions at the village and household levels
- Ensuring ownership and participation by increasing health awareness, knowledge, and skills among community members,
- Promoting gender equality in accessing health services
- Improve the utilization of peripheral health services by bringing the gap between the communities and health facilities through HEWs, reduce maternal and child mortality
- Promote life style conducive for good health.

In order to achieve these objectives HEP has introduced the following household and community packages (see HEEC, MFOH:2007)

- Disease prevention and control. This package focuses on the preventions of HIV/AIDS, TB, STIs, malaria, and services in First Aid emergency measures.
- Family health. This package includes maternal and child health, family planning, immunization, Nutrition and adolescent reproductive health.
- Hygiene and environmental sanitation. The includes excreta disposal, solid and liquid waste disposal, water supply and safety measure, healthy home management, control of insects and rodents and personal hygiene
- And health education and communication.

According to HEP, ‘All roads lead to health extension program!’ HEP believes that there should be active support to HEP from the government, the development partners and the community if the program is to succeed. Rural communities access both preventive and curative services in health according to the architecture of the primary health care tier:

- The village health facility is the health post which is constructed by the community with some assistance from the local administration.
- Each village health post would have two female health extension workers that are salaried and trained in the household and community health packages.
- The village health delivery services is mainly prevention and promotion with some curative and treatment services of diseases of impact; malaria, diarrhea, TB, HIV/AIDS
- For every five health posts there would be a nucleus health center that delivers curative services for in and out patients referred from health posts.
- The nucleus health center assists in the building of capacities of HEWs and vCHWs through training in disease prevention and supervision of HEWs in collaborations with the woreda health office.

### 3.2 What has HEP done so far? Impacts

HEP has brought vivid changes in health in the rural communities.

#### 3.2.1 Community awareness of disease prevention

Informants reported that the attitude of communities and households towards disease prevention has improved. Informants reported that at the beginning of HEP, their communities were suspicious about the objective of HEP. It was difficult for them to understand of the role health workers that do not give curative services. It was difficult for them to see the lessons on disease prevention given by HEWs as aspects of health delivery services.

The community was hesitant to accept the health extension workers activities. They even used to unleash dogs at HEW's during house to house promotion service to show their disapproval. This is because they were expecting to get curative services. [AKCL]

But, this attitude is changing. A participant in vCHWs FGD says:

*'The community accepts us and likes our services. The community has learnt that it can save the money it used to spend on medication by preventing itself from exposing itself to diseases. They do appreciate our work and follow what we teach them to do.'* [T.KA.C FGD]

The disease incidence rate especially in infectious disease like malaria, diarrhea and water born diseases is on the decline. Community leaders said that malaria is controlled; incidences of diarrhea and water born illnesses have declined. The mortality of children and others has also declined. This tendency has been reported in all sites visited. Community informants say:

*'HEP has helped us to know how to prevent ourselves from illnesses and how to take care of our children. Before HEP there were many problems of communicable diseases but now this is reduced [T.E. FGD, C].*

*'We used to suffer from disease epidemic, malaria infection, water born disease and infection of contagious diseases. Now we are able to prevent ourselves from such disease.'* (AAKL)

### **3.2.2 Family Health**

Informants reported that the family health practices have significantly improved with HEP. They said that the number of children and mothers taking regular vaccination has increased. The number of women attending ante and post natal care services is increasing. The practices in feeding babies and mothers are changing. Mothers are using breast feeding and supplements for their babies. The following quotes are cited as evidences:

*'I really have benefited from HEP. I used to give birth on every year. Now I am giving breast feeding. Now I take contraceptives and give breast feeding and am not pregnant' [T.E. FGD, C.]*

*'HEP is saving the lives of mothers and children. It has brought better changes in health. All children get vaccinated, mothers make check up when pregnant and consult HEW on their pregnancies.'* [T.E. FGD, C]

*'HEW's provide services on child delivery, malaria prevention, polio immunization, chicken pox prevention, family planning and contraceptive pills. We are benefiting from the services because we are healthier than ever.'* [AAKL]

### **3.2.3 Hygiene and environmental sanitation**

Site observations including household visits made by the study team and data from community informants show that the HEP has brought significant changes in environmental hygiene and sanitation practices of communities and households. Communities reported that they have learned how to keep themselves and their environment clean. Most households use pit latrine, practice hygienic practices at home, protect drinking water from contamination, and keep their children clean.

A participant in a community focus group discussion says:

*'We have started drinking clean and safe water, keeping our houses and environment clean, use pit latrine, separate animal shed from our homes, use separate kitchen.'* [T.E. FGD,C.]

### 3.2.4 Health education and communication

The major activity of HEP is health education and communication. HEWs and vCHWs are conducting health education and promotion at households, in community meetings, holidays and any social gathering. woredas with ESHE support have been effective in health education and communication. The study shows that community discourse in disease prevention, care for mothers and children, environmental hygiene and sanitation is emerging. Practices that expose individuals and communities to health risk are disappearing and are being replaced by those that promote health.

### 3.2.5 Participation: community and government (local, regional and federal)

The practice of employing health workers whose job is to teach people on how to implement the preventive activities and promote health ownership at household and community level is a new approach. Consequently, HEP faced some challenges during implementation.

Informants said that it was hard for them to see health workers that do not give needle injection and at the same time claim to be health workers. HEWs and vCHWs also reported that it was difficult to convince people that most diseases that affect the community could be avoided by applying preventive practices. Working on the household and community packages of HEP was not easy.

A community leader says,

*'The usual community perception of health workers was driven from the practice of giving curative services to sick people. People here did not see the value of prevention when the program started. ' [ODKL]*

Health workers perception of health was based on curative delivery services. It was difficult for people with this attitude to see health services in the absence of cure and medical treatment of patients. Informants in the health sector admitted that it was not easy to see if HEP would work.

Health extension workers were assigned to work in HEP under difficult circumstances. They reported that it was difficult to convince the communities including the leadership of their roles as health workers. The immediate expectation from the beneficiaries was to get curative services at a closer health facility. Beneficiaries demanded for curative services and insisted that they invested in the health post to get such services.

HEWs and their collaborators, the woreda and village administration, pushed forward in their activities and tried to convince the communities by (i) doing observable interventions, (ii) teaching and promotion activities. Although a very demanding task, HEWs activities started to make an impact on the attitude of people towards HEP. A village leader says,

*'With repeated teaching and negotiation with the community and the use of model families, now the attitude of the community is changing. People have started to believe in preventive practices as ways of avoiding*

*illnesses. Now they appreciate the work of HEWs. They are actively participating in preparing and using pit latrines, keeping the environment clean. Model families are influencing others to change their life style in health.’ [ODKL]*

The use of simple, doable and of impact interventions in preventive practices brought positive changes in the perceptions of people. Community participants in FGD say:

*‘We learnt from HEWs that by doing simple things at home we can protect ourselves from diseases. Keeping our houses, children and environment clean protects us from deadly diseases. These are simple things that anybody can do. Since we started keeping our homes clean, our children and family members have become healthy. Now we know the benefit from using family planning and we are taking contraceptive methods happily. We are feeding our children as per the training given by the HEWs. Some families are models and we follow them and learn from them.’ [O.D.C.FGD]*

*‘We are attaining knowledge with regards to our health. We have started to keep our environment clean, use latrines, drink clean water, keep our selves clean and feed our children and use family planning methods and prevent ourselves from ‘ HIV/AIDS.[ODCFGD]*

In all the study sites, communities exhibited knowledge of the aim objectives of HEP, the role of HEWs and vCHWs and model families, the activities included in the program and the responsibilities and obligations community members have if the program is to succeed. A community leader says:

*‘We are implementing EPI, family planning, health education, environmental sanitation with the use of household latrine and garbage pits. The community values and acknowledges the efforts made by HEWs and the knowledge they received in health care ‘ [SLCL]*

The health extension workers did their level best to influence the community towards preventive health. Some of the activities that have repeated come out from the interviews and FGDs with regards to HEWs are:

- changing the behavior of the community towards practicing disease prevention and health promotion
- enhancing community values and norms in favor of promoting and maintaining good health
- delivering services in MNCH
- Training of vCHWs and model families

A community health worker says:

*'The HEW's enlightened us on the purpose of the program. We have learned about disease prevention methods and family planning in the health program. We, in turn, are providing the community with the knowledge on preventing diseases by avoiding practices that harm them. We are introducing the practices recommended in the health extension package. At the beginning, the community was reluctant to accept us as health promoters. Gradually as we continued to show good practices, they started to listen to what we say. Now, the community is implementing the health extension package. It is using pit latrine and practically every household has a latrine. The community is showing better understanding towards HIV/AIDS and PLHA. They openly discuss HIV/AIDS and are showing interest to help PLHA. They are keeping their family and household environment clean. They are implementing the advice given to them on child and pregnant mother feeding practices and care. [OBvCHW-FGD]*

The effectiveness of HEWs in community mobilization and passing messages in key interventions in HEP varies, however. Woredas that received training in health communication and negotiation skills by ESHE proved to be more interactive better organized and motivated. The level of knowledge demonstrated in RMNCH is higher as compared to the non ESHE woredas. The description given by a HEW on how she cares for mothers and newly born babies is reflective of the impact of the interventions of ESHE. She says:

*'I check the month of pregnancy, hair, eyes, tongue, neck if she has goiter, weight, height, BP(blood pressure), baby position if she is pregnant and expected birth date, register date and time of delivery. I advice mothers to use family planning programs after 45 days of delivery, follow immunization program, pay attention to their personal hygiene, keep their babies clean, feed breast milk for the first 6 months and use supplementary feeds after 6 month of their newly born babies.'* [SLHEW]

The HEP strategic approach to changing the life style of the rural population favorable for health is the use of model families. The training of model families is taking place. Some sites that have successfully graduated model families exhibited that such families have been effective in influencing communities in:

- (i) raising community awareness on prevention and promotion of health
- (ii) use of hygienic practices --personal, household and environmental,
- (iii) use of pit latrine
- (iv) separation of human shelter from animal shed
- (v) use of safe drinking water
- (vi) use of family planning methods
- (vii) use of feeding practices for babies, children and mothers (breast feeding, nutrition supplement of mothers and children with available resources)
- (viii) use of vaccination services, ante and post natal care.

The model family strategy is found to be an appropriate way of promoting doable and easy interventions that have a major impact on the health of the households and communities. Model families have been

reported to have influenced reluctant households to make use of the interventions in the health extension package. The model families were able to exhibit themselves as clean and healthy families. They became role models in health for the community.

Social life in the rural communities is characterized by discussing common issues among neighbors and spending more time together. The model families and the vCHWs live in the community and spend more time with neighbors. This helps them to discuss with the neighbors on the HEP interventions. The significance of such discussions looks to be impacting the use of pit latrine, feeding practices, use of safe water, and environmental hygiene and vaccination.

A community leader says:

*Model families have exhibited many good things: keep their houses clean, prepare and use pit latrines and keep them clean, have good relation with the community especially their neighbors, keep themselves and family members clean, keep their surrounding clean, separate their shelter from that of their animals, take vaccination on regular basis, work closely with vCHWs and HEWs. They are influencing the community to do the same. They are teaching the community. We used to suffer from different diseases. Now we are learning to take preventive measures and we are not experiencing any epidemic. We have separated the animal shed from our shelter; we have started using pit latrines, keeping our children clean. As a result we do not suffer from eye diseases and diarrhea. We are keeping the kitchen separate from the bed room and we do not suffer from smoke.[ODCL]*

The role being played by vCHWs in educating the community on prevention and promotion is acknowledged by all stakeholders interviewed and participants in FGD. Although there is disagreement as to what should be the roles of vCHWs, beneficiaries reported that vCHWs are important players at grassroots based health service. Some of the activities of vCHWs mentioned by community informants are:

- Assisting in disease prevention and control: HIV/AIDS prevention and support to PLHA, distribution of malaria bed nets, treating malaria with coartum, TB management especially use of community dots, treatment of diarrhea by using ORS.
- Assisting in family health: vaccinating children and mothers, feeding including breast feeding, care for pregnant mothers and use of ante and post natal care, feeding of pregnant women and mothers, breastfeeding of newly born babies, safe and clean delivery at home(TBA), distribution of family planning methods (CBRHA)
- Assisting in Community mobilization in environmental hygiene and sanitation: hygienic practices at individual and family level, household and environmental sanitation, preparation and use pit latrines, and protection of drinking water from contamination, separation of animal and human shelter, separation of kitchen from living rooms
- Collection of community health data: collection of basic data on child birth and mortality.

ESHE woredas exhibited better in the use of vCHWs for promotive activities especially in passing RMNCH messages, use of community forums and structures to pass health messages and engage communities in prevention and promotion of health. HEWs and vCHWs in ESHE woredas meet more frequently to



discuss what they have done and decide on what they need to do next. In ESHE woredas vCHWs do more promotion activities whereas in other woredas especially in Tigray, vCHWs are involved in delivering health care services such as treating malaria patients, supervising TB patients and administering safe home based delivery.

The link among community, HEWS, vCHWs is emerging; and in some woredas it looks to be stronger. A CHW says:

*'We work closely with HEW, plan and implement together. We have monthly meetings for evaluating our activities. We conduct two meetings on every sub village in a month. We evaluate the works done with the community especially in pit latrine preparation and also discuss what we want to accomplish in the following weeks. We really are close to the community and model families. After seeing the changes observed, the community is now grateful. And we are also happy to serve our brothers and sisters to see them improving and practicing a healthy life style. We teach the community family planning, balanced diet, feeding of babies and mothers, hygienic practices including, use of pit latrines, and household management on every meeting and on holidays. The model families are becoming good examples for others as they are influencing their neighbors to implement the household package. Households in the community have made a lot of changes. They are keeping themselves and their families clean. Most families have pit latrines, and illnesses of children and adults are not happening as they used to be in the past.'* [TE FGD, vCHWs]

The leadership at all level from village up to the federal is appreciative of HEP. The perceptions leaders at different levels of government structure have towards HEP is similar. They all agree that HEP should focus on disease prevention and health promotion. However, the level of understanding in this group of stakeholders varies.

The kebele and woreda leaders reflected that since the introduction of HEP, many positive changes in health are observed in the community. Local government informants say that the program empowers the community to be responsible for its health. The community is participating in implementing the interventions in the package.

Local officials appreciate the use of HEWs to spearhead the implementation of HEP. The fact that HEWs speak the local language and know the culture of the communities they serve is advantageous. HEWs easily communicate and influence the community. They say within a short time HEWs have brought a big change in the communities towards preventive practices in health.

Village leaders are involved in the selection of vCHWs. The most dedicated individuals are selected from each sub-kebele to work as vCHWs. The HEWs and vCHWs work closely. They think that the collaboration among local leaders, communities, HEWs and vCHWs is effective in the promotion of hygienic practices, child and mother immunization, pit latrine preparation and use, malaria prevention, IMCH, HIV/AIDS, and facilitating community conversation.

The woreda administration, woreda health office, the nearby nucleus health center are involved in HEP. Woreda administration has been mainly involved in the recruitment of HEWs and construction of health posts. The woreda health office is involved in assisting HEWs through training and supervision, and supply and logistics. The nucleus health center is involved in capacity building through training and supervision of HEWs. It also treats referred patients from health posts.

The roles of the regional and federal governments are the same. They have been focusing on the training of HEWs and making all logistics and supplies available at all levels of services including the health post. They are also encouraging and inviting all development partners to be involved in HEP.

The federal and regional authorities in health see HEP as a program of preventive and promotive intervention health package. The thinking is that changing the behavior of people by helping them to develop skills and knowledge in prevention is a way out to reduce disease burden of the country.

They say that in order to instill behavior of disease prevention, curative services should be given at health center while the health post should focus on disease prevention and health promotion. A federal informant says, "By focusing on prevention we could develop a behavior in prevention in the rural communities. We want our people to demonstrate ownership of health through prevention. Mixing up both preventive and curative services in one package undermines prevention.' The general belief is that people's life style towards health would change by focusing on prevention and promotion.

*'Prevention is connected with life style. As people become users of latrine and keep their environment clean, separate the kitchen from the living room, separate animal shed from home residence, keep themselves clean and start feeding themselves balanced diet and continue to practice things that do not expose them to illnesses such as HIV/AIDS, TB and other communicable diseases, HEW would not have much work in the community and can be retrained to work as community nurses. This should have to be done following evaluations of the change of attitude of communities towards preventing diseases and life style in health. Our strategy is make the system work, give it time and should not mix up so many things at one time. Let's focus now on prevention and create the knowledge, attitude and practice of prevention. The other thing is that we have not utilized the potential in communities, even 10%. Our basic philosophy in the HEP is that every household should be a producer of health and should get knowledge and skill in health. Primary units of health producers are households themselves ' (FMOH)*

The FMOH is working closely with the regions to ensure that the HEP structure is in place in terms of human resource, health facilities both health posts and nucleus health centers. A federal informant says in the coming two years all health posts would be anchored to a nucleus health center. 3200 health center would be operational. Every village would have a health post, two health extension workers. All needed logistics and supply for health facilities would be met in collaboration with donors. It is reported that 30,000 HEWs are needed to cover the whole country, out of which 24,534 have been trained and deployed and another 6000 are under training and would be deployed soon.

HEP has the full support of the regional and federal governments. The key informants are optimistic about HEP.

### 3.2.6 Development partners

Development partners are those which are non-governmental organizations involved in health. This review made contacts with some selected partners. The Center For National Health Development in Ethiopia, UNICEF, ESHE, USAID, Path Finder, the association of Public Health of Ethiopia, at the federal levels, REST, TDA, ODA, ADA at regional levels.<sup>1</sup>

The perception of development partners of HEP is positive. They are all happy with the program objectives and principles. They all agree that HEP is doing well in the prevention and promotion of health. They all agree that it is the best approach to make health services accessible to the rural communities in the country. They all think that development partners should assist and make HEP implementation successful. They say that through HEP they can reach the people.

They also say that HEP is community based, cost effect, encourages voluntarism, works on prevention and makes health service accessible to the rural community. HEP is doing well with prevention of communicable disease such as malaria, HIV/AIDS, TB and the promotion of hygienic practices and the use of contraceptives. They say the use of model families for accelerating change in health behavior is correct. Key informant say,<sup>1</sup>

*'In HEP we would anticipate the need to invest more on creating model of behavioral change in health. It is likely that the first 10% could require us more investment. However, if we create the model families then the behavioral change would happen and move fast, for we have created model health behaviors in the community that everybody would like to imitate. The idea of model families and vCHWs has a lot of advantage to instill behaviors of prevention and promotion'. [BDP]*

*'HEP has created good ground for collaboration with partners. Now the collaboration with sectors and partners is good such as during vaccination and other related community activities. During the implementation of health activities at kebele, development partners participate in HEP in terms of finance, supply of commodities and materials, construction of health posts, supplies of drugs and vaccines.' [LDP]*

Interested partners like USAID and those affiliated to the organization like ESHE and Pathfinder are assisting in strengthening services in family health. Moreover, UNICEF and USAID are working to strengthen the capacity of HEWs by giving them training in MNCH. A key informant says:

*'USAID has been interested in maternal, neonatal and child health. We are involved in the HEP to strengthen this component. ESHE, a USAID funded project, is working on this, too. Through Path Finder we are promoting Family Planning. We are trying to make ESHE and Pathfinder follow the same path. We believe that the Ethiopian society is complex and it varies very much. Any intervention has to address this. ESHE*

---

<sup>1</sup> Development partners in health that have been mentioned by regional health bureaus are included in the regional reports. However, the lists are not exhaustive.

*is trying to bring out the capacity in the community by working with vCHWs and model families. These are believed to be the ones that bring behavioral changes of the community towards health. They also assist HEWs. The main challenge in the health service was access. Now with HEP, this problem is addressed. We have been working to make sure that access to health is expanded. The HEP is a wonderful opportunity to expand on health access.’ [B.DP]*

The role of development partners towards the realization of the HEP objectives is immanent when one sees at what ESHE is doing. It is observed that the level of link among woreda collaborating offices namely the health office, the woreda administration and the health center, village leadership, community, HEWs and vCHWs and model families is stronger in ESHE woredas.

Informants in ESHE village sites reported of high immunization rate, use of contraceptives, and care for mothers and their babies in terms of follow up and feeding, preventing harmful traditional practices such as female genital mutilation. They also reported of better supervision practices and use of health information and documentation. A village leader says:

*‘Our Kebele is rated top rank and is described as a super model kebele, for what we have accomplished in HEP. The region has also awarded the HEWs for the achievement they underscored in the training and graduation of Model families. In addition, the achievement of our kebele HEWs was reported in the national media. [SLKL]*

A number of development partners have been engaged in community health care services before the introduction of HEP. Development partners in community health have been using different types of community based health workers. CHWs (Community Health Workers) were used to implement health activities at community levels. Some used CBRHA (Community based Reproductive Health Agents), some say TBA (traditional birth attendants) some say Community Health Promoters, some say Community Health Agents.

The HEP introduced HEWs as leaders in the community based health services. It says all non salaried volunteers in health are voluntary Community Health Workers. All vCHWs have to report to HEWs and have to be trained and supervised by HEWs. According to HEP, vCHWs give voluntary service and are not financially remunerated. Development partners would have to start harmonizing their resources and work at village level with HEWs as per HEP guidelines. A key informant working in FP says,

*‘Pathfinder<sup>2</sup> has the same approach to reproductive health and family planning as HEP. Our CBRHA are assisting HEWs in the distribution and management of family planning services. The main objective of Path Finder is to make FP services available to the community. FP is the key to family health and poverty alleviation. Path Finder introduced CBRHA because there were not HEWs or health posts when it started the CBRH program. Now our CBRHA are working closely with HEWs and we can easily fit in to the structure of HEP.’ [DP,PF]*

USAID is assisting in capacity building such HIMS, logistic and supply systems and overall system building. There are also practices in village HMIS. HEWs and vCHWs collect basic health statistics

of the community such as births and deaths. There is also clinical data with graphic display in every health post. HEWs record services rendered, making graphs and posting them on health post walls to show trends in EPI, number of visitors for ante and post natal care, nutrition supplements given, visits conducted, number of model families graduated and on training such as number of vCHWs by sex, educational background, display of key interventions taking place in the village, documentation of minutes of meetings, discussions and remarks made by supervisors.<sup>2</sup>

The documentation and use of health information varies by HEWs and the support they get from development partners. ESHE sites look doing better than non ESHE villages. ESHE woredas make use of collected information for subsequent actions. There is also more interaction between HEWs and Woreda supervisors in ESHE sites on the basis of the village health information collected.

HEP has created a lot of space for development partners to work on any component of the packages. A key informant from development partners says, 'HEP is an open program and has space for those who would like to support it within the policy framework.'

The role of ESHE in HEP is described as an example that other development partners could think of the support they can give. ESHE is involved in HEP and is working towards improving the

- communication and negotiation skills of HEWs and vCHWs,
- collaboration among key stakeholders, the community, HEWs, vCHWs, local leadership including the woreda through training and supply of health education and monitoring and evaluation materials
- assisting in the facilitation techniques of training HEWs, vCHWs, and model families: facilitation skills, use of materials for monitoring activities such as the use of the Family Health Card, supportive supervision, in M&E, developing modules for training HEWs,
- Giving IRT (integrated refresher training) and training in IMNCI (Integrated Management on New born and Childhood illness) to HEWs
- Promotion of EPI, nutrition, care for pregnant and lactating mothers, feeding of babies (breast feeding exclusive and additive feedings, micronutrients, vitamin A, and iron deficiency).
- Supports the Health Extension Education Center in the development of materials for HEP including tools to be used during supervision. It also supports the health extension departments in the focus regions.

Other development partners are involved in HEP. UNICEF supplies drugs and vaccination for children. The Catholic Church gives slabs for pit latrine in Tigray. A number of partners are involved in disease prevention especially HIV/AIDS.

MVP<sup>3</sup> (Millennium Village Project) is testing interventions that development partners need to consider to make primary health care reliable, equitable, and accessible. These include:

---

<sup>2</sup> Path Finder is involved in community health and uses the CBRHA which are paid small amount of money on monthly basis. The CBRHA are viewed by HEP as vCHWs. The implication is that they should not be given financial incentive to deliver the services that they are doing.

- The strengthening of health posts with cold chain facilities. Essential drugs and vaccines are to be stored at health clinic level to make EPI effective and be managed by health post staff. The idea is to make services in health accessible and reliable.
- Strengthening the nucleus health centers in the project areas by equipping them with laboratory equipments for conducting blood, urine and stool tests, building OR wing for emergency and obstetric services.<sup>3</sup>
- Building the capacity of HEWs and CHWs through refresher training and skill based training like assisting in delivery and managing MCH cases.

The FMOH invites development partners in health to assist in HEP and make a difference in the health service delivery of the rural communities. The ministry knows that there are so many gaps in HEP that development partners could fill in.

### 3.3 HEP study thematic areas

This section of the report describes the gaps that exist in collaboration and linkage among stakeholders in HEP. It also tries what could be done to bridge the gaps.

The thematic areas identified in these review include (i) access and demand (ii) quality (iii) systems (iv) referral linkage and (v) partnership/collaboration/coordination: role of kebel/woreda administration and other community leaders in support of HEP

#### 3.3.1 Access and demand

The challenge in access and demand is analyzed from (i) that of recruiting more vCHWs and graduating model families as per the HEP implementation manual (ii) community mobilization in preventive and promotive health, (iii) motivation and volunteerism of vCHWs and (iv) task shifting.

##### *(i) Graduation of model families and vCHWs*

Te graduation of more model families and involvement of more vCHWs is key in the implementation of HEP. This huge task requires the participation and involvement of the local administration, community leadership and the community at large; the collaborating sectors such education and agriculture, the skillful approach of HEWs, and close support and supervision of the woreda health office including the nearby health center.

However, the overall trend is that the graduation of model families and the involvement of more vCHWs is far behind expectation. The major obstacles are that the HEWs in most cases are overburdened by tasks top be done at the health post and the visits they have to do to implement the household and community packages. They also have inadequate skills in communication, education and transfer of skills and knowledge.

*'We have not gradated any model families. We have started the training. It is very*

<sup>3</sup> MVP-the millennium village project is testing an integrated model in development to achieve MDGs. Hawzien woreda is selected for the experiment. Key interventions in health are tested in relation to agriculture and education and see their synergistic effect on development. MVP thinks that curative services should be delivered at village clinic/health post

*difficult to implement the model family training package. We have also problem in recruiting voluntary community health workers. Those who volunteered to work as community health workers are very few. It has become difficult to convince the community. [AAHEWs]*

*/The HEW training is weak. They lack skills of communication and understanding and evaluating attitude of their clients. Some get angry with their clients. Some shout at them and discourage families from implementing the household package. We are assisting them, but they are the ones that meet the households during visits. The lack of communication and persuasive skills in HEWs is slowing down the involvement of households in attending regular training sessions. [TKA.WHO]*

### ***(ii) Community mobilization in preventive and promotive health,***

Informants confirmed that village leaders are involved intermittently in the mobilization of the community such as in the preparation of pit latrines, vaccination, and environmental hygiene and sanitation campaigns. They are also involved in the selection of vCHWs, selection of households for training them as model families. They are involved in the evaluation of activities conducted in HEP, supervision of HEWs and vCHWs and model families.

The degree and depth of involvement of village leaders, however, differ from woreda to woreda and from village to village. The review indicates that ESHE woredas and villages demonstrated higher involvement of the village leadership in HEP than the non ESHE woredas and villages. Respondents in ESHE sites and Tigray reported that there are attempts to use community structures such as *mahber*, *ididr*, *equib*, religious holidays, and community rituals to pass HEP messages.

Although there are such promising activities, the level of linkage and collaboration remains infantile and needs to be strengthened. The level of linkage and collaboration is not taking place as expected or described in the HEP implementation guide. All sites have not trained adequate number of vCHWs in the expected ratio of one vCHWs for 10-20 households. All sites have not graduated model families as planned in the HEP. Some have just started by involving fewer families.

### ***(iii) Motivation and volunteerism of vCHWs***

The review team observed that the use of vCHWs is not predictable. All informants with the exception of government officials suggest that there should be some kind of financial incentive to vCHWs. Collaborating partners are giving small amount of money for covering transportation expenses and lunch during dislocation from their homes; for example, when they attend training or review meetings.

Government says, incentives to vCHWs should be non financial such as community recognition and awards and prizes. According to government position, vCHWs should be volunteers and voluntarism should be time bound. The concept of vCHWs does not mean long term employment.

The dilemma is that some services like assisting during child birth demand skills. The treatment of illnesses like managing community DOTS, malaria drugs such as coartum, diarrhea using ORS and

determining epidemic symptoms require skills. The government's position is understandable. However, vCHWs have to be compensated. Who should compensate vCHWs should be open for discussion. If the HEP is to succeed in behavior modification, more investment is expected at the initial stage. It is understood that as shift of responsibility moves to the household, then the involvement of vCHWs would be minimal.

The idea of gradating more model families looks to be a way forward to reduce workload of vCHWs. Until such thing is realized, it looks evident that there should be ways of motivating vCHWs, without formally committing to regular financial incentive.

#### *(iv) Task shifting*

The HEP takes the HEWs as critical staff of the health human resource structure at grassroots level. HEWs are in charge of leading the implementation of HEP. The HEP program as indicated earlier has 16 packages under four classes of categories. HEWs are expected to implement all the interventions by involving vCHWs and model families. HEWs are expected to graduate all households as model families within three operational years.

All agree that it is difficult to conduct 96 hours of teaching and conduct regular visits<sup>34</sup>. The major problem is that it is difficult to bring all the selected model candidates together and attend the same training sessions. The visit is also takes time as villages are very big in size and households are scattered. There is not transportation facility to move HEWs quickly from one sub village to the other. Some households live far apart in the range of 3-6 kms.

Task shifting looks apparent. In some regions, some of the HEP packages are shifted to vCHWs, a case in point is the MVP sites in Tgray. In order to give time for HEWs to work in critical areas of intervention directly connected to MDG 4 and 5, the following tasks could be done mostly by vCHWs:

- Disease prevention and health promotion
- Environmental hygiene and sanitation
- Treatment of malarias with coartum, management of community DOTS to treat TB, use of ORS to treat diarrhea
- Collection of community health statistics
- Distribution of family planning methods/contraceptives
- And assisting in home based delivery.

#### *3.3.2 Quality of health care service delivery*

The HEP model which focuses on prevention and promotion of health at village level is an innovative one. But most of the nucleus health centers that are intended to give curative services are not in place. The existing operational health centers have serious shortage of clinical nurses and health officers, medical supplies and equipments to address the curative services in MNCH. These limitations make the quality and

---

<sup>4</sup> According to the Health extension implementation guide, HEWs are required to give 96 hours of training on all the 16 packages and conduct household visits of model families to see if they are implementing them. Model families should attend over 70 hours and should be evaluated positively in implementing the household packages in order to graduate.



access in primary health care weak. This may make the attainment of MDG4 and 5 difficult which requires governments to

- Remove financial, geographic, and cultural barriers to free clinic access
- Properly equip and staff clinics
- Promote maternal and child health through antenatal clinics integrated within primary care clinic providing all essential basic health services.
- Promote institutional births assisted by skilled birth attendants
- Guarantee free access to basic and comprehensive emergency obstetric care
- Promote gender equity and women's empowerment
- Protect confidentiality and privacy for women seeking care.
- Promote integrated, synergistic health care of mother and child
- Enhance preventive and promotive maternal and child health care in addition to therapeutic strategies

(Source MDG in health strategy: Reliable Equitable Accessible Community Healthcare<sup>5</sup>)

HEWs are required to give special attention to the health of mothers and children under five. They give the education on MCH. However, HEWs do not assist in delivery because they lack practical skills to do that. This has decreased the level of confidence of beneficiaries on HEWs. Because HEWs do not assist women in labor, communities carry such women to the closest health center. Informants say that the health centers do not readily assist such women. Paying for transportation is expensive. Sometimes there is no road from the health post to the health center. It is also far. The serious complaints regarding women on delivery are distance from health post to the health center, financial and psychological. HEWs also feel embarrassed in that they are not able to give the service. A HEW says:

*'We are not able to handle facility based delivery; the health post space is small and is not conducive for providing health provider assisted delivery. People are not happy that we are not able to give basic treatment services for a sick child, mother or adult. As health workers we get embarrassed to admit to the clients that we are not trained to give curative services. Sometimes children get ill with pneumonia and die. The community really gets dissatisfied since we cannot help them apart of advising them to go to the health center. Many poor families fail to go to health center and resort to traditional treatments.'* (ODHEW)

Clients complain of distance to carry a patient from a village to a health facility where treatment is sought to be available. They complain of transportation expenses, lack of transportation services such as transport cars, ambulance services, and logistical expenses especially when relatives accompanying a patient have to stay away from home.

---

<sup>5</sup> The REACH model is a health strategy approach in primary healthcare services designed to guide countries to achieve MDG 4, 5 and 6. The REACH model expects village clinics to deliver both curative and preventive services. It requires the use of midwives, clinical nurses, community health workers and even health officers to be deployed at village level.

### 3.3.3 HEP systems

This section sees into (i) logistics and supply (ii), village HIMS, (iii) participatory planning, and (iv) transportation.

#### (i) Logistics and supply

HEWs are working in poorly equipped and supplied small size health posts. Health posts have shortage of essential drugs and commodities such as vaccines, ORS and palliative drugs. Some do not have delivery beds and health post equipments essential for MNCH as per the HEP requirement. The rooms are small and there is no waiting room for critically ill patients or for emergency cases. Support to HEP should address this need.

Health posts are ill equipped. HEWs say they have difficulties to monitor pregnant mothers and newly born babies and children under age of five. HEWs are unable to deliver facility based delivery assistance for women seeking assistance during delivery. The data from beneficiaries at community level show that a number of health posts are not functioning due to lack of equipments and supplies; HEWs are unable to conduct the visits of households because of distance, patients are not referred because of lack of nucleus health center.

A Health Center officer said:

*'There are 23 health posts under one health center in the woreda. However, only 4 posts refer patients to the health center. This is due to the location of the health center. The Health center is not centered to link all health posts. Transportation, distance, finance and lack of skills of HEWs to make referrals are some of the predicaments in referral linkage between health post and health center.'*

The HEP makes drugs at health post to be given free of charge. But the drugs given free of charge at health post are charged if they are given at a nucleus health center. Other curative drugs like antibiotics have to be purchased from private clinics at higher prices. Health facility pharmacies are reported to be always lacking the most needed drugs. Patients who have been to health centers complain of difficulties they faced to access the services. The prices of drugs they are asked to buy are exuberant. The bureaucracy for producing free medical service paper is time taking and complicated.

#### (ii) Village HIMS,

HEWs and vCHWs collect information. However, their ability to make use of data and plan new activities for intervention is weak. They only report such information to the woreda. The woreda health bureau is not seen making use of the information to plan interventions with HEWs and vCHWs. Use of data to plan activities has been observed in ESHE woredas, however. As HEP is community based intervention, developing the capacity of HEWs to understand and interpret vital statistics in health is essential. Both in the pre and in-service training, this skill needs to be given attention. Woreda supervisors must be able to use and understand village health information and show HEWs how to make use of such information.

### **(iii) Participatory planning**

There are obstacles related to governance, knowledge and skills that are delaying the implementation of HEP. The rapid appraisal identified the following as areas of intervention for improved implementation of HEP. The first weakness is the lack of consistent support from the local administration. The support they get from the village and woreda administration is not as per the HEP implementation manual and guide. As it has been indicated earlier woreda administration lacks the capacity to closely support and follow activities of HEWs and vCHWs.

The second major obstacle is the support that HEWs get from the woreda health office and the nucleus health center is limited and irregular. The role of the woreda health office in helping HEWs and vCHWs to implement the HEP activities is clearly stipulated in the implementation manual. The woreda health office and the nucleus health center lack the capacity and means to play their role as per the HEP guide. The nucleus health center let alone to offer capacity building activities to HEWs such giving short training and supervision is not able to manage all referral cases from health posts.

### **(iv) Transportation**

The villages are geographically big and the sub villages are scattered. HEWs have to walk for 3-4 hours to travel from one sub village to the other. This has affected their ability to visit households and get enough time for discussion and negotiation with families. The problem has to be addressed if HEWs are to make the visits to households on regular basis.

#### **3.3.4. Referrals**

HEWs hardly make referrals because they do not give curative services. Members of the community travel to the closest health facility on their own without getting referral from the health post. Some patients do come to the health post looking for assistance. However, HEWs advice those to go to the health center or hospital in the woreda or zone. This has disconnected HEWs from assuming full responsibility in the management of the community health needs. In effect, it has reduced their level of acceptability. Thus, interventions in HEP should help in the establishment of close link between health posts and the nucleus health center. Referrals have to be run smoothly.

As per the four tiers system of health delivery service in the country, there is one nucleus health center for five health posts. The major activity of a nucleus health center is to deliver curative services. Patients that seek curative treatment are referred to the nearby health center. Health centers are also expected to assist technically in training and supervision. However, the referral linkage and the technical support that health posts are supposed to get from health centers are very weak. There is little technical assistance coming to HEP from health center. The link is very much limited to supply of basic commodities such as family planning methods and vaccines.

Referral linkage with health center is weak. Patients are advised to go to health centers, but there is no mechanism for follow up. Patients sometimes get discouraged and stay at home due to distance and financial problem. A kebele leader says:

*'There is poor relationship with the health center or hospitals and patients referred to the health center do not get cooperation from the facilities. Shortage of drugs is a problem. We have to buy drugs from private pharmacies and they are expensive.'* [kebele leader]

This could be because the health centers have shortage of human resource, supplies, equipment and transportation. The number of health centers already built is very low while over 80% of the required health posts are built. It is only 30% of the expected health centers are constructed. Therefore, most health posts do not have nucleus health centers. According to HEEC (FMNOH),

*'We have planned to produce 30,000 HEW and actually we have deployed 24,534 with 80% coverage. 6000 are now under training and very soon coverage would be 100%.'*

The number of health centers out of the total expected, less than 650 are functioning. The FMOH thinks that in the next two years the number will be reached and all health posts will be anchored to their respective health center. There are also additional 800 district hospitals under construction.

The challenges to make a nucleus health center functional are human resources, equipment and supply of medical commodities. Unless development partners assist it would look farfetched to make all nucleus health centers and the district hospitals operational in the next two years.

All in all the linkage and collaboration of the health post with woreda administration, health office, health center remain weak due to lack of capacity.

### **3.3.5 Partnership/Collaboration/coordination: Role of kebele/woreda administration and other community leaders in support of HEP**

According to HEP program management and governance, the woreda administration, woreda health office, and the woreda health center are stakeholders in the overall management and implementation of HEP.

The woreda administration is required to:

- (i) allocate budget and other sources
- (ii) co-ordinate activities implemented by government and non-government bodies, and
- (iii) assist in, monitoring and evaluation.

The woreda administration in all sites visited is involved in the selection of candidates to be trained as extension health workers, construction of health posts and nucleus health centers. HEWs are paid their salaries and no complaint has been reported. However, the woreda administration is not reported to be involved in the monitoring and evaluation of HEP in the villages. In ESHE woredas, the administration is more involved than in non-ESHE woredas.

The woreda health office is mandated to perform the following activities:

- (i) provide technical, administrative and financial support;

- (ii) allocate budget and supplies to health center and health posts,
- (iii) adapt communication materials,
- (iv) provide supportive supervision of HEWs and the overall management of health centers and health posts
- (v) plan and provide in service training to HEWs and woreda Health office staff and
- (vi) obtain reports from health posts and health centers and provide information to regional health bureau/zonal health department.

ESHE woredas use adapted communication materials because of the technical support they get from ESHE. However, non-ESHE woredas depend on the materials sent to them from the Health Extension and Education Center. The woreda health offices do not have the capacity to adapt communication materials.

The woreda health offices have assigned focal persons for the HEP and a nurse who is supposed to do the supervision every month, but normally done on every three months. The major obstacles for conducting regular supervision are shortage of manpower, logistics and transportation. The supervision is based on checking activities done and commenting on what HEWs need to do. It is difficult to say there is supportive supervision in practice

The FMOH is aware of this and it is now training 3200 supervisors and one supervisor would be able to see 5 Health Posts. This would increase the frequency of visits. It is hoped that there would be opportunity to make supervision supportive instead of evaluative.

The woreda health office is also expected to conduct in-service training to HEWs and as well to its staff. The woreda health bureau is too weak to meet this responsibility. ESHE, however, is helping woredas to conduct training and capacity building of HEWs and vCHWs and give supportive supervision.

With regards to HIMS that the woreda health bureau is supposed to compile all reports coming from the health post and health center and submit them to zone or regional health bureau. The health posts were observed documenting their activities, some on files and others on charts and graphs. ESHE woredas look to be better organized in information documentation and management. But the documentation of activities and epidemiological data is very weak and is not managed systematically.

As per the HEP guideline, the FMOH and Regional Health Bureaus have major roles to play in HEP. The HEP concept has been developed at the central level in consultation with regions. The FMOH has prepared guidelines, HEP profile and different implementation manuals and training modules. The FMOH is working on the career structure of HEWs, is mobilizing national and international resources by popularizing HEP objectives and modes of delivery. In collaboration with ESHE the HEEDC is preparing different communication materials and training modules. The logistics and supply system is being developed in collaboration with development partners and would be implemented soon. The HIMS is being developed. Village HIMS has started. HEWs are collecting vital statistics at village level. Bilateral and multilaterals are assisting FMOH in its effort to make health services accessible, equitable and achieve MDG 4 and 5.

As per the guideline in HEP, regions are in charge of the training of HEWs, building of health centers and as well as ensuring that all woredas have health posts in their respective villages. Regions in collaboration with woredas are supposed to make sure that all health facilities be it health center or health post are equipped with essential medical commodities, drugs and equipments. Regions are required to make sure that the HEP structure with facility, human resource and supportive structures at village, and woreda are all in

place. The regions are working to make the health structure complete and functional. They are providing technical and administrative support to woreda health offices, adapting implementation guidelines to local conditions especially the use of local languages, strengthening HIMS, logistics and supply services at a limited level. There is a problem of capacity in terms of human resources and logistics.

Federal and regional authorities have strong conviction and commitment to make the HEP exemplary health service delivery model for developing countries. They strongly believe in the promotion and prevention of health services as central in health care for rural communities. Federal authorities in health are creating conditions for more investment in health at village level by inviting all development partners and interested group to give their support through the HEP structure. The FMOH in collaboration with the regions has been following closely the activities of HEWs and those who have done excellent works are rewarded in colorful ceremonies.

However, both the center and the regions have not succeeded in mobilizing local and international resources to make the HEP fully operational as planned. As has been mentioned earlier, the majority of health posts are not anchored to health centers because the number of health centers in place and that are operational are less than 30% of the required number. Health posts are not equipped with basic medical tools, drugs and supplies, transportation and communication services, supportive supervision and follow ups, in-service training, regular monitoring and evaluation as per the HEP implementation manual.

#### **4. Discussion: RMNCH and Curative Services**

The critical challenge in HEP is the RMNCH and the curative services associated with it. The MDG 4 and 5 can only be met so long as the HEP is able to deliver services in RMNCH at a community level. HEP has moved further in such a way that household focused intervention would ensure transfer of knowledge and skills in health and families would be beneficiaries of such a practice. HEP does recognize the need to focus on RMNCH and has put it at the center of the program.

The challenges in RMNCH are not only prevention and promotion but curing sick mothers, newly born babies and children under five. The government policy in HEP is that there should be more time given to work on instilling attitudes and beliefs in prevention of diseases and promotion of health in beneficiary communities.

As a matter of temporary strategy, it is necessary to separate cure from prevention. The FMOH strategy as has been underlined in the preceding sections is that at household and community level where the health post is functional, the work of HEWs and vCHWs and the role of other stakeholders should be on implementing the sixteen packages on preventions and health promotion. The curative services would be given at the nucleus health center. The policy assumes that there would be one nucleus health center for every five health posts. It is assumed that the nucleus health center would be accessible for patients referred from health posts.

As has been discussed under gaps in HEP, the structure of one nucleus health center for every five health post is far from being realized. The issue of accessibility of patients either referred by HEWs from health posts or going by themselves to health centers and hospitals has been reported to be difficult: transportation, access to drugs, logistics for the patient and those accompanying patients, and readiness on the side of the referral facility to treat such patients. With regards to assisting women during delivery, HEWs are expected to do that. However, as has been reported in the preceding sections, HEWs lack the practical skills to assist during delivery.

Health workers and organizations involved in primary health care especially in RMNCH report that pneumonia is one of the major killers for children under five. HEWs are not expected and do not have the skill to treat pneumonia and do not have the knowledge and ability to administer antibiotics.

What is happening in RMNCH in HEP is promotion of family planning commodities, preventing practices that expose to reproductive health illnesses such as STI, HIV/AIDS and other harmful practices such as female genital mutilation, early marriage; give services in ante natal care such as advising women expected to face difficulties during delivery to be close to hospital or health center during the last week of expected date of birth —very difficult for peasants to do so.

HEWs advice mothers on how to take care for themselves and their newly born babies such as use of hygienic practices, feeding both breast and supplementary, take vaccination. HEWs advise mothers to report to the health post when a baby is febrile, refuses to suck and shows syndromes of discomfort. However, they cannot assist in treating sick babies, apart from advising mothers to take the patient to a nearby health center or district hospital. There is no assistance from the health post to transport the sick baby to the referral health facility. Families report that they get discouraged and end up going to traditional

healers. It looks reasonable to think of the common illnesses that affect babies and find ways of making the service available at the nearest health facility. This has to be medically decided.

The gap in assisting delivery at health post is a matter of training HEWs to develop the skill. In some whereas CHWs with experience in assisting in birth like the traditional birth attendants are managing safe, clean home delivery. This gap can be resolved by giving training to both HEWs and vCHWs as is currently being done in Tigray and Amhara.

The issue of treating pneumonia remains controversial, for it requires HEWs to learn how to administer antibiotics including needle injection. The argument for making pneumonia treatment close to the people is that the illness does not give time for the patient. If baby patient doses not get the treatment quickly, it dies

The question is what could be done to strengthen HEP to address some of the critical illnesses that concern the communities and stakeholders in health.

As has been underlined in the preceding section, the HEP should not be left to government alone. The ESHE intervention practices in communication and RMNCH messages, material development, strengthening supervision, and linkages of stakeholders should be taken as good example for other partners. ESHE sites have demonstrated better capacity in the implementation of HEP; graduated more model families, use health information for planning activities, closely linked relation among stakeholders—community, local leadership, sectors and woreda administration.

The other good practice that is happening in Tigray is the MVP intervention in health MVP has strengthened both preventive and curative services in its intervention sites by equipping and strengthening health posts, nucleus health centers including the referral health center at Hawzien. The practice has completely reversed the disease burden in the area. MVP has temporarily employed nurses in health posts to assist HEWs to deliver services in RMNCH and other prevention activities. The idea is to build the capacity of HEWs to assist in delivery as well as gradually give curative services on critical diseases like pneumonia.

The FMOH argument is, as has been mentioned earlier, that most diseases are preventable and the patient load would be reduced if preventive and promotive health behavior is developed in the community. The idea of giving curative services at health post is not closed. The HEP recognizes the treatment of malaria, TB, and diarrhea at health post level. The pneumonia treatment at health post has to be seen in the light of good evidences. Pneumonia treatment is related to distance. A study is made to determine whether the distance between health post and nucleus health center would delay access to treatment of pneumonia patients. Under good evidences pneumonia treatment could be treated at health post level. A key informant at federal level says:

*'Giving curative services at health post is not closed. It will depend on our evaluation of the context. For example if there are hard evidences to include treatment of pneumonia at health post, there is no reason why we should not include it along malaria. But it has to be substantiated with evidence if we are to include it as a treatable disease at village level. The pneumonia issue is being studied in consultation with the School of Hygiene and Tropical Diseases of the University of London. Distance is being mentioned as a factor to be considered i.e. distance between the HP and the HC. We can see this after we get good evidences.'* (FMOH)



Furthermore, the HEP anticipates that as households become owners of health, HEWs would be relieved from the visits they are doing and will have more time to be trained as community nurses. 'HEWs could be graded to diploma level like becoming community nurses gradually. The career structure for HEWs is being developed.' (FMOH). This would lead to the bringing of some critical curative services close to the community. It is, however, essential to give time and space to instill the knowledge, attitude and practice in health prevention and promotion.

The community, the local leadership, HEWs, vCHWs say that there should be some curative services offered at health post. They say HEWs should have skills in administering antibiotics. HEWs also say that they need basic skills like needle injection and follow up of patients taking antibiotics prescribed by doctors. They would like to treat pneumonia patient. Community leaders, local administrative leaders and health center informants also agree that the health post should not be limited to prevention and promotion.

Considering the problems of linkages with health centers and hospitals which are mostly affected by distance, lack of means of transporting patients, logistics and shortage of drugs, it would be desirable if some critical but curable diseases could be managed at health post. Health professionals say there should be standard set as to the type of diseases to be treated at health posts and the manner of treatment.

The demand for including basic curative services at health post looks to be overwhelming. On the other hand, the government's position of pending antibiotic based treatment services such as giving injections and treating illnesses with antibiotics to give time to prevention is logical and sound. As HEWs start focusing on curative services, the attention they would give to the demanding and most important task of changing people's thinking towards prevention would be jeopardized.

On the other hand, the problem of distance, logistics, poor service delivery at the referral facility as reflected by all informants indicate that something must be done to accommodate some of the critical services in cure. Taking the complex nature of Ethiopian societies, it would be appropriate to selectively introduce curative services in health posts where access to a nearby referral health facility looks difficult either because of distance, lack of road transportation, and other communications in case of emergencies. Within the HEP framework there should be leeway where a health post could accommodate clinical services considering the context of the intervention site. HEP needs to be a context sensitive health delivery service community program.

## **5. Recommendations and Conclusion**

### **5.1 Recommendations**

The following recommendations are based on the suggestions made by participants of the study including the observations made by the research teams and the data collected from key informants and focus group discussions.

#### ***(i) Access and demand***

There should be more investment in the training of model families by allocating budget and technical support to speed up the process. HEWs need assistance from government and development partners. The woreda health office and the nucleus health center have to actively participate in the training process.

The use of vCHWs has been found to be basic for promoting preventive health practices and improving health outcomes. It is thus recommended that investment needs to be made on vCHWs until the community exhibits ownership of health. In order to maintain the momentum in vCHWs, both training and incentives should be considered. Such incentives and training opportunities should be done in a uniform manner. While the social recognition and respect such volunteers get from the community remains the main driving force for vCHWs to continue giving the service, dislocation from their source of income can force them to stop giving such essential services. There should be ways of addressing this.

#### ***(ii) Quality***

The review revealed that HEWs and vCHWs need capacity building through training in order to deliver the services expected of them. The following recommendations are forwarded:

##### ***(a) Improve and revise the pre-service training modules in HEP***

The training modules are too broad to be covered in the training time. The curriculum and the training modules should be revised. More time should be given to MNCH training, communication skills. HEWs must have skills and knowledge in curing diseases that cause mortality of mothers and children under five. They need skills in integrated management of new born childhood illnesses (IMNCI).

##### ***(b) Improve in-service training***

HEWs are not getting systematically organized supportive training and supervision to develop their skills and capabilities in HEP. The link with the woreda and health center should be strengthened to ensure that HEWs are supported and visited and their work supervised. There is emphasis in linking HEWs to the community leadership. Although this is important HEWs need to get ideas and advises from professionals with better knowledge and experience in community health service delivery. HEWs need skills in conducting supportive supervision during the training of vCHWs, pedagogical skills in the transfer of knowledge and skills to vCHWs and model families, in the supervision of household activities and facilitating feedback sessions. In-services training opportunities need to focus on these skills and abilities.

There should be adequate supply of simplified message focused materials in all the packages that HEWs can use to train model families and the community at large. The assistance that ESHE is giving to the sites where it is working with simplified message focused materials has to be scaled up.

***(c) Improve supervision practices***

The woreda health bureau needs to be strengthened with staff that can supervise, assist in training as needed, monitor and evaluate activities of HEWs in the health posts and during home visits. It is likely that a woreda will have more nucleus health centers and health posts as the HEP becomes fully operational. In order for the woreda health office to be able to ensure quality health service, it is recommended that development partners give attention to the capacity building of the woreda health office in supportive supervision practices

***(d) Improve working conditions of HEWs***

The working condition of HEWs have to be improved: address the housing, transport, space of health posts, water and electricity services, and equipment needs of HEWs.

**(iii) Systems**

The HEP has to improve in key systems: logistics and soupy, village HIMS, partnership in planning and transportation services

***(a) Improve logistics and supply***

According to UNICEF availability of supply and logistics is satisfactory. The major problem is distribution. However, most health posts and health centers reported that they have serious shortage of equipments, drugs, sanitary commodities. It is recommended that the distribution systems well as the supply should be harmonized and woreda health offices should ensure that essential health commodities are available at each health facility.

***(b) Improve community based health information management system (HIMS) including using data for decision making***

Monitoring, evaluation supervision and reporting have to be strengthened at health post level; basic health statistics, documentation, and reporting.

The health information management system especially the collection of basic data on new born and dead is a good beginning. But this has to be expanded in such a way that data could yield the identification of cause of death, the number of pregnancies in women to track abortions, death and miscarriage and number of children in a family for targeting interventions. Such data when aggregated at regional and national level would be useful.

HEWs need computer skills to enter data. HEWs have to be trained in the use of health information community and clinical data for identifying, planning, prioritizing and evaluating of intervention activities.

***(c) Improve participatory planning***

Participatory planning as per the HEP requirement is not institutionalized. Most of the work in HEP is left to HEWs. The village leadership, community and vCHWs including the woreda should participate in the planning and monitoring of interventions in family and community health packages. It is also envisaged that other stakeholders such as sectors and partners should be part of the planning and evaluation of HEP village interventions. The broader community also has to be involved and contribute to participatory planning and evaluation.

Thus, to make this institutionalized and operational it is recommended that a HEP village committee involving HEWs, village leaders community representatives, vCHWs representatives, sectors and partners be formed to cater for participatory planning, evaluation and monitoring as well as dissemination of information. The broader community could participate by organizing community dialogue and conversation on emerging issues.

#### ***(d) Improve transportation services for HEWs***

Transportation is a major challenge for HEW to conduct regular visits of households and attend meetings at different sub villages.

It is recommended that the transport needs of HEWs need to be addressed fully and immediately by considering the village context. Some may need mules, other bicycles, etc.

#### ***(e) Improve referrals***

Referral Linkage between the health post and nucleus health center remains weak. Those health posts that have nucleus health center where they could refer patients have no formal way of referring patients and getting feedback on patients referred. There is also problem of transporting patients to the referral health center. The logistics problem is also mentioned, for most rural communities are poor and find it difficult to meet the logistics related to displacement, purchase of drugs. Referral nucleus health centers in most cases are ill prepared to handle patients coming from different villages. Many health posts could not be anchored to nucleus health centers, because such health facilities are not constructed.

It is recommended that the referral linkage has to be worked out by making referral formal and standard, constructing more referral health centers, and addressing the logistic and transport constraints. Referral health centers should be strengthened with human and material resources including transportation services for staff during training and supervision; giving ambulance services to patients in critical condition. Strengthening the health center is basic to the success of HEP. Development partners have to assist in this respect.

#### ***(iv) Improve collaboration and participation of stakeholders***

##### ***(a) Strengthening community participation***

It is also important to strengthen the relation among HEWs, vCHWs, the community, and the village leadership. Although there are indications that these is happening to some extent, it is clear that HEP cannot be realized unless these key stakeholders team up and create synergistic effect on implementation. Stakeholders say that there should be capacity building of communities through training in health

management, cost sharing schemes such as community health assurance, building of infrastructures such as access roads.

The existing social capital in communities should be used to promote more health insurance for the community especially in supporting patients referred and with financial problems. The experience in *idir*<sup>6</sup> could be adapted to initiating community health insurance with initial grants from cooperating partners. The experience in *equib*<sup>7</sup> can be used for the introduction of loan free of interest scheme so that individuals can borrow money to cover medical expenses. Such a process can contribute to the sustainability and scalability of essential health services without overburdening the government, and over depending on donor funds.

#### ***(b) Strengthening the roles of woreda, health center, woreda health office in HEP***

The relation among woreda health office, Health Center and Health Post needs to be strengthened. The health center should assist in capacity building activities of HEWs such as delivering focused training in MNCH, supervision of health post conditions and activities of HEWs.

The woreda health office as has been indicated above has to be strengthened to give supportive supervision to HEWs, evaluate health post conditions, make all supplies needed available on time.

#### ***(c) Strengthening political participation***

The political leadership at different levels has to be targeted during capacity building activities including in the evaluation of HEP. Health has to be seen as a political issue and as a basis for integrated rural development and poverty alleviation. The woreda and village political leadership have to be actively involved in community mobilization, creating village structures that speed up implementation. They could take a lead in the use of social capital in villages, for example, they could play vital role in the establishment of community health insurance scheme by activating available traditional structures such as the *idir* and *equib*.

#### ***(d) Strengthening sectoral linkage and participation***

There are government sectors in the villages like schools, development agents and extension workers in agriculture and rural development. Available structures have to work together to create synergy. Health, education and agriculture as well as infrastructure are very much related to each other.

#### ***(e) Defining roles of NGOs and CBOs***

The roles of NGOs and CBOs in HEP should be defined. The support such entities give to HEP should be clarified. Harmonization of resources from donors in order to ensure consistency and equity in the program is essential.

---

<sup>6</sup> *Idir* is a community based institution where members contribute certain amount of money on monthly basis in order to cover expenses of funeral ceremonies and give some financial assistance to the family of the deceased.

<sup>7</sup> *Equib* is a community based institution where interested group agree to contribute money on agreed time intervals. The contributed money is taken by members turn by turn. It is an institutionalized loan system which is free from any interest.

## **(v) Strengthening RMNCH and curative services in diseases of impact**

The major concern of this study is how to improve health outcomes in relation to improved health of mothers newly born babies and children.

### ***(a) Improving feeding practices of mothers, babies and children under five***

While all the success stories in prevention and promotion remain the basis for achieving safety of mothers and their children, malnutrition is the underlying cause for mother and children poor resistance to illness. How to improve child and mother feeding with available resources and introducing activities that generate income for mothers should be part of improving the life of women and their children.

### ***(b) Improving access to ante, post natal care and safe delivery service***

The health of mothers and their newly born babies have to be ensured through improving the quality in ante, post natal care and clean and safe delivery services. It is recommended that HEWs and vCHWs continuously improve in MNCH through regular refresher training. The clinic equipments should be checked regularly to ensure safe delivery. There should be a separate room for mothers and children under treatment at the health post.

### ***(c) Curative services for diseases of impact***

This has been controversial in HEP although some diseases like malaria, TB, diarrhea are included. It looks necessary to include pneumonia, for it is one of the major killers of children under five. HEWs and other health workers say that pneumonia has to be treated immediately.

The most effective strategy would be to identify the type of treatments that could be given at health post and give more training to the existing health extension workers and most probably shift some of the tasks they do to vCHWs to get them time to treat diseases of impact such as pneumonia. This implies that there is a need to revise the training curriculum of the HEWs and the need to give in service training on critical curative services and on follow up of patients. This would also imply that there is the need to redesign or expand the health facility by building a room or two for delivery services and inpatients on emergency. However, such an intervention should not bring more recurrent cost to the government, although per capita expenditure of government in health is expected to increase.

## **5.2 Conclusion**

The efforts made by the Ethiopian government and its development partners to make health service accessible to the rural communities are commendable. The HEP could be a model for many African countries that share the same socio economic conditions with Ethiopia. The HEP is a participatory strategy in health that involves all stakeholders. It is a typical community based model and its conceptual framework is based on community ownership of health. In this sense the model lends itself to sustainability and scalability.

The HEP although is said to be cost effective requires huge assistance from partners to make it functional with the minimum input in health. Thus, development partners have a lot of space to be part of the HEP. The argument with regards to curative services at health posts should be underpinned by realities and good

practices. It should not be argued in a dogmatic way or from a position of power. HEP has so many gaps that have to be addressed on the principle of collaboration, coordination and harmonization of resources, skills and knowledge. The government's concern of the need to instill beliefs and attitudes in disease prevention is well taken and should be appreciated, for that is the only effective means to reduce disease burden.

The existing health extension model has to be maintained and the emphasis should be on prevention and promotion and its objectives of making households producers and multipliers of health should be enhanced. HEP is proving, beyond doubt, that communities and households own health. It is a matter of assisting them to realize this potential and helping them to use available structures and create new structures to prevent themselves from illness. Thus, all support should be channeled through the structure of HEP. There should not be any parallel system that ultimately erodes that focus of the program.

It looks that if HEP is very much left to the government only. Government has to encourage development partners to participate in HEP. Development partners as ESHE is doing have to be involved. What looks clear is that the government has made a health structure that aims at reaching every household. This structure needs a huge support from development partners if Ethiopia is to successfully implement HEP and achieve MDG 4 and 5.

**Annexes:**

**Annex A: Study sites by region, woreda and kebele**

Region	Woreda : Dodota		Woreda: Boset		Remark
Oromia	Kebele:	Kebele:	Kebele:	Kebele:	
	Hudesa Bitela	Dodota Alem	Dunguro Tieyo	Buta Daricha Geda	
Amhara	Woreda ; Arthuma farsi		Kutaber		
	Kebele	Kebele	Kebele	Kebelke	
	Goilbo Arba	Dermesa	Haroye	Alansa	
SNPPR	Woreda; Silte		Woreda Lemu		
	Kebele	Kebele	Kebele	Kebele	
	Kechacho	Demala	Kedigsa	Dubanchu	
Tigray	Woreda: Enderta		Woreda: Kel;te awlalo		
	Kebele	Kebele	Kebele	Kebele	
	Derbi	Dediba	Aynalem	Mahber Weni	

As indicated above, the source of data are key informants and FGDs. Table 2 shows the number and type of key informants interviewed and FGDs at kebele, woreda, region and federal levels.



**Annex B: Source of data by stakeholders (key informant Interview and FGD)**

Source of data	Federal	Regional	Woreda	Kebele
FOCUS GROUP DISCUSSION				
Community	-	-	-	16
vCHWs	-	-	-	16
KEY INFORMANT INTERVIEW				
HEWs				16
kebele leaders				16
Community leaders				16
Woreda leaders			8	
Woreda Health bureau			8	
Woreda health center			8	
Regional health Bureau		4		
Regional Development partners		5		
Federal government	2			
Federal Non-government	6			

## Annex C1: Amhara development partners in health

Development Partner	Activity
ESHE USAID (Essential Health services for Ethiopia)	Health communication and RMNCH
FHI Ethiopia	HIV/AIDS, Health Choice for Youth
World vision	Libo-comcum school and health promotion
Mary Stops international Ethiopia (MSIE)	Family planning and reproductive health
CVM	HIV/AIDS prevention and control
Carter center Ethiopia	Intergrated malaria and trachoma prevention and control
Mensin for Mensin	Reproductive Health and HIV/AIDS prevention
Plan Ethiopia	Child centered community Health program
Amhara Development Association (ADA)	Community Based reproductive Health
DKT	Family Health, HIV/AIDS and community Health Education
AMA (anti-malaria association)	Integrated Malaria, HIV/AIDS and community Health Education
Path Finder	Family Planning and Reproductive Health
Packard Foundation	Family Planning and reproductive Health
Association of public health of Ethiopia	Capacity building in community health
Intra health	PMCT, VCT, HIV/AIDS
UNICEF	Supply of equipments, drugs and vaccines
UNDP	HIV/AIDS
Africa development fund (ADF)	Works in construction of health posta and health centers and rural water supply and sanitation program
Management for Science (MSH)	General health
Rational pharmaceutical Management (RPM+)	Supply and distribution of drugs
CARE	Youth Reproductive Health
Christian Voluntary Mondale (CVM)	HIV/AIDS
IPAS	Save delivery
Organization for Rehabilitation and Development of Amhara (ORDA)	HIV/AIDS, Reproductive health
World Vision	HIV/AIDS and training of community counselors
Food for Hunger International	Primary health care
Sweden international development agency (SIDA)	Community health
Clinton Foundation	HIV/AIDS

## Annex C2: Oromiya development partners in health

Development Partner	Activity
ESHE	HEP; communication, capacity building in RMNCH
ODA	Reproductive Health and family Planning
GFTAM	HIV/AIDS, TB. MALRIA
FGAE	Family Health; family planning and reproductive Health
Path Finder	Family Planning and Reproductive Health
World Vision	Construction of Health posts, HIV/AIDS
OSSA	HIV/AIDS
UNFPA	Family planning
Mari Stops International Ethiopia	Family Planning and Reproductive Health
UNICEF	Supply of medical equipment, drugs and supplies, vaccines to health facilities
Packard foundation	Family Planning
Rational pharmaceutical management (RPM+)	Supply of drugs
Save the Children	Youth reproductive health, HIV/AIDS
Clinton Foundation	HIV/AIDS

### Annex C3: SNNPR development partners in health

Development Partner	Activity
ESHE	Capacity building of HEWs, vCHWs, in communication and negotiation skills, RMNCH
Path finder	Family Planning and Reproductive Health
FGAE	Family Health; family planning and reproductive Health
Path Finder	Family Planning and Reproductive Health
World Vision	Construction of Health posts, HIV/AIDS
OSSA	HIV/AIDS
Association of people living with HIV/AIDS of SNNPR	HIV/AIDS
Mari Stops International Ethiopia	Family Planning and Reproductive Health
UNICEF	Supply of medical equipment, drugs and supplies, vaccines to health facilities
Irish AID	Primary health care, construction of clinics, training of CHWs
Goal	HIV/AIDS, Primary health care
Action AID	HIV/AIDS and Reproductive Health
SYNODS	HIV/AIDS and Reproductive Health
Rationale pharmaceutical management (RPM+)	Distribution of drugs and supplies
IPAS	Reproductive Health
Save the Children	HIV/AIDS, Reproductive health
ITECH, JHPIEGO	HIV/AIDS

#### Annex C4: Tigray development partners in health

Development Partner	Activity
Millennium; village project	Primary health care strengthening preventive and curative services in primary health care
REST	Family Planning and Reproductive Health
TDA	Construction of health posts
FGAE	Family Health; family planning and reproductive Health
Path Finder	Family Planning and Reproductive Health
World Vision	Construction of Health posts, HIV/AIDS
OSSA	HIV/AIDS
Association of people living with HIV/AIDS of Tigray	HIV/AIDS
Mari Stops International Ethiopia	Family Planning and Reproductive Health
UNICEF	Supply of medical equipment, drugs and supplies, vaccines to health facilities
MSF Holland	HIV/AIDS
Rational pharmaceutical management (RPM+)	Supply of drugs
Save the Children	Youth reproductive health, HIV/AIDS
Clinton Foundation	HIV/AIDS

## **Annex D: Documents consulted**

FMOFED (2006 ). *Ethiopia Building on Progress: a Plan for Accelerated and Sustained Development to end Poverty* (PASDEP, 20005/6—2009/10)

FMOH , Ethiopia. *Health Sector Strategic Plan 2005/6—2009/10*. September 2005.

FMOH. Ethiopia. *Ethiopia s Third national Accounts,2004/2005*. Addis Ababa. 2007

FMOH (2007). *Health extension program in Ethiopia: Profile*. ( Health Extension and Education Center , FMOH)

FMOH (2007). *Health Extension implementation Guide*. (Health Extension and Education Center, FMOH)

JSI. *The Last Ten Kilometers: what it takes to achieve health outcome in rural Ethiopia*. April 17, 2008. JSI. Research and Training Institute, inc. power point presentation.

UN millennium Project a quick wins. MVP handbook REACH model in Health.

*Available documents at health posts were consulted, too*



JSI Research & Training Institute, Inc.

**The Last Ten Kilometers Project**  
JSI Research & Training Institute, Inc.  
PO Box 13898  
Addis Ababa, Ethiopia  
Phone: +251 11 662 0066  
Tel: +251-11-6620066  
Fax: +251-11-6630919