Somali Region HEP profile

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1. Back Ground

2. Regional Background

Somali Region (Somali: *Gobolka Soomaalida*); is the eastern-most of the nine ethnic divisions of Ethiopia. the capital of Somali Regional State is Jijiga. The Region is divided into nine zones which are further subdivided in to 52 Districts (Woredas). District (Woreda) is the basic decentralized administrative unit and has its own administrative council. The region borders Kenya to the south-west, the Ethopian regions of Oromia, Afar and Dire Dawa (Diridhawa) to the west, Djibouti to the north and Somalia to the north, east and south.

Based on the projection of 2007 Census conducted by the Central Statistical Agency of Ethiopia (CSA), the Somali Region has a total population of 4,613,774, consisting of 2,565,901 (56%) men and 2,047,873 (44%) women; urban inhabitants number 621,210 or 14% of the population, the rest 86% of the population are rural inhabitants. With an estimated area of 279,252 square kilometers, this region has an estimated density of 15.9 people per square kilometer. For the entire region 688,623 households were counted, which results in an average for

the Region of 6.6 persons to a household, with urban households having on average 6.3 and rural households 6.7 people.

3. Health Status of the Region

Ethiopia is listed under the poorest health status related to other low income sub Saharan countries and Somali Region remains extremely poor health status when compared with other regional states of the country. Most common causes (85%) of morbidity and mortality is attributed to infectious diseases and malnutrition; which can be avoided by simple promotive and preventive measures like immunization services. This is accompanied by wide spread poverty along with the general low income of the vast majority of the population and inadequate access to clean water and basic sanitation facilities. Also poor and limited access to physical health service aggravates the burden and seriousness of illnesses.

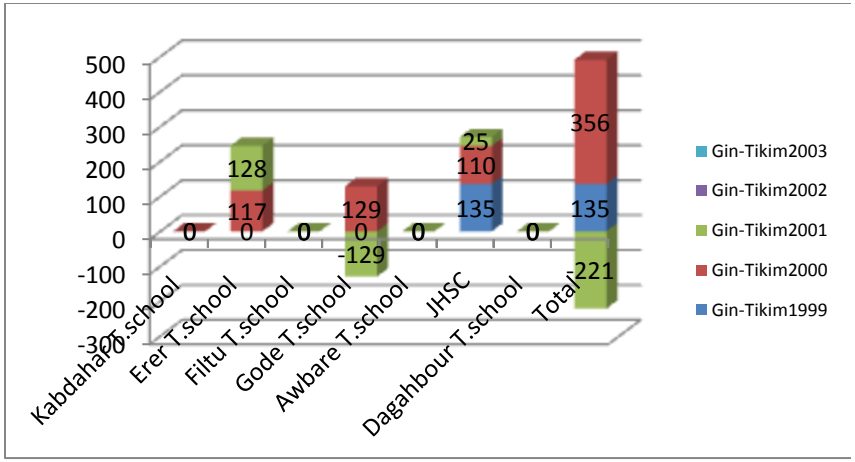
According to SRHB annual report, the potential health coverage of the region stands 81% (Health post coverage = 62% and Health Center Coverage = 14%); the Health Extension Workers Regional coverage is 58% , the family planning coverage stands 4%; immunization (pentavalent) coverage is currently 42% while the latrine coverage of the region is 9%.

Currently, the region has 6 hospitals, 290 Health Centers and 851 Health Posts (Constructed plus Rent Health Posts).

2 Introduction

HEP was first started in Ethiopia in 1995 and was first started at four pilot regions (Tigirai, Oromia, Amhara and SNNP). After it was perceived as it is effective approach to reach the most needy population; it was extended throughout the Nation.

Health Extension Program was first launched in 1999 E.C. at Somali Regional State four years after the national launching of the program. It was first started with a training of 135 HEWs at Jijiga Nursing School and then training of 406 HEWs at four HEW training sites (Kebridahar, Erer, Gode, and Awbare) followed by training of 569 HEWs at six different HEWs Training sites (Kebridahar, Gode, Erer, Awbare, Degahbur and Filtu). The fourth batch, 327 HEWs consisting of 100% females has been deployed on Hidar, 2002 and Fifth batch which is the last , 533 HEWs consisting of 100% females has been deployed on Meskerem, 2003.



1. *Definition and Philosophy of HEP*

The Health Extension Program (HEP) is a defined package and essential promotional, preventive and selected high impact curative health services targeting households. Based on the concept and principles of PHC, it is designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom. HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facility based services.

The philosophy of HEP is that if the right knowledge and skill is transferred to households they can take responsibility for producing and maintaining their own health.

The HEP is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. It is expected that almost all of the activities listed in the National Child Survival Strategies are to be implemented through the HEP.

To provide coverage for the whole country, the government has decided to accelerate the implementation of the HEP by training and deploying 30,000 Health Extension Workers by 2009.

A kebele is the smallest governmental administrative unit, and on average has a population of 5000 people. By 2009, each kebele will have a health post which will be the operational center for two HEWs, who will be responsible for providing outreach services. Construction of health posts and training of HEWs are being accelerated to reach these targets.

At the community level, in addition to HEWs, there are also groups of Voluntary Community Health Workers (VCHW). It is important that HEP links VCHWs to HEWs and ensures each group supports the work of the other. HEWs are most effective when working in collaboration with VCHW both to extend contact with families and the community, and to share different skills.

The HEP is a core component of the broader health system while the strategies for the interventions focus on the household and community. The success calls for coordinated action at all levels. Health Centers in particular have a crucial role to play in providing federal care, technical and practical support to the HEP. The Woreda health offices similarly have an important role to play in support of the health centers and the health posts. The government has shown high commitment in prioritizing the HEP Program by ensuring it receives the necessary financial and political support.

2. *Goals of the HEP*

The overall goal of the program is to:

- Create a healthy society and reduce rates of maternal and child morbidity and mortality.

3. Objectives of the HEP

The vast and unlimited objectives of the HEP include:

- To improve access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas.
- To ensure ownership and participation by increasing health awareness, knowledge, and skills among community members.
- To promote gender equality in accessing health services.
- To improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through HEWs.
- To reduce maternal and child mortality.
- To promote healthy life style.

4. Components of Health Extension Package

HEWs are responsible for explaining and promoting the following preventive actions at community level.

A. Disease Prevention and Control

- HIV/AIDS and other sexually transmitted infections (STIs) and TB prevention and Control
- Malaria prevention and control
- First Aid emergency measures

B. Family Health

- Maternal and Child Health
- Family Planning
- Immunization
- Nutrition
- Adolescent Reproductive health

C. Hygiene and Environmental Sanitation

- Excreta disposal
- Solid and liquid waste disposal
- Water supply and safety measures
- Food hygiene and safety measures
- Health home environment
- Control of insects and rodents
- Personal Hygiene

D. *Health Education and Communication*

5. Implementation Strategy of HEP

As a major nationwide health program, HEP requires substantial investment in human resources, health infrastructure and provision of equipment, supplies and commodities, as well as other operating costs.

2.5.1 Human Resources

Candidate HEWs must be women aged 18 years or older with at least 10th grade education. HEWs are selected from the communities in which they reside in order to ensure acceptance by community members. Selection committees are comprised of a member nominated by the local community, representatives from the Woreda Health Office, Woreda Capacity Building Office and Woreda Education Office. Following selection, the HEW completes a one year (Developed Regions) or six months (Developing Regions) course of training which includes coursework as well as field work to gain practical experience.

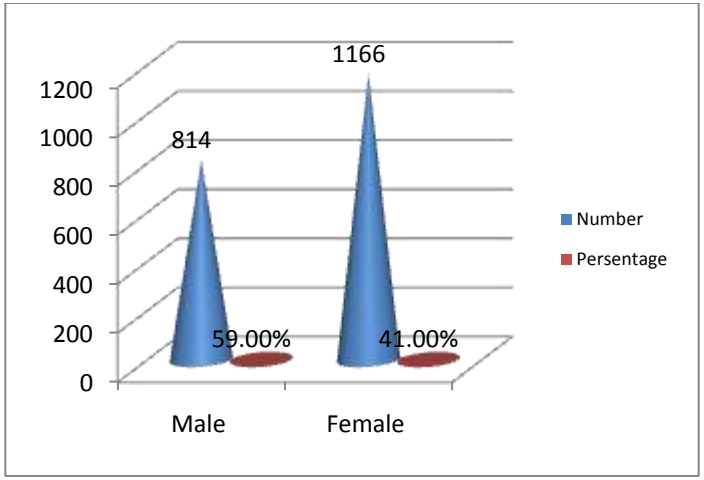
With a calculation of two HEWs for each 600 – 3,000 Population the target HEWs of the Somali Regional State is 1,920 HEWs and this is to be reached at the end of the EFY 2002 E.C.

Due to the low literacy rate of the region specially women; and in order to accelerate the implementation of the program; Somali Regional State used to train both ladies and Boys who have completed grade 8th and above for six months.

Fortunately after four years of the launching of the program at the Region; SRS-HB finally succeeded to train only ladies who have completed grade 8th and above for Health Extension Workers.

Graduation of Female HEWs (lt) & Females on training (Rt).

Since the launching of the program in the region 1,970 HEWs were trained and deployed to the 52 Woredas of the region. Out of the total HEWs 814 (40.8%) are male and the rest 1,166(59.2%) are female. Even though the Woredas' HEWs coverage varies; 102.6% of the regional target is achieved.



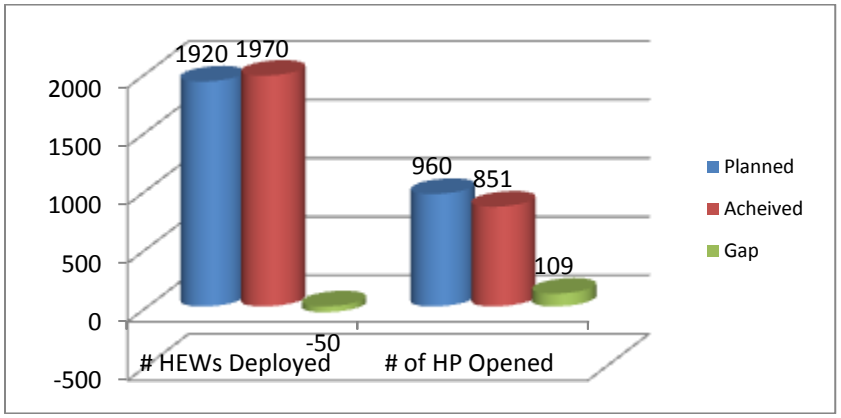
Female & male proportion of SRS HEWs.

2.5.2 Construction of Health Posts

The operational center of the HEP is the health post, which functions under the supervision of the Woreda Health Office, Kebele administration, with technical support from the nearest Health Center. Health Posts are located at kebele level to serve a population of 5,000 (Agro pastoralists) or 600 – 3,000 (Pastoralists). Where possible, Health Posts are located near other public services and institutions (e.g. Kebele Administration Offices) to foster enhanced coordination among government service providers. In localities where health posts are not yet built, the services are provided in provisional posts.

Each Health Post is staffed with two HEWs. If there are VCHWs (e.g. TBA, CBRHA) in the community, they work together with HEWs.

Before the launching of the HEP (1999 EC) there were 152 Health Posts which were functioning as a health station staffed by PHW and nurse. After the HEP was started the Region has set a target of construction of 960 Health Posts; with this currently there are 851 Health Posts (Rent and constructed Health Posts); this means 88.6% of the target construction



Status of HEWs & Health Posts at SRS.

Due to the large area of the region and the irregular movement of the pastoral community of SRS; it is difficult to construct a health post for every 600-3,000 population; therefore, besides construction of Health Posts; SRS uses locally adopted health posts at those locations where construction of health posts was found hard; this is done with the participation of the local community.

2.5.3 Procurement of Contraceptives, Medicine and Supplies

Health Posts must be adequately provided with equipment materials and supplies required to deliver the different packages of essential services to the community. Medicines and supplies are procured and distributed to the health posts by the Federal Ministry of Health, Regional Health Bureaus and Woreda Health offices. Supplies are provided by Health Centers or Woreda Health Offices to the health Posts.

Since the starting of the program in the region; RHB with a collaboration of FMoH, UNICEF and UNDP; 605 Health posts were medically equipped (given Health Post Kit); this means alongside the newly opened and those under construction health posts; some 372 Health post kit (medical equipments) is required.

For proper data storage and recording; 283 Health Posts were given 2 Registration books each (Family Planning, Antenatal Care, Delivery and Post Natal Care Registration Books). Similarly for proper reporting; SRHB adopted the newly HIMS Health Post reporting format and is to print and distribute on Tir, 2002 E.C.

HEW at Kubijaro Health Post with Registration Books, Umbrella, and Radio.

In order HEWs and other Governing bodies at Woreda know more about the program they should have guidelines; therefore more than 1500 HEP implementation guidelines were distributed to HEWs, Woreda Administrators, Woreda Health Offices and Zonal administrations

2.5.4 Health Extension Approaches

A. Health Extension Workers

HEWs are required to spend 75% of their time conducting outreach activities by going from house to house. During these visits, HEWs are expected to teach by example (e.g. by helping mothers care for newborns, cook nutritious meals construction of latrines and disposal of pits). HEWs utilize the following three approaches.

B. Model Families

HEWs identify and train model families that have acceptance and credibility by the community, as early adopters of desirable health practices to become role models in line with health extension packages. Model families help diffuse health messages leading to the adoption of the desired practices and behaviors by the community.

The aim of the HEP is to improve the access and equity of preventive and promotional essential health services at house hold level.

This can be reached by selecting household heads and training them as model house hold for four months; this heads will complete the sixteen packages of the HEP and will practice the packages at their home and environment.

Regarding model house hold training the region put 230,000 as target and Since the launching of the HEP in the region 44017 (19.14%) HH have graduated.

C. Community Based Health Packages

HEWs communicate health messages by involving the community from the planning stage all the way through evaluation. HEWs utilize Women and Youth Associations, Schools and Traditional Associations such as Idir, Mehaber, Ekub, (Hagbad or Ayuto) to coordinate and organize events where the communities participate by providing money, raw materials and labor.

D. Health Posts

At the Health Post HEWs provide antenatal care, delivery, immunization, growth monitoring, nutritional advice, family planning and referral services to the general population of the kebele.

2.5.5 Capacity Building

As we all know, in any professional training, young graduates who just have completed their college study, immediately after graduation cannot function as fully fledged professionals until they go through two to three years of experience in their own field of specialty and this is very much true in the case of health related fields. Therefore Health Extension Workers cannot be expected to master both the theoretical knowledge and practical skill immediately after graduation. The actual skill comes through practice in their own respective Kebeles where they will be deployed, and through subsequent on the job training to reinforce their skill.

i. Integrated Refresher Training (IRT)

Preliminary assessments have shown that there is a gap in some of the practical skills of HEWs, since HEWs were trained on a limited set of topics from the broader HEP curriculum including immunization, family planning, HIV/AIDs, Monitoring and evaluation. The MOH has therefore decided to provide Integrated Refresher Training.

RHB has given an in service training of IRT to 410 HEWs who are on their job; this means that only 20.8% of the total HEWs have received the training.

Fig :- IRT for HEWs conducted Dagahbour Hospital 2002

ii. Clean and Safe Delivery

According to the FMOH HEWs cannot attend deliveries until they receive one month duration training on techniques and skills of Clean and Safe delivery.

Therefore, in order to enable HEWs attend normal deliveries; RHB has given clean and safe delivery to 118 HEWs; this makes only 6. 2% of the total HEWs of the Region.

Fig :- Clean &safe delivery training conducted Jarati Health center 2002

iii. Supervisory and ToT Trainings

For the HEP, besides the trainings of HEWs; it additionally needs support from trained individuals during basic training and after deployment and implementation of the program at lower level.

To do this and ensure incapacitating of HEWs; RHB trained 40 and 15 health professionals from Hospitals and Health Centers on Integrated Refresher Training(IRT) and Clean & Safe Delivery Respectively.

To build the capacity of WoHo and strengthen HEP implementation at woreda level RHB traine and deployed 107 HEP supervisor to 52 woredas in the region .

2.5.6 Program Management and Governance

a. Planning Process

The HEWs, in collaboration with the members of the kebele Council, begin work by first conducting baseline surveys. Based on the survey findings, health problems are identified and prioritized, and plans of action are prepared. The draft plans of action are submitted to the Woreda Council through the Kebele Council for approval. Once

approved, the plans are disseminated to the Woreda Health Office, Regional Council and Regional Health Bureau.

b. Roles and Responsibilities

Clear identification of roles and responsibilities is imperative for effective planning, implementation, monitoring and evaluation of the HEP. Duties and responsibilities of different government stakeholders at each level are described below:

i. Federal Ministry of health

- ✓ Develop overall program concept, standards and implementation guidelines
- ✓ Determine career structure for HEWs
- ✓ Mobilize national and international resources
- ✓ Provide communication tools and materials
- ✓ Procure medical equipment and supplies
- ✓ Set up Health Management Information System

ii. Regional health Bureau/Zonal Health Department

- ✓ Provide technical and administrative support to Woreda Health Offices
- ✓ Adapt Implementation guidelines to local conditions
- ✓ Adapt communication tools and materials into local languages and distribute to Woreda Health Office
- ✓ Obtain reports from Woreda Health Offices and provide information to the MOH
- ✓ Mobilize regional resources
- ✓ Establish referral systems between Health Posts and Health Centers
- ✓ Strengthen Health Management Information System

iii. Woreda Administration

- ✓ Allocate budget and other resources
- ✓ Co-ordinate activities implemented by Governmental and Non-Governmental bodies
- ✓ Monitoring and evaluation.

iv. Woreda Health Office

- ✓ Provide technical, administrative and financial support to HEP
- ✓ Allocate budgets and supplies to Health Centers and Health Post
- ✓ Adapt communication materials
- ✓ Provide supportive supervision of HEWs and the overall management of health Centers and Health Posts
- ✓ Plan and provide in service training to HEWs and Woreda Health Office staff
- ✓ Obtain reports from Health Posts and Health Centers and provide information to Regional Health Bureau/Zonal Health Department.

v. Health Extension Workers

- ✓ Management operations of Health Posts
- ✓ Conduct home visits and outreach services to promote preventive actions
- ✓ Provide referral services to Health Centers and follow up on referrals
- ✓ Identify, train and collaborate with VCHWs
- ✓ Provide reports to Woreda health Offices

c. Monitoring and Evaluation

Monitoring and evaluation are integral and important components of the HEP and contain both technical and managerial purposes. Monitoring is the process of regularly reviewing achievements and progress towards the goal. In this context, monitoring is the process of measuring, analyzing, and communicating information on the implementation of the HEP for effective decisions making at all levels.

Evaluation is carried to assess whether objectives are met and to determine the effectiveness and efficiency of the program. This helps to correct and improve the future planning process.

Monitoring and evaluation have to be built in to the program from the outset as an integral part of the planning process. Monitoring and evaluation requires a health management information system to measure progress against objectives indicators and targets. Both qualitative and quantitative methods can be used to evaluate HEP. Tools or techniques to be used in collecting qualitative data are observations, in-depth interview, and focus group discussions. In quantitative evaluations, tools used should include surveys. Quantitative and qualitative data

are used together to give a clearer picture of the situation about the performance of the program.

Fig :- Supportive supervision conducted ,Shinile zone Aysha woreda Dagago Health post 2001 E.C

The HEWs collect information with standardized reporting formats. The HEWs must keep accurate and timely records of their activities. The information is passed on to the kebele council and Woreda health office for review and action. At the kebele level, the kebele committee, HEP and VCHW meet weekly and provide a report to the kebele cabinet on program implementation. During town hall meetings the community identify weaknesses and strengths and provide ideas for improvement.

i. Supportive Supervision

Supportive supervision enhances capacity and helps to correct any constraints encountered in the implementation of the HEP. Effective supervision requires a team of experts with an appropriate mix of skills, strong management abilities and continuity among team members.

A supervisory team drawing its members from different disciplines is established at the federal, regional, and Woreda levels to direct and support HEWs so that they effectively perform their duties. The teams will be involved in all aspects of program management including planning, implementation, monitoring and evaluation. Through these planned and coordinated supervisory activities at various levels, it will be possible to ensure that the quality and quantity of work is to the standard and in line with the general government policy.

Members of the team are trained in skills needed for supportive supervision (facilitation, interpersonal communication, problem solving and analytical skills), oriented on various tools and methods (such as peer review, performance assessment tools) and provided with opportunities to frequently upgrade their

technical skills. The supervisors are trained on a specially designed curriculum.

At each level the supervisory team prepares its own annual plan, checklists and detailed schedule for each supervisory visit.

6. *Challenges to the Implementation of the Program*

- Short age of HPs construction and Medical Equipments to cover all rural kebeles .
- Lack of man power working the HEP at Regional Level.
- Lack program awareness at Woreda and zonal level .
- Poor communication facilities and transportation means for supervision.
- In adequate means of communication and transportation hinders supervision and reporting (HEP monitoring & Evaluation).
- Community life style (Nomadic way of life affects the program implementation at Kebele level).
- Lack of budget allocated for HEP monitoring and evaluation at Woreda level.
- Lack of supportive staffs in the health posts (Cleaners and Guards).
- Poor capacity of WoHo to support the program at Woreda level .
- Highly need of the community curative service Rather than preventive service.
- High turnover rate of Trained HEP supervisors.
- Ineffectiveness of HMIS in supporting planning, decision making, and monitoring and evaluation process.
- Weak Referral system .

7. *Success of the Program*

I. Number of Health posts constructed, Equipped and Staffed increased from 290 to 851 HP
II. Vaccination (Penta 3)coverage raised from 14.6% to 42% in the last three years (1999 to 2002)
III. Latrine coverage in the Region increased From 7% to 31%
IV. Households graduated from 16 packages from 0% to 50.84% of the total house holds.

8. *Health Extension of tomorrow*

- Construct and equip with health posts kit to cover all rural Kebele.
- Deploy adequate man power at regional level .

- Conducting HEP advocacy meeting to all zonal, Woreda administration (Cabinets) to establish strong political commitment system which support the program planning , implementation , Monitoring and Evaluation at lower level .
- Train HEP supervisors and build their capacity (For every 3 HPs one Supervisors to strength the program)
- Establish and strengthen communication facilities all level by putting Radio each HPs, Woreda.
- Establish 9 Zonal HEP co-coordinators to facilitate monitoring and evaluation between the Region and 52 districts.
- Procure motor bikes for HEP supervisors to conduct monthly based supervision to every health posts.
- Allocate adequate budget for health posts and HEP supervisors for Regular Supportive Supervision.
- Conduct continues capacity building activities for HEWs and Woreda level staff.
- Deploy health posts supportive staffs (Cleaner and Guards).
- Strengthen referral system by Allocating budget and building the capacity of health centers in the region.

9. Annex