Federal Democratic Republic of Ethiopia
Ministry of Health

Health Extension Program

Profile

July, 2015

Addis Ababa, Ethiopia

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Forward

The Health Extension Program (HEP) is a home grown, innovative, community-based strategy to deliver preventive, promotive and selected high impact curative services. HEP is a mechanism to ensure active community participation in the creation of awareness, behavioral change, and community organization and mobilization, and to bridge the gap between the community and health facilities. Through HEP, communities have been able to access essential health services provided at the village and household levels; the HEP has served as a vehicle for bringing key reproductive, maternal, neonatal and child health interventions to the doorstep of all Ethiopians.

The government's commitment to HEP is exemplified by the training and deployment of more than 38,000 Health Extension Workers (HEWs). HEWs are mostly women, paid through government payroll, who have been deployed to over 16,000 health posts, in both urban and rural Ethiopia including the pastoralist areas. Prompted and encouraged by the success of the HEP, the Health Development Army (HDA), was established to further extend the reach of the HEWs to families. HDA is a network of women volunteers organized to promote healthy behavior and practices and prevent disease through community participation and empowerment. The HDA has effectively facilitated the identification of local salient bottlenecks that hinder families from utilizing key reproductive, maternal, neonatal and child health services and to come up with locally grown and acceptable solutions to address them. To date, we have been able to mobilize over three million women to be part of an organized HDA.

The HEP and HDA programs have enabled Ethiopia to reduce under-five mortality by two-thirds three years earlier than the target date for achieving the Millennium Development Goals. With unprecedented increase in skilled birth attendance in the last couple of years, coupled with tremendous increase in contraceptive prevalence rate, Ethiopia is also on track to achieve the intended reduction in maternal mortality.

The following are some of the unique features that have contributed to the success of the HEP:

1. The program is indigenous and homegrown and carefully tailored to the context of the country.
2. Committed staff are recruited and selected from their local communities, with cultural and linguistic competence and credibility.
3. The program is supported by comprehensive and robust one-year training, followed by need-based structured in-service training.
4. Services delivered are holistic and comprehensive and cover a range of priority public health issues.
5. The program is an integral part of the health system.
6. HEW's are civil servants on government payroll.

The HEP and HDA programs are the jewels and flagships of Ethiopia's health service delivery strategies. Through this document we wish to share some details on the HEP and what we have been able to accomplish over the past decade through this program. I want to take this opportunity to share with you that we are also in the process of establishing an Institute to serve as a conduit for the promotion, learning and researching of strategies adopted by the HEP and HDA programs. Stay tuned!

Dr. Kesetebirhan Admasu
Minister, Ministry of Health

Acronyms

CSA	Central Statistics Autority
CBNC	Community Based Neborn Care
FMOH	Federal Ministry of Health
GTP	Growth and Transformation Plan
HC	Health Center
HDA	Health Development Army
HP	Health Post
HEP	Health Extension Program
HEW	Health Extension Worker
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
HMIS	Health Management Information System
ICCM	Integrated Community Case Mnagement
MDG	Millennium Development Goal
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother to Child Transmission
RHB	Regional Health Bureau
TVET	Technical and Vocational Education Training

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Executive Summary

Ethiopia is the 2nd most populous country in Africa, after Nigeria, with the majority of the population (about 84%) living in rural areas. With the goal of making basic primary health care services accessible to the rural community, the Ethiopian government launched the health extension program (HEP) in the agrarian areas beginning in2003. Based on lessons from the successful implementation of the agrarian health extension program, the HEP has expanded to urban and pastoral areas, and the government is introducing reforms to meet the needs of pastoralist and urban communities.

The HEP is intended to transfer ownership and responsibility of maintaining health to individual households so that communities are empowered to produce their own health. The focus of HEP is disease prevention and health promotion, with limited curative care. It is the healthcare service delivery mechanism of the people, by the people, and for the people by involving the community in the whole process of healthcare delivery and by encouraging them to maintain their own health.The program involves women in decision-making processes and promotes community ownership, empowerment, autonomy and self-reliance.

Health Extension Workers (HEWs) are the centerpiece of the HEP. They are young women with at least a 10th grade education have received a one year pre-service training. They are selected from the community that they serve. Because of this, they speak the local language, and live in and serve their own communities. On average, one HEW serves a total of 2,500 populations. They are deployed in pairs at the kebele level, which is the smallest administrative unit with an average of 5,000 population.

At the kebele level, HEWs are tasked to lead health related activities, from planning, to execution and monitoring. Primarily they are responsible to get a total of 16 health packages implemented properly in all the households in their respective kebeles. These packages were identified based on the health needs of the community and are categorized into four major components. The first categoryis related to hygiene and sanitation, with seven focus areas - personal hygiene, water and sanitation, food hygiene, latrine, solid/liquid waste disposal, housing condition, and control of insects and rodents. The secondcategory is family health - maternal and child health, family planning, immunization, nutrition, and adolescent health. The third category is related to disease prevention and control - HIV prevention and control, tuberculosis prevention and control, and malaria prevention and control. The fourth category is health education,

HEWs implement the 16 packages of the health extension program through promoting healthy behaviors and practicesand helping families to become “model families”. Model families are families that have adopted all the necessary health packages within their own families as well as influencing others to be models. HEWs use different opportunities like schools, women and youth associations, and the HDA for health promotion. HEWs use three modes of service delivery – house-to-house visits, health post based provision of services, and outreach. Services provided by HEWs include antenatal care, attending normal and safe deliveries, post-natal care, administering vaccines, assessing and managing sick children (particularly pneumonia, diarrhea, malaria, malnutrition, and neonatal conditions), conducting growth monitoring, providing nutrition counseling, providing family planning services (including Implanon insertion), and facilitating referrals for services.

At the community level, in addition to HEWs, there is also the HDA. The government of Ethiopia (GoE) believes organizing citizens to function voluntarily in a development army can serve as a tool to acceleratethe achievements of the Growth and Transformation Plan (GTP) targets. About five to six households are organized in a ‘one to five network’. Again, five to six networks (which is about 25 to 30 households) come together to form the health development team, all of whom live in the same village. The HDA effectively facilitates the identification of local salient bottlenecks that hinder families from utilizing key reproductive, maternal, neonatal and child health services and comes up with locally grown and acceptable solutions to address them.

In the past ten years, Ethiopia has achieved remarkable progress in improving the health status of mothers and children. A noteworthy progress is the reduction of child mortalityfrom 123 per 1000 live births to 88 per 1000 live births in the same period.Another example of progress is the unprecedented increase of the contraceptive prevalencerate. According to the Ethiopian Demographic Health Survey (EDHS), the contraceptive acceptance rate increased from 15% in the year 2005 to 29% in 2011. The HEP has made a significant contribution to these and other achievements. Furthermore, the HEP is an important model through which services such as management of selected childhood illness and insertion of the Implanon for family planning have been gradually shifted to HEWs through a continuous capacity building process.

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1. Background

Ethiopia is the 2nd most populous country in Africa, after Nigeria. Projections from the 2007 population and housing census estimate the total population for the year 2015 to be 90 million. A significant proportion of the population (84%) resides in the rural areas. The Federal Democratic Republic of Ethiopia is composed of nine Regional States: Tigray, Afar, Amhara, Oromia, Somali, Southern Nations Nationalities and Peoples Region (SNNPR), Benishangul-Gumuz, Gambella, and Harari; and two City Administrations, council of Dire Dawa and Addis Ababa. The regional states and city administrations are subdivided into woredas (districts) and kebelles. A woreda[1] is the basic decentralized administrative unit and has an administrative council composed of elected members. Four of the nine regional states (Tigray, Amhara, Oromia and SNNPR) are considered as agrarian regions.

It is clear that multifaceted steps have to be taken by the government and the people to eradicate poverty in Ethiopia. Millions of Ethiopians, especially those who live in rural areas, are exposed to a variety of preventable diseases, including malaria, tuberculosis (TB) and childhood illnesses. Ethiopia's maternal, infant and under-five mortality rates are still among the highest in the world. The Ethiopian Government has formulated a series of Health Sector Development Programs (HSDP I, II, III and IV 1997-2015) in line with the Plan for Accelerated and Sustained Development to End Poverty (PASDEP), Growth and Transformation Plan (GTP) and aims to achieve the health-related Millennium Development Goals (MDGs).

Despite the gains that were made in the implementation of HSDP I, its review carried out in 2002 came up with important gaps limiting access to primary health care services to needy populations. Some of the identified gaps were:

- Basic health services had not reached the needy at the grass root level,
- The expansion of health facilities delivering primary health care has been limited,
- There have been gaps in applying the core principles and practices outlined in the health policy, and there was uneven distribution of health facilities meant to deliver primary health care services.

[1] Woreda is the next administrative structure above a kebele and an equivalent to a district with an average population of 100,000 to 150,000.

Evaluation of HSDP I also revealed constraints in the availability of trained, high-level health professionals. Therefore, in response to the country's health problem, the government introduced "Accelerated Expansion of Primary Health Care Coverage" which was initiated during HSDP II (2002/03 – 2004/05). In addition, based on the "model Family Initiative" in Tigray, a community-based health care delivery system, named the health extension program (HEP) started during HSDP II (Admasu, 2013). The new initiative to further promote participatory community engagement and adoption of health lifestyles is the implementation of Health Development Army (HDA), which was introduced around 2010/11. The new introductions were also in congruence with a health policy which focuses mainly on providing quality promotive, preventive and selected primary curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children.

2. Introduction

The HEP is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households. Based on the concept and principles of primary health care (PHC), it is designed to improve the health status of families, with their full participation, using local technologies and the community's skills and wisdom. The philosophy of HEP is that, if the right knowledge and skills are transferred to households, they can take responsibility for producing and maintaining their own health.

To provide coverage for the whole country, as thus far, more than 38,000 HEWs have been trained and deployed at kebele level (A Kebele is the smallest governmental administrative unit, and on average has a population of 5000 people). Currently, almost all rural Kebeles have Health Posts which are the operational centers for two HEWs.

HEW providing ANC service at Health post

Box 1: List of Health Extension Package

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

Family Health
- Maternal and child health
- Family planning
- Immunization
- Nutrition
- Adolescent reproductive health

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

Health Education and Communication

At the community level, in addition to HEWs, there is also the HDA. The Government of Ethiopia (GoE) believes voluntarily organizing citizens into a functional development army can serve as a tool to hasten the achievement of GTP targets. The HDA is a group of people or household heads organized based on settlement or social proximity to participate, teach and learn from each other and to take practical actions for the betterment of individuals, families and community health. The name “army” denotes a group of committed, enthusiastic persons who are prepared to achieve a certain task or objective. Based on the kebele, about five to six households are organized in a ‘one to five network’, and again the networks come together to form ahealth development team comprised of 25 to 30 households living in the same village. Implementation of the HDA was started in 2010/11, with progress being made in the organization and network formation over the past three years. According to MOH’s annual report, more than 440,000HDA groups with over three million one-to-five networks had been formed in 2013/14.

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 referral care, technical and practical support to the HEP. One Health Center is expected to provide both technical and administrative supports to an average of five health posts. The network of one health center with five health posts is calledPrimary Health Care Unit (PHCU) (Figure 1).

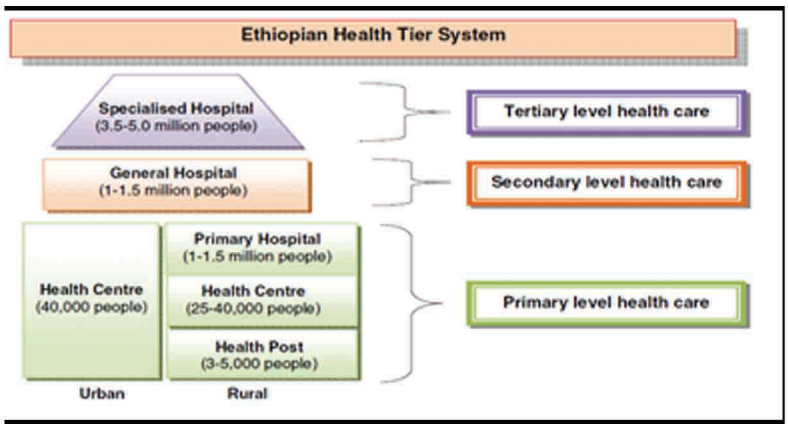

Figure 1: Ethiopian Health Tier System

3. Goal

The overall goal of HEP is to create a healthy society and reduce preventable morbidity and mortality with particular attention towards improving maternal and child health.

4. Objectives

The objectives of the HEP are:

- 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 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

5. Implementation Strategy

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

5.1. Human Resources

Candidate HEWs must be women aged 18 years or older with at least a 10th grade educationresiding in rural areas. 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 course of training consisting of coursework as well as fieldworkin order to gain practical experience at selected health facilities.Courses for HEWs are held at Technical and Vocational Education Training Schools (TVETs) of the Ministry of Education with the support from the Health Bureau and health service management at different levels.

5.2. Construction of Health Posts

The operational center of the HEP in the rural area is health post, which functions under the supervision of the health center, and Kebele administration. Health posts are located at Kebele level serving about 5000 population. 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 by two HEWs.

Health post at Atsbiwemberta woreda, Tigray

5.3. Organizing Health Devlopment Army

Health development army refers to an organized movement of the community through participatory learning and action meetings. The HDA is designed to accomplish the following critical tasks:

1. Identify locally salient bottlenecks that hinder families form utilizing key services and implementing the HEP and prioritize those that they want to address as a team;
2. Come up with feasible strategies to address these problems;
3. Implement the strategies, and
4. Evaluate their activities

The HDA also engages the larger community through meetings involving the all residents. These large public conferences provide the platform to share prioritized bottlenecks and strategies, and share best practices.

One to five network members on daily meeting, Oromia

5.4. Supplies and equipment

Health Posts are 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. According to Integrated Pharmaceutical Logistics System (IPLS) health posts are considered as one of the dispensing units of the health center and thus health centers forecast the needs of health posts and include them in HC's annual plan.

5.5. Health Extension Approach

Health extension workersare required to equally split their time between the community and the health post. HEWs use the following key approaches to avail the service packages to their target community.

Model Families

The main aim of the health extension program is to get families to graduate as model families by implementing all the necessary packages of the HEP within their own family. To facilitate thegraduation of more model families, HEWs use the HDA. One-to-five network leaders receive 60 hours of training on the health extension package by HEWs and health center staff. Once they have completed the training, they are followed by health extension workers to implement the packages in their household. Through this process, when the trainees get the key health actions implemented in their ownhousehold, they graduate as a model family in a big community festival and receive certificates. Trained 1-to-5 leaders, discuss about the HEP twice/week in their network,and assist team members to implement the package and graduate as model families.

Community Based Health Packages

In addition to the model family activity, HEWs implement a community package, which aims to communicate health related messages by involving the community at different stages, from planning to evaluation. To strengthen the community structure below the health extension worker, the Ethiopian government launched “Health Development Army”. This is an initiative designed to scale-up best practices of the HEP for wider coverage, with particular attention to family health services. In addition to using the HDA, HEWs use different community networks, schools, women and youth associations as well as traditional associations; such as idir, mehaber, and ekub, to coordinate and organize events where the community participates by providing money, raw materials and labor and communicating messages to a wider audience.

Health posts

At the Health Post HEWs provide antenatal care, delivery, postnatal care, immunization, growth monitoring, nutritional advice, family planning, first aid, and referral services to the general population of the Kebele. Moreover, after pilot testing, gradually various service packages, such as, Integrated

Mothers and their chidlen are waiting for sevices at HP

Community Case Management (ICCM), Community Based Newborn Care (CBNC),nor plant insertion were added.

School Health

HEWs are engaged in various school health activities. These include, but are not limited to: adolescent sexual and reproductive health, hygiene and sanitation, provision of vaccines, first aid, and health promotion for prevention and control of communicable diseases.

5.6. Program management and governance

Planning

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 health center for approval. Once approved, the plans are disseminated to the woreda health office, regional council and regional health bureau. .

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:

Type of Institution	Major responsibilities
Federal Ministry of Health	• Develop overall program concept, standards and implementation guides • 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.
Regional Health Bureau/Zonal Health Department	• Provide technical and administrative support to woreda health offices • Adapt implementation guidelines to local conditions

Type of Institution	Major responsibilities
Regional Health Bureau/Zonal Health Department	• Adapt communication tools and materials into local languages and distribute to Woreda Health Offices • 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 HMIS
Woreda Administration	• Allocate budget and other resources • Co-ordinate activities implemented by Governmental and Non-Governmental bodies • Monitoring and Evaluation.
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 through Health Centers and provide information to Regional Health Bureau/Zonal Health Department.
Health Center	• Assist Health Extension workers during planning and reporting • Integrate the health posts plan and reports into the health center • Provide administrative and technical support • Assign supervisors and ensure a supportive supervision is carried out timely • Assist HEWs during health development army training

Type of Institution	Major responsibilities
Health Extension Workers	• Manage 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 Health Development Army System.
Health Development Army	• Collect and analyze basic health related information of the community • Hold regular meetings with their members • Assist members to have individual change plans • Provide regular report to health extension workers

Monitoring and evaluation

Community Health Information System (CHIS) has been introduced at the health post level. The system generates Quantitative and qualitative data to give a clearer picture of the situation about the performance of the program.

The HEWs collect information with standardized formats andkeep it in a family folder. The HEWs must keep accurate and timely records of their activities. The information captured is passed on to the Kebele Council and health center for review and action. At the Kebele level, the Kebele Committee, HEP and HDA meet weekly and provide a report to the Kebele cabinet on program implementation. In addition, health centers organize a meeting with their catchment health posts and discus on reports and action plans. The monthly reports of the health extension works includes, but are not limited to the following key indicators:

- Immunization, breastfeeding, use of Oral Rehydration Salt (ORS), adolescent parenthood, antenatal care, assisted delivery, contraceptive use, and tetanus toxoid immunization.

- Use of Insecticide Treated Nets (ITNs), anti-malarial drugs, HIV and sexually transmitted infections, TB follow-up and First Aid and self care.

- Facilities for liquid/solid waste disposal, safe drinking water, healthy home environment, sanitation and hygiene.

- Access to and utilization of preventive and promotive health services, referrals, adequately-staffed and well-maintained health posts, participation in basic health/demographic data collection, provision of financial support for health posts

Supportive Supervision

A supervisory team drawing its members from different disciplines is established at the Federal, Regional, Woreda and health center levels to direct and support HEWs so that they effectively perform their duties. The frequency of supervision is quite different – a health center focal person for each health post is expected to visit their respective health post at least once in a week. However, supervision from regions and federal levels is less frequent and very few selected health posts are visited during integrated supportive supervision. At each level the supervisory team prepares its own annual plan, checklists and detailed schedule for each supervisory visit.

The health center supervisor is involved in all aspects of program management including planning, implementation, monitoring and evaluation. Supervisors 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.

Supportive supervision

6. Status of Health Extension Program

6.1. Number of Health posts and HEWs

The number of health extension workers aligned with the number of health posts available in Ethiopia. The following, figure shows the cumulative trend for over nine years.

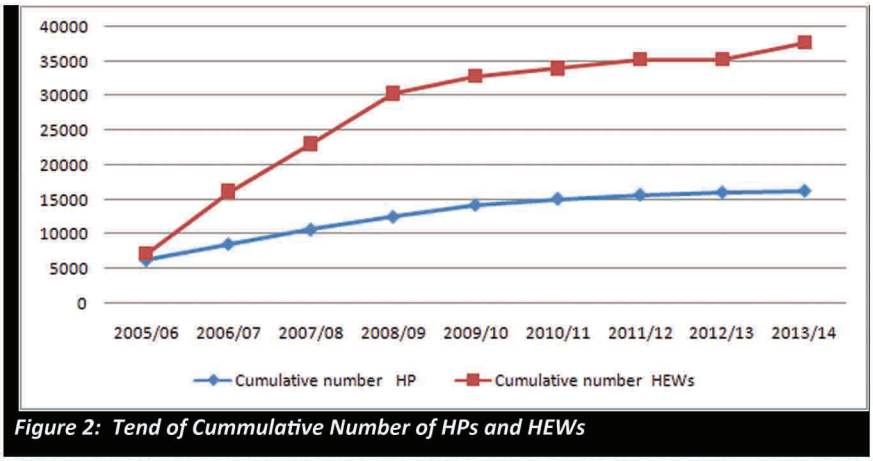

Figure 2: Tend of Cummulative Number of HPs and HEWs

6.2. Contribution of HEP

Since its rollout in 2004, the health extension program (HEP) has shown substantial outcomes in areas related to disease prevention, family health, hygiene, and environmental sanitation. The program has improved the skewed distribution of health facilities and human resources. In five years, Ethiopia's human resources for health doubled as a result of the deployment of more than 34,000 HEWs. A 2010 study indicates that about 92% of households were within an hour's (5 km) distance from a health facility. HEP has enabled Ethiopia to increase primary health care coverage to76.9% in 2005 and 90% in 2010.A 2010 nationwide study found that over half (52%) of the health posts were open for at least five days a week, and about 62% were open on Saturdays and/or Sundays. In addition, a community satisfaction survey covering more than 10,000 people indicated that 60% of the respondents rated all components of the HEP services as very satisfactory or satisfactory, with family planning receiving the highest score (76.5%). (FMOH 2010).

Data from the 2011 Demographic and Health Survey (CSA and ICF International 2012) indicate the following improvements in health indicators between 2005 and 2011: under-five mortality declined from 123 per 1,000 live births to 88 per 1,000 live births; the contraceptive prevalence rate increased from 15% to 29%; the total fertility rate decreased from 5.4 to 4.8; skilled birth delivery increased from 5% to 10%; and the use of insecticide-treated nets increased from 1.3% to 42%. Even though, it is difficult to directly link the aforementioned results to the HEP, there is no question about its significant contribution to the achievements.

Since the introduction and deployment of HEWs, there has been an increase in the proportion of women who have utilized family planning, antenatal care, and HIV testing. As per the 2011 EDHS 27% of family planning users obtained their contraceptives from health post or Health Extension Worker (HEW). This proportion increased from 16% in 2005 and it was nonexistent in 2000. In addition, a home visit during pregnancy has generally improved utilization of maternal health services.

A strong evidence of a dose-response relationship has been demonstrated between the HEP and better maternal and child care practices, which indicate that the program is an effective platform for improving family health practices at scale (Karim, 2013). According to study done in West Gojjam zone, Amhara region, "model families" were 3.97 times more likely to use contraceptives compared to those who are not model families. Model family status contributed

Success story - Life-saving treatment close at hand

Source: JSI/L10K project

It was a hot day with an occasional breeze and a perfectly clear blue sky but Hiwot Berhe and Freweyni Tesfaye do not seem bothered by the heat as they work tirelessly in the health post where mothers come in search of treatment for their sick children. The Dedebit health post is located in North West zone of Tigray region in Ethiopia and serving a population of 5710. Since Hiwot and Freweyni, the health extension workers, took training in integrated Community Case Management (iCCM) four years ago they have been able to assess, classify, and manage common childhood illnesses such as pneumonia, malaria, and diarrhea in children less than five years old. Their case load to-date has reached 2382 which is a heavy load for a health post according to their Supervisor.

Dedebit is located 17 kms. away from Mai Hanse town which used to be the closest town where health service was provided. Availability of transportation to Mai Hanse was a challenge which many families faced in earlier days when health care for their sick children was not available at the health post. The road into town was a dirt road and difficult to travel on especially in cases of emergency. As a result, many of these parents resorted to traditional treatment and though some children may recover most would end up being sicker or even die.

After their ICCM training, Hiwot and Freweyni gave orientation to women development team leaders, religious leaders, and kebele officials who would later on be their right arm in raising awareness on child health. In addition to services they provide at the health post, Hiwot and Freweyni take turns in making regular home visits and they treat a sick child if they come across one. The most common sicknesses they say are malaria, pneumonia, and diarrhea. Ergibaye Gerenchael is a 19-year-old mother with a three months old son. In November 2014 she visited Dedebit health post because her son was sick with diarrhea. Freweyni assessed his situation and advised Ergibaye to give her son oral rehydration salts (ORS) by showing her how and then provided her with ORS packets and a zinc supplement to take home.

Ergibaye is regularly visited by MizanTikabo, a woman development team leader. Mizan is a volunteer who makesregular home visits to households she is assigned to and provides advice and information on beneficial health practices. It is during one of these visits that Ergibaye told Mizan about her son's condition

and Mizan advised her to take him to the health post immediately.

Ergibaye is grateful that child health care service is provided at their doorsteps. “If this was not so, we would have had to travel 17 kms into Mai Hanse town to reach the closet health center”, she says and continues with a broad smile, “Now we save money and time by visiting the health post instead. We are also more comfortable having out children treated here because we are familiar with Hiwot and Freweni since they both visit us in our homes regularly”.

Beyond their ability to manage childhood illness or refer sick children, today Hiwot and Freweyni are respected members of their community. ICCM has given them the skill to carry out curative service, in addition to preventive health care service, which has improved their acceptance by the community. Freweni who has worked the longest (ten years) has been acknowledge and awarded by the Woreda Health Office for her hard work and accomplishment.

The HEW while providing the service

6.4. Expansion to urban and pastoralist areas

FMOH has initiated the training of Health Extension Workers and Health extension professionals for the pastoralist and urban areas, respectively. The service packages in both areas were adapted from the rural package. In addition, some packages, such as, mental illnesses have been added to the urban package. In the urban areas health extension professionals, who are nurses with 3 months training, are based at the health center or woreda health office. Even though some promising results have been registered in some areas, given the fact that, the urban health problem is now different from the rural areas and the mobile nature of the pastoralist community, revision of the packages and service modality for both areas is imperative.

6.5. Program challenges

Based on various reports and assessments of HEP the following program challenges have been identified:

- Some of the Health Posts are not fully furnished with the necessary equipment and supplies
- Inadequate means of communication and transportation impede supervision and reporting
- Limited motivation and commitment of some of the health extension professionals in urban areas
- The low uptake for upgrading of HEWs to level 4 and above delayed the promotion of HEWs in their career structure.
- The weak link between health posts and health centers in some of the PHCUs affected the provision of the necessary support to HEWs

6.6. Way forward

Demand for quality and wider scope of services of HEP is growing among community. As socioeconomic, demographic and epidemiological transitions happen, the demand for quality service and the type of services is also changing. To satisfy the demand of the community, the health extension program needs to transform to the next level. The transformation requires improving the skills and competence of HEWs and HDA. Revisiting of HEP service package in the coming years is also critical to sustain the gains made so far and address the needs of the community. Besides creating mechanism for motivating and retaining HEWs and HDAs and improving the health post accordingly are among the issues that needs to be addressed in the near future. Moreover, considering the nature of health extension program – addressing multiple sectors' issues, strengthening the collaboration with other sectors is a priority.

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