NATIONAL ASSESSMENT OF THE ETHIOPIAN HEALTH EXTENSION PROGRAM

Dissemination Workshop

Abridged Report

Skylight Hotel, Addis Ababa, Ethiopia
November 11, 2019

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Acknowledgment

This assessment was made possible because of the exemplary desire exhibited by the Ministry of Health of Ethiopia to make evidence-based decisions. The Bill and Melinda Gates Foundation's willingness to respond to the quest for evidence is a good example of responsive program support. The MERQ team would like to express its deepest appreciation to the Ministry of Health for taking a bold move to have an independent assessment of its flagship program and for trusting a local team of experts for the assignment. We would like to also express our gratitude to the Bill and Melinda Gates Foundation, for providing the required financial support for the conduct of this study.

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Preface

As a country of more than 110 million people with more 78% rural residents, ensuring provision of preventive, promotive and curative health services with access and equity in mind is critical. Cognizant of these, an innovative approach which employed an army of women health workers known by the name health extension workers was initiated in 2004. The program has become a flagship intervention, which has managed to employ 36,633 HEWs deployed all over the country in agrarian, pastoralist, and urban settings. The program also established 17,685 health posts. It is believed that, the HEP program has played a pivotal role in improving access, in reducing maternal and child morbidity and mortality.

Although there are plenty of studies which were done in the last 15 years, almost all studies were focused on specific interventions within the HEP with limited geographic coverage; as a result of which they had very limited role in helping policy makers to make decisions. Since recently, the status of the health extension program was also creating mixed feelings/opinions on its performance and relevance. Moreover, there was a need to have a clearer understanding of the program, in order to make decisions as part of the upcoming major strategic planning activities in the health sector. Thus, the need for a comprehensive assessment was imminent and vital.

With the intention of ensuring complete independence, while maintaining responsiveness to the needs for evidence of the stakeholders; the MOH commissioned MERQ Consultancy PLC to conduct a comprehensive assessment of the health extension program, through funding from the Bill and Melinda Gates Foundation. This assessment employed mixed methods where extensive document review, qualitative exploration by engaging managers, policy makers, community, health extension workers as well as other health care providers and quantitative survey of households, health extension workers, health posts, as well as health centers; which was done by taking a representative sample of Woredas from all regions in Ethiopia was conducted from October 2018 to June 30, 2019. Specific areas which needed more exploration were also examined including health care financing, cost effectiveness of HEP packages, status of the training institutions of the HEW, attrition as well as the attitudes of health care workers towards the HEP.

The prime focus on this abridged report is to highlight the prominent findings as it pertains to the current status of the program and the factors and possible explanations for its current status. The key findings are synchronized with the recommendations which are further detailed through relevant action items. Although, the prominent findings are included in this report, the source report for this, which has all the details are given in the main report which will be shared shortly after incorporating reflections from the dissemination workshop.

1 Introduction

1.1 Overview of the assessment

Introduced during the second phase of the Health Sector Development Program (HSDP-II), the Health Extension Program (HEP) has been a platform for the delivery of primary healthcare particularly to rural communities in Ethiopia. Over the years the program has not only been expanded to reach majority of rural populations but also been adapted to meet the special needs of pastoralist communities and disadvantaged groups in urban settings.

Although there is a general agreement among stakeholders regarding the role of the HEP in improving the health of Ethiopians, there was a need for comprehensive assessment because of the absence of clarity on the current status of the program. The national assessment on the health extension program was started with the intension of addressing the information gap regarding the performance, determinants, and prospects of the HEP by conducting an in-depth examination and analysis into different aspects of the program.
This abridged report shows the methods employed and the findings of the health extension program as implemented in the pastoralist and agrarian settings. The findings of the urban health extension program are given in a separate report.

1.2 The national assessment on HEP: Why?

Being implemented for the last 15 years, there were mixed thoughts about the current status of HEP and administrative reports were the only source of information about several aspects of HEP.
There were plenty of studies conducted on the HEP. But these studies focus on very specific aspects of HEP and fail to show the influence of factors at different levels of the health system. Moreover, they were not, mostly, linked to the decision-making process in the health system. This assessment is considered timely as major decisions regarding the future of the HEP are currently looking for comprehensive evidence and it is being conducted at the eve of the HSTP-II.

1.3 Objectives

In order to understand the program comprehensively, the objectives of the assessment were:

1. To assess the relevance of components of the HEP to the health needs of Ethiopians
2. To assess the implementation status of the HEP
3. To assess the population coverage of essential services related to the HEP
4. To assess adequacy of resources for the implementation of the HEP
5. To explore the contribution of HEP to recent gains in health status
6. To identify determinants of implementation of HEP at different levels
7. To determine key areas of intervention for future improvement of HEP

1.4 Study Description

Funded by the Bill and Melinda Gates Foundation, MERQ Consultancy PLC has done the national assessment on the Health Extension Program in Ethiopia.
The study has three key components –

Component 1 - **Primary data with mixed Methods**: A comprehensive nation-wide assessment employing **quantitative and qualitative** methods

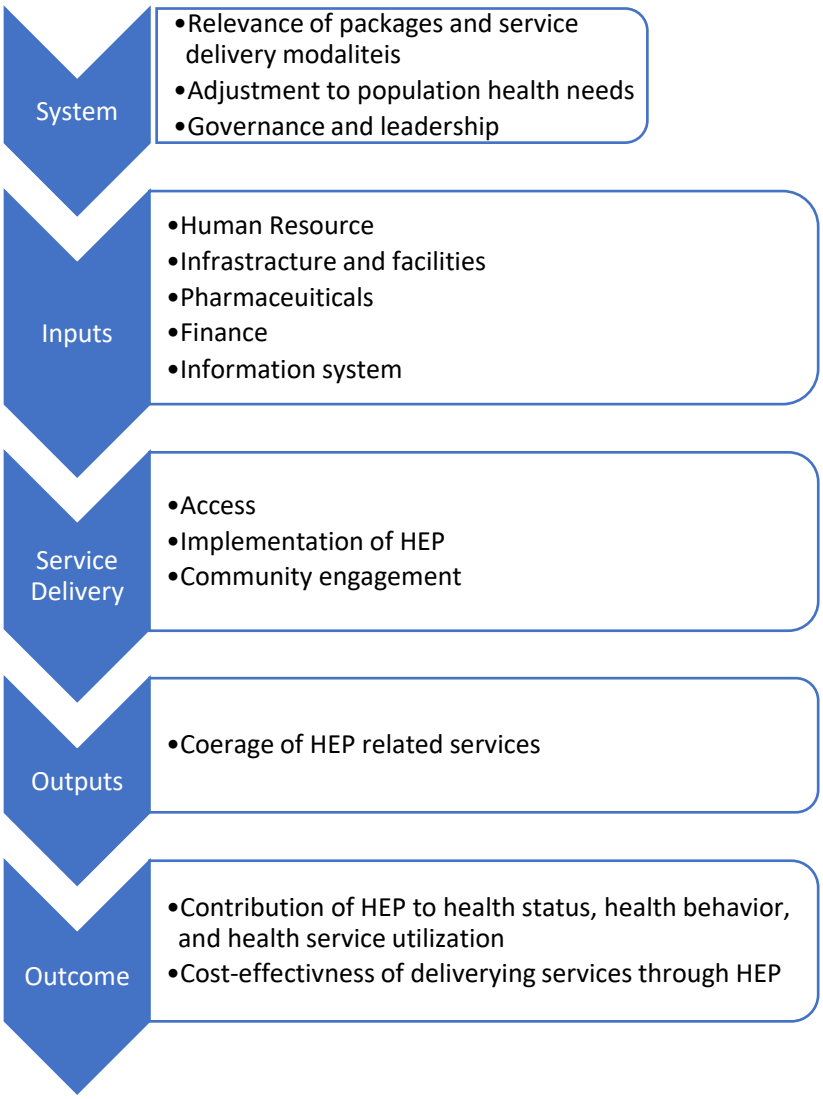
Component 2 - **Systematic review on HEP**: Review of published and gray literature with and without meta analyses

Component 3 - **Synthesis and recommendation**: A participatory process of synthesizing evidences and formulating recommendations.

The assessment increases the understanding of actors in the health sector and inform decisions regarding the future of the Health Extension Program.

1.5 Assessment Framework

The assessment was guided by the Primary Health Care Performance Initiative (PHCPI) framework, that has five domains: system, inputs, service delivery, outputs, and outcome.



PHCPI Framework adapted for assessment of the HEP in Ethiopia

1.6 Principles

The following key principles were adhered to throughout the conduct of the assessment.

Comprehensiveness – examining all aspects of the program

Focus on utilization – conduct the study with end users in mind and through consultations with users to make sure their information needs are considered optimally.

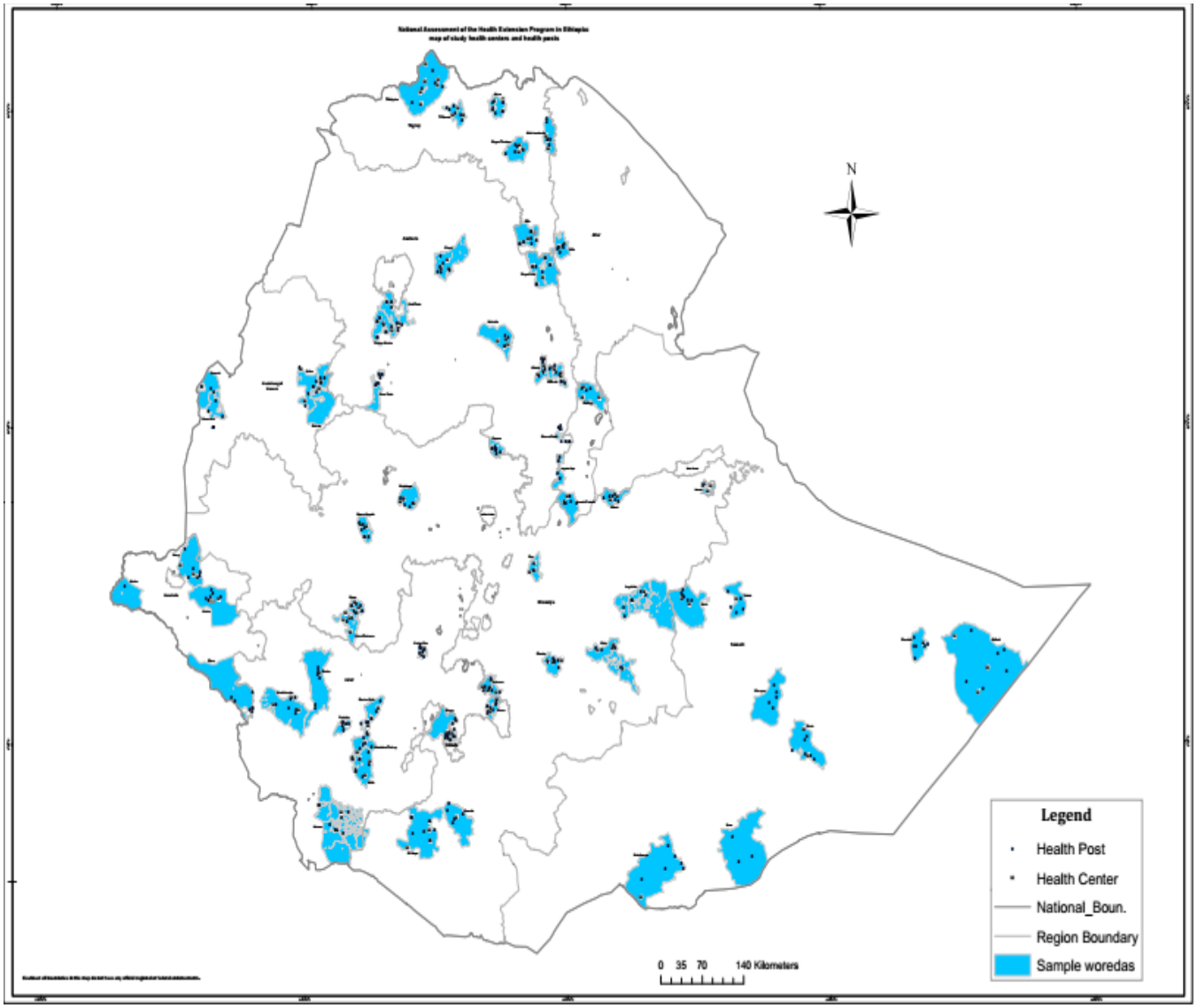
Independence – the actual conduct of the study was done by the MERQ team with complete independence. Analysis of the data was also done by the study team.

Responsiveness – to optimize utilization, we have been responsive in terms of including questions that the potential users had during the preparation of the protocol and the data collection tools.

1.7 Scope of the assessment

The assessment was conducted in all regions (353 kebeles from 62 woredas). It was conducted in agrarian, pastoralist and urban settings. In these settings, 12868 respondents from 7122 rural households participated for quantitative assessment. In addition, 343 HPs, 132 urban HCs and 179 rural HCs were assessed in relation to the HEP. The assessment also included interviews with 584 HEWs. As part of the qualitative study, 85 FGDs and 122 KIIs (a total of 207) from all levels of the healthcare system were conducted (community, HP, HC, Woreda, Region, Federal). In the systematic review, published articles, gray literature and documents were reviewed. After identification and screening of 3822 documents, 67 documents were reviewed (22 for qualitative synthesis and 45 meta-analysis)

Map of study sites



Collaborative Synthesis and Recommendation Formulation:

Following completion of the collection of the data and analysis; multiple workshops were held to go through a collective interpretation of the findings and to formulate corresponding recommendations respectively.

1.8 **Study duration**

October 1, 2018 to October 31, 2019

1.9 **Challenges**

The main challenge in this assessment was the unrest that the country faced just before and during the data collection. There were significant delays at the data collection phase, because of the need to replace some study sites.

1.10 **What is in this abridged report?**

This report summarizes the key findings which are linked with recommendations. The recommendations are then further elaborated in action items. The recommendations are informed by the national assessment of the Ethiopian Health Extension program. Multiple consultative meetings where the recommendations were formulated, vetted and refined have been held.

Some of the areas for which more than two options were provided were handled through debates. Although some aspects of the program call for longer term visioning, most of the interventions are believed to be practicable because they are the direct derivatives of the findings from the primary data (qualitative and quantitative) as well as the extensive document review as part of the national assessment.

The recommendations are formed based on 10 key building blocks which came out to be prominent in this assessment. They are presented here with those key building blocks as the main titles with a brief description of the current expectations/standards, summary of key findings followed by the key recommendations.

For ease of understanding and as recommended by the ministry of health, the recommendations are forwarded with 4 components (maintain, modify, add and drop).

In the recommendations, the following should be taken as defined below:

Maintain: means keep the current practice with no or only minimal change.

Modify: means make changes to the way the program is delivered currently.

Add: means consider a new addition to the current program

Drop: means eliminate the practice/approach from the current program

The report has five sections. Section 1 presents a brief introduction of the national assessment; section 2 presents summary findings and recommendations on different thematic areas of the agrarian and pastoralist HEP. Section 3 presents a summary of action points suggested by a joint team of experts (comprising assessment team members and MoH experts) to translate the assessment recommendations into action. Section 4 is specifically about urban HEP assessment; it presents summary of key findings, recommendations, and action points from the Urban HEP Assessment. Section 5 provides a list of immediate next steps that are suggested to facilitate the translation of recommendations and action points into practice.

2 Summary of Findings and Recommendations on Agrarian and Pastoralist HEP

2.1. Service packages

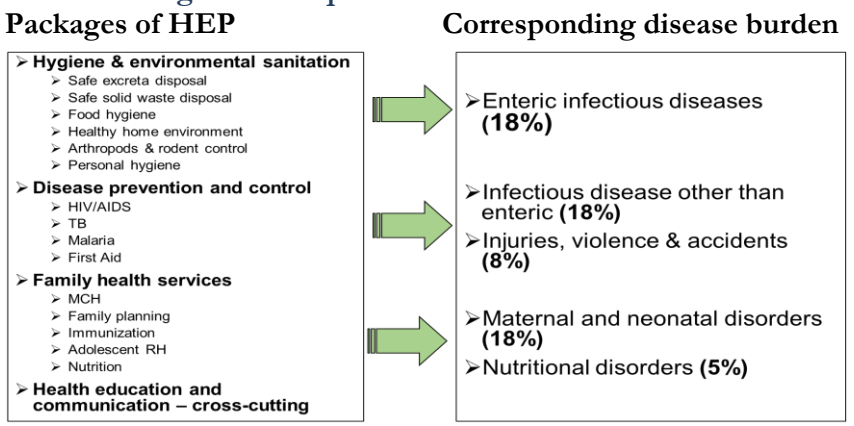
Expectations and standards

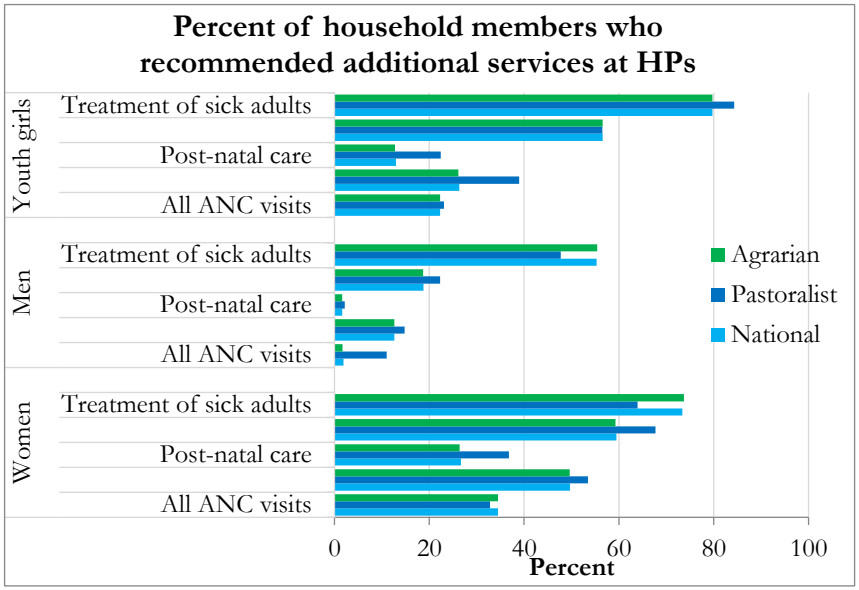
- HEP has 18 packages in the areas of 1) hygiene and environmental sanitation, 2) disease prevention and control, and 3) family health. All packages are expected to be implemented in parallel by all health posts.
- Initial packages have expanded in volume of services in response to community needs and demand from specific program stakeholders.

Summary of key findings

- Despite substantial improvement in health indicators since the beginning of HEP, communicable, maternal, neonatal, and nutritional disorders (CMNNDs) still constitute 60% of the total DALYs lost in Ethiopia. Moreover, there is increasing burden of non-communicable diseases calling for increasing access to prevention and control actions.
- None of the HEP packages are adequately implemented to a level where the community can sustain adopted behaviors
- All the packages of HEP are relevant in addressing the major causes of morbidity and mortality among rural communities. Recently added packages of NCDs and mental health has also created opportunities to address the increasing burden of NCDs. HEWs are providing clinical services including antenatal care, other maternal health services, and treatment of sick children; however, providing clinical services through the current health posts with existing capacities of HEWs and other material resources has led to compromises in quality of care.
- Availability of more comprehensive services at health posts has a positive impact on acceptance of HEWs and linkage of community-based health promotion activities with service uptake.
- Communities have high demand for more comprehensive services at HP level. This demand has not been adequately addressed for different reasons including 1) decision to keep clinical/curative services separated from health promotion and disease prevention activities, 2) limited trust of the community on HEW's ability to provide clinical services despite generally high level of trust and acceptance and availability of selected clinical services at HPs, and 3) low awareness of communities regarding services that are already available at HPs

Illustrative figures and quotes





Recommendations

Level of change required	Suggested changes
Maintain	• The current packages should be continued by addressing their implementation challenges.
Modify	• HEP packages should evolve with clear milestones to graduate (bring to an end) packages upon achievement of sustainable behavior change at household level. Hygiene and environmental sanitation related packages have to be intensively implemented for a defined period of time with a clear roadmap to graduate packages upon achievement of pre-defined criteria for sustainable behavior change.
	• Health and health system literacy has to get adequate attention either as part of each package or as a separate package.
	• Provide clear standard operating procedures for health post operations in different contexts to guide implementation, monitoring and evaluation, and controlling of health posts.
Add	• Packages should incrementally expand with the goal of meeting communities' expectations for more comprehensive services at health posts including comprehensive maternal health services, treatment and referral for common childhood illnesses, and treatment of common communicable diseases among adults, and screening and referral for common other illnesses including NCDs. Allow packages to vary across health posts depending on local realities including proximity to health centers and hospitals. Versions of HEP packages should be developed for: o HEP unit in a HC or primary hospital: for kebeles with HCs or primary hospitals o HPs that should implement basic set of packages o HPs that should implement comprehensive set of packages
	• Conduct a prospective analyses of birth outcomes among deliveries attended by HEWs to generate additional evidences on capacity of HEWs in handling labour and delivery.
Drop	• Avoid delivery attendance by HEWs until adequate evidences are generated regarding the skill levels of HEWs in managing normal labor and detecting complications.

2.2. Service delivery modalities

Current expectations and standards

- HEP packages are implemented through home visits, health post visits, and outreach sessions in different community-based settings. Exposure of households to HEP through these packages leads to better implementation of HEP at household level in different settings.
- Female HEWs in agrarian settings and male HEWs in pastoralist settings are the primary providers of HEP services.
- Innovation diffusion and scale-up are the two commonly referred theories behind the design and implementation of HEP

Summary of key findings

- Health seeking behavior of rural communities is sub-optimal. Static services alone won't allow the health system to adequately expand coverage of essential health services.
- There is high community acceptance and approval for HEP service delivery through home visits, health post visits, and outreach sessions. Female HEWs are highly recommended for home visits; however, limiting HEWs to only female gender was criticized for: 1) difficulty to reach all segments of the population within a kebele because of distance, geographical barriers, and security concerns and 2) difficulty to achieve behavioral change at household level without involving men in a patriarchal society.
- Involving males as HEWs has been approved as appropriate by large portions of the community.
- Campaign-based approaches and strategies involving coercion/ punishment to increase implementation of HEP at household level didn't achieve sustainable behavior change in relation to construction and utilization of latrines and utilization of maternal health services.
- Implementation of HEP has high level of deviation from theories that are thought to have informed the design of HEP (innovation diffusion).

Illustrative figures and quotes

Current status of selected HEP related indicators, 2019

Indicator	Coverage (HEP assessment finding)		HSTP (2020) Target
	National estimates	Regional variability	
CPR	46.6%	(0.0%, 55.3%)	55%
Unmet need for FP	22.5%	(9.7%, 34.5%)	10%
ANC4	48.3%	(1.2%, 72.1%)	95%
Facility delivery	54.9%	(7.3%, 80.2%)	90%
PNC	25.5%	(0.4%, 60.1%)	95%
Improved latrine	20.0%	(4.7%, 27.2%)	82%

"…. I have been serving as WDA leader for the last six years. In the past, we all (mothers) use to give birth at home … HEWs taught us about the importance of facility delivery. Now, we are following pregnant women within our one-to-five networks so that they give birth at health facilities …However, punishing mothers who deliver at home has become a problem for us (WDAs); we also get punished if a mother in our network delivers at home."

WDA from an FGD

Recommendations

Level of change required	Suggested changes
Maintain	• Static, home visit, and outreach service delivery modalities • Female HEWs responsible for contacting women during home visits
Modify	• Enhance the use of health post visits as entry point for provision of comprehensive health promotion and disease prevention services. The increasing role of health post visit as means of exposure to HEP has to be used an emerging opportunity to rethink entry points for more comprehensive household level behavior change interventions.
	• Revise behavior change theories and strategies in a way that consider variabilities in the needs of specific behavioral outcomes and cultural contexts.
	• Increase involvement of men and youth as targets of HEP
	• The strategy for outreach modality should be designed in a way that includes social capital or indigenous social institutions like idir, equb and others.
Add	• Include male health workers for HEP
	• HEP for pastoralist communities requires a different arrangement of service delivery. Conduct a more detailed analyses of experiences in mobile health team, mapping movements of pastoralist communities, and other program specific experiences to redesign service delivery modalities in pastoralist areas.
	• Redesign pastoralist HEP by conducting more detailed analyses of experiences in addressing health and other social needs of pastoralist communities including villagization/settlement of mobile communities, mobile health team, mapping movements of pastoralist communities, and other program specific experiences.
	• Strengthen inter-sectoral collaboration to ensure that strategies to implement HEP in pastoralist communities are integrated/ coordinated with other community-based services including villagization and animal health services.
	• Develop code of ethics for health extension workers that is adaptable to the local community values, and enhance their acceptability among community members (human centered approach).
	• Initiate Family Health Team approach in rural HEP.
Drop	• Avoid the use of campaign-based approach to influence behaviors that need continuous communication with household members like latrine construction and utilization. • Avoid punishment or coercion measures for not having facilities or using services

2.3. Implementation of HEP

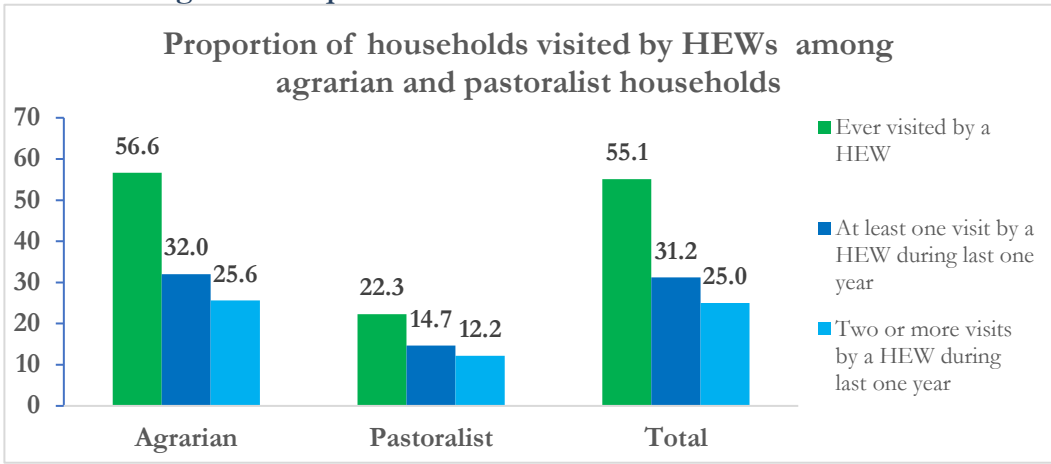
Current expectations and standards

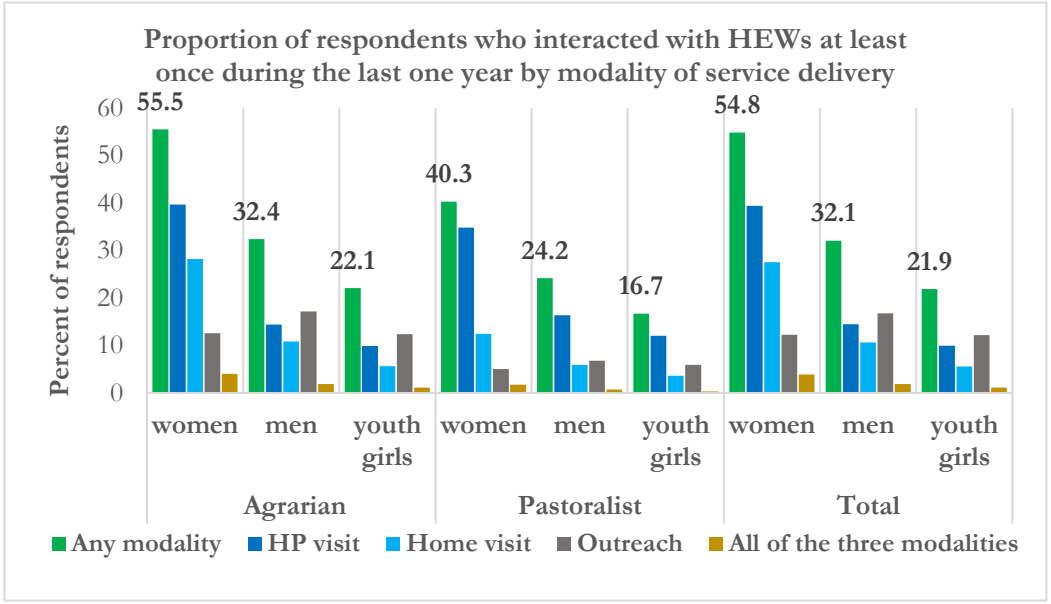
- Repeated exposure to HEP through home visit, outreach sessions, and health post-based activities is expected for households to transform in a way that allows them produce their own health.

Summary of key findings

- Health posts are almost universally available at the kebele level and physically accessible for the vast majority of the community. Availability and physical accessibility of health posts, however, didn't translate into actual access to services.
- Exposure to HEP among agrarian and pastoralist communities is low. Despite the relatively higher level of importance of home visits and outreach sessions to bring about household level behavior change, exposure to HEP is shifting towards health post-based services than household and community-based health promotion and disease prevention activities.
- Implementation of HEP has been very low in **pastoralist** communities compared to that in agrarian communities.
- Human resource related factors are likely to be the primary drivers of intensity of HEP implementation. Professional mix and level of education, rather than number of HEWs in a HP, are associated with better implementation of HEP through home and HP visits. HPs with midwives/nurses or level 4 HEWs had better implementation of HEP in terms of both home visits and health post visits.
- Progress towards full implementation of HEP at household level is sub-optimal. HEP related factors explained only a small portion of variation in HH level implementation of HEP signifying lack of effectiveness of current behavior change strategies for household level behavior change.

Illustrative figures and quotes





Recommendations

Level of change required	Suggested changes
Maintain	• Universal availability of HPs at kebele level • Model family training as a strategy for HEP implementation
Modify	• Behavior change strategies should be adapted to behavioral outcome and context specific approaches/models. No single behavior change model will allow transformation of all HEP related behaviors. • Expand workforce at health post by number and professional mix to ensure that HEWs have adequate time for home visits and outreach sessions while at the same time health posts operate full time. • Strengthen linkage between demand creation and service provision activities by increasing availability of services at health post level and further enhancing health center – health post linkage. • Consider a phased approach to implementation of HEP packages through which each package that requires behavior change at community level will be a focus area of intervention at different time periods during which intensified social and behavior change strategies will be implemented until a sustainable change is observed. This will allow avoiding unnecessary spread of HEP resources over too many activities at a time. • Home visits and most of the outreach sessions of HEWs should focus on demand creation through health and health system literacy instead of attempting to take facility-based services to the home of potential users. • Intensify focused outreach services to selected areas where men and youth can be targeted (markets, schools, periodic community gatherings, religious institutions, and community-based organizations) depending on local context.
Add	• Flexible but regulated working days and working hours allowing HEWs to plan reaching target populations including women, men, and youth in different public gatherings.
Drop	• Forcing households to adopt desired behaviors • Coercion/punishment as a strategy to influence HH behavior • Campaign based approaches for behaviors that require time to change

2.4. Human resource for HEP

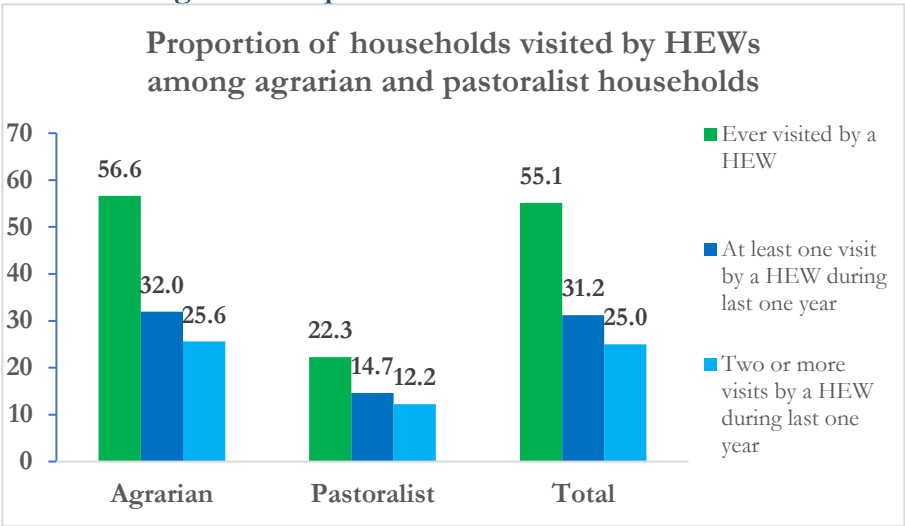
Current expectations and standards

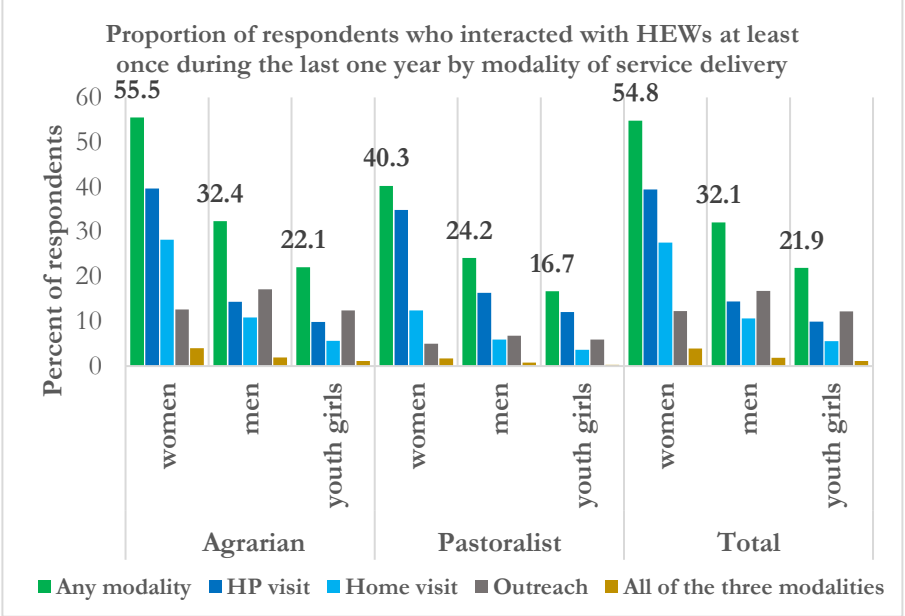
- Two HEWs in a health post expected to serve an average of 5,000 population

Summary of key findings

- Most HPs are staffed with at least two HEWs. However, the current workforce has challenges in competency and motivation.
- Gaps in competency of HEWs is primarily linked to sub-optimal pre-service training in relation to 1) recruitment of trainees, 2) medium of instruction, 3) training capacity of institutions as opposed to large class sizes, and 4) limited compliance of trainings with training curricula.
- Several health posts have more than two HEWs, at least one level 4 HEW; some have nurses or midwives. Availability of at least one level IV HEW, midwife, or nurse is associated with better implementation of HEP but increasing the number of HEWs within a HP was not associated with better performance.
- Health centers are attempting to fill the skill gap of HPs by assigning their staff to rotate at health posts. This approach has been criticized for logistical challenges and inefficiency associated with travel time.
- Introduction of additional interventions over time markedly increased the workload of already strained HEWs. Full implementation of the current HEP packages requires more health workers in each health post. The current HEP packages require sets of skills in diverse areas of health disciplines that can be broadly categorized as midwifery, clinical, and environmental health related skills. A single category of health worker is unlikely to satisfactorily master all required skills.
- Attrition rate is fairly low despite high intention to leave among HEWs implying that there is high level of work dissatisfaction, retention of only less competent staff over time, and high risk of losing large number HEWs if alternative job opportunities emerge. Increasing the satisfaction level of HEWs requires a comprehensive package that facilitates respecting the rights of HEWs as civil servants, and allowing them to grow professionally to more diverse fields of related specialties.

Illustrative figures and quotes





Recommendations

Level of change required	Suggested changes
Maintain	• Upgrade level 3 HEWs to level 4
Modify	• Revise entrance criteria for HEW training to consider opportunities created by large numbers of students completing high school and university preparatory schools. Introduce entrance exams involving HEW training institutions.
	• Build the capacity of HEW training institutions in the areas of involvement in student recruitment, instructors' capacity, management of practical attachment programs, and strengthen their regulation
	• Strengthen regulation of HEW training institutions.
	• Review and balance duration of training for HEWs with content of curriculum
	• Match practical attachment sites with learning outcomes. Consistently assign trainees at health post level as part of practical attachment.
	• Strengthen the provision of IRT on regular basis using training materials translated into local languages
	• Respect the rights of HEWs as civil servants in the areas of transfers, leave, and career structure.
	• Transform workflow and information system of health posts in a way that guarantees continuum of care that is resilient to staff turnover. This will require making CHIS a more dependable source of information about households than the memory of individual HEWs.
	• Mobilize underutilized staff of health centers to work in health posts until adequate health post capacity is built. Develop incentive packages to motivate HC staff to work temporarily at health posts.
Add	• Address language barrier in training of HEWs by introducing English language competency tests for entrance.
	• Open career development for HEWs to allow them grow in more diversified areas of specialties allowing competent HEWs to compete and occupy positions in other levels of health institutions.
	• Mobilize underutilized staff of health centers to work in health posts until adequate health post capacity is built. Develop incentive packages to motivate HC staff to work temporarily at health posts.
	• **Number of staff:** Revise human resource standards of HPs to allow assignment of more health workers in each HP.
	• **Staff mix:** Consider staffing HPs with a team of health workers composed of HEWs and other health professionals with expertise allowing the provision of more comprehensive services at HP level. Assigning more than two HEWs in a HP may not be an effective way of using limited public resources. Consider adding health workers with additional set of to increase number of health workers in a HP. The willingness to assign more HEWs in each HP is an opportunity that can be redirected to diversifying skills and gender at HP while at the same time alleviating workload on HEWs.
	• Initiating virtual learning modalities for HEWs as a continuous professional development strategy.
	• Provide simple technology applications serving as job aid and decision support tools.
	• Consider performance-based incentives to health posts and HEWs based on auditable performance data.
Drop	• Assigning more than two HEWs in a health post is not an effective way of using limited public resources.

2.5. Physical facilities, infrastructure, and basic utilities

Current expectations and standards

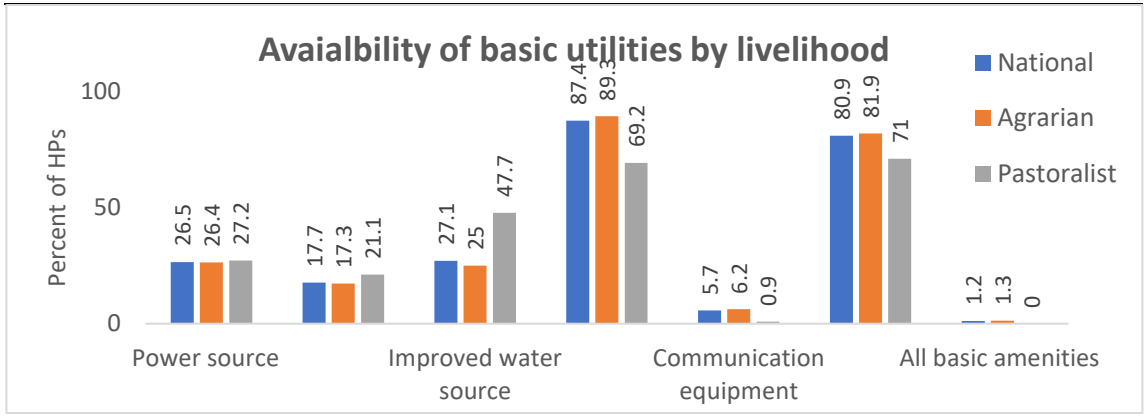
- One health post is expected to serve a total population of 5000 in agrarian settings and 3000 in pastoralist settings.
- Health posts have construction standards and require continuous supply of basic utilities. Access to road, electric power, safe water source, and sanitary facilities are requirements for effective implementation of HEP

Summary of key findings

- Health Posts are almost universally available.
- Most of the available HPs do not meet standards of infrastructure and physical facilities.
    - Only 37% of health posts fulfill building standards.
- Majority of health posts do not have access to basic utilities including water and electricity.

Illustrative figures and quotes

Background	Health post to pop ratio	HEW to pop ratio	% HPs with 5000 or less catchment pop	% HPs with 3000 or less catchment pop
National	5760	2599	42.1	17.7
Livelihood				
Agrarian	6057	2728	36.8	13.9
Pastoralist	2919	1361	93.3	53.9
Region				
Tigray	5941	2875	36.9	12.0
Afar	3779	1256	82.5	57.4
Amhara	5963	2834	25.0	8.1
Oromia	6498	3110	33.4	6.7
Somali	2526	1268	100	58.5
B/Gumuz	2120	935	95.4	82.2
SNNPR	5361	1966	53.9	29.8
Gambella	3718	424	91.6	81.5
Harari	4576	1509	58.7	17.5



Recommendations

Level of change required	Suggested changes
Maintain	• Health Center to Health Post linkage to overcome challenges related to lack of electric power at health posts.
Modify	• Responses to the increasing population size within a kebele should focus on expanding capacity within a health post instead of constructing additional health posts. • A phased approach to renovation/reconstruction of health posts should be introduced with due consideration to: 1) the need to expand services 2) the importance of avoiding any more sub-standard construction, 3) the limited capacity of the country, and 4) the availability and accessibility of infrastructure and utilities within the kebele • Coordinate efforts to renovate or reconstruct health posts in line with plans for expansion of services within each PHCU. • Initiate an innovative approach to mobilize resources for renovation of health posts from government, community, and other funding sources. • **Multi-sectoral approach:** Negotiate at a higher level to ensure that health posts are prioritized in infrastructure development projects (road, electricity, water, and telecommunication) targeting rural communities. • Consider long term plans to solve lack of residential houses for health post staff. Actions should include multiple options including constructing residential houses in health post compounds, incentivizing private leasers, and facilitating access to land for HP staff intending to construct their own houses.
Add	• Introduce enforcement of regulatory standards on future health post construction and/or renovation activities to prevent investment on sub-standard constructions.

2.6. Equipment, drugs and other medical supplies

Current expectations and standards

- Health posts are currently allowed to keep only program drugs for which no revenues are collected.
- Supplies reach health posts through health centers and woreda health offices

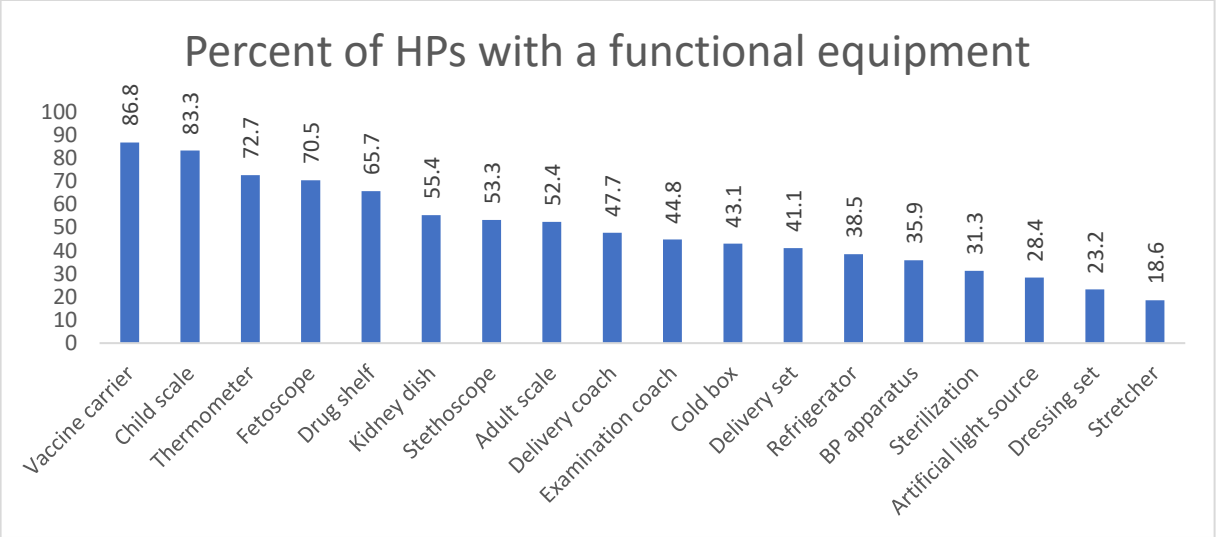
Summary of key findings

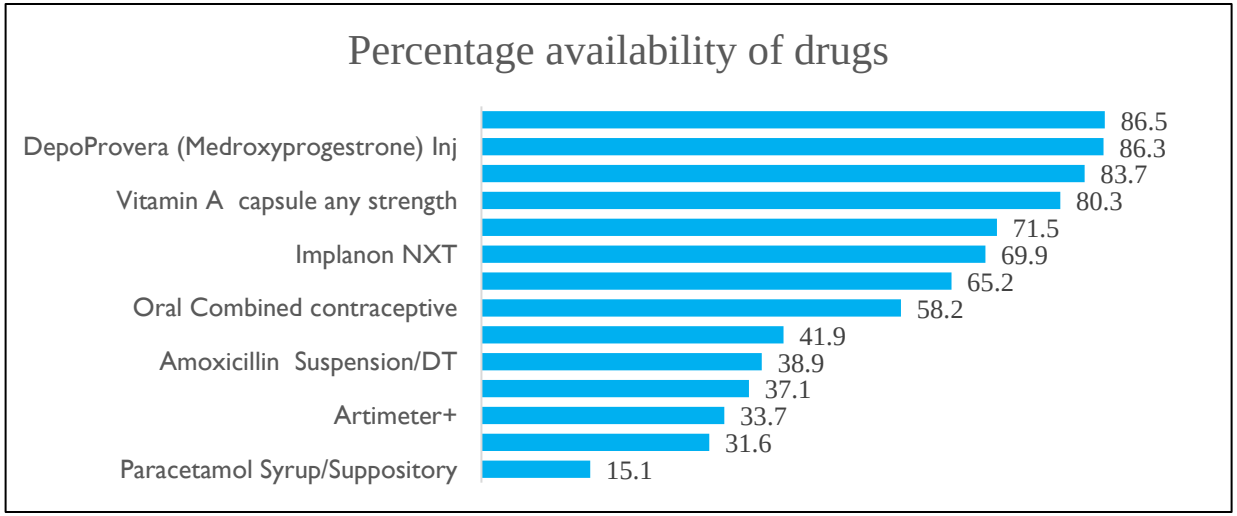
Essential equipment required for the provision of services under the current packages are very often not available or not functional at health posts.

Availability of tracer drugs varied across items. Both shortage of supply and inadequate supply management system were related to stock out of tracer drugs and other medical supplies.

Unavailability of functional medical equipment possibly explains compromised quality of health post-based services including low effective coverage of ANC.

Illustrative figures and quotes





Recommendations

Level of change required	Suggested changes
Maintain	• The supply of program specific drugs and other medical supplies like family planning commodities and vaccine supplies.
Modify	• Strengthen IPLS implementation through regular supportive supervision and introduction of simple electronic technologies. • Revise drug list of health posts to match revision in scope of services provided at health posts including possible expansion of clinical services. • Build the capacity of health post staff on supply chain management system for drugs and other medical supplies. • Ensure appropriate storage and usage of drugs and other medical supplies. • Explore and introduce alternative sources of funding the supply of drugs and other medical supplies for consumption at health post level. • Strengthen quality assurance of imported medical equipment including BP apparatus. • Ensure availability of durable and quality assured equipment at health posts, and insure their continued maintenance
Add	• Assess the feasibility and effectiveness of alternative for financing HP based services through mechanisms including community-based health insurance and incentivizing private sector involvement at the village level. • Explore options for expansion of investigations involving dip-stick technologies to address the gap in laboratory facilities as services expand at health posts.

2.7. Financing of HEP

Summary of key findings

- Investment on HEP has been increasing in nominal terms. However, the share of spending on HEP in relation to total expenditure at health center and health post level has been continuously declining since 2010.

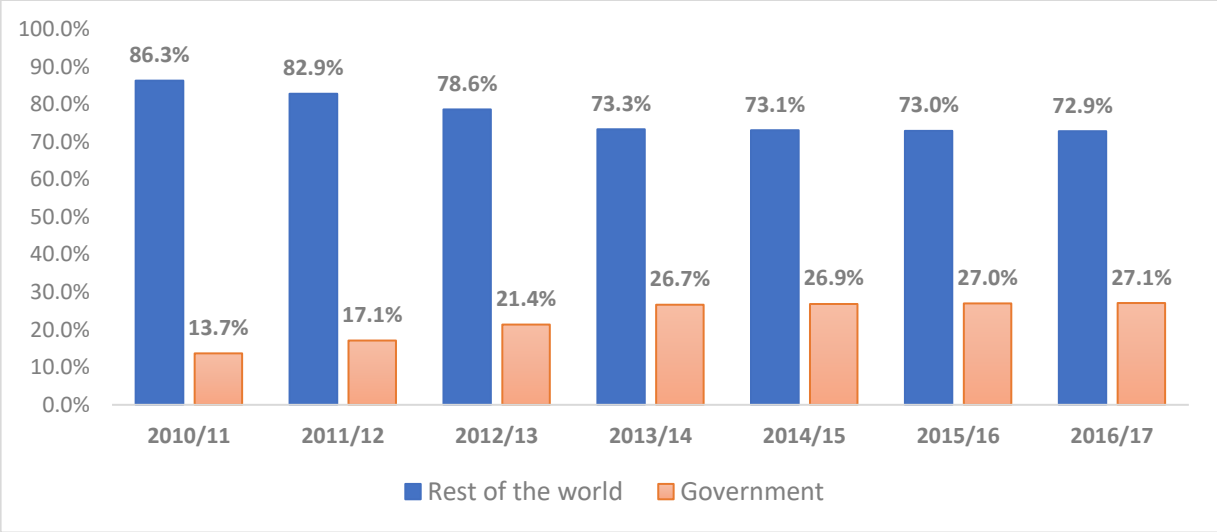
- Except for voluntary contribution of time/labour at community level, government and donors are almost the only financing sources of HEP.

- Government share in financing HEP has been increasing over the years. However, HEP is still a highly donor dependent program with 73% of its spending still coming from donors.

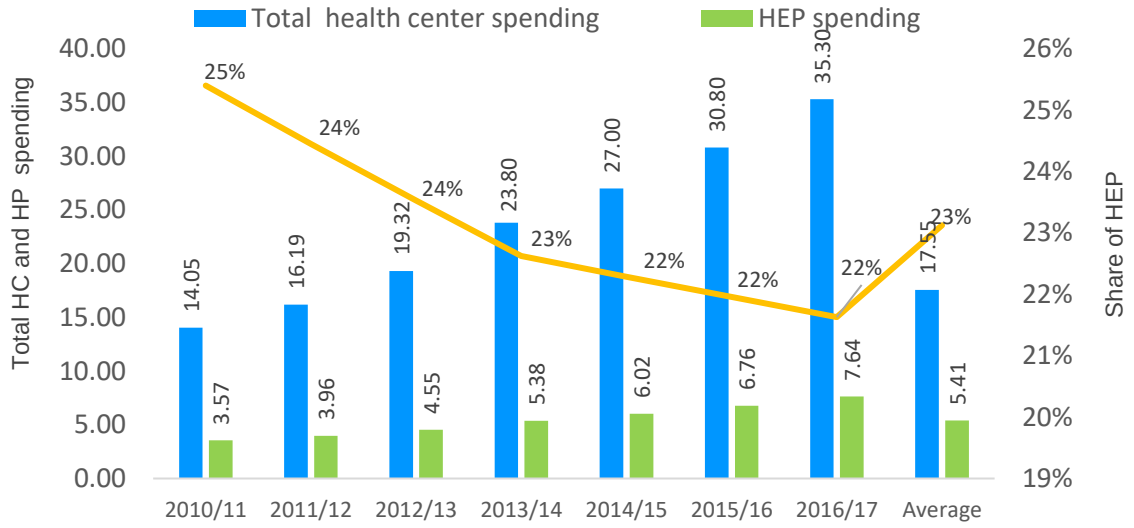
Illustrative figures and quotes

Trend in sources of HEP expenditure, 2007/08 to 2016/17 in billion ETB

(Source: National Health Accounts)



HC and HEP spending (In billion ETB) and share of HEP spending (in %) 2010/11-2016/17



Recommendations

Level of change required	Suggested changes
Maintain	• Expanding government share in financing for HEP
Modify	• Increase the rate at which domestic financing schemes substitute donors with the ambition of ensuring financial sustainability of HEP.
Add	• Consider alternative sources of financing HEP packages including CBHI.

2.8. Community engagement and ownership

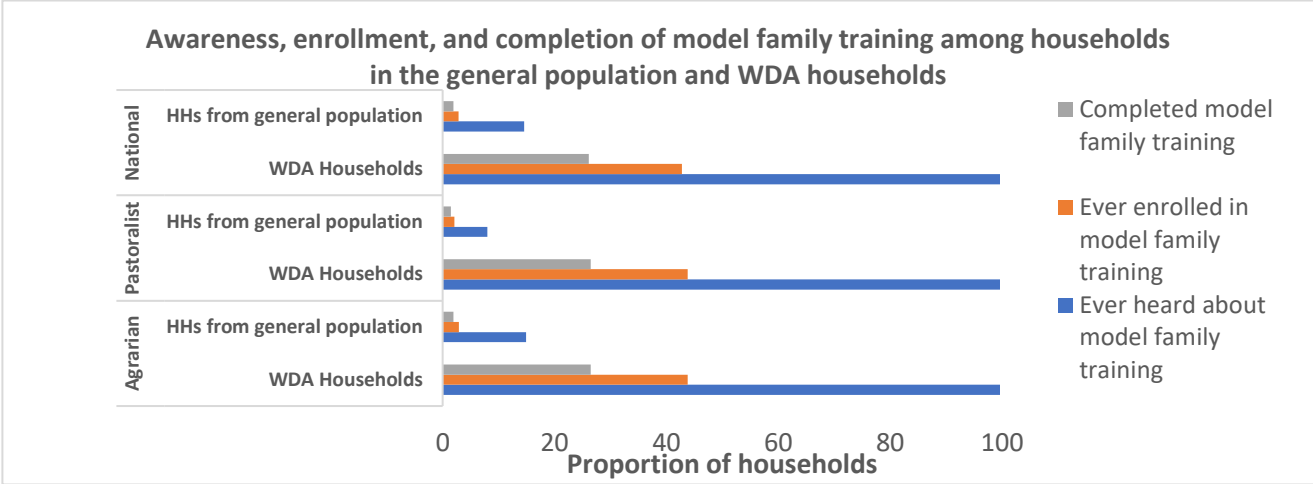
Current expectations and standards

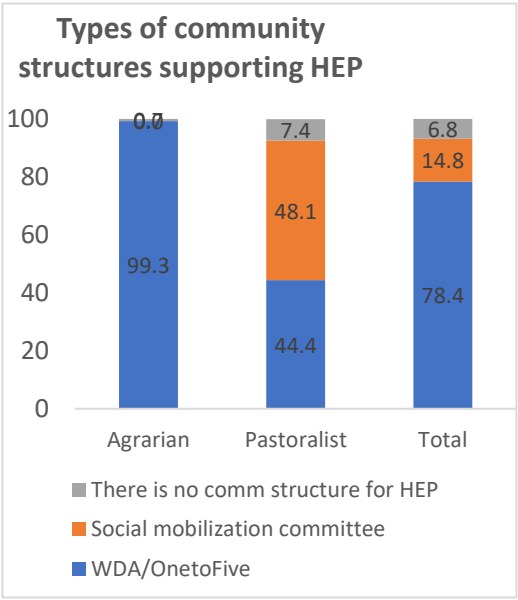
- Community engagement and ownership is a major pillar of the Ethiopian health sector in general and that of HEP in particular.
- Current strategies for community engagement and ownership rely on model family training and the use of WDAs and/or SMCs

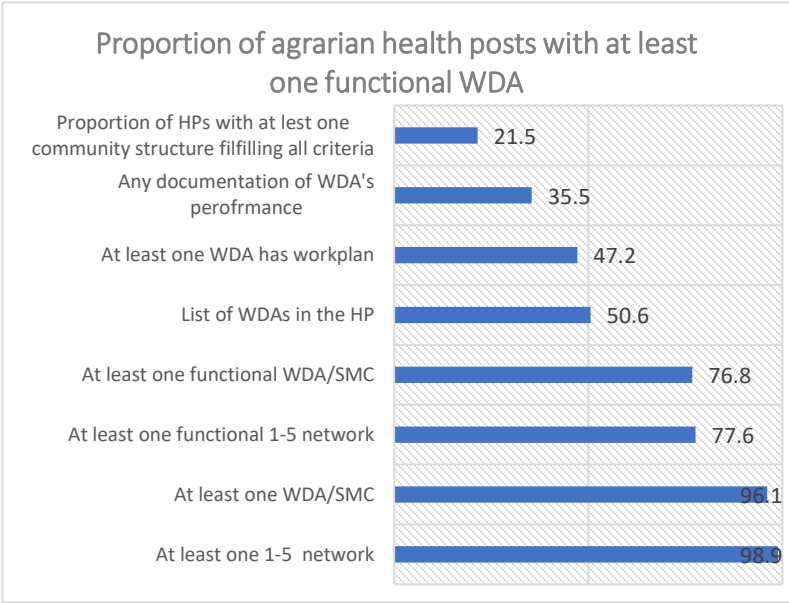
Summary of key findings

- Model family training is an effective strategy to increase household level implementation of HEP. However, only a very small portion of the population are aware, enrolled, and completed the training.
- WDA and/or SMC structures are widely available but with very limited functionality in supporting HEP.
- Among the primary reasons
- WDA leaders and SMC members are not models in their health behaviors. Selection of WDA leaders gives very little attention to health behavior.
- WDA leaders currently have low acceptance and are mostly considered as political agents.
- The use of WDAs alone has resulted in underutilization of community potentials from men, religious leaders, and traditional leaders.
- Roles and responsibilities of WDA leaders sometimes overestimates their capacity and ignores the fact that these leaders are volunteers.

Illustrative figures and quotes







Recommendations

Level of change required	Suggested changes
Maintain	• Keep community engagement central to HEP
Modify	• Strengthen model family training by providing clear guidelines, increasing HEWs' time spent for training of families and arranging experience sharing sessions between model families and others.
	• Introduce a system that allows HEWs to track enrollment, progress, completion, and recognition of model families.
	• Ensure all community volunteers working with HEWs are model in their health behavior before involving them as voluntary health agents.
Add	• Redesign community structure for HEP with renewed branding, capacity, and responsibilities. Consider the following features to address challenges faced by the WDA approach: o Link HPs with all segments of the kebele population including men, women, and youth with different roles and positions in the society o Allow community structures to vary across regions and within regions depending on culture and functionality of existing structures. o Involve all segments of the population including youth, women, men, traditional leaders, religious leaders, and other influential individuals. o Use fewer (manageable size) community volunteers to serve as change agents and community mobilizers o Keep community volunteers accountable to HEWs.
	• Incentivize volunteerism and limit duration of service to a pre-defined period of performance. Recognition and free enrollment to CBHI scheme are among possible approaches to incentivize voluntary health agents.
	• Make maximal use of opportunities created by: 1) relatively better availability of literate community members, 2) high level of school enrollment among adolescents and youth, and 3) increasing use of communication technologies including cellphone and the internet.
Drop	• Reliance on single approach to community participation • Avoid creating expectations of becoming salaried workers among community volunteers

2.9. Information system/M&E

Current expectations and standards

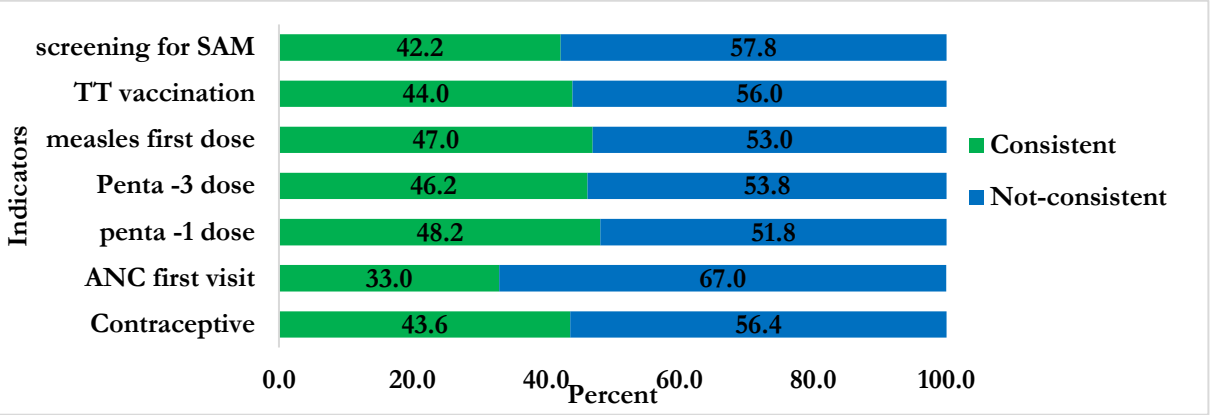
- The routine health information system of Ethiopia is guided by a centrally defined set of indicators and data capture, processing and reporting tools that are revised regularly to ensure responsiveness to the dynamic information needs of stakeholders.
- Health posts are responsible to compile reports on indicators all of which are reportable to all levels of the health system.
- Reportable HEP data should be first documented in health cards stored in family folders (in agrarian) and registers (in pastoralist).
- Talley sheets should be used to summarize data on service delivery which will then be summarized and reported to HCs on a monthly basis.

Summary of key findings

- The current health information/M&E system that captures data for measurement of indicators reportable up to the federal level focuses only on outputs of specific programs implemented through HEP with very limited attention to monitoring the process of HEP at lower levels.
- Kebele level indicators directly linked to the performance of HEP involve definitions with unrealistic targets (HDF, ODF, 100%CBHI enrollment) resulting in lack of sensitivity to intermediate progress of health posts.
- Data recorded and reported by health posts is largely inconsistent with source documents mostly resulting in over reporting of performance.
- Information use is limited at health post and higher levels.

Illustrative figures and quotes

Record or data consistency between tally sheet and health cards or registers, by indicator



Proportion of health posts by reporting accuracy on selected indicators

Indicators	Proportion of HPs with accurate report	over report	under report
# of women who received contraceptives	52.8%	37.2%	10.0%
# of women who received ANC first visit	59.7%	30.9%	9.4%
# of women who received four ANC visits	62.7%	29.0%	8.2%
# of children <1 yrs of age who received Penta 1 dose	60.1%	30.2%	9.6%
# of children <1 yrs of age who received Penta 3 dose	60.1%	32.4%	7.5%
# of children <1 yrs of age who received measles 1st dose	58.8%	35.5%	5.7%
# of women who received TT vaccination	56.5%	35.9%	7.6%
# of children <5 yrs of age screened for acute malnutrition	54.2%	39.0%	6.9%

Recommendations

Level of change required	Suggested changes
Maintain	• Data disaggregation by level of service provision (HP, HC)
Modify	• Revise definitions of indicators with unrealistic targets.
	• Expand electronic CHIS with dashboard features facilitating information use in situations with limited data processing capacity.
	• Enforce the use of family folders to record any encounter between HEWs and household members.
Add	• Regular data verification system involving a component to do community level verification on a random sample of service users in order to minimize deliberate over reporting
	• Performance management system relying on auditable progress in coverage as well as quality of services
	• Initiating incentive mechanisms to encourage improved data quality and use
	• Include process indicators of HEP for monitoring implementation of HEP service delivery modalities at least at health post, health center, and woreda levels.
Drop	• Eliminate formal and informal incentives to over reporting

2.10. Governance and leadership

Summary of key findings

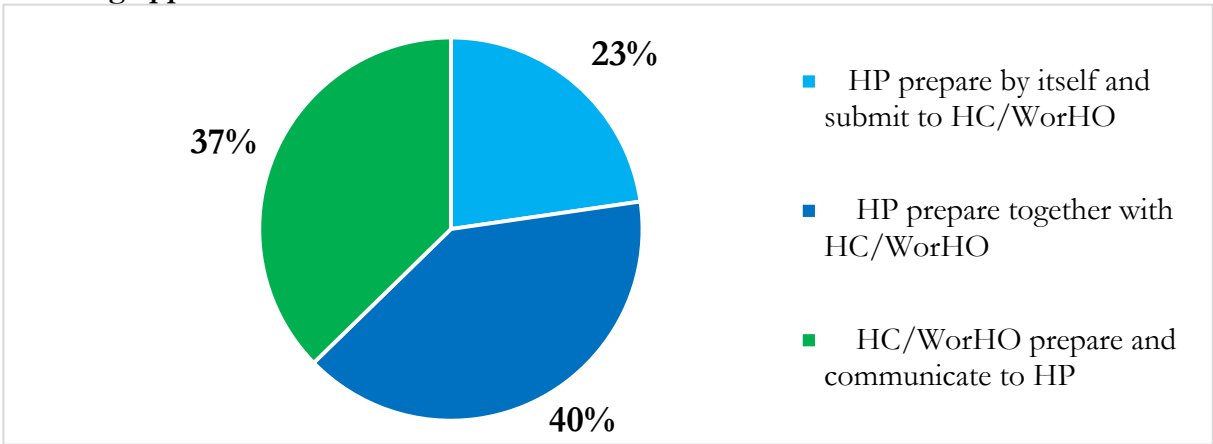
- There has been limited guidance on how HEP should evolve in the future.
- Planning is usually top down; some HPs do not have documented annual plan.
- Dual accountability of HEWs and parallel reporting are common among health posts.
- Single standard of HP didn't fit the realities of populations at the kebele level. Services provided, staffing patterns, supplies and equipment, and infrastructure needs of HEP in kebeles with a health center are different from those located far from a health center. The current standard of health posts didn't acknowledge this difference leading to inefficient use of available resources.
- Supervisory support from health centers hasn't been adequate. Whenever provided, team-based supervision of health posts has been more supportive of HEP implementation than individual HEP supervisors.
- Restrictions in rights of HEWs as civil servants have been frequently reported. This has been a major source of dissatisfaction among HEWs.
- Accountability is limited at health post level leading to high rate of absenteeism and closure of health posts

Illustrative figures and quotes

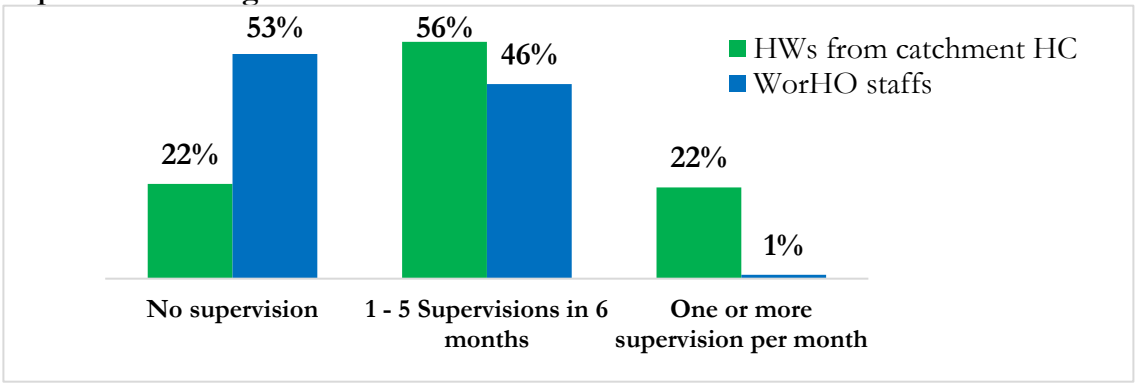
Proportion of HPs with annual plan

- Plan was observed in the HP - 79.9%
- Plan reported available but not observed - 7.9%
- No plan - 12.2%

Planning approach for HEP



Supervision during the last six months



Recommendations

Level of change required	Suggested changes
Maintain	• Health Center – Health Post linkage for technical support and administrative oversight.
Modify	• Clarify lines of accountability of HEWs/HPs to avoid dual accountability and overlapping responsibilities.
	• Ensure alignment of priorities and targets of different health programs with those of HEP.
	• Strengthen intersectoral collaboration at all levels guided by collaborative frameworks enforced at higher levels.
	• Ensure that HEP plays vital role in facilitating Kebele level intersectoral collaboration with the intention of addressing social determinants of health.
Add	• Introduce service and input standards for multiple categories of HEP implementers. One option could be classifying HEP structures as: o HEP unit in a health center (for kebeles with HCs) o HPs implementing basic set of packages o HPs implementing comprehensive set of packages
	• Rebrand health posts along with changes in their function and structure. Consider changing names from health post to a one that reflects upgrading to a facility with more comprehensive services in order to boost demand for both existing and newly added services.
	• Develop a roadmap showing clear path on how HEP and its components should evolve in the coming 10 to 20 years.
	• Consider administrative board for health posts involving community members in the overall oversight of health posts.
	• Provide clear guidelines on involvement of HEWs in "non-health" activities with the purpose of keeping their involvement to activities that: • Create opportunities for health promotion and disease prevention activities and addressing social determinants of health • Do not create negative co-notation for HEWs by any member of the society • Can be pre-planned to avoid too much compromise in routines of HEP • Increase the power and acceptance of HEWs • Are planned in a framework facilitating intersectoral collaboration

3 Action Points Suggested for Operationalizing Recommendations

3.1. Introduction

The 2019 national assessment of the Health Extension Program resulted in a set of recommendations related to the design, implementation, and management of the program. A team of experts composed of the national assessment team from MERQ Consultancy PLC and experienced primary healthcare experts from the PHC and HEP Directorate of Ministry of Health held a workshop to develop action points that can effectively translate selected recommendations from the national assessment into actions. This section presents action points proposed by the team.

3.2. Action points to implement recommendations on HEP Packages

1) Plan for evolution of HEP packages

- Develop a clear roadmap with a clear theory of change determining what HEP and its target populations should look like in the long term. The roadmap should clearly state:
    - Which packages should be continuously provided at kebele level?
    - Which packages or components of packages should graduate (end) at a certain time upon achievement of sustainable behavior change in the community?
    - Set criteria to graduate packages or specific components of packages and ensure their sustainability. In doing this, focus on packages or components of packages that can be implemented by mainly the health sector and which has the potential to be supported by development partners.
- Revise health education package to emphasize on comprehensive health and health system literacy
- Develop a strategy clearly describing how HEP packages can be added, dropped, or modified in the future. Link HEP package revision activities with revision of essential health service packages.

2) Classify packages and components of packages for different contexts depending on accessibility of alternative health facilities

- Determine HEP packages for three categories of target communities in rural areas

Category of Rural Kebele	Packages needed
Kebeles where there is a health center	Exclude services that are available at health center No clinical services Focus on home- and community-based health promotion and disease prevention activities
Kebeles within a reasonably short (less than an hour walking) distance from a health center	Basic packages Keep current packages by addressing issues in quality of care
Kebeles far from a health center	Comprehensive packages Include additional priority clinical services including comprehensive MCH services and treatment of common adulthood illnesses that can be provided without the need to establish a laboratory unit.

- Defining the roles and responsibilities of each type of HP in relation to service delivery:
  Category A: are health extension program components which will be organized as part of the health center. The health center will have a HEP unit, which will focus on community-based interventions. Curative services of the existing HEP will be delivered by the health center leaving HEWs with the responsibility of only community-based activities. There will be no separate HP in these kebeles. HEWs (HEP unit in HC) will be bridges between the health center and the community, and also undertake activities that may arise from index cases observed at HC (eg. dropout tracing for services, index tracing for epidemics, etc).

  Category B: are health posts which will operate with the existing HEP packages by addressing gaps in quality of service delivery. There is no need to expand services at this time because health centers are somehow accessible to the community (within one-hour distance). These HPs need additional workforce (category) to address gaps in quality of existing services.

  Category C: HPs that should provide comprehensive set of packages by expanding existing services to respond to the need and demand of communities living far from health centers. These HPs will have additional health professionals that can provide comprehensive health services (maternal and child health services, treatment of childhood illnesses using IMCI as an approach, treatment of common adulthood illnesses, screening for chronic health conditions, rapid diagnostic tests. Services that can be provided without the need to establish a laboratory facility will be provided in these HPs.

3) Avoid delivery services at health posts except in situations where human and material resources are fulfilled based on current standards

- Pass directives abandoning delivery at health post except in situations where special arrangements are made to ensure availability of the required human and material resources
- Initiate a study on quality and outcomes of delivery services provided by HEWs.

3.3. Action points on service delivery modalities and implementation

- Develop and implement guidelines for the provision of home- and community-based health services by following index cases seen at health posts.
- Develop and implement SOP for service provision through home visit, health post visit, and community-based outreach sessions. Home visits and most of the outreach sessions of HEWs should focus on demand creation through health and health system literacy instead of attempting to take facility-based services to the home of potential users.
- Revise behavior change theories and strategies in a way that considers variabilities in the needs of specific behavioral outcomes and cultural contexts. Specific behavioral theories be required for different health outcomes (eg. family planning use, latrine construction, child vaccination …) thus leading to different approaches to increase each of the HEP targeted behavioral outcomes.
- Introduce standards focusing on friendliness of health posts for adolescents and youth. Strengthen the capacity of health posts including HEWs with the purpose of increasing utilization of health posts by youth.
- Strengthen linkage between demand creation and service provision activities by increasing availability of services at health post level and further enhancing health center – health post linkage.
- Consider a phased approach to implementation of HEP packages through which each package that requires behavior change at community level will be a focus area of intervention at different time periods during which

intensified social and behavior change strategies will be implemented until a sustainable change is observed. This will allow avoiding unnecessary spread of HEP resources over too many activities at a time.

- Intensify focused outreach services to selected areas where men and youth can be targeted (markets, schools, periodic community gatherings, religious institutions, and community-based organizations) depending on local context.
- Strengthen outreach services to schools with a focus on reaching youth and facilitating communication of health messages between school communities and parents.
- Revise the implementation manual of HEP.
- Enhance the capacity of HEWs on communication of health information to the community (communication and facilitation skill, attitude and value clarification on health outcomes, problem solving skills, etc)
- Allow male health workers to work in health posts as needed. Determine the conditions/local contexts whereby male health workers are needed (which may include: topographic difficulties of local areas, contextual cultural issues in need of male health workers, the components of the packages in need of influencing male community members, etc).
- Redesign pastoralist HEP by conducting more detailed analyses of experiences in addressing health and other social needs of pastoralist communities including villagization/settlement of mobile communities, mobile health team, mapping movements of pastoralist communities, and other program specific experiences.
- Develop specific approaches for different pastoralist communities based on their mobility, frequency of mobility, duration of stay away from their common residence, and route of mobility.
- Maximally utilize opportunities create among pastoralist communities (locally recognized community members: clan leaders, religious leaders, and other relevant social structures) to increase the health literacy (including their awareness on common health and health related problems), knowledge on availability of services and service uptake.
- Utilize the One-Health approach to reach out these communities and work with the agriculture and education sectors to create enabling environment.
- Actively participate in inter-sectoral initiatives that create more enabling condition and context for health service delivery for pastoralist communities (eg. villagization, accessing infrastructure and facilities, etc).
- Develop code of ethics for health extension workers that is adaptable to the local community values, and enhance their acceptability among community members,
- Identify possible scenarios in which FHT can operate in rural settings and develop the operational manual for its effective implementation.
- Avoid the use of force or coercion to achieve change in behavior of households/individuals.

3.4. Action Points on Huma Resource for HEP

1) Revise human resource standards for HEP

- Revise human resource standards of health posts based on the three categories of packages proposed for the three categories of kebeles (kebeles with HCs, kebeles close to HCs, and kebeles that are far from HCs).
    - Assign HEWs to HEP units in health centers (Category A) located in rural kebeles
    - Add a midwife or comprehensive nurse to address quality issues in health posts to provide basic HEP packages (Category B)
    - Assign multi-disciplinary team of mid-level health professionals in HPs to implement comprehensive packages (Category C)

- Develop a detailed budgeted plan on how to operationalize these changes in human resource for HEP.

2) Strengthen pre-service training

- Revise recruitment criteria for HEWs. Consider the followings while revising criteria for selection:
    a. Allow male HEWs
    b. Focus on capacity of trainees to allow enrollment of trainees with better capacity
    c. Include English language skills for screening
    d. Entrance exam by training institutions
- Recruit trainees as early as possible after release of grades of 10th grade graduates of each year in order to get better performing students.
- Involve training institutions (TVET and HSCs) in the recruitment process;
- Standardize the structure and governance of training institutions in the way that can enable adequate support from the health sector and making the governance of TVETs under the regional health bureau
- Review the curriculum of HEW training in a way that enable easy delivery of modules and appropriate management of scope of the curriculum. The curriculum should show the detail tasks needed against the time through which the course should be delivered.
- Match expected learning outcomes of trainees to the type of facility for practical attachment (eg. Health center or health post) or setup (community or skill development unit or health facility).
- Create an environment in which the HEW trainees know the context in which they will be deployed after graduation, by exposing them to health posts and community throughout their training.

3) Improve human resource management of HEWs

- Introduce flexible but regulated working days and working hours allowing HEWs to plan reaching target populations including women, men, and youth in different public gatherings.
- Prepare action plan to address the issues of HEWs related to their rights as a civil servant (transfer, leave and career structure, etc) and create a continuous update on the progresses;
- Transform workflow and information system of health posts in a way that guarantees continuum of care that is resilient to staff turnover. This will require making CHIS a more dependable source of information about households than the memory of individual HEWs.
- Prepare a guideline to determine how and to what extent support to health posts will be provided by HC staff and how such engagement will be incentivized.
- Consider performance-based incentives to health posts and HEWs based on auditable performance data. Developing guideline to undertake performance-based incentive

4) Build the capacity of the current workforce

- Upgrade competent level 3 HEWs to level 4
- Use the need for additional workforce as an opportunity to resolve challenges related to career path of HEWs by making them train in to different field of studies (nurses, midwives, environmental health professionals…).
- Devise continuous capacity development program for training institutions (eg. fulfilling skill development units) and their instructors (eg. effective teaching skills, practical session management, package focused trainings, etc) with the aim of updating the developments and changes in the HEP and addressing knowledge, attitude and skill gaps identified on HEWs.

- Provide adequate supervision of trainees in practical sessions (in health posts and community) and enable the training institutions have adequate resource for management and supervision of such activities.
- Provide IRT on regular basis. Make IRT available and a requirement by all HEWs.
- Update IRT materials continuously to respond to changes in the program and emerging health and health related problems in local context.
- Translate IRT materials in local languages to create better understanding of the content for the current workforce.
- Initiate virtual learning modalities for HEWs as a continuous professional development strategy.
- Provide simple technology applications serving as job aid and decision support tools.
- Open career development for HEWs to allow them grow in more diversified areas of specialties allowing competent HEWs to compete and occupy positions in other levels of health institutions.
- Develop a virtual continuous capacity building scheme for HEWs to fill their knowledge and skill gaps in addition to regular IRTs. The virtual capacity building can be integrated with the efforts made to expand CHIS (using tablets as a platform of virtual learning). In addition, developing software to assist their decisions at service delivery.

3.5. Action Points on Physical facilities, infrastructure, and basic utilities

1) Develop three categories of HEP service providing units within PHCUs

- Map HPs in relation to their proximity to their Health Center or Primary Hospital.
    - Decentralized Quick Mapping: Registration of the health facilities by woreda and showing distances of each HP in relation to the HC and availability of transport means. This can be used as a quick understanding of the situation for possible piloting of the options and planning for further steps.
    - Central Mapping of health facilities: Mapping of the health facilities (HP, HC, Hospitals) assisted by GPS points and in a way that can show the transport routes and other determinants of access. This will help in the strategic management of expanding access to health facilities and services to the community.
- Based on obtained information, categorize HPs/kebeles in to three categories:
    A. Category A: HEP Unit in HC – for rural kebeles that have a HC
    B. Category B: HPs with Basic Services – for kebeles within an hour walking distance from a HC
    C. Category C: HPs with Comprehensive Services – for kebeles that are too far (beyond an average walking distance of one hour) from a HC

- Reach at a consensus to redirect responses to the increasing population size of kebeles towards expanding capacity within a health post instead of constructing additional health posts except in situations where geographical barriers are clearly a barrier.
- Develop a long-term plan with a phased approach to renovation/reconstruction of health posts with due consideration to: 1) the need to expand services 2) the importance of avoiding any more sub-standard construction, 3) the limited capacity of the country, and 4) the availability and accessibility of infrastructure and utilities within the kebele
- Coordinate efforts to renovate or reconstruct health posts in line with plans for expansion of services within each PHCU.

- Initiate an innovative approach to mobilize resources for renovation of health posts from government, community, and other funding sources.
- Multi-sectoral approach: Negotiate at a higher level to ensure that health posts are prioritized in infrastructure development projects (road, electricity, water, and telecommunication) targeting rural communities.
- Consider long term plans to solve lack of residential houses for health post staff. Actions should include multiple options including constructing residential houses in health post compounds, incentivizing private leasers, and facilitating access to land for HP staff intending to construct their own houses.
- Introduce enforcement of regulatory standards on future health post construction and/or renovation activities to prevent investment on sub-standard constructions.

3.6. Action Points for Equipment, drugs and other medical supplies

- Revise drug list of health posts to match revision in scope of services provided at health posts including possible expansion of clinical services.
- Strengthen IPLS implementation through regular supportive supervision and introduction of simple electronic technologies.
- Include supply chain management system related topics in IRT of HP staff.
- Ensure appropriate storage and usage of drugs and other medical supplies.
- Strengthen quality assurance of imported medical equipment (donated or purchased) including BP apparatus.
- Assess the feasibility and effectiveness of alternative for financing HP based services through mechanisms including community-based health insurance and incentivizing private sector involvement at the village level.
- Explore options for expansion of investigations involving rapid test technologies to address the gap in laboratory facilities as services expand at health posts.

3.7. Action Points on HEP Financing

- Increase the rate at which domestic financing schemes substitute donors with the ambition of ensuring financial sustainability of HEP.
- Consider alternative sources of financing HEP packages including CBHI and fee for services

3.8. Action Points on Community Engagement & Ownership

- Revitalize model family training approach as a community engagement and ownership strategy, whereby model families can serve as examples for the rest of the community.
- Develop guideline for the operationalization of model family training including recruitment, enrollment, follow-up, and recognition of model families, and contribution of model families.
- Arrange experience sharing sessions for model families and other households.
- Initiate a study to assess rate of diffusion of HEP practices through model family training.
- Avail resources for model family training at local community level.
- Restructure community structure to support HEP
    - Avoid reliance only on WDA structure for community engagement. Devise community structures that vary across regions and within regions depending on culture and functionality of existing structures. These structures should sever as a link between HPs and all segments of the kebele population including men, women, and youth with different roles and positions in the society.

- Develop a strategic document that guides community structure for HEP, in a way that enable the inclusion of all segments of the population including youth, women, men, traditional leaders, religious leaders, and other influential individuals.
- Community structures to be engaged with HEP should focus on the use of fewer (manageable size to develop their capacity) community volunteers to serve as change agents and community mobilizers. At kebele level, members should be representative of different population segments.
- Volunteers of HEP should report to HPs
- Recruitment of community volunteers should take advantage of increasing literacy rates

- Institutionalize mechanisms that can incentivize volunteerism and limit duration of service to a pre-defined period of performance. Recognitions and incentives may be non-monetary, including recognition through certificates, enrollment to CBHI scheme for free or with a reduced premium.
- Make use of technology for the capacity building, follow-up, and dissemination of health information to community agents.

3.9. Action Points on Information System/ M&E

- Revise the set of indicators used for M&E of HEP to include HEP process indicators at least for use at HP, HC, and WoHO levels. Also revise indicators attached with unrealistic targets and lack sensitivity to progress in level of implementation of HEP (eg. model kebele)
- Strengthen CHIS implementation with focus to data quality
- Enable CHIS with backend analysis, and synthesis of data whereby HEWs (with limited capacity to analyze data) use information generated from the system.
- Enable CHIS platform help HEWs to record every encounter with their targets during home visit, outreach sessions, and health post-based service provision
- Establish a monitoring mechanism whereby family folders are complete and include up to date information about households including each household member.
- Strengthen data verification mechanisms by involving communities in the process.
- Initiate innovative mechanisms to encourage improved data quality and use
- Eliminate formal and informal incentives to over reporting.
- Encourage all levels of the health system to reset overestimated baseline data and establish actual baselines free from previously over reported figures.

3.10. Action Points on Leadership & Governance

- Develop a roadmap to provide long term guidance to the evolution of HEP.
- Decide and introduce service and input standards for multiple categories of HPs.
- Rebrand health posts along with changes in their function and structure. Consider changing names from health post to a one that reflects upgrading to a facility with more comprehensive services in order to boost demand for both existing and newly added services.
- Establish administrative board for health posts bringing health center staff with community members together in the overall oversight of health posts. For this effect, start from the HPs providing comprehensive services,

then it will be cascaded to the other HP levels. Provide administrative guide on the establishment of administrative board for Health posts.

- Provide clear guidelines on involvement of HEWs in "non-health" activities with the purpose of keeping their involvement to activities that:
- Strengthen HC-HP linkage for technical support and administrative oversight.
- Make the accountability of health extension workers to their health center, and avoid informal and disarrayed line of accountability. Make the other administrative and technical units access HPs only through HCs.
- Ensure alignment of priorities and targets of different health programs with those of HEP.
- Set a clear structural and functional alignments between priority health programs and HEP as an implementation platform.
- Strengthen intersectoral collaboration at all levels guided by collaborative frameworks enforced at higher levels.
- Ensure that HEP plays vital role in facilitating Kebele level intersectoral collaboration with the intention of addressing social determinants of health.
- Provide directions on depoliticization of HEP and minimize involvement of HEWs in activities that potentially diminish their acceptability as health cadres.
- Involvement of HEWs in non-health activities should focus on those that:
    - Do not create negative co-notation for HEWs by any member of the society
    - Can be pre-planned to avoid too much compromise in routines of HEP
    - Increase the power and acceptance of HEWs
    - Are planned in a framework facilitating intersectoral collaboration"

4 Urban HEP: summary of key findings, recommendations and action points

4.1. Overview of the Urban HEP Assessment

Ethiopia has one of the fastest growing urban populations in the world, in which the urban population has more than doubled in the past 20 years. This makes Ethiopia's annual urban population growth rate higher than the average in Sub Saharan Africa, which is the fastest urbanizing region in the world. Approximately 70-80 percent of the urban populations live in slums characterized by substandard housing and a lack of basic sanitation, services, and infrastructure. Although urban areas have better access and utilization of health services than the rural areas, the urban poor is still disadvantage due to unequitable access and utilization of available health services.

In response to multifaceted health problems and risks of the urban poor the government launched the urban health extension program (UHEP) with aim of creating a healthy-environment-healthy-lifestyle by ensuring equitable access to preventive essential health interventions through community-based health services, with a strong focus on sustained preventive health actions and increased health awareness. The UHEP is a package of basic promotive, preventive, and curative health services implemented based on the principle of primary health care to improve health and wellbeing of families. The program has 15 sub packages categorized under four major packages namely: hygiene and sanitation, family health, prevention and control of communicable and non-communicable diseases, and injury prevention, first aid and mental health packages.

Being implemented for more than 10 years, there were mixed thoughts about the current status of HEP and administrative reports were the only source of information about several aspects of UHEP.
There were plenty of studies conducted on the HEP. But these studies focus on very specific aspects of HEP and fail to show the influence of factors at different levels of the health system. Moreover, they were not, mostly, linked to the decision-making process in the health system. This assessment is considered timely as major decisions regarding the future of the UHEP are currently looking for comprehensive evidence and it is being conducted at the eve of the HSTP-II.

The national assessment on the health extension program was started with the intension of addressing the information gap regarding the performance, determinants, and prospects of the UHEP by conducting an in-depth examination and analysis into different aspects of the program. The objectives of the study include:

- To assess the relevance of the UHEP to the health needs of the urban community
- To determine satisfaction, motivation and burnout status of the UHEP workforce
- To assess adequacy of resources for the implementation of the UHEP
- To assess the implementation status of the UHEP
- To determine key areas of intervention for future improvement of the HEP

The study was conducted from October 2018 to July 2019. All the nine regions and the two city administrations were included in the qualitative study, health center assessment, and urban health extension professionals survey. The household survey was undertaken in Addis Ababa and Dire Dawa city administrations only.

The UHEP assessment employed a concurrent mixed method approach using both quantitative and qualitative methods. The household level quantitative survey involved collection and analysis of primary data from women respondents, who are head or spouse of the samples of households; households with lower economic status, who are considered as primary targets of UHEP were included in the study. A total of 1735 households from Addis Ababa

(1124) and Dire Dawa (611) were included in the household survey. Sample households of Addis Ababa were drawn from those enrolled in the SafetyNet program, a program which was intended to economically empower unemployed urban poor. The facility level survey included health centers head (132 health centers) and urban health extension professionals (UHE-ps) from all regions and city administrations (Addis Ababa and Dire Dawa). The qualitative assessment involved officials/managers, experts, and service providers from different levels of the health system (FMoH, RHBs, ZHOs, sub-city health offices, WoHOs/town health offices, and Health Centers,) and community members (including WDA leaders, women from households that are UHEP service users/model households, women and men from none service user households).

4.2. Urban HEP Packages

Expectations and standards

- The UHEP has 15 packages in the areas of 1) hygiene and environmental sanitation, 2) disease prevention and control, and 3) family health. Those packages are implemented through different service outlets: household, school, youth center, workplace and streets for homeless communites.
- A combination of different approaches is being used by UHE-ps, to deliver the UHEP packages: model family training, women development army, front liners/models training at school and youth centers.

Summary of key findings

- The existing UHEP packages are not adequate to solve the multidimensional problems and disease burdens of the urban community. There was variation in degree of UHEP packages relevance in addressing the health needs of the urban community.
- Relevance of UHEP in addressing NCDs was broadly questioned. The UHEP has given little attention to emerging chronic diseases, which are major challenges to urban population.
- Estimate for Ethiopia showed that the NCDs account for 42% of deaths and contributes to 69% of the Disability Adjusted Life Years (DALYs) in 2015.
- WASH interventions are not adequate to address the underlying causes of water, hygiene and sanitation related problems of the urban community. WASH related problems remained challenges and priority problems in urban areas.
- Inadequate multisectoral collaboration among stakeholders working on WASH negatively affected implementation of WASH packages.
- The bottle necks that hindered implementation of WASH through the UHEP were beyond the scope and capacity of the UHEP.
    - Lack of latrines, shortage of clean water and poor waste disposal system were frequently reported as being root causes for WASH problems of the urban community.
    - From the total of 1735 households, 31% dispose wastewater on an open field (improper disposal), 3% practice open defecation, and 67% had either communal or shared latrine. Among HHs having toilet facilities 85% had no access for hand washing facility with soap or substitute near their toilet.
- More than 70% of urban population in Ethiopia reside in slums, characterized by overcrowding, poor housing condition, absence of safe water and sanitation facilities. The rapid and unplanned urbanization exacerbated challenges to provide safe and adequate water, infrastructures for waste management, housing and health services.

Illustrative figures and quotes

"It is hard to say the health extension is fully addressing the community's health needs…There are problems related with latrine and sewage system and when you educate the community in the absence of those infrastructures, they say why are you educating this when it's not even available. You should correct this first. So, we go to other sectors and fight, but the responses we get are not timely, there is no immediate solution..."

(UHE-p, Kirkos, Addis Ababa)

"Previously, diabetic mellitus and hypertension were considered as the diseases of the wealthy people. Nowadays, diabetic mellitus is common among the poor community. … Hypertension, diabetes and mental health problem are increasing from time to time. … Cancer is increasing because it is not easily diagnosable."

Health center head, Dire Dawa

Recommendations

Level of change required	Suggested changes
Maintain	• The current packages should be continued with tailored implementation approach that consider local context.

Modify	• Revise the packages to meet the changing needs and expectation of urban community.
	• Design contextualized and tailored interventions by disaggregating urban areas into different categories (i.e. city administrations/regional capitals, zonal towns, and small towns).
	• Strengthening the multisectoral collaboration for successful implementation of UHEP through integrated planning, implementation, monitoring and evaluation of WASH interventions at all levels of the system.
	  o High level integration of urban health policy should be considered, and clear roadmap with monitoring, evaluation and accountability system should be in place.
	• Establishment of new structure at woreda or sub-city or town level to coordinate and liaise WASH interventions at woreda and higher level by deploying experts with sanitary engineering competency
	• Establishing a platform to link the WASH interventions with TVETs and higher institutions to promote innovative technologies that can solve the bottle neck with locally available resources and technology options.
	  o Innovation of locally applicable technologies for WASH, particularly to avail latrine for poor community living in slum areas (linking with TVET and other technology institutes)
	  o Subsidizing the construction of WASH infrastructures at HH level (mainly for latrine construction).

Add	• Consider additional clinical services (screening, examination, diagnosis, and follow-up) for maternal and child health, and non-communicable diseases to address health needs of hard to reach population including homeless and marginalized segment of the community.

4.3. UHEP service delivery modalities

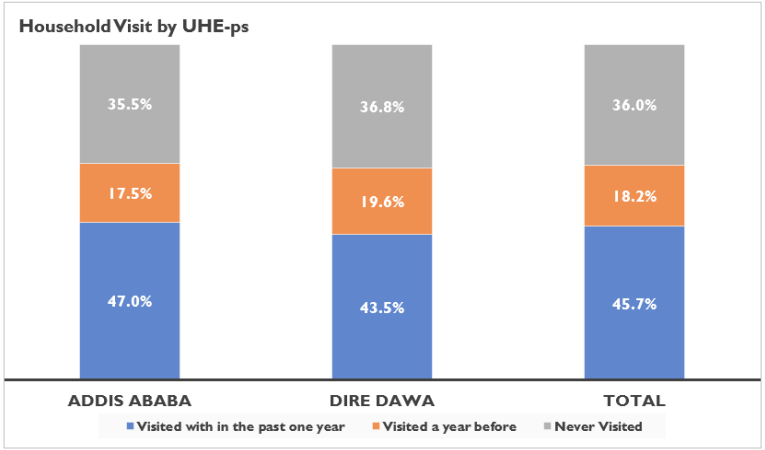
Expectations and standards

- The UHEP uses a combination of implementation modalities and approaches to deliver the packages to the intended target beneficiaries. Home visit, model family, women development army, and family health team approaches are the major one.
- The UHE-ps are expected to spend significant working time (3 days per week) to implement the UHEP through home to home visit.
- Model families and WDAs are the major support networks who play a major role in the implementation of health extension program packages.
- Family health team (FHT) is one of UHEP implementation approaches designed to improve access and equity of primary health care through a multi-disciplinary team. It is aimed to serve the neediest segment of the population, the urban poor, with high impact interventions alongside health promotion and diseases prevention efforts to the general public.

Summary of key findings

- Home visit is the major service delivery modality which was found to be relevant means of UHEP implementation at household level.
- Despite its relevance, conducting home visit was the most challenging and unpractical for some segment of urban residences. It was not practical and relevant for urban employed community (self-employed, working on small business, and government employees), due to overlapping of working hours.
- On the other hand, home visit has a significant association with most of expected outcomes that UHEP intended to bring. Household who received visit had positive association with intended outcomes of UHEP.
- In general, training and implementation of model household was relevant and effective to implement some of the UHEP packages and components. However, only small proportion of households included in the study were declared to be a model family.
- Model households have a significant association with intended outcomes of UHEP.
- The WDAs and one-to-five group are important collaborators of UHE-ps who facilitate implementation of the UHEP packages at household level. They serve as a bridge between UHE-ps and the community. WDAs engage in identification of households that require UHEP interventions, coordination sanitation campaigns and dissemination of health information. They also serve as UHE-ps in areas where UHE-ps are not available or assigned.

Illustrative figures and quotes



▪ Despite their important role, the WDAs were reported to be non-functional and less accepted by the community due to their administrative role and political affiliation, and lack of adequate knowledge, skill and practice of UHEP packages to be a role model for other households they lead. ▪ The FHT is found to be the most relevant UHEP service delivery modality which helped to address emerging and dynamic health needs of urban community with preventive, curative and rehabilitative services. Among the UHEP service delivery points, household and school level implementation of the approach was reported to be better; whereas, relatively poor implementation was recorded at youth center, workplaces and homeless community. ▪ The approach was reported to have benefited economically disadvantaged segment of the population, homeless individuals, and people with chronic diseases, bedridden patients and elders. ▪ In general, absence of clear and standard guideline for implementation of UHEP through different modalities (home visit, WDA and model family) was a major challenge that resulted in implementation variation across towns/cities.	*"As a reason, it is reported that the house of most urban people is closed during the day, and they are not available whenever UHE-Ps go to their house to provide services. Some households tell their maids not to open the door whenever UHE-Ps knock at their door. Because if this reason, the UHE-Ps couldn't accomplish the planned house to house service provision..."* Health center Head. Bahirdar

Recommendations

Level of change required	Suggested changes
Maintain	• Home visit still remains as a major service delivery modality to reach households • Use of community networks such should be strengthened by addressing all the challenges related with WDA. • Strengthen and scale-up implementation of FHT approach by ensuring availability of commodities, medical equipment and supplies.
Modify	• Design tailored approach to reach households which cannot be accessed during working hours. Identify alternative communication strategies to address this segment of the population • Revise and strengthen the community networks, who can serve as primary collaborators and contact points for UHE-ps, by using locally acceptable and valued social structures like *edir* and *mahiber*. • Revise model family training approaches and design tailored strategies to provide model family training for urban poor. • The FHT approach shall involve other non-health professionals such as social workers, psychiatrists, economists (to work on income generating activities), and sanitary engineers to address root causes that affect health and wellbeing of the urban poor.

Add	• Collaborate with private and government owned mass medias to promote UHEP packages and create awareness about the program.
	• Promote UHEP through different electronic and print medias to create awareness and improve acceptance of the program by the urban community.
	  o Work with mass medias to broadcast audio visual programs focusing of the UHEP packages.
	  o Produce audio visual IEC/BCC materials to improve community access to health information and education related with health and health related issues.
	• Establish free UHEP call center from which the urban community can get information and counseling service on any health and related issues at their convenient time; it can also serve as a reference or source of information for the UHE-ps.
	• Consider use of electronic health information communication strategies that fits the context and need of urban population.

4.4. Implementation of Urban HEP

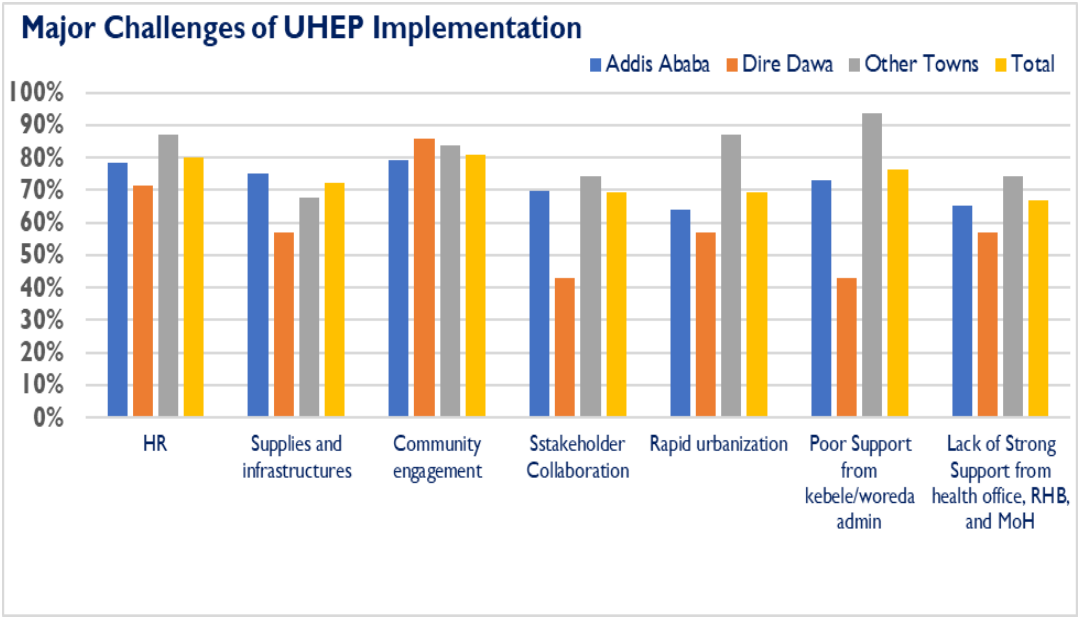
Expectations and standards

- The UHEP packages and services are designed to address promotive, basic curative and rehabilitative health needs of the urban community.
- The packages are being implemented at household, school, youth centers, workplaces and places where homeless community are found.
- The major implementation strategies include home to home visit, community mobilization, training of models (households, teachers, students and youth), and collaboration with formal and informal community structures (WDAs, religious leaders, and civic associations).
- Households with lower economic status having health service need for either of maternal, child, communicable and/or non-communicable disease are priority targets of UHEP that require more frequent visit and close follow-up by UHE-ps andFHT.
- As per the UHEP implementation guideline the UHE-ps are expected to spend significant working time (3 days per week) to implement the UHEP through home to home visit at target households (economically poor and households with under 5 year children, pregnant and lactating mothers, and individuals with NCD & CD).
- The UHE-ps are also expected to reach every household assigned under their catchment, at least once a year, regardless of their health need and economic status.

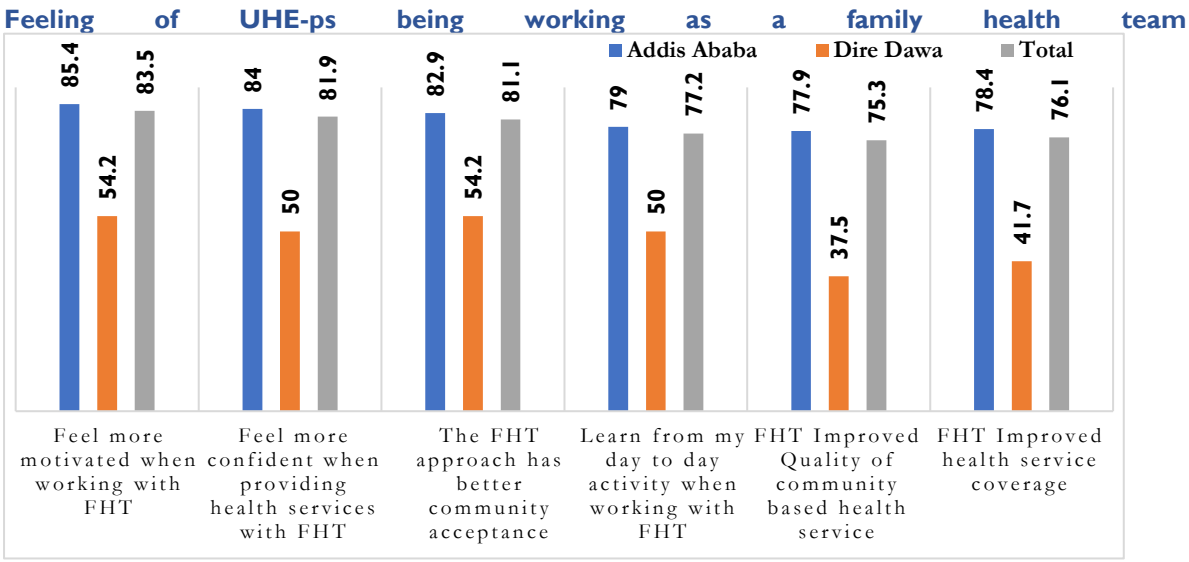
Summary of key findings

- Though source populations of this study were households with lower economic status that are priority targets of UHEP interventions, the finding showed poor implementation of the packages.
    - About 36% of households included in the survey were never visited by UHE-ps and more than 18% were not visited within the past one year.
    - Only 18.5% of households completed and graduated as a model family. Majority of households who didn't received the training were not asked to take the training or had no access for training.
- Poor acceptance due to the failure to provide clinical services demanded by the community.

Illustrative figures and quotes



- Inadequacy of human resource and supplies, low community engagement, and poor stakeholder collaboration were among the major challenges that hindered implementation of UHEP.
- Inadequacy of drugs and supplies required to provide community-based health services through the FHT approach.
- Absence and shortage of UHEP implementation guidelines and manuals for school and youth center were also reported as critical challenge to implement the packages.



"The basic problem with school health service is the absence of guideline on how service is offered. Recently, the guidelines are developed and orientation given to the health extensions and responsible bodies… there were some limitations like fulfilling hygiene and sanitation facility, carrying out regular checkup of students and availing the immunization service timely, but currently because the developed manuals the activities will be carried out for futures…"

UHEP Expert from Dire Dawa city administration health bureau

Recommendations

Level of change required	Suggested changes
Maintain	▪ Model family and home to home visit shall remain the major implementation mechanism. ▪ Strengthen implementation of FHT approach by addressing challenges related with availability of supplies (drugs, medical supplies, and equipment), commitment and motivation of team members.
Modify	▪ Design tailored strategies to recruit and train more model households. Consider use of audio-visual training materials to facilitate self-learning for household who are not able to physically attend the training. ▪ Ensure availability of all necessary materials and equipment for the implementation of the UHEP. o Conduct national level inventory and quantify required materials and equipment. o Strengthen the supply chain management system to ensure availability and periodic refill of commodities for UHEP. o Conduct periodic assessments to check functionality of the supply chain management system and proper utilization of commodities supplied for UHEP. ▪ Strengthen multi-sectoral collaboration to enhance implementation of the program. Involve different sectors who have stake in providing solutions for root causes of urban health problems.
Add	▪ Ensure adequate engagement of mass medias in supporting implementation of UHEP. ▪ Involve celebrities as urban health champions ▪ Establish health corners at condominium and apartments sites to ensure access of UHEP service for servants/ maids and the residents. ▪ Establish health corners at condominium and apartments sites to ensure access of UHEP service for servants/ maids and the residents, mainly to provide services such as NCD screening, contraceptive, HIV testing and counseling.

4.5. Human resource for UHEP

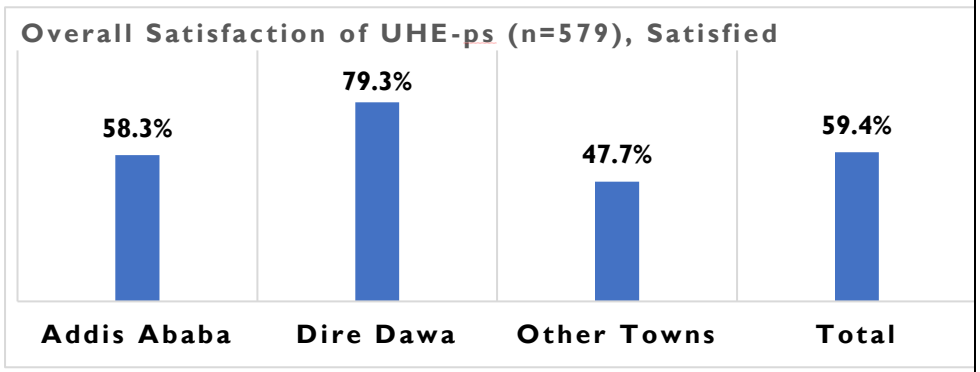
Expectations and standards

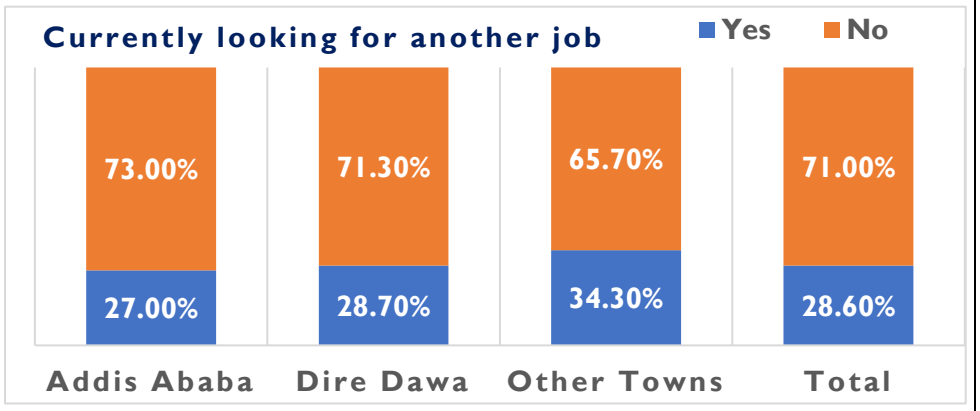
- The UHEP is being implemented using health extension professionals with diploma in nursing and additional training on UHEP packages and implementation approaches/strategies.
- A UHE-p is expected to serve 400-500 household. In urban setting, the UHE-ps are directly accountable to the catchment health center; where the HC management is responsible for both technical and administrative issues related to the program, including provision of pharmaceuticals, medical equipment and supplies that are required for implementation of UHEP.

Summary of key findings

- The UHEP workforce analysis result showed that higher level of job dissatisfaction, demotivation, and intention to leave among the UHE-ps.
- High workload, low community acceptance, low salary pays, absence of recognition, motivation scheme, absence of career development, and inadequate opportunity to advance their education were major causes of dissatisfaction and demotivation for the UHE-ps.
- Limited educational and career development opportunities create frustration and demotivation among the UHE-ps.
- The highest attrition rate among UHE-ps was in Addis Ababa where 38.5% of ever deployed UHE-ps left the system.
- High prevalence or risk of burnout among UHE-ps, where 4% of the respondents had sever burnout which requires intervention. Moreover, the prevalence of depression among the UHE-ps was 8.9%, which is high.
- Higher proportion of UHE-ps (41.2%) are serving more than 500 households. This indicates inadequacy of UHE-ps to cover the existing households.

Illustrative figures and quotes





Recommendations

Level of change required	Suggested changes
Maintain	▪ Deploying UHE-ps with diploma nurses in clinical nursing and 3 months pre-service training on UHEP.
Modify	▪ Fulfill human resource (i.e. UHE-ps and FHT members) as per the standard specified in the UHEP implementation manual and FHT implementation guide. The number of UHE-ps should be increased based on the existing number of households in the catchment areas; and all households should be covered by the program. o Design and implement proper human resource planning at all levels. o Design and implement retention mechanism to reduce turnover of UHE-ps.
Add	▪ Consider incentive packages to ensure UHE-ps are compensated and recognized based on their effort and performance. Enhance motivation of UHE-ps by designing and implementing performance-based motivation schemes with financial and non-financial incentive mechanisms. ▪ Develop appropriate career structure for UHE-ps to keep the motivated and reduce attrition. ▪ Develop automated system to establish accurate and valid performance monitoring of UHE-ps through selected key performance indicators.

4.6. Equipment, drugs and other medical supplies

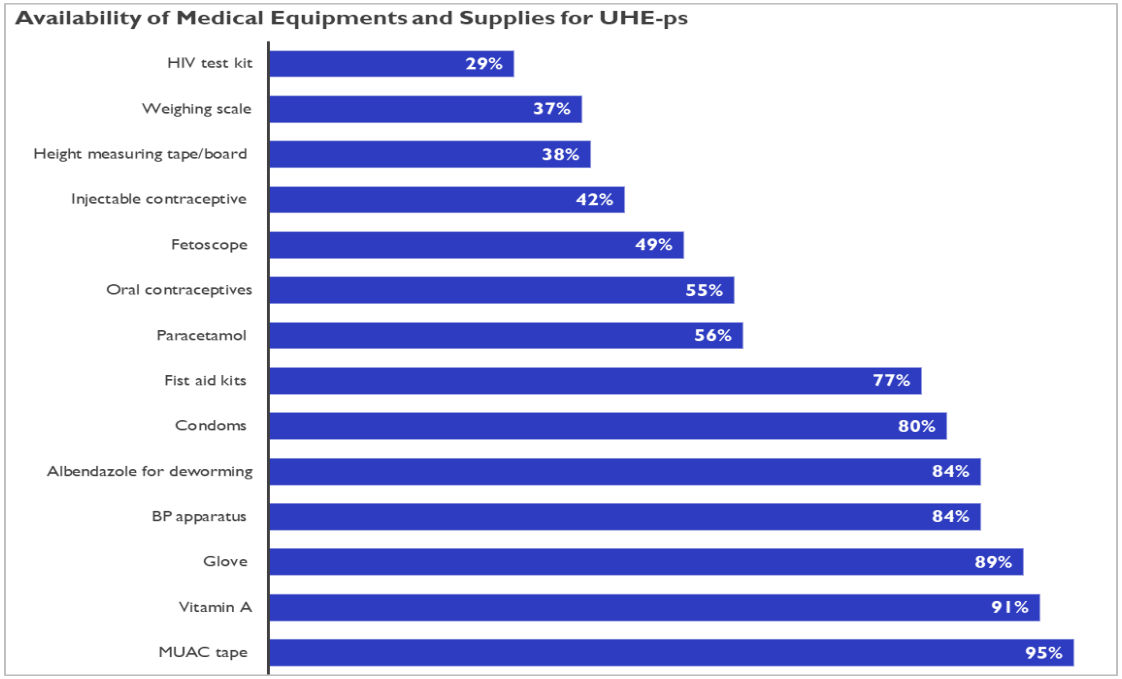
Expectations and standards

- The UHE-ps are expected to provide preventive, curative and rehabilitative services during home to home visit. The UHE-ps should be equipped with BP apparatus, stethoscope, glucometer and other necessary medical equipment.
- The professionals also need to have weight and height scales for nutritional screening and growth monitoring of children.
- Similarly, other drugs and supplies such as HIV test kits, short term family contraceptives, first aid kits are highly required to implement the UHEP.

Summary of key findings

- Medical equipment's and supplies were not adequately available for UHE-ps.
    - Significant proportion of UHE-ps had no equipment such as BP apparatus and stethoscope that are vital for screening of major NCDs. Similarly, a shortage of HIV test kits was cited as a major impediment to provide HIV screening services.
    - Only 37% and 38% of UHE-ps had weight and height measuring scale, respectively.
- Absence of strong supply chain management system to ensure availability of adequate resources was the major bottle neck for the implementation of UHEP.

Illustrative figures and quotes



"… I work in Amanuel group to initiate people to do HIV test but in majority of cases, clients returned home without getting the services because of HIV test kit limitation."

UHE-p from Shewarobit town

Recommendations

Level of change required	Suggested changes
Maintain	▪ Supply and refill of supplies and medical equipment through the health post supply chain management system.
Modify	▪ Implement standard logistics and supply management tools such as RRF and bin card to control stock status of UHEP supplies.
Add	▪ Consider the UHEP department as one of dispensing unit and ensure proper and timely refill of pharmaceuticals, medical equipment and supplies.

5 The way forward

Immediate next steps to strategically implement recommendations and proposed action points require taking timely actions that link the assessment with piloting and implementation. These actions should include:

1. **Establishing a taskforce**
    - Translating recommendations of the national assessment into actions by operationalizing the proposed action points or developing alternative courses of actions requires close follow-up. Establishing a taskforce to follow-up the use of evidences from the assessment will facilitate optimal use of findings.
    - The taskforce may include members from the PHC and HEP Directorate and other directorates from MoH, other stakeholders, and a representative of the HEP assessment team

2. **Pilot testing**
    - Recommended actions need to be field-tested before considering large scale implementation. Packaging and testing recommended actions in representative woredas will facilitate learning and optimize efficiency and effectiveness of future changes in HEP.

3. **Road map**
    - Recommendations from this assessment should inform the development of a long-term roadmap of the HEP.
    - It is important to mobilize relevant stakeholders for the development of the HEP Roadmap as an immediate next step.

The National Assessment of the Ethiopian Health Extension Program

A Comprehensive Study

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