THE NATIONAL ASSESSMENT OF THE ETHIOPIAN HEALTH EXTENSION PROGRAM

Evidence Brief for Action

August, 2020
Addis Ababa, Ethiopia

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MINISTRY OF HEALTH-ETHIOPIA
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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

IIfPHC-E
International Institute for Primary Health Care in Ethiopia

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WHAT IS THE EVIDENCE BRIEF ABOUT?

This evidence brief summarized the key findings of the National Assessment of the Health Extension Program in Ethiopia. It also highlights important areas that need attention and puts forward actions that need to be taken as part of efforts to optimize the Health Extension Program. Using the comprehensive quality improvement framework, the contents of this evidence brief are organized under six themes: Effectiveness, Efficiency, Accessibility, People-centeredness, Safety and Equity. The final part of the brief calls for acting on evidence - using the evidence from the National Assessment of the Health Extension Program and other related studies to make policies and decisions that improve the implementation and outcomes of the Health Extension Program.

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MERQ has carried out this study with utmost adherence to scientific standards with optimal utilization of the evidence at the center.

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Monitoring Evaluation Research & Quality Improvement

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MERQ (Monitoring, Evaluation, Research and Quality Improvement) Consultancy PLC: is a consulting firm established by a team of qualified professionals with extensive expertise and experience in the areas of health and social sciences. MERQ conducts and provides technical support on monitoring and evaluation, research, organizational capacity assessment, situational analysis, survey, database management, data analysis, development of guidelines, SOPs and manuals, and capacity building.

We envision to be a pragmatic choice for research and scientific inquiries in Ethiopia and beyond. Our focus on rigor, responsiveness and focus on utilization has brought us a long way and has allowed us to establish strong collaborations with multiple local and international academic and research institutions. We have a sister company under the same name in the United States, which makes our international collaboration solid.

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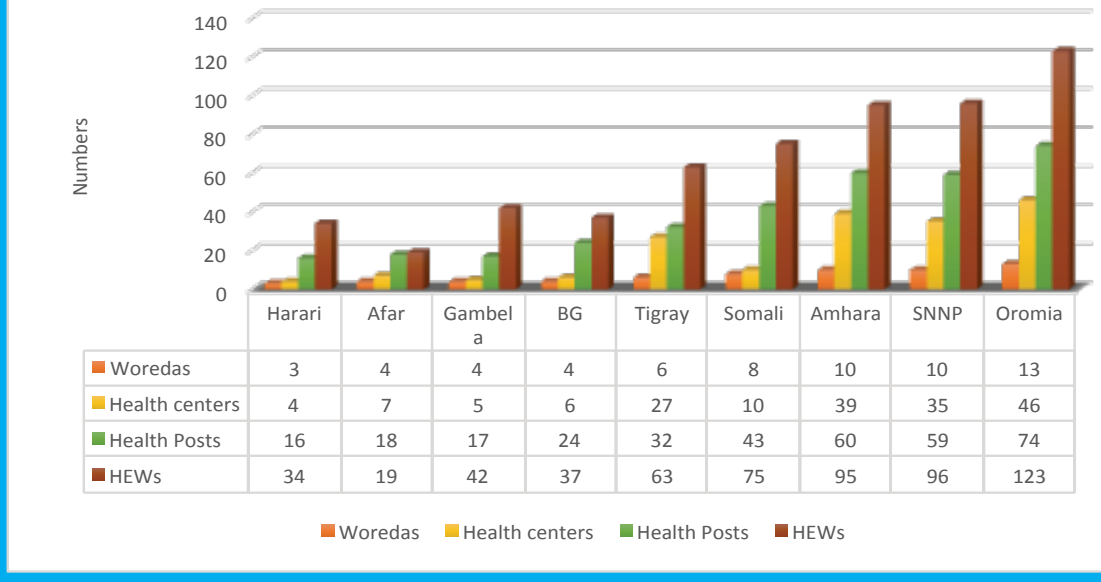
info@merqconsultancy.com or visit us at www.merqconsutlancy.org or at our office: 8th floor, Tadesse Chekol Building, P.O.Box 54023 Tel.+25111854754, Arada sub city Addis Ababa, Ethiopia for your research, scientific inquiries and training needs.

THE HEP ASSESSMENT (2019)

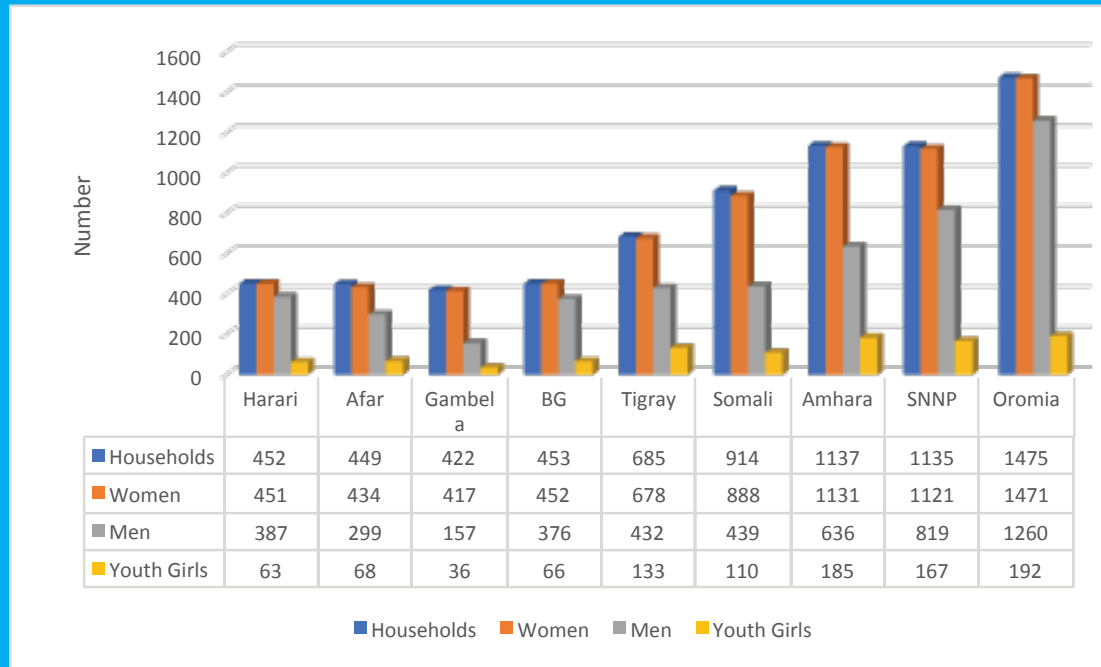
The national HEP assessment which was done from April to September, 2019 has unequivocally shown the current status of the program and has enabled us to pinpoint key areas of intervention. The national scale of the study and use of the PHCPI framework together with collaborative engagement of all stakeholders at all stages gave this assessment the power to play a critical role in informing decisions.

Summary of the study:
where, how many, who…



	Harari	Afar	Gambela	BG	Tigray	Somali	Amhara	SNNP	Oromia
Woredas	3	4	4	4	6	8	10	10	13
Health centers	4	7	5	6	27	10	39	35	46
Health Posts	16	18	17	24	32	43	60	59	74
HEWs	34	19	42	37	63	75	95	96	123

Figure 1 Woredas, Health facilities and HEWs included in HEP assessment



	Harari	Afar	Gambela	BG	Tigray	Somali	Amhara	SNNP	Oromia
Households	452	449	422	453	685	914	1137	1135	1475
Women	451	434	417	452	678	888	1131	1121	1471
Men	387	299	157	376	432	439	636	819	1260
Youth Girls	63	68	36	66	133	110	185	167	192

Figure 2 Number of households, men, women and girls included in HEP assessment

This evidence brief summarizes the key findings, with optimizing the program at the core. This document doesn't include the UHEP.

It is presented using a comprehensive QI framework, the findings are also linked to the key parameters.

Figure 3: summary framework

Areas of Evidence summary for HEP Optimization

Health Extension Program (HEP)

	Major Milestones
2020	HEP Optimization Roadmap
2019	Degree program in Family Health launched
2018	Family Health Team (FHT) introduced under Urban HEP
2016	Second Generation HEP
2011	Introduction of Health/Women Development Army (WDA/HDA)
2010	Introduction of treatment of pneumonia in to HEP
2009	HEP expanded to urban areas
2008	Introduction Community Health Information System (CHIS)
2006	Introduction to model family; expansion to pastoralist areas
2004	Deployment of HEWS
2003	Selection and training of HEWs
2002	HEP Inception

The changes:
Population vs # of HP

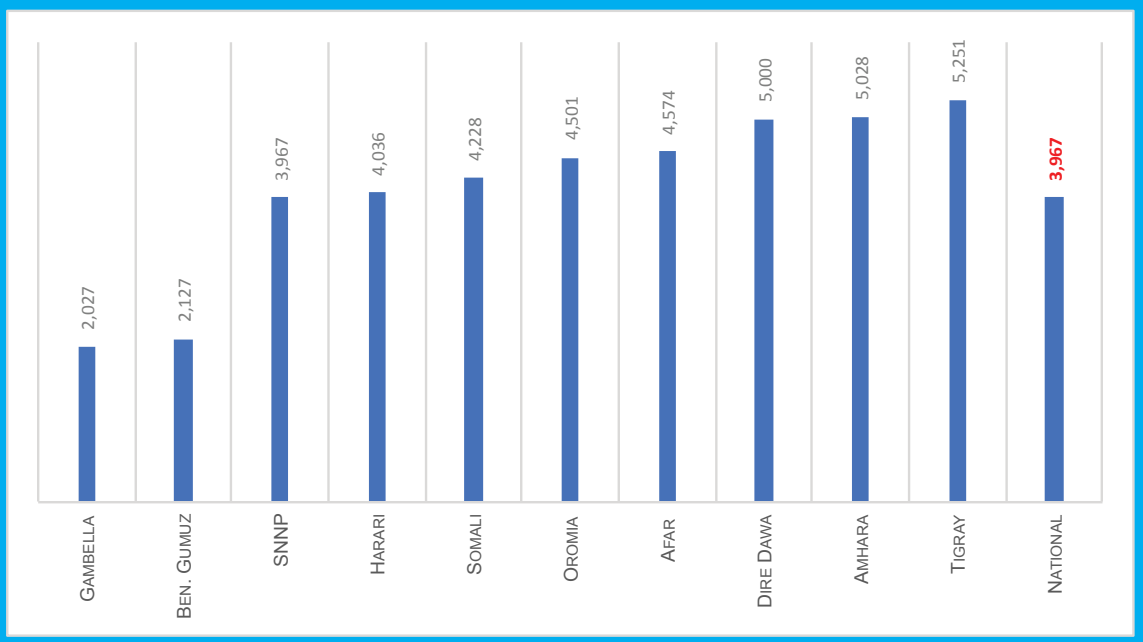


Figure 4 Rural Population per Health Post (2019)

IMPROVE EFFECTIVENESS

Deliver HEP services that are adherent to an evidence base and that results in improved health outcomes for individuals and communities in Ethiopia.

Summary of evidence:

About half of the general population are reached with HEP packages

- The implementation of the HEP packages at the household level was 50.8% among households in the general population and 60.6% among the households of Women's Development Army (WDA) leaders.
- Treatment-seeking for children with diarrhea, pneumonia, or fever was inadequate, with fewer than half of those children being brought to the attention of a health professional.
- A 10% increase in the proportion of households reached through home visits was associated with a 19% increase in the adoption of HEP-related behaviours among households.
- A 10% increase in the proportion of pastoralist households who had interactions with HEWs through HP visits was associated with a 16% increase in the adoption of HEP-related behaviours at the household level.

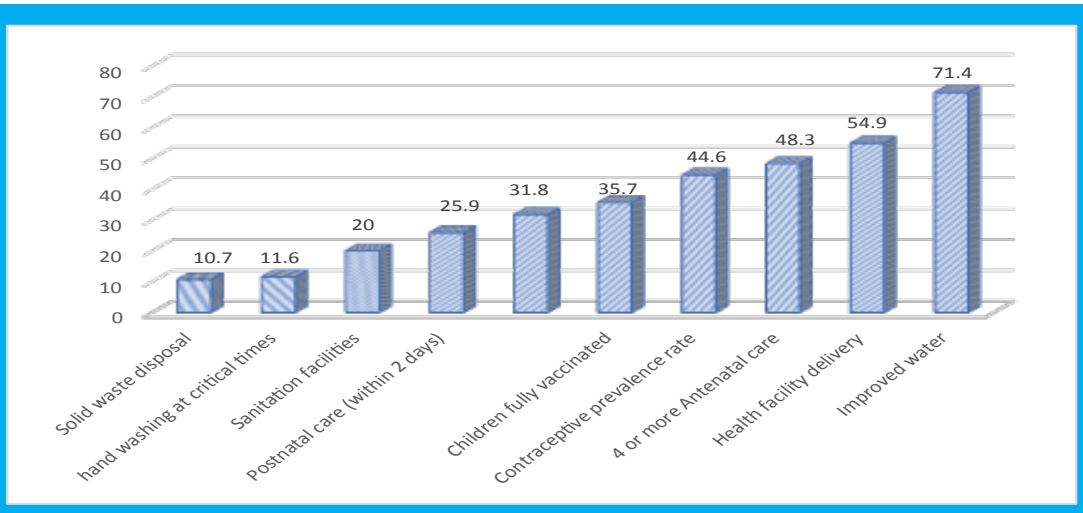


Figure 5 Coverage of selected services

Areas that need attention:

Improve comprehensiveness and address bottlenecks.

- The HEP packages lack the comprehensiveness needed and are currently exhibiting sub-optimal quality and coverage because of inadequate inputs, particularly in human resources.
- There are also implementation challenges related to community-engagement strategies, the information system, and leadership and governance.
- Men and youth have largely been excluded by the HEP in both service delivery and community-mobilization strategies.

Actions required:

Comprehensive optimization of the HEP

- Service delivery modalities need to be expanded to reach all segments of the population
- Revising HEP's inputs to ensure an adequate supply of human and material resources
- Further investment on HPs need to consider their distance from Health centres
- Introducing a professional mix at the Health post level

MAXIMIZE EFFICIENCY

Strengthen the HEP implementation mechanism so that it maximizes the utilization of available resources from government, development partners and communities.

Summary of evidence:

A relative decline in HEP funding calls for improving efficiency.

- Although investment in the HEP has been increasing in nominal terms, the share of spending on the HEP in relation to total expenditure at the HC and HP levels, however, has been continuously declining since 2010
- Between 2010/11 and 2016/17, HEP spending increased from 2.4 billion ETB (USD 0.52 billion in terms of PPP) to 5.1 billion ETB (USD 0.58 billion in terms of PPP).
- Over the same period, the share of the total PHCU-level spending represented by HEP spending declined from 25% to 22%.
- The HEP's share of the Total Health Expenditure declined from 8.9% in 2010/11 to 7.1% in 2016/17 and the government's share of HEP spending increased from 20.8% in 2010/11 to 40.3% in 2016/17.
- Child health represents the largest portion of HEP spending, accounting for 46% of the program's total expenditure.

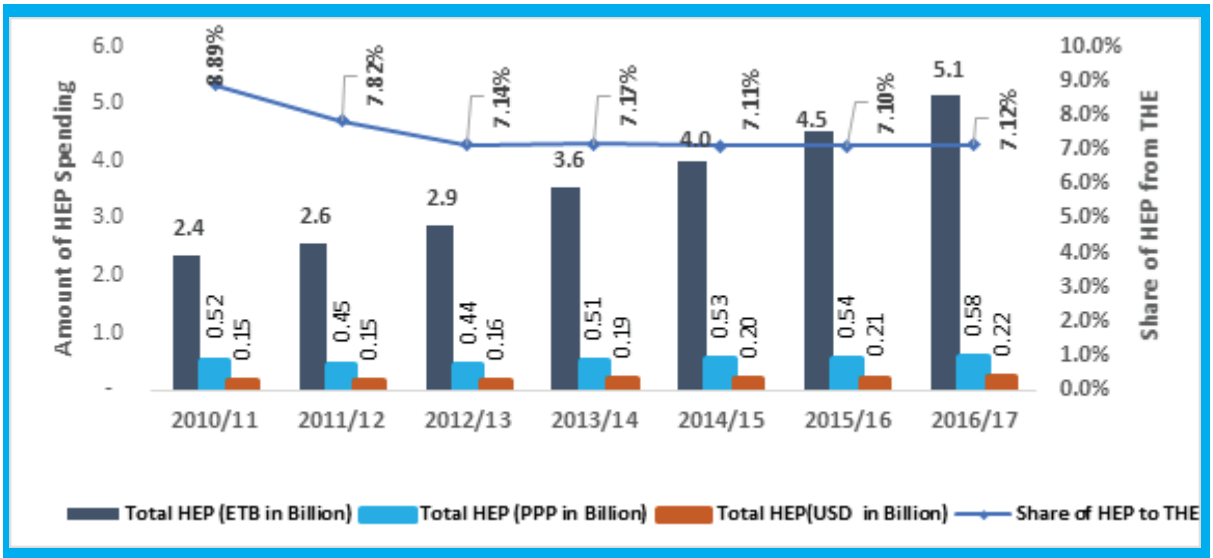


Figure 6: Among of HEP spending and share of HEP from the total health spending, 2010/11-2016/17

Areas that need attention:

Increasing share of domestic and local funding for HEP

- Government share of HEP financing
- HEP share of total expenditure
- Equitability of funding of the various HEP packages

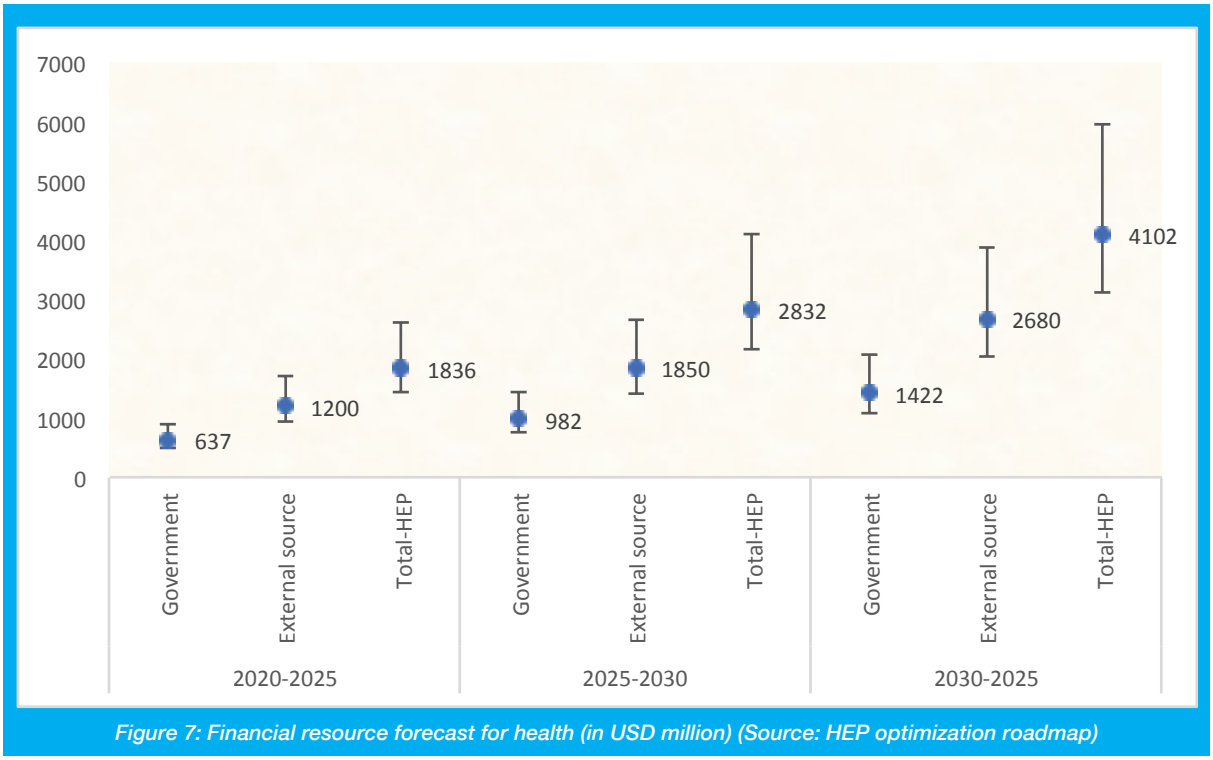


Figure 7: Financial resource forecast for health (in USD million) (Source: HEP optimization roadmap)

Actions required: Assess the feasibility and effectiveness of alternative financing for HP based services through mechanisms including revolving funding, community-based health insurance and incentivizing private sector involvement at the village level, pay for performance.

- Expanding government share in financing for HEP
- 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.
- Economic evaluation of key aspects of HEP

EXPAND ACCESSIBILITY

Make HEP services timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to the need.

Summary of evidence:

Despite universal availability of HPs, there are important barriers that limit access to services.

- 43.9% of women, 51.5% of men, and 49.3% of youth girls recommended either expanding the current packages or adding new packages of services.
- The most common reason for the low uptake of ANC services was the long distance to the HP (overall 33.2%: 24% of women in agrarian and 32.1% in pastoralist settings).
- One of the challenges to the implementation of the FHT approach was the long walking distance needed to provide services.
- The reportedly high workload of HEWs affects the timeliness of the services they provide.
- Although HPs are almost universally available, most them do not meet the standards for infrastructure, physical facilities, or basic utilities.

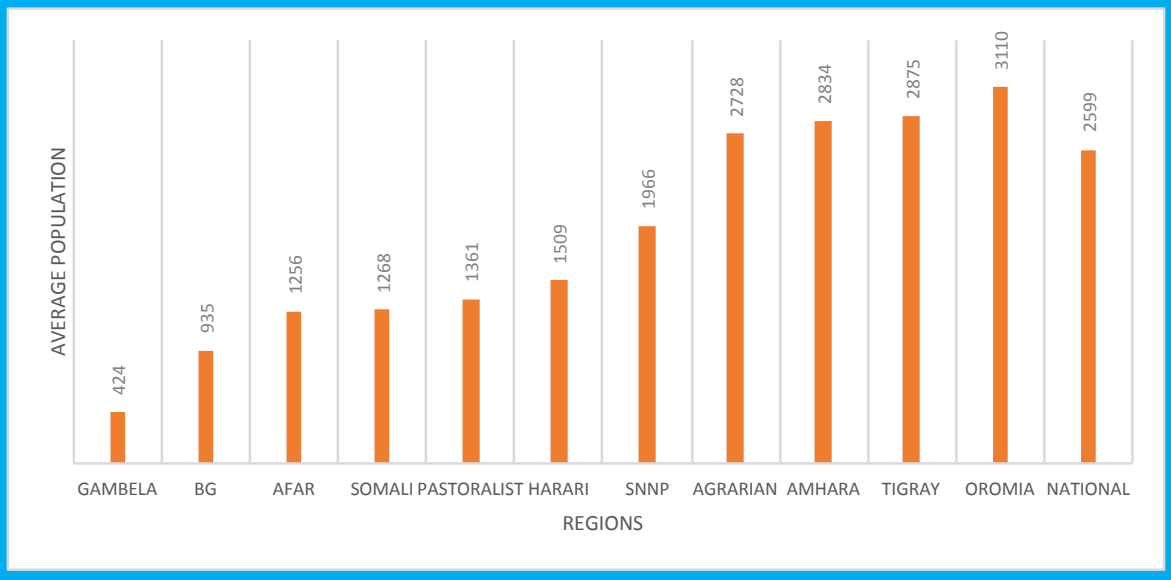


Figure 8: Average population served by HEWs

Areas that need attention:

Improve access to services by reducing barriers.

- Strengthening Health centre to health post linkage to overcome challenges related to lack of electric power at health posts.
- Ensuring that health posts are prioritized in infrastructure development projects (road, electricity, water, and telecommunication) targeting rural communities.
- Building the capacity of HEW training institutions in the areas of involvement

Actions required:
Renovation and/or reconstruction as needed

- 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 the need to expand services, the importance of avoiding any more substandard construction, and 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.

MAKE IT PEOPLE-CENTERED

Deliver HEP which considering the preferences and aspirations of communities and their culture.

Summary of evidence

- Model family training is an effective strategy for increasing the household level implementation of the HEP.
- Only 14.9% of women in agrarian settings and 8.0% of women in pastoralist settings reported being aware of the model family training.
- Enrolment and graduation rates were very low, with only 2.9% of agrarian and 2.1% of pastoralist households reporting having ever been enrolled in the training.
- WDA structures were reported to be available in 97.0% of agrarian kebeles. Similarly, 92.5% of pastoralist HPs reported the availability of either a WDA, a 1-to-5 network, or an SMC structure that supported the HEP in their respective kebeles.
- Only 25.9% kebeles have a WDA density of more than 30 per 1000 households. The functionality of the existing structures is also very low.
- The limited capacity of WDA leaders and SMC members was the other major challenge to community engagement with the HEP.
- The use of WDAs alone has resulted in the underuse of community potential, including that of men, religious leaders, and traditional leaders.

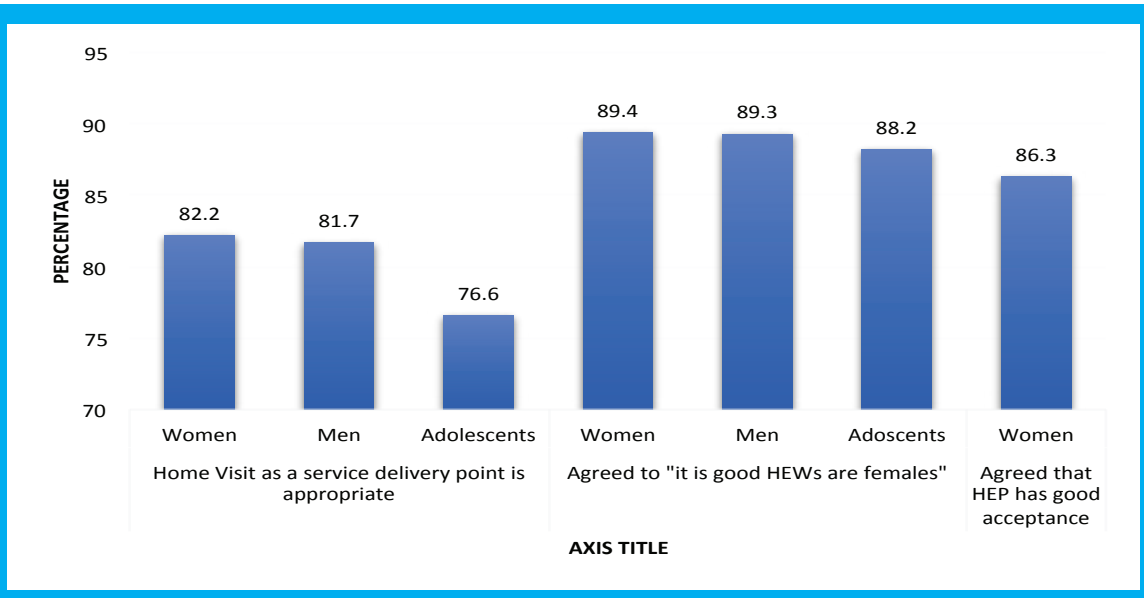


Figure 9: HEP response to community needs

Areas that need attention:
Strengthening model family approach

- 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.
- All community volunteers working with HEWs should be selected only among model families.
- Avoid reliance on single approach to community participation
- Avoid creating expectations of becoming salaried workers among community volunteers

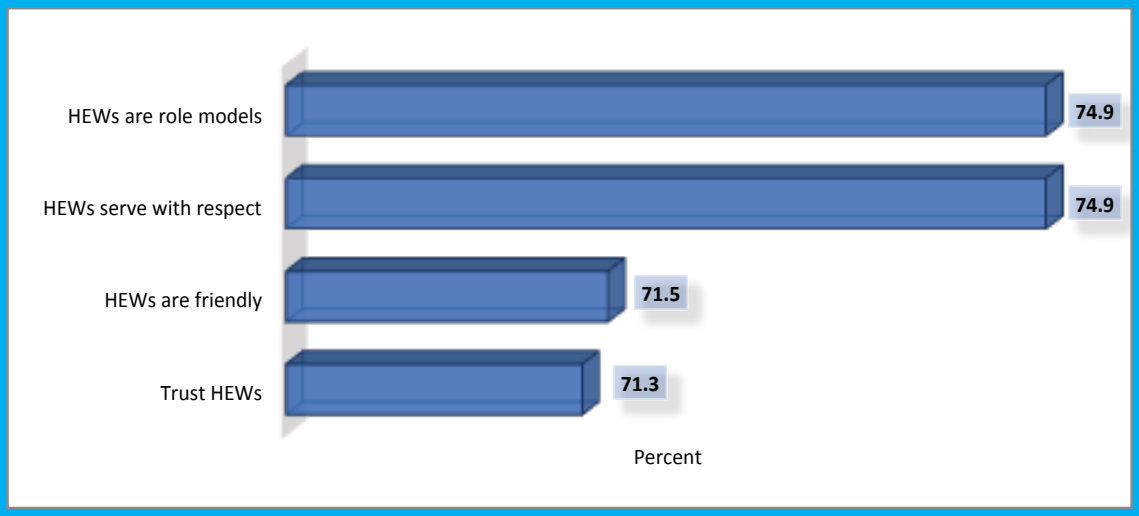


Figure 10: Socio-cultural relevance of HEP service delivery points

Actions required:

Expand community engagement and empowerment mechanisms for Health Extension Program (involve more categories of volunteers to reach all segments of the population).

- Introduce a system that allows HEWs to track enrolment, progress, completion, and recognition of model families.
- Redesign community structure for HEP with renewed branding, capacity, and responsibilities. Consider the following features to address challenges faced by the WDA approach.
- Incentivize volunteerism and limit duration of service to a predefined period of performance.
- Make maximal use of opportunities created by: 1) relatively better availability of literate community members, 2) high level of school enrolment among adolescents and youth, and 3) increasing use of communication technologies including cell phone and the internet.

ENSURE SAFETY

Deliver HEP services in a way that which minimizes risks and harm to HEWs and all types of service users.

Summary of evidence:
A considerable number of HPs don't meet safety standards

- 59% of HPs have an all-weather road connecting them to the nearest referral HC.
- Only 43% of HPs have their own fenced compound, which could compromise the quality of service delivery and the prevention of infection.
- Although, the majority (81%) of the HPs meet the minimum standard number of rooms, only 37% of health post buildings were up to the standard.
- Only 12% of HPs have incinerators, 7% have placenta pits, and 74% use open pits for solid waste disposal.
- A little more than a quarter (27%) of HPs have an improved water source in the facility.
- Most HPs (87%) have a functioning latrine for clients/patients.
- Only 1.2% of HPs have all basic amenities.
- The availability of equipment for infection prevention and control was very low.
- Only 57% of HPs had implemented first expiry, first out (FEFO) stock rotation; damaged and expired products were available in 75% of HPs.

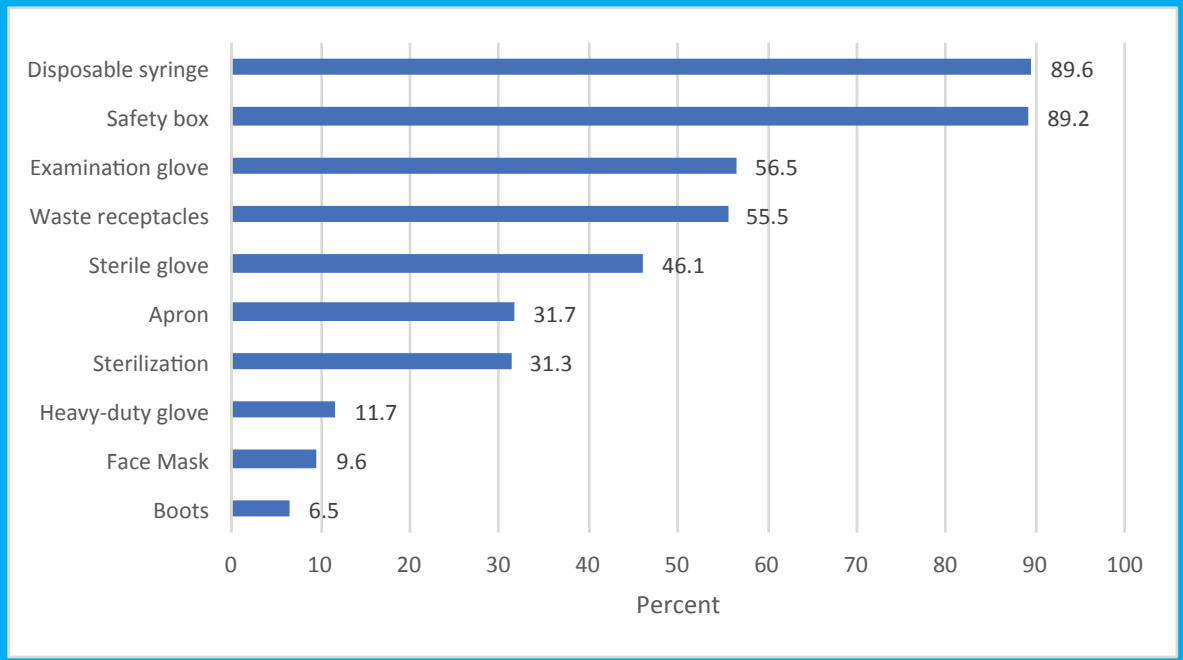


Figure 11: Availability of infection prevention equipment in HPs (n=343)

Areas that need attention:

Ensuring the availability and quality of basic amenities in Health Posts is essential for safe delivery of HEP

- Availability and quality of basic amenities
- Continuous supply of infection prevention supplies
- Timely

Actions required:

Equipping and regular monitoring of Health posts with the required based amenities as stated in the HEP implementation guideline.

- Renovation of health posts that lack basic amenities
- Ensuring availability of infection prevention supplies
- Ensuring availability and adherence to safety measures
- Enable the overall work environment at kebele level so that the health extension workers are motivated and safe to provide services in all service delivery modalities

Ensuring equity in the HEP implementation by age, gender, regions and packages

6

REDUCE DISPARITY

Deliver HEP services that don't vary in quality because of community characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.

Summary of evidence:
There are disparities in HEP implementation and outcomes

- There are significant disparities between agrarian and pastoralist as implementation of the HEP has been very slow in pastoralist communities compared to agrarian communities.
- Disparities between rural and urban are also considerable as a result of which urban health extension program was introduced later with a relatively different model.
- HEWS are females and the current HEP is focused on women and children and men's health hasn't been a major priority till the present time. Disparities between by gender
- There are regional disparities in the implementation and outcomes of HEP Ethiopia with some regions more advanced than others.
- There are also inter-package disparities in the implementation of HEP with more focus given to the family health component of the program.

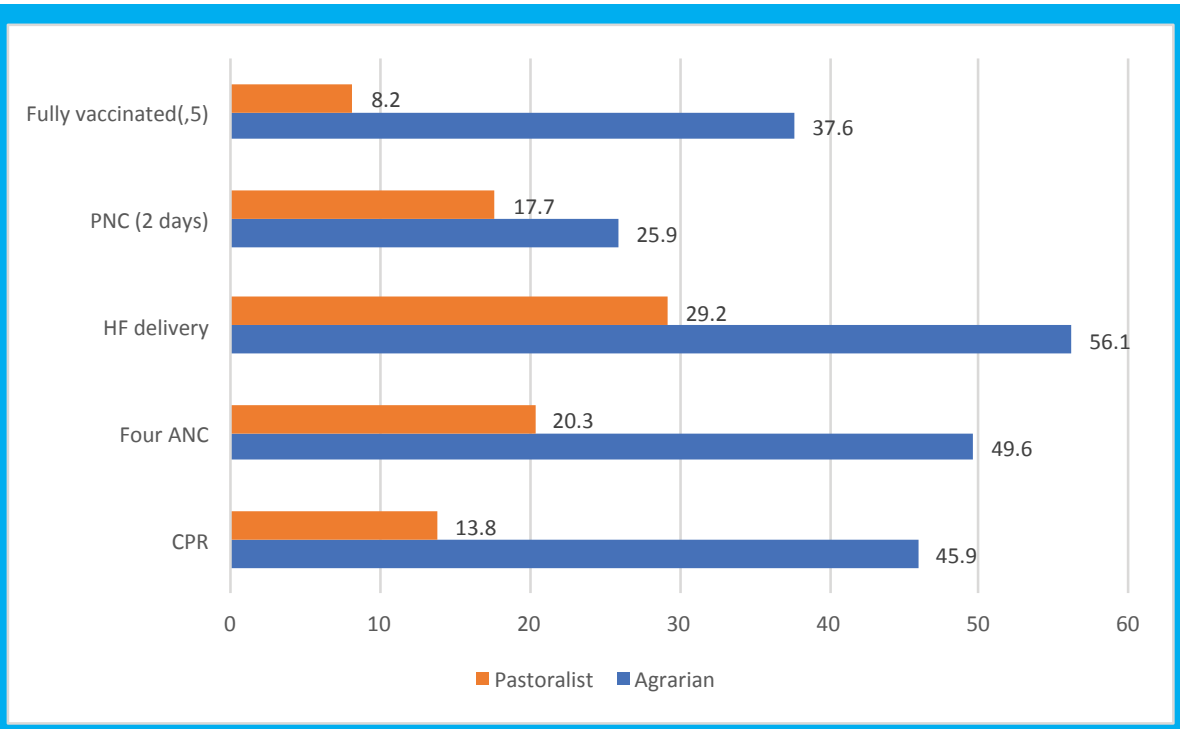


Figure 12: Comparison of Family Health indicators between agrarian and pastoralist areas

Areas that need attention:
Strengthen the use of equity lens in HEP implementation

- Having better evidence on the levels and reasons for disparities
- Disaggregated presentation of performance indicators
- Using the equity lens in planning, implementation and evaluation

Actions required:

A contextualized HEP service delivery modality that addresses equity within and between regions should be used for agrarian, urban and pastoralist settings of the country.

- More attention to underserved areas and population groups
- Equitable funding of HEP across regions and packages
- Redesign pastoralist HEP by conducting more detailed analyses of experiences in addressing health and other social needs of pastoralist communities.
- 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.

Improving quality of evidence and using it to inform decisions at local levels

7

ACT ON THE EVIDENCE

Generate quality evidence and promote its utilization to inform decisions

Summary of the evidence:
High coverage of CHIS with evident need for quality improvement

- 3 in 4 HPs implemented the standard CHIS system (FF) with variations among regions
- 70% had compile kebele information (profile), 80% of HEWs had a training on CHIS, and 84% were able to show their annual plan.
- The current health information/M&E system that captures data for measuring indicators reportable up to the federal level focuses only on the outputs of the specific programs implemented through the HEP, with very limited attention paid to monitoring the process of the HEP at lower levels.
- The kebele-level indicators that are directly linked to the performance of the HEP involve definitions with unrealistic targets (e.g., HDF, ODF, 100% CBHI enrolment), resulting in a lack of sensitivity to the intermediate progress of HPs.
- The data recorded and reported by HPs are largely inconsistent with source documents, mostly resulting in the over-reporting of performance.
- The use of information is limited at the HP and higher levels.

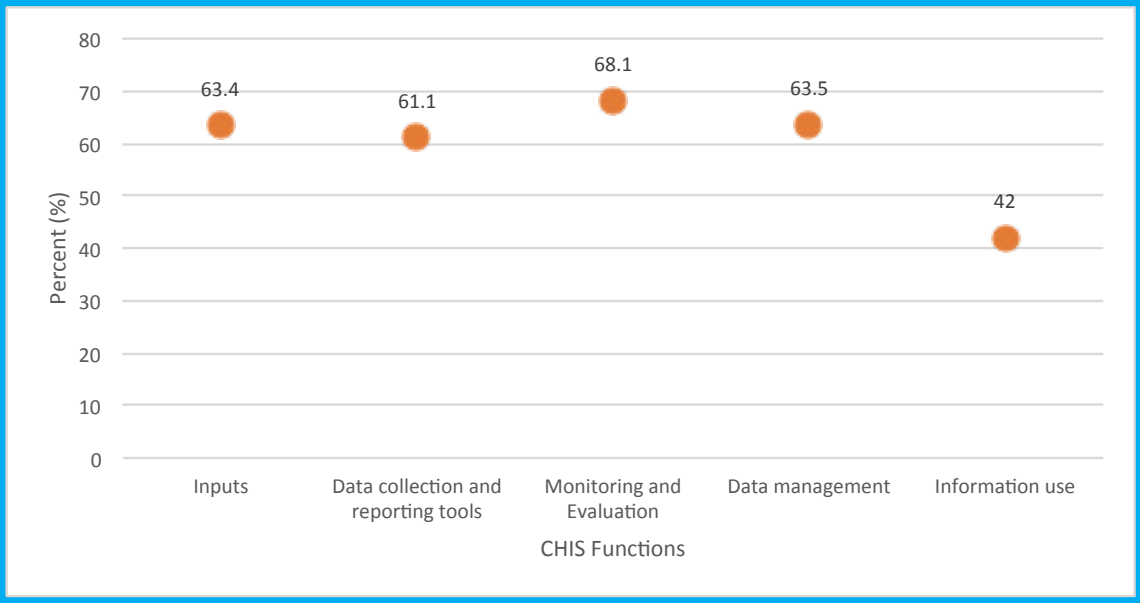


Figure 13: Percent of HPs that met CHIS standards

Areas that need attention:
Capacity, quality and evidence use

- Ensuring universal coverage of CHIS in HPS
- Regular data quality assessment and improvement
- Training of HEWs on CHIS data use
- Supportive supervision on CHIS data use
- Improving information use at local levels

Actions required:

The CHIS should be modified and/or redesigned in such a way to produce relevant data covering the key implementation areas for effective monitoring and evaluation activities and enhance data use for improvement.

- Data disaggregation by level of service provision (HP, HC)
- Expand electronic CHIS with dashboard features to facilitate information use
- Enforce the use of family folders to record encounters between HEWs and household members.
- Include process indicators of HEP for monitoring implementation of HEP service delivery modalities at least at health post, health centre, and woreda levels.
- Establish data verification systems including community level verification on a random sample of service users as well as introduction of innovative technologies in order to minimize deliberate over reporting.
- Introduce a performance management system that relies on objective auditing of coverage and quality of services.
- Initiating incentive mechanisms to encourage improved data quality and use.
- Transform information system of health posts in a way that guarantees a continuum of care that is resilient to staff turnover.
- Eliminate formal and informal incentives to over reporting

HEP OPTIMIZATION ROADMAP: 2020 – 2035

Informed by the findings of the HEP assessment and through a rigorous consultative process and by benchmarking local and international experiences and trajectories, the roadmap has identified transformative agendas which will optimize the HEP.

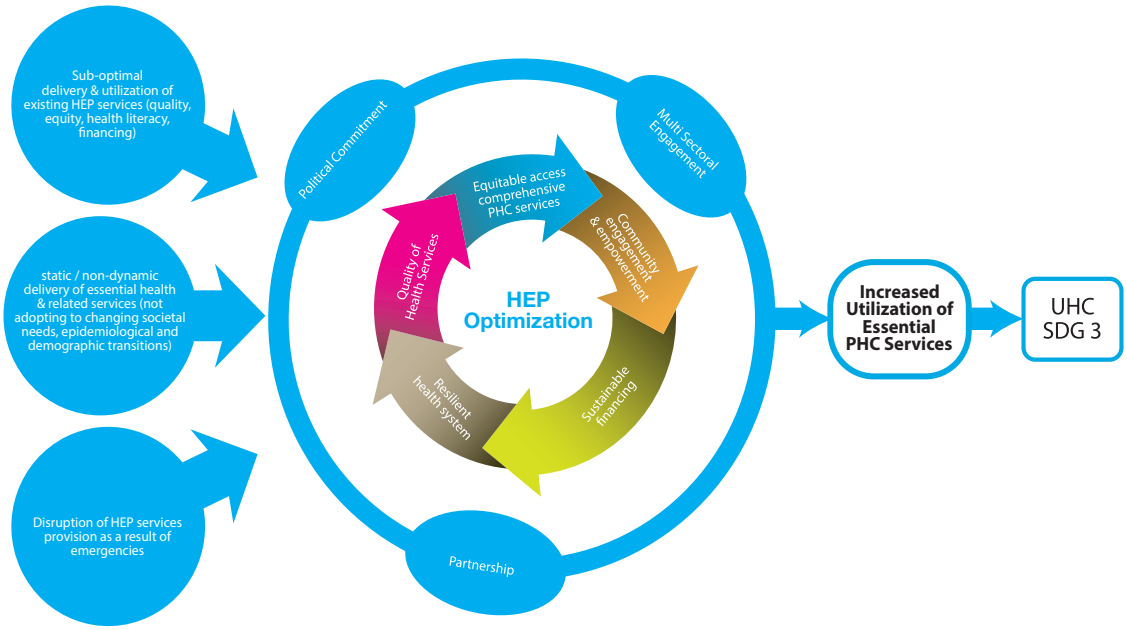


Figure 14 Theory of change of HEP Optimization (Source: HEP optimization roadmap)

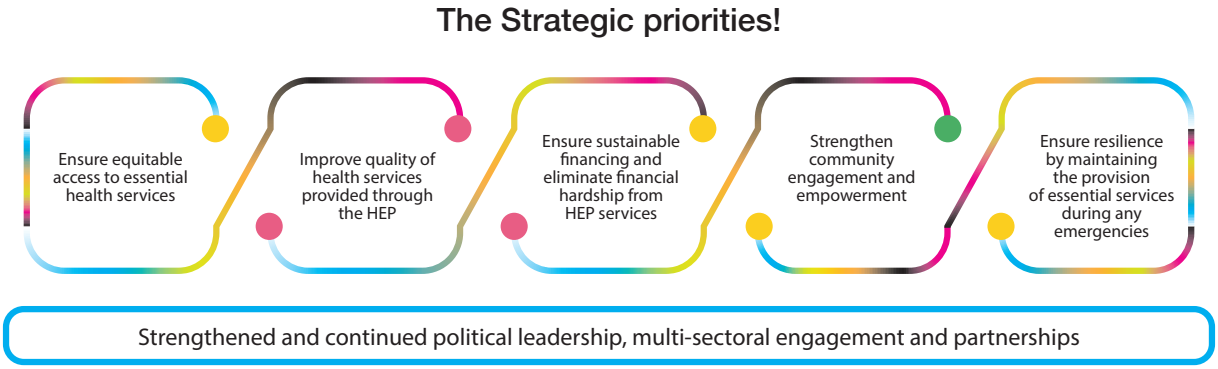


Figure 15: Strategic objectives of HEP optimization roadmap (Source: HEP Optimization roadmap)

The Milestones on the Roadmap:

The key milestones in the coming 15 years will transform the program where comprehensive services will be provided safely, efficiently, effectively, where Ethiopians access high quality PHC and the program is informed with high quality evidence.

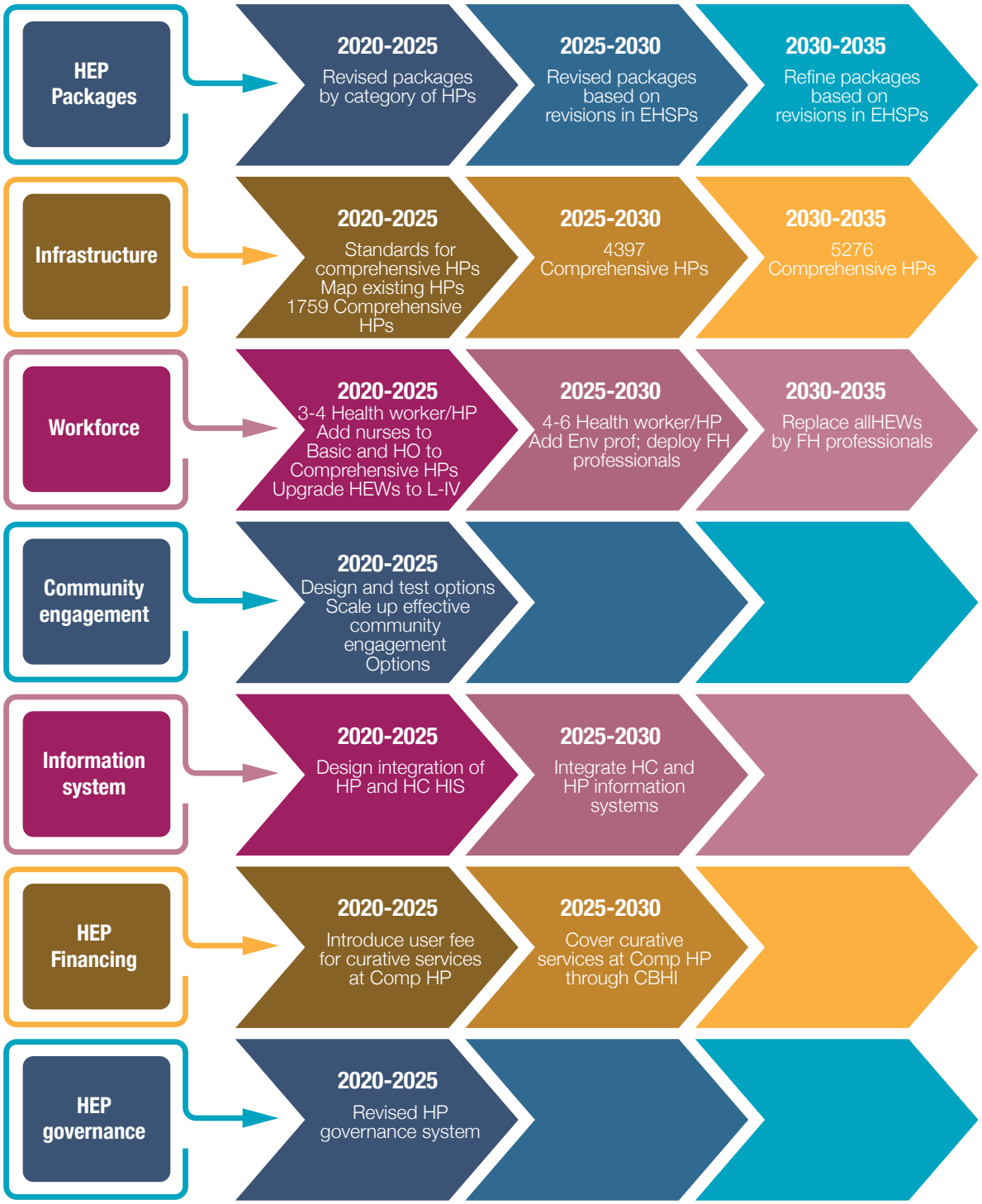


Figure 16 Timeline for HEP optimization milestones (source: HEP optimization roadmap)

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