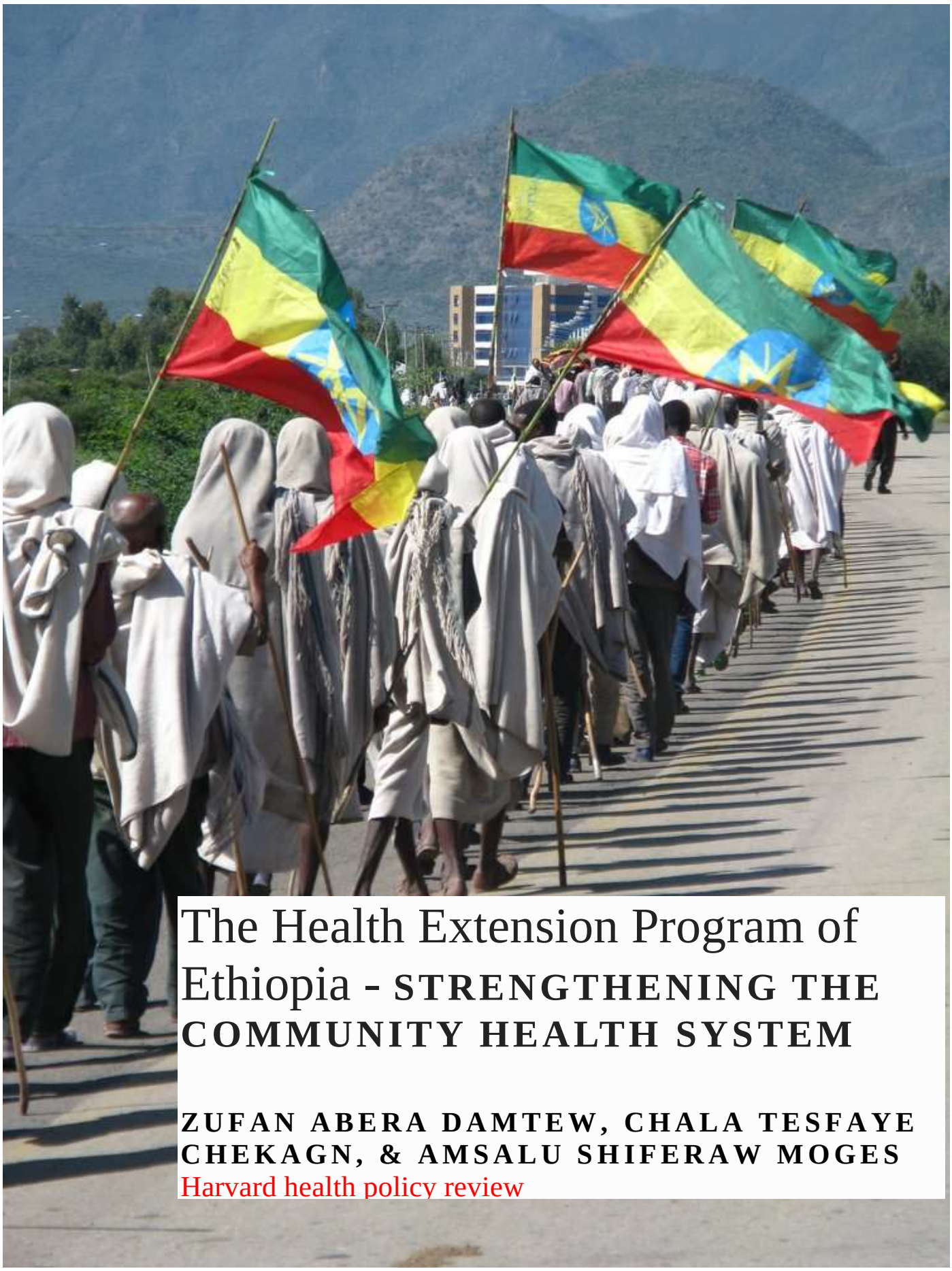

The Health Extension Program of Ethiopia - STRENGTHENING THE COMMUNITY HEALTH SYSTEM

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Harvard health policy review

BACKGROUND

Over the past decade, Ethiopia has achieved dramatic progress in improving the health outcomes of its population. Ethiopia has accomplished the United Nations Millennium Development Goal 4 (MDG4) by reducing child deaths by 67%– from 204 per 1,000 live births in 1990 to 59 per 1,000 live births – three years ahead of schedule. [1] The maternal mortality ratio plummeted from 871 maternal deaths per 100,000 live births in 2000 to 353 per 100,000 in 2015, translating to about 12,000 maternal deaths a year.[2] There was also a vast improvement in hygiene and sanitation coverage as well as a reduction of major communicable diseases. These achievements are the result of the Health Extension Program (HEP), launched in 2004 to develop a community-based accelerated expansion of health facilities.

HEP STRATEGY

More than 38,000 government-salaried female Health Extension Workers (HEWs) are deployed in the country. [3] Two HEWs are assigned to one health post to serve a population ranging from 3,000 to 5,000 in a village "kebele". HEWs provide key health services through fixed and outreach bases. They spend half of their working time conducting home visits and outreach activities and the remaining half at their health post providing basic curative, promotive and preventive services. The HEWs represent the health sector in the local administration. Under the chairmanship of the kebele administrator, with other line sectors such as health, agricultural development agents, teachers and other elected members from the kebele constitute a kebele council, bringing together administrators and sector representatives. This ensures close links with interrelated sectors and promotes sectoral and community coordination at the local level. The design of HEP package was based on analysis of major health problems and disease burden of the population. Initially, 16 health packages categorized into four principal components (family health, disease prevention and control, personal and environmental hygiene, and health education and promotion). However, recently, additional services were included, particularly for children and women, such as integrated community-

based case management, community-based newborn care, and providing long-acting family plan

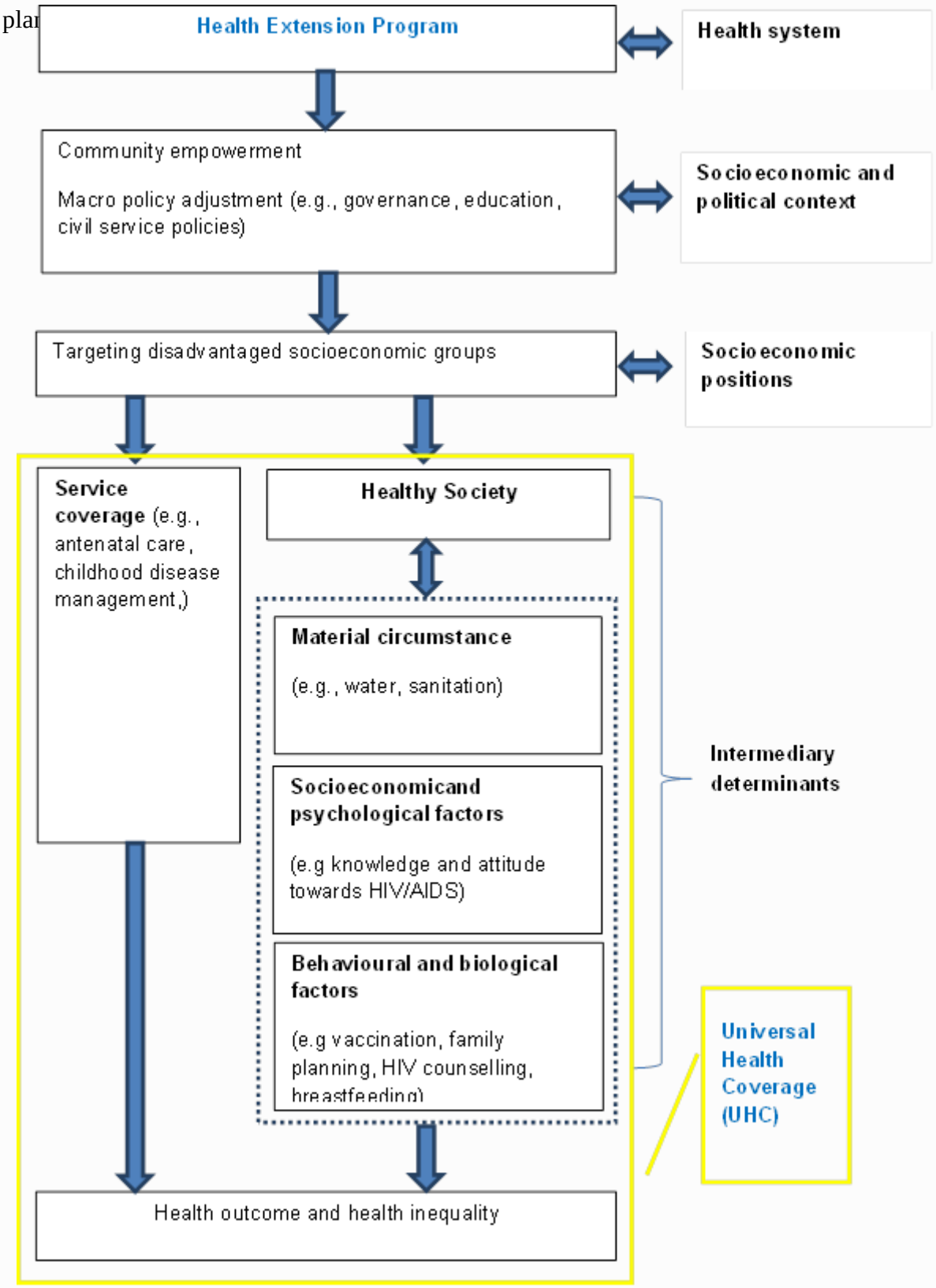

Exhibit 1. Health Extension Program and Universal Health Coverage Model in Ethiopia

HEP brings community participation through awareness creation, behavioral change communication, and planned and systematic community mobilization. Community engagement for improved lifestyle was initially based on innovation of diffusion theory, which focuses on model household graduation. Model households go through an intensive vetting for graduation and are publicly recognized by local leaders after completing key health extension practices at the household level. Model households also provide mentorship and act as role models for their neighbors. This has brought about impressive results concerning health outcomes resulting in significant reduction of harmful traditional practices, improved lifestyles and use of health services. However, there was a gap in quality and comprehensiveness. Hence health development army was initiated in 2012 for engaging everyone in the community through an organized and inclusive manner, particularly the under-served and disadvantaged groups.

The Health Development Army as part of universal coverage for basic health services, a complimentary initiative undertaken by the Ethiopian Government is the establishment of the Health Development Army (HDA). HDA is a systematic, organized, inclusive and collaborative movement of the neighboring Households through active participatory learning and actions to practice key health activities. HDA is designed to bring about transformational change in health outcomes and ensuring every household is reached. The HDA provides an effective platform to engage the community in the planning, implementation, monitoring, and evaluation of health and other programs. Women are organized into one to five household networks and groups of 25 to 30 families and are encouraged and engaged in learning, practicing and collaborating with each other to bring significant practical and attitudinal change. In one to five network, six households are organized based on social and geographic proximity. among five or six households one will be lead to advise/inform and counsel her team members.


TRUST
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Exhibit 2. HEW counseling mother on family planning, Amhara region, Ethiopia.

INITIATION OF THE SECOND GENERATION HEP

As literacy and socio-economic status of the population improve, the demand for quality and comprehensive services also increases. Besides, changes in demographic trends, epidemiology, and urbanization require more comprehensive services covering a wide range of quality health services. To respond to the rapidly changing situations, the Government is revisiting and calibrating the HEP. As addressing equity and quality of health services is the main focus of the new Health Sector strategy most essential services are shifted and shared to the community level. To this end, improving the competency of HEWs and the HDA members is fundamental. The second generation rural HEP includes upgrading of 35,000 HEWs from level III to level IV, renovating, expanding, equipping, and supplying health posts with the necessary equipment and supplies, shifting essential services to the community level, and institutionalizing the HDA platform. Pastoralist HEP will be redesigned to be tailored to pastoralist settings to address geographic equity disparity. In cities and urban areas, a Family Health Team approach will be scaled up. The Family Health Team approach engages various professionals to address the complex situation and health problems found in urban settings. The main aim of the initiative is to reach the neediest and most vulnerable segment of the population in urban areas, that in turn address avoidable inequalities in accessing quality health care.

STRATEGIC PARTNERSHIPS

The Government is the principal stakeholder of the HEP. The Government plays a central role in the construction of health posts, training and deployment of HEWs. It is covering recurrent costs such as salaries for HEWs. The local community contributes for the construction and renovation of health posts and residents for HEWs. Development partners also provide financial and technical support to strengthen community-based services.

ABOUT THE AUTH

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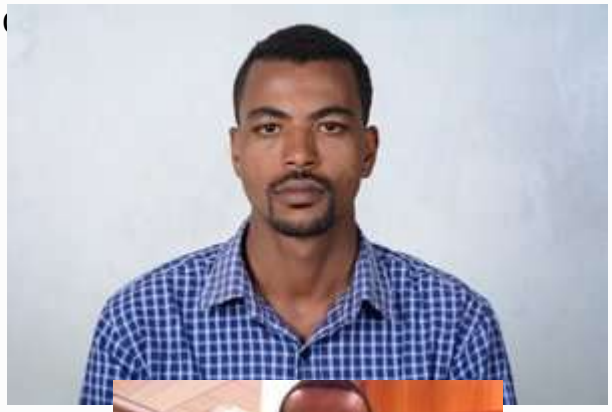

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