



**International Institute for  
Primary Health Care in  
Ethiopia**

**Primary Health Care Unit in Amhara Region  
Field Visit Report**



**February, 21-24, 2017**

## **Table of Contents**

Background	3
Day One: Meeting at Amhara Regional Health Bureau	4
Health Science training college:	7
Day Two: Visit to the PHCU	8
Day Three: Debriefing at the Regional Bureau	14
Conclusion and Recommendation	15
Annex I: Field Visit Schedule and Objective	16

## Background

One of the missions of the international institute for primary health care is to provide international training on primary health care. There are three trainings for different groups of audiences focus on PHC. The training has a field visit component where participants travelled to regions and visit PHCUs up to the household level. Thus, this field visit is organized to select possible PHCU in each region prior to the trainings as potential field visit sites. The sites are expected to be close to the main city of the region and with better performance.

The purpose of the visit was:

- to establish relationships with the Regional Health Bureau and promote IIPHC
- to visit 1 PHCU (1 primary hospital, 1 health center, 1 health post, 1 model household) and 1 HEW training center
- to collect documentation on each site visited relating to feasibility and accessibility of sites; to document the PHCU in pictures and films
- to look for collaborators, discuss the way forward and establish points of contact at RHB, PHCUs or with other stakeholders met during the trip
- to collect materials on PHC ((books, guidelines, brochures, flyers, etc).

## **Day One: Meeting at Amhara Regional Health Bureau**

We started our visit from the Amhara regional health Bureau. We met Dr. Abebaw who is the head of the regional health Bureau and his team of expert on primary health care.

Prof. Mengesha has provided background information on the establishment of the institute and the purpose of our visit. He also acknowledged the activities carried out by the institute so far including the training for international and local participants; and the fact that the training has both class room lecture and field visit. The purpose of this visit was to select model primary health care sites for the training participants. He also added that this trip is the third in its kind and two regions have already been visited by the IPHC staffs. The model sites will serve as field visit sites for the international trainees to show how the primary



health care functions at the grass root level.

The outcome of this visit is to select the sites and in the future the institute would like to orient the health facility staffs, model household heads, and the community volunteers on how to interact and communicate with guests/visitors and tell their story genuinely.

Prof. Mengesha mentioned that his team would like to visit the training centers for the HEWs for today and the primary health care sites visit will be for tomorrow.

Dr. Abebaw appreciated the IIPHC's cause and he said his teams are ready to support us during our stay. He also said his team is working towards the woreda transformation which is one of the FMOH HSTP agenda. He further explained how the primary health care system works in the region as follow:

Since mothers are the primary care givers at the household level, proper training was given to these mothers which we called the level one training. This training includes water and sanitation, ventilation; infectious disease prevention such as malaria, TB etc and maternal and child health issues.

At the health post, HEWs work both at the household and health post and register all their work. At the health center, the prevention activities are done through the health post in addition to their basic clinical care service. At the HC you will see maternal waiting center to help expecting mothers at their final stages of their pregnancy and delivery; it also provide minor surgery for some cases. In general, 80% of curative services are given at the health centers and for some major surgeries such as cesarean section the primary hospital will be on board.

If we properly perform the basics activities at the household level, it will solve major health problems we have today. It was good that our prevention efforts are recognized internationally.

Dr. Abebaw added that his team and the primary health care owners need training on transformational leadership. He believes health centers are critical part of the prevention effort and such training will support their system. With this remark, we went to meet the team responsible for the health extension program in the same office. There, we continue our discussion on the program.

We mate with experts on primary health care at the regional office and had further discussion with them (Mulunesh Tesfa, Woudeneh Gereme & Meselew Chanayalew).

Mulunesh (human resource personnel at the Amhara regional Health Bureau) gave us some introduction about the training program for the HEWs as follow:

There are five health science colleges in the region; all provide training for HEWs both at level 3 and 4. Previously, training in health extension program was provided by the Technic and vocational training centers; however because of change in the package such as provision of clinical services on selected problems of mothers and children and other changes, the training brought back to the health science colleges.

Once the HEWs finish their level 3 training, they are required to take COC; however, the process did not go as expected and many are still waiting for the COC. The training is given for both level 3 and 4. Currently, 250 generic HEWs are being trained.

The other experts added that there are challenges the HEWs training program is facing. For instance, the naming and assignment of the HEWs when they graduate; ideally the HEWS are supposed to be called as urban and rural workers. But since the training curriculum is the same for both group; it has created some confusion and complaint from both the students and the administration. Thus the classification is on hold for some time now.



that there is no mention of urban-rural categorization; so the training is given just as level 4 training.

After our discussion with the dean, we were able to visit the training facility and classrooms while students were in class. The training center has some laboratories for practical sessions although they were not well equipped. There are no model houses for demonstration.

## **Day Two: Visit to the PHCU**

We travelled to West Gojam Zone and met with the zonal health office head Mr. Amare. Our discussion at the zonal health office was started by Prof. Mengesha's introduction of our institute and the purpose of our visit. Mr. Amare was already informed about it and arranged the site visit with his team.

Since the primary hospital was in the same town where the zone office is, we started our visit from the Hospital. Before the visit, Mr. Amare mentioned some of their success in maternal health service; he said there are 88 health posts in the zone at the health centers they have maternal waiting home where expecting mothers wait for their due date away from home and monitored by health workers. To support this waiting center, each household donate one quintal of cereals annually and the community as a whole donated three million birr. Currently, the zonal health office is negotiating to with the government to get farm land not owned by anyone. They plan to grow cereals and have regular annual harvest in the future. The communities in the zone have also contributed around twenty seven million birr to buy ambulance service. He said the woman development armies are well organized here at the zone; they have their own uniform clothing and are known and well accepted by the community.

Despite the above mentioned success Mr. Amare believe that there is much more to do; he mentioned the four health sector transformation agenda and he acknowledged the challenge with information/data management and use. He said his teams are strongly working on it.



We met Ato Amlaku Belay, at the Finote-selam hospital which is the primary hospital for the near-by health centers. Ato Amlaku is the CEO of the hospital and welcomed us to his office. After a brief introduction by Prof. Mengesh, the CEO started to respond to our quires.

The hospital was established in 1954 and provides service for up to 1.5 million people.

It has 11 GPs, 2 specialists, 21 pharmacists, 13 lab tech, 13 midwives, 77 nurses, 2 anesthesiologists and radiologists. It has 102 beds; its occupancy rate was 102%. It's capacity is beyond a primary hospital. Three out of 100 patients return home without any service. They had 472 deliveries in the first quarter and 532 in the second quarter of the year.



The health workers are very competent and committed; they network with health centers in their catchment and provide support. In these health centers, their main support is on maternal health; they even send their ambulance to the rural areas when there is a need. They also have catchment meeting with the health centers to provide regular feedback.

They are also planning to provide support to the near-by hospitals.

They have two x-ray machines, morgue and incinerator; however, the hospital doesn't have library and wi-fi service. Although the hospital offers some housing service for few health workers in the compound it was not enough. The hospital has currently shortage of clothing for patients.

HMIS and information: Each department in the hospital use manual HMIS and data are entered in to computer centrally. They sent their report to zone office weekly, every two weeks and monthly. They manage ART data separately and also use smart care for data management. The main challenge of the hospital is staff turnover and shortage of specialist drs. They wish to have training on infection prevention and leadership.

**At the Health Center:**

We have visited Mankusa health center; when we arrived at the health center, it was around 11:00 am.

Staff composition: There are 4 health officers; 4 lab tech; 3 pharmacists; 1 environmental health expert and 7 clinical nurses.

The health center has PHEM conduct surveillance of certain diseases and maternal death.

The HC provide out-patient service and it has only 2 beds and provides in-patient service for those who need 24 hour observation. It has trained health worker who manage the cold-chain;

They provide delivery service and have mothers waiting area for those coming afar. They have collected 131 quintal of crops from the community for the mothers who will be staying at the maternity waiting centers.



They are now planning to secure land for farming and generate resource for the same cause.

The health center has At Menkusa health center, they had 102 deliveries per month. They haven't recognized challenges in their health facility; however, they constantly receive comment on their infrastructure. They believe the building is not up to the standard.

Mankusa Health Center, maternity waiting center

They do get support from the Woreda regularly; according to the head, one person is assigned and spend three days a week at the health center and report back. Regarding training need, they have had a number of training and now they would like to have training on infection prevention.

**At the Health Post:**

We have also visited the nearby health post; there we were greeted by the two HEWs (Yenework and Meseret) and the woman development army (WDA). During the visit the HEWs described their daily activity as follow: they divide their Keble in to 13 'Gote'; in any normal day, one of the HEW will stay at the health post to provide health service while the

Family folder and medicine shelve at the health Post

other HEW went house to house and visit her community members.

The HEWs acknowledged that a team of experts from the health center visit them and provide them technical support. The HEWs also have functional CHIS (community health information system). They have family folder; whenever there is new member to a family their folder is updated. They also collect information and report to health center weekly and monthly.

Inside the health post, there were graphs, tables and charts which show the catchment population size, number of children, pregnant mother and their yearly performance by activities.

We asked the HEWs about their strengths and challenges they face in this line of work; so they mentioned that having strong woman development army was their positive achievement. And all the mothers in their kebele gave birth at health facility.

Their challenge was they did not see any change in their carrier; they said they served for 12 years and it is just recently that one of the HEWs received training opportunity to upgrade

herself to level four. In addition, the HEWs do not have clothing, shoes and umbrella unlike the agricultural extension workers. There is shortage of ambulance and the kebele is very large compared to other sites.

**Model Household Visit:**

After our visit at the health post, we went to one of the model household. The house was developed by an engineer; it has separate bed room, living room and windows. There was

Model Household at Menkusa woreda

also separate bed for the children; the family use bed net and it was hanged above the bed during the visit. Although the floor was mud, the house was fairly clean and spacious with high roof. The household do not have radio but they will have in the future.

The head of the household was asked who the prime care giver in their family is and he said we all are responsible to produce our own health and added that the mother is responsible for the care of the new born in the family.

Typical Ethiopia Hospitality by the HAD's

### **Day Three: Debriefing at the Regional Bureau**

We went back to the Amhara regional health bureau and discussed what we have observed in the field. We started by sharing what we have observed and the field as documented above and summarized as follow:

- Health science college need more demo-practical session
- HEP has to provide clear direction on the carrier development of HEWs
- There has to be a demonstration models at the HC
- Provision of information at each site has to be standardized especially
- Provide SBCC for the mothers at the maternity waiting centers

After that Dr. Abebaw, acknowledge our observation and confirm it. One of the issues we raised was the lack of models for teaching both in the health center and the health science training college. He mentioned that the models are found in many places in the region however, these two sites must also have it.

He also acknowledge the importance of preparing a formal health education program for mothers in the waiting center instead of let them watch media which are not relevant for them. It is also possible to introduce formal education. It is also possible to invite students

from health Science College in the form of community attachment help with the health education in the health centers and maternity waiting area.

Dr. Abebaw also emphasized their need for leadership training for the primary health care managers as there were more people coming to the administration and more were replaced.

### **Conclusion and Recommendation**

In general, our visit was fruitful and we managed to select and observe one PHCU however, the sites were considerably far from the regional city. This could be a challenge to finish PHCU visit in one day as planned.

Since the result of such visit is meant to be for educational purpose, it will be good to show the sites where the PHCU is not successful. It is better for people to understand what it means by poorly functional PHCU.

## **Annex I: Field Visit Schedule and Objective**

**International Institute for Primary Health Care in Ethiopia (IifPHC-E)**

**Amhara Region tentative Feld Visit Schedule, B/Dar**

**February 21 – 24, 2017**

<b>Day</b>	<b>Time</b>	<b>Activity</b>
Tuesday, February, 21	09:00 am	Arrive at B/Dar Airport
	10:30 am – 12:00 pm	Meeting with Amahara RHB, Head Dr. Abebaw
	12:30 pm – 02:00 pm	<b>Lunch Break</b>
	02:30 pm – 05:00 pm	Visit HEWs Training Center (Health College)
Wednesday, February, 22	09:00 am – 12:00 pm	Model Household Visit
	12:30 pm – 02:00 pm	<b>Lunch Break</b>
	02:30 pm – 05:00 pm	Health Post Visit
Thursday, February, 23	90:00 am – 12:00 pm	Health Center Visit
	12:30 pm – 02:00 pm	<b>Lunch Break</b>
	02:00 pm – 05:00 pm	Primary Hospital Visit
Friday, February, 24	09:00 am – 12:00 pm	Debriefing with RHB and contact people
	4 pm	Departure to Addis Ababa

IifPHC staffs:

Prof. Mengesha Admassu, Executive Director

Dr. Seblewengel Lemma, Research Officer

Hiwot Tadesse, Office Manager

**February 21 – 24, 2017**

### **Objectives of the Visit**



- ❖ To visit PHCU (Primary Hospital, Health Center, Health post, Model Household) and HEW training center with the aim of selecting sites suitable for field visits for international trainees.
- ❖ To collect documentation on each site visited relating to feasibility and accessibility of site.
- ❖ To create/strengthen relationships with Regional Health Bureaus and promote IifPHC's.
- ❖ To look for collaborators, discuss way forward and establish points of contact at RHB, PHCUs or with other stake holders met during the trip.