

Tigray Regional State Site Visit Report

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TIGRAY REGIONAL STATE SITE VISIT REPORT

Trip duration: January 2 – 4, 2017

Report prepared by: Melody Kelemu, Training Officer

Sites visited: Mekelle and Hawzen, Tigray

Trip Background

In keeping with its training mission, the International Institute for Primary Health Care hosts international delegates from different African countries and beyond who seek to share experience on the Ethiopian Health Extension Program (HEP). The trainings are comprised of a theoretical in class training component and an applied component that includes a field trip. The field trip consists of visiting a Primary Health Care Unit (PHCU) and Health Extension Worker training college to witness the realities of HEP implementation on the ground. Generally, a PHCU consists of care for a population of about 100,000 people served by an average of 4 health centers, 20 health posts, 40 Health Extension Workers (HEWs) and according to some definitions, a primary hospital. For the purposes of IfPHC's regional state trips, a PHCU is comprised of a household, a health post, a health center and a primary hospital. In addition, IfPHC will visit a HEW training college on each trip. IfPHC has planned to visit a Primary Health Care Unit and HEW training college in each of the nine regional states of Ethiopia and select the ones that are most suitable for visit by international trainees.

By going on these regional site selection trips, IfPHC staff members become familiar with the workings of the various PHCUs to be visited and can confidently share their knowledge with trainees prior to or during the field visits. Each of the nine regional states will be visited turn by turn. Furthermore, previous international trainees from different countries have emphasized the crucial role played by the field trip saying that they gained valuable knowledge during the field trip portion of the training, knowledge that they could not have gained otherwise. The regional field trips are also in keeping with the first year plan of

action which specifies a nation-wide site visit. Additionally, the field visits by IIfPHC members gives the Institute a chance to record video footage and take photographs of the sites so that in cases where trainees are unable to go out on field visits, there are multimedia options that will give them a good idea of what they could have seen. Additionally the videos and photographs can be used for promotion of IIfPHC and its field trips. However it is important to note that additional work by a professional camera crew is necessary if the videos and photographs are going to be used for promotional purposes.

Recently the Federal Ministry of Health (FMOH) had charged IIfPHC with training 400 individuals from Woredas health offices across the nation that were deemed low performing according to the maternal and child health indicator. 120 of the 400 have been trained so far in two training rounds that lasted from Dec. 5 – 9, 2016 (first round) and Dec. 13 – 17, 2016 (second round). 50 trainees were trained in each round and both rounds had trainees who came from the SNNP Region and Tigray Region. Therefore, an additional motivation for conducting the site visits is to follow up with some of the trainees who participated in the first 2 rounds of training and strengthen contact with them. For this reason it has been decided that the first site visit will be to the Tigray Region followed by Hawassa in the SNNPR.

In addition, IIfPHC recognizes the importance of working collaboratively with community members, health experts, health bureaus and other stakeholders. Once suitable PHCUs and HEW training colleges are selected, IIfPHC can develop a pool of trainers and facilitators from each site according to the Institute's guidelines to ensure high quality trainings where sensitive topics are dealt with appropriately and the information disseminated is uniform. In general, the site visit trips are an effective way of initiating and strengthening the relationship with stakeholders in the different regions. In the future we plan to train the facilitators and speakers at the health centers, health posts and primary hospitals in each region to ensure the quality of delivery.

Objectives of the Site Visit

- I. To create or strengthen relationships with Regional Health Bureaus and make them aware of IIfPHC's mission, vision, objectives and services offered.

2. To visit 1 PHCU and 1 HEW training center with the aim of selecting sites suitable for field visits for international trainees.
3. To collect documentation on each site visited relating to feasibility and accessibility of site.
4. To create visual records (photos and videos) of site visits so that in the event of international trainees being unable to go to the sites in person, the visual records will be used as an acceptable substitute.
5. To look for collaborators, discuss way forward and establish points of contact at training colleges, PHCUs or elsewhere in the sites visited.

Trip Goers (Visitors)

There were 3 members of IlfPHC who went to Tigray:

1. Prof. Mengesha Admassu, Executive Director
2. Luidina Hailu, Communications Officer
3. Melody Kelemu, Training Officer

It was decided that only three out of the seven staff members at IlfPHC should go on the field trip because the office would be left empty if everyone left. The remaining staff members will take turns going to the other regional site visits until every IlfPHC staff member has gone to at least one trip. Prof. Mengesha will be present on each of these trips.

Trip Details

Initially the plan was to travel to two PHCUs in Tigray then select the better option that is more suited to the needs of international trainees in terms of accessibility, quality of PHCU services, quality of PHCU equipment etc. However due to time constraints it was necessary to limit the trip to one PHCU visit. A day-by-day description of the trip follows below.

Day 1

We started off the first day by meeting with Dr. Hagos Godefay, the Director at the Tigray Regional Health Bureau. Dr. Hagos explained the vision of the Bureau which is to see “a healthy family in every household of Tigray” followed by the mission which emphasizes

“health promotion, disease prevention, care and cure and support of patients and development of a democratic health system.” Professor Mengesha introduced IlfPHC and explained the objective of our trip. Taking the trip objective into account, Dr. Hagos suggested that we visit the cities of Hawzen and Hintalo. We were then introduced to Ato Mulugeta who was put in charge of showing us around the two cities. Later, Ato Muluget decided that Hintalo was too far out of the way and Hawzen only would do.

Later in the day we met with a few of the trainees from the Transformational Leadership Training that IlfPHC had given in December 2016. The trainees were asked if they had given the Transformational Leadership Training themselves to their colleagues and a few such as Sister Selome and Hewan Tesfay replied that they had but others like Sister Wahid Kassa said they had not had time to train others because the Acute Watery Diarrhea (AWD) outbreak had been a major priority. Prof. Mengesha told all the ex-trainees that if they had any problems or needed support in any way, IlfPHC is happy to lend a helping hand. This marked the end of the first day.

Day 2

On the second day we visited the Dr. Tewelde Legesse Health Science College with trains Health Extension Workes. There we met with Ato Dagneu, the Dean of the College. Ato Dagneu told us that so far the College has trained 114 Level Four HEWs and 163 Level Three HEWs. All of the HEWs trained so far have been female. The training consists of eight months of theoretical in-class courses followed by a community practicum lasting two months for Level Four HEWs and three months for Level Three HEWs. There are 16 components to the curriculum in keeping with the 16 packages that HEWs are expected to educate and practice. Level Three HEWs are required to have a minimum of a tenth grade education while Level Four HEWs need to have at least two years of work experience as a Level 3 HEW in addition to a tenth grade education. However Ato Dagneu noted that some Level Four HEWs have eight to ten years of work experience. For a HEW to upgrade from Level Three to Level Four she needs to have completed her national qualification COC examination, have good work performance and a few years of health extension work service. 98% of the students that start graduate from the Health Science College. Level Four HEWs generally score around 70% on the COC but Level Three score lower grades because of low computer literacy.

There are plans underway to create an opportunity for Level Four HEWs to become community nurses. However currently there are no opportunities for career growth beyond Level 4 which causes some displeasure on the part of HEWs. Regardless, the attrition rate of HEWs was not too bad. Ato Dagnew explained that the HEWs get 540 birr stipend per month per person. All additional expenses are covered out of pocket. Ato Dagnew also informed us that the Menelik Health Science College has a separate program to train urban HEWs and that so far around 50 urban HEWs have been trained. There is also another Health Science College in Axum but they train rural HEWs only.

After visiting the Dr. Tewelde Legesse Health Science College we went to a model household. The plan was to go to start our visit at a model household and work our way up to a health post, health center and finally a primary hospital.

The residents of the model household we visited were a widowed woman, W/ro Kidane Aregawi and her four children. W/ro Kidane had been recognized for her exemplary household many times with awards from the community, the city and the regional state of Tigray. She told us that her life and life of her children had been significantly improved since a HEW started visiting her house. Because of the education she has received from the HEW, her house is equipped with an outhouse complete with a lidded pit latrine and a contraption for hand washing. One of the more impressive features of the house was a biogas fueled stove. An underground digester next to the outhouse is used to collect manure from cows and also human waste from the bathroom. The waste product is then fermented inside the digester and the resulting methane is channeled into a small cooking stove in the house via a duct. W/ro Kidane said that since the biogas required manure from a minimum of only four cattle, she is able to use the stove readily.

She further explained that before the installation of the biogas stove, her children would refuse to cook and both she and her children had trouble breathing inside the house because the dried dung and wood they formerly used as fuel produced a lot of smoke. The family also used the biogas fuel to power the lamps in the house. Another advantage she said was that the children could now study late into the night using the biogas lamp whereas the fuel they previously used would irritate their eyes and make reading difficult due to smoke. Her children who had previously hated cooking because of the discomfort caused by the

smoke emitted by using wood as fuel, have now gained independence and regularly use the biogas stove to cook for themselves whenever they want. She said that the HEW had taught her that in addition to all the advantages the biogas stove offered her family, it also reduced deforestation which is a major issue in places like Hawzen where vegetation coverage is already low. Professor Mengesha suggested that the excess biogas can be stored and sold to generate money for the family.

Other features of the model household included a water reservoir that collected water from land catchment and roof runoff. The owner of the house explained that water shortage used to be a major problem and it was difficult to maintain hygiene and sanitation but now with the water reservoir, the family has access to clean water all year round.

Once inside the house we saw that there were different living quarters for humans and animals, an architectural feature that does not exist in most traditional households as people and animals live under the same roof. Separating houses from barns minimizes the spread of disease. We noticed that all the beds in the household had mosquito nets hanging over them which contributes to a significant drop in malaria cases. Overall the house was kept very clean and organized. Next, we drove to the Health Post in Debre Hiwot.

Once we arrived at the Health Post in Debre Hiwot Kebele we saw that there was a circular piece of sheet metal with two hands like a clock face but instead of numbers it had different locations. We were told that this was used to indicate where the two HEWs assigned to the Health Post were at any given time so that patients could seek them out in an emergency. Once inside the Health Post we were introduced to the HEWs who showed us the different equipment and facilities available. Mounted on the wall was a map of the area served by the Health Post. The HEWs take turns visiting each area on the map to make sure everyone is well served. The Health Post was well-equipped with medical devices and pharmaceuticals to take care of the community's basic and essential health needs. The walls were covered with educational posters to teach community members but also to guide HEWs. On the walls were also shelves that contained patients' medical records in paper form and educational reading materials for patients and HEWs alike.

The HEWs then showed us hand drawn charts and graphs on flip chart paper documenting their reach within the community. After we had seen all the charts and graphs, Prof.

Mengesha suggested that the graphs and charts can give a more complete picture if percentages are used instead of absolute figures and if there are denominators and targets included. He also suggested including the size of the catchment area and the population served by the Health Post. Thus we completed our tour of the Health Post at Debre Hiwot Kebele and drove to the Health Center.

We arrived at the Health Center, located at Meghab and were promptly given the tour of the whole Health Center. Upon arrival we met the director of the Health Center, Ato Ayte Kalay who was also the director when Professor had visited the Health Center nearly a year ago. This was a positive informal indicator showing that employee turnover was somewhat low. We started the tour by visiting the Health Center compound. First we saw an incinerator for burning biological waste followed by a placental disposal pit. While both were kept in good condition, Prof. Mengesha suggested that the placenta pit can be improved by adding a weight-activated trapdoor lid to ensure hygiene. We also learned that in this area, unlike some other regions of Ethiopia, mothers choose to take stillborn children home with them so the placenta pit is used exclusively for placentae not still born fetuses. After the placenta disposal pit, we saw large reservoirs for water. The director, Ato Ayte told us that the area suffers from severe water shortage so they need to store water in these large vats. But despite the water shortage, diarrhea and maternal death are very low and getting lower every year. Walking around in the compound, we saw a tent that was a little removed from the rest of the facility. We were told that the tent served as a quarantine when there were cases like Acute Watery Diarrhea (AWD).

The Health Center is also active in community mobilization. For example, the Freweyni cluster in Meghab had been declared open defecation free (ODF) a few years ago but lost ODF status recently. The Health Center has plans underway to make transitions into ODF last once reached. The Women's Development Army (WDA) is very strong in Meghab and are helping to curb the problem of losing ODF status in kebeles that once attained it.

Once inside Ato Ayte Kalay's office, he showed us the many accolades and awards that the Health Center had received. This Health Center, he informed us, is ranked seventh in the Tigray Region in terms of overall quality of service. The Health Center's renown is such that visitors from different regions have come to learn about the exemplary data collection

methods. In addition, at the Federal level, the Health Center has been ranked very high for data collection quality.

Ato Ayte told us about the steps taken by the Health Center not only to treat patients but also to promote health in the community. One such initiative was the production and distribution of stone sinks. The sinks are made of stones that are readily available, easy to clean and very durable. Moreover the Health Center actively develops strategies to improve the entire health system of the area. Ato Ayte told us that if the health system as a whole is strengthened, it does not matter whether there is a change in leadership, the system will remain in good standing. One of the changes they have made recently to create a strong Health Center is the allocation of a car dedicated specifically to transporting medication. Previously, the ambulance was used to transport people, medication and anything else necessary. Another effort towards improving the Health Center is the cultivation of values like honesty and transparency. Ato Ayte told us that he had been notified that we would be visiting his Health Center just the previous day. Most other health centers would be inclined to hide the unpleasant aspects of the health center and only show the good work done, but at this Health Center, we were assured that what we were seeing was the real, unadulterated truth.

Walking around the Health Center, we met woman who had delivered their first few children at home before the Health Center was opened but once they delivered their first child at the Health Center, always came to the Health Center for prenatal care, delivery and postnatal care because they were so happy with the service they received there. We were able to see the entire Health Center and note that it was very well equipped and kept very tidy. This brought our visit of the Health Center to a close.

The last site to be visited for that day was a Primary Hospital in Hawzen. The Primary Hospital used to be a health center but has since been upgraded to a primary hospital. The Primary Hospital has been able to take some of the best practices it followed when it was a health center and apply it in the primary hospital. One of these practices is allowing pregnant mothers to have a coffee ceremony in the facility. Previously health facilities did not allow women admitted for delivery to have a coffee ceremony in the facility; the mothers saw the coffee ceremony as a relaxing social activity and would cite it as one of the reasons they chose to give birth at home surrounded by their loved ones. However once

the health center, now turned health post, started allowing the coffee ceremony, mothers were more willing to deliver inside the health facility. Like the Health Post and Health Center we had visited before it, we found the Primary Hospital to be well-equipped and hygienic.

We also had a chance to visit the reception desk and record room at the Primary Hospital. Here we noticed that the Hospital was still keeping paper records of all the clients but we were informed that there were plans underway to digitize all records.

Day 3

Meeting with Dr. Hagos Godefay Debebe, Bureau Head, Jan. 4, 2 pm

On the third day we were scheduled to meet Dr. Hagos Godefay Debebe, the Tigray Regional Health Office Head. Upon meeting him, Prof. Mengesha started by thanking Dr. Hagos for all the hospitality we received in our stay in Tigray. Prof. Mengesha introduced IlfPHC, the work that we do and then suggested Dr. Hagos speak to the Transformational Leadership Training trainees from Tigray to see firsthand the impact that our work has. Dr. Hagos was unaware of the Transformational Leadership Training until this point and voiced his opinion saying that the Regional Health Bureaus should be notified before any such trainings take place and that it is inappropriate for the Federal Ministry of Health to bypass the Regional Health Bureaus because of decentralization. Telling the Regional Health Bureau about the training would have also made it easier to follow up with the trainees. Dr. Hagos recommended that IlfPHC visit the newly built research center in Tigray and if possible, to train the newly hired staff in the future.

Prof. Mengesha commended Dr. Hagos for the impressive strides made by the Region in improving access to healthcare. Prof. Mengesha then shared his opinion about storing biogas and selling it later and presenting the data in the health post using percentages and Dr. Hagos accepted both recommendations.

Dr. Hagos emphasized that implementation is hard but the reality comes alive in health posts where one can see equity, intersectoral collaboration, prevention and promotion come into play. He said that it is imperative that an institute like IIfPHC see the reality on the ground because without that the trainings will be meaningless. He said that although it can be easier to deal with inequity on smaller scales such as at the health post level, inequity remains a major issue at the regional and national level where there is a lot more heterogeneity.

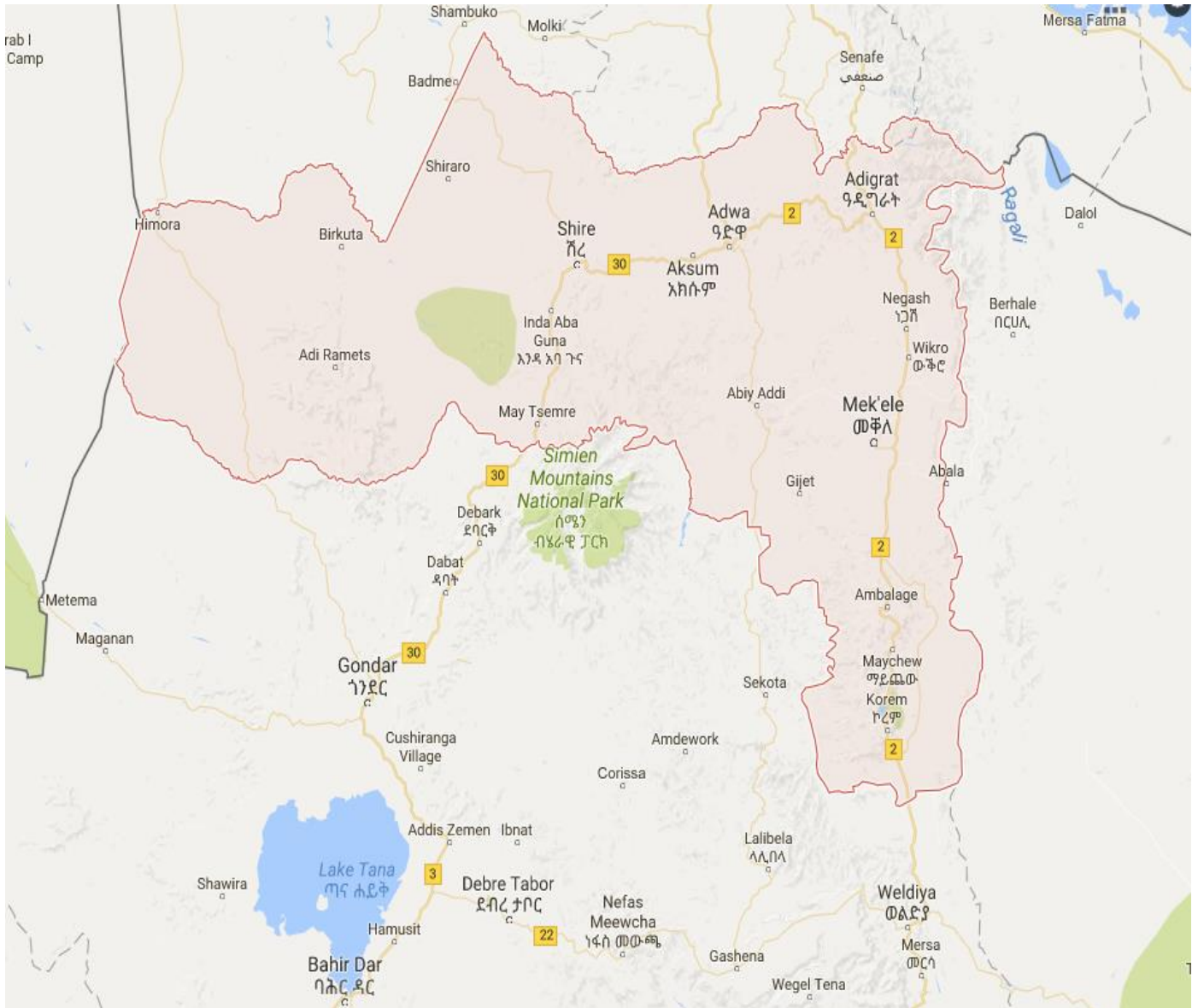
The positive results we see now have taken a lot of time and effort, he told us. Dr. Hagos remembers when the HEP was started and HEWs had vicious dogs released on them by the members of the households they visited. Some children threw rocks at them while community members asked “how do they think we lived before them?” all because they did not understand the value of the HEWs. But with the help of institutions like IIfPHC, the success of the HEP can be appreciated not just nationally but internationally.

We thanked Dr. Hagos for all the hospitality and warmth we were shown in Tigray adding that we were all immensely impressed with all the success they had amassed in such a short time. This brought the whole trip to a close.

Conclusion

After having visited the Health Extension Worker training college, model household, health post, health center and primary hospital in Tigray we walked away with a renewed sense of the immense advantages that primary health care can confer to a community. Based on weather, accessibility, quality of healthcare service and hospitality, we have chosen the sites visited in Tigray to be one of the places we take international trainees.

Map of Areas Visited



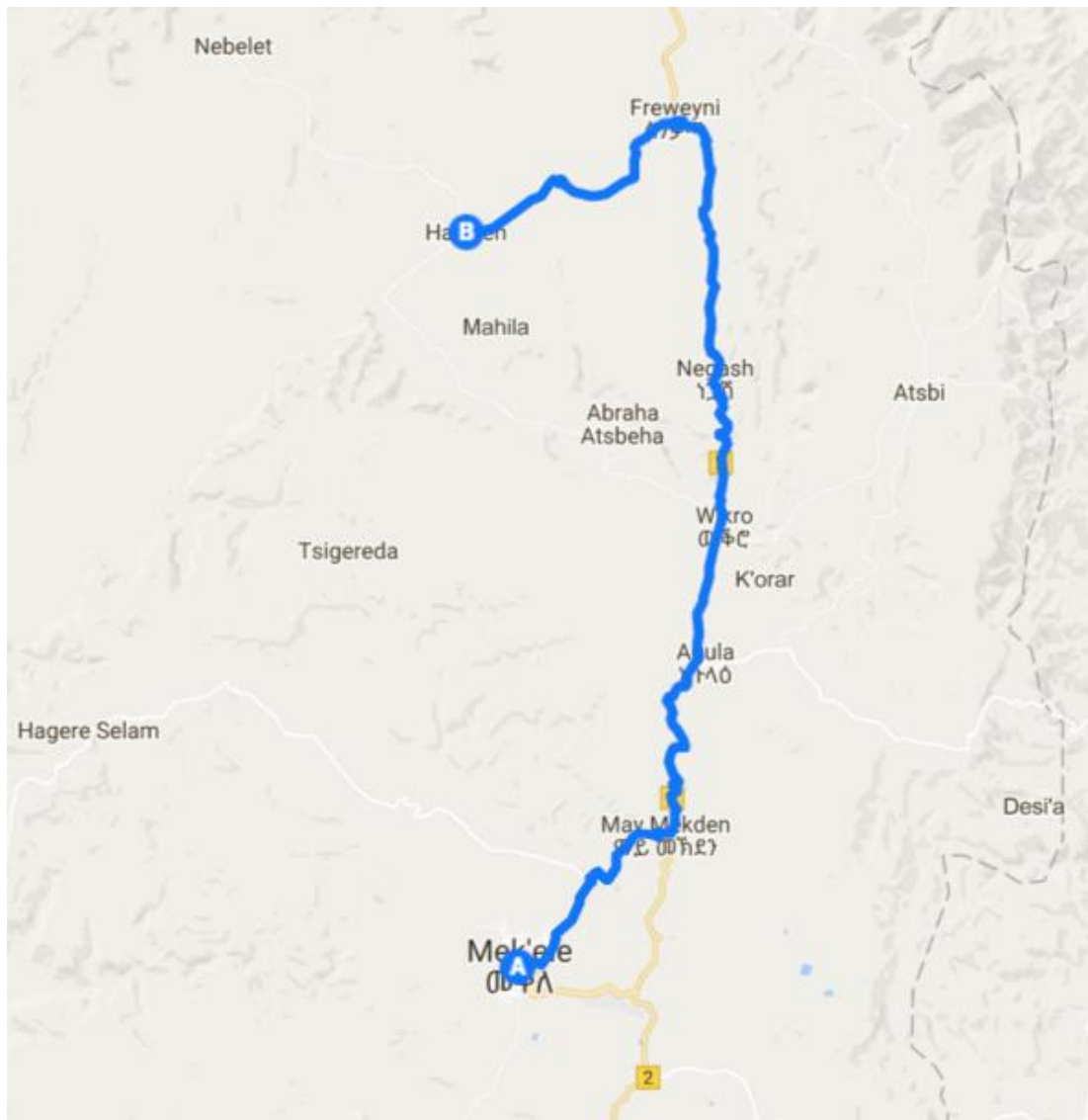
Map of the Tigray Regional State (area shaded in pink)



A Mek'ele, Tigray, Ethiopia

B Hawzen

Route from the capital, Mekelle to the PHCU site, Hawzen.



Zoomed in route from the capital, Mekelle to the PHCU site, Hawzen

Trip Itinerary

Day	Time	Activity
Monday, Jan. 2	9 am	Arrive at Mekelle Airport
	10:30 am – 12 pm	Meeting with Tigray RHB
	12:30 pm – 2 pm	Lunch
	2:30 pm – 3:30 pm	Visit HEWs Training Center (Health College)
	4 pm – 5 pm	Meet Transformational Leadership Training trainees
Tuesday, Jan. 3	9 am – 10:30 am	Household Visit
	11 am – 12 pm	Health Post Visit
	12:30 pm – 2 pm	Lunch
	2:30 pm – 3:30 pm	Health Center Visit
	4 pm – 5 pm	Primary Hospital Visit
Wednesday, Jan. 4	9 am – 12 pm	Debriefing with RHB and contact people
	2 pm	Departure to Addis Ababa