Brief Communication

Preliminary Assessment of the Implementation of the Health Services Extension Program: The case of Southern Ethiopia

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Abstract

The purpose of this study was to generate usable information on the implementation of the newly initiated Health Services Extension Program in Ethiopia. A cross-sectional study was conducted in seven administrative zones of SNNPR in February 2008. It was found out that average achievement of construction of health posts, certified role model households and deployment of health extension workers were 78%, 4.3% and 63%, respectively. Both achievements and challenges were observed in the implementation of the program. Since the program is at its stage of infancy, it needs due attention towards the endeavors of the program by all concerned bodies and partners striving to see improved health status of the population. [*Ethiop.J.Health Dev.* 2008;22(3):302-305]

Introduction

The health status of Ethiopia is poor compared to other low-income countries. It is estimated that more than 75% of the health problem in the country is largely attributed to preventable communicable diseases and under-nutrition. Data from Federal Ministry of Health (FMOH) show that acute upper respiratory infections and helminthes are among the top ten leading causes of out-patient visits in the country (1). The prevalence of these diseases is mainly due to poor socio-economic condition, low level of awareness about health and inadequate health service delivery across the country.

The current health policy of Ethiopia demands commitment from all concerned bodies and mainly focuses on prevention and promotion components of health care, and development of equitable and acceptable standard of health service to reach all segments of the population (2,3). The strategy of the policy, which was developed in 2004, adopted an integrated and innovative health service delivery at the grass root level through the implementation of the Health Service Extension Program (HSEP). Each rural kebele (the lowest administrative unit) is expected to have one Health Post (HP) staffed by two female Health extension Workers (HEWs). The primary aim of the HSEP approach is to bring health service delivery to the rural community at family level where 85% of the total population resides.

Accelerated expansion of primary health care service strategy has also been endorsed as part of facilitating the implementation of the HSEP with a major focus towards community level services. The major emphasis of HSEP is on prevention, promotion and minimum curative services. The main components of HSEP are disease prevention and control, hygiene and environmental sanitation, family health service, health education and communication (4,5).

Of the nine regional states and two city administrations of Ethiopia, Southern Notions and Nationalities People's Region (SNNPR) was purposively selected for the present study Administratively, SNNPR is subdivided into thirteen zones and among the zones of the region, seven administrative zones namely Guragie, Hadiya, Kembata-Tinbaro, Wolaiyta, Gamugofa, Sidama and South Omo plus Alaba and Konso special woredas were purposively selected for the present assessment. The assessment was carried out in February 2008 by an independent investigators working for the Ethiopian Health and Nutrition Research Institute.

Objective

The main objective was to generate useful information on the implementation of the newly initiated health service extension program in selected administrative zones of SNNPR.

Methods

Health impact evaluation survey was conducted across the country with a special focus to Ethiopia's national response to HIV/AIDS, Tuberculosis and Malaria. The present assessment is part of the health impact evaluation survey of global fund that was conducted in selected administrative zones of SNNPR. The investigators have used the opportunity and integrated this assessment work with health impact evaluation survey carried out in SNNPR.

The investigators of the survey developed both quantitative and qualitative methods of data collection tools. Thus, structured questionnaire was developed to collect information from zonal/woreda HSEP coordinators. The questionnaire was designed to collect general information, resource availability, program implementation, major constraints and success information of the program since its inception.

Discussions were also made with selected Health Extension Workers (HEWs) at Health Post (HP) level. Further discussions on the overall implementation of the program were made with selected community members and observations were made in some model households

(HHs). In selected model households, pieces of information on the three indicators; namely toilet construction and utilization, bed net condition and proper utilization, and vaccination of children were collected. Data collection, and observations were made by the investigators and descriptive statistics were employed for the analysis.

Results

Table 1 shows the number of rural kebles rainging from 134 in Kembata-timbaro to 527 in Sidama. Achievements of constructions of health posts, establishment of model households and deployment of HEWs are also shown by percentages. Heath post construction ranged from 39% in South Omo to 111% in Wolaiyta. Less percentage of health posts construction in South Omo zone appeared to be due to the mobile nature of the pastoral population. On the other hand, in Wolaita zone 111% health post construction was reported as a result of the populous nature of the zone that demanded more than one health post construction in some rural kebles plus early and dedicated implementation of the program.

In each rural kebele, there were one to two Health Extension Workers (HEWs) and it was identified that study zones have deployed and achieved on average 63% of HEWs so far. Most HEWs reside in kebeles where the health post is located. It was reported that almost all HEWs collected health & health related information from their kebeles and prioritized the implementation plan based on the information obtained from their respective communities.

The implementation of the health extension program has three components; namely provision of community based health package, capacity building of potential families to be role model households, and service delivery at the health post level. Health extension workers spend more than 70% of their time by making home-to-home visits and communicating health messages in their communities. Health Extension Workers provide family health services mainly antenatal care, immunization, distribution of bed net and anti malaria drugs at the health post level.

Table 1: **General information about the selected administrative zones, February 2008**

Zone	Total Woreda	Total Rural Kebele	Total HHs	Total HPs	Total HEWs	Total Model HHs
Gamo-gofa	15	466	328,666	371 (80%)	544 (58%)	11,543 (3.5%)
Guragie	15	420	340,000	370 (88%)	511 (61%)	16,000 (4,7%)
Hadiya	10	312	286,038	220 (71%)	366 (59%)	10,775 (3.8%)
Kenbata-timbaro	7	134	169,112	128 (96%)	158 (59%)	15,690 (9.3%)
Sidama	19	527	580,000	327 (62%)	1,054(100%)	12,790 (2.2%)
South-Omo	8	248	101,762	96 (39%)	243 (49%)	2,417 (2.4%)
Wolaiyta	12	281	354,796	313 (111%)	355 (57%)	14,000 (3.9%)

Discussions

One of the components of HSEP is building the capacity of potential families to be role model households. It was found out that due to the recent start of the program, of all households in the study zones, on average 4.3% were trained and certified as model households so far. Since strong efforts have been undertaken by HEWs to identify and train additional model households on a continuous basis, it is hoped that the capacity of more and more role model households (HHs) will built up soon.

In the health extension operation guidance, ther is a statement that describes woreda health office and health centers take the responsibility to offer supportive supervision for health posts. However, due to various reasons and especially staff shortage at woreda level, comprehensive and strong supervision was very limited. It was also found that there was variation in salary scale among HSEP coordinators in some woredas. The authors, therefore, would suggest assigning additional committed supervisor/s in each woreda, and maintaining equivalent salary scale for HEWs like that of Gurage Zone. Although there appear to the competing priorities of agenda at woreda level, the issue of health service extension program has to be given equal importance since the health of the community is the centerpiece of all development programs.

From the discussions carried out in the communities, it was observed that the communities have actually trusted the program and suggested an inclusion of basic curative services in the program. In the condition where HEWs are the only health care providers within the community, the preventive and curative dichotomy appears untenable.

The creation of effective and equitable health system is not an end by itself, but it is a basic requirement to achieve better health outcomes. Although the health extension program is a new initiative, since its inception it has brought positive achievements and has faced challenges as well.

Patients who visit health posts for curative aspects are expected to be referred to the near by health center. From the assessment result it appeared that, in most of the selected administrative zones, there was no strong referral system with follow-up mechanism between the health posts and health centers. Contact with nearest

Summary of the major achievements and challenges of HSEP in the study zones

Based on the compiled routine performance report, zonal HSEP coordinators have disclosed the following achievements and challenges

Achievements
➢ Increased bed net utilization that resulted in the decrease of malaria incidence.
➢ Increased family health services coverage especially vaccine coverage has shown dramatic change.
➢ Increased latrine construction and utilization.
➢ Disease outbreaks are immediately reported.
➢ Maintenance of updated vital statistics at the community level has been increased.
➢ Increased community awareness about their health.
Challenges
❖ Resource limitations, such as supervisors, medical equipment supplies of drugs for minimum curative services, budget, furniture and vehicle.
❖ Absence of well established referral system.
❖ Limited supportive supervision of HSEP at woreda level.
❖ Turn over of HEWs in some areas due to flawed recruitment of HEWs candidate from the very beginning.
❖ Absence of clear understanding among HEWs about their career issues.
❖ Unattractive salary scale for woreda HSEP coordinators.

health centers seems to be very weak (6). Thus, the possibility of establishing system of referral and follow-up mechanism between health posts and respective health centers has to be clearly worked out.

Health extension workers have the least access to relevant and updated information because they work in rural communities where there is a limited means of communications (7). In the present study, it was found out that in most administrative zones, in service training and refresher courses have been provided for selected HEWs. Some of the HEWs requested additional on-the-job trainings including orientations on how to operate refrigerator. It is the authors' hope that such request should be handled by the respective health center.

As most HEWs were very enthusiastic to discharge their duties and responsibilities, there were also few HEWs who were not fully committed to their daily activities. It was also observed that, few HEWs were promoted and transferred to woreda towns without making replacement. It is obvious that such kind of measures will weaken the program and it needs serious consideration.

Thus, the authors suggest establishment of reward mechanism as a means of encouragement and creation of health competitive environment within and among woredas. Further more, letting HEWs to have a clear understanding that they are government employees and of course will have a professional career like that of other civil servants would increase their commitment to serve their communities.

In conclusion, although the health service extension program is at its stage of infancy the activities that are being carried out are very encouraging. Like an infant needs special care, due attention has to be given by all concerned bodies and partners towards the endeavors of this integrated and innovative program. The authors would also like to recommend scaled up assessment to be carried out in SNNPR and other regions as well.

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