Review Article

The Health Extension Program: A flagship for bringing health services to the doors of communities

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Abstract

Recognizing the need for strengthening the health care delivery system in the country, and to bring services to the doors of communities, the Government of Ethiopia has launched the Health Extension Program (HEP). HEP is a new initiative developed as one of the components of the Health Sector Development Program (HSDP-II), which is an innovative community based health care delivery system. In order to address the acute shortage of human resources in the areas of health, and the prevailing constraints in the training of health professionals, HEP has also become a centerpiece for the "Accelerated expansion of primary health care coverage" program. Under HEP, in the coming two years, over 30,000 health extension workers (HEWs) will be trained and deployed for some 15,000 health posts, which includes the construction and/or upgrading of 3153 health centers. The main objective of HEP is to improve access and equity to preventive essential health interventions provided at village and household levels with focus on sustained preventive health actions and increased health awareness. It also serves as effective mechanism for shifting health care resources from being dominantly urban to the rural areas where the majority of the country's population resides. The Government has now trained and deployed close to 17,500 HEWs, and they were assigned to about 9000 health posts (villages), and this comprises over 60% of the planned 33,200 HEWs to have blanket coverage. HEP is considered as the most important institutional framework for achieving the Millennium Development Goals.

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Introduction

The health status of the people of Ethiopia is very low compared to other developing countries, which is compounded by high population growth, which is 2.7 million per annum (1). As the available health service was very limited and was organized mainly in urban areas, the majority of the rural population was not able to access modern health care services. This situation has led to ineffective health care delivery system, which cannot respond to the health needs of the population at large. Furthermore, the health service delivery system of the country operated for years in isolation without the involvement of other sectors such as education, agriculture, water, etc. which are relevant for development of health of the nation. This state of affairs had failed to meet the demands of most in need, as they were geographically or socially remote to benefit from such facilities.

In Ethiopia, it is estimated that 61 percent of households have access to an improved source of drinking water with access in urban areas much higher than in rural areas (94 percent and 56 percent, respectively). In urban areas, 90 percent of households have access to piped water compared to only 13 percent of rural households. On the other hand, the major source of improved drinking water in the rural areas, which is 39 percent, is protected spring (2). An estimated 75 percent of health problems of the country are due to infectious and communicable diseases, which could be easily prevented or controlled by applying simple sanitary measures. However, they still contribute to the high morbidity and mortality, especially among infants and children. Infant and under five mortality rates were recorded at 77 and 123 per 1000 live births, respectively (1), whereas, the maternal mortality ratio stood at 673 per 100,000 live births, which are still the highest among Sub-Saharan African countries (2).

In a similar manner, contributions from communities and their direct participation in health activities have been hampered for years. As a result, communities were not given opportunities to play an active role in deciding the type of activities they want, and get involved in the kind of actual

service they receive. In similar setting where communities take active participation to produce their health, results showed significant improvement in the health of the population.

Such a situation prompted the Ethiopian Government to seriously and critically re-evaluate and re-examine existing policies and strategies in order to address the huge service delivery gap prevailing in the country.

The objectives of this article therefore, are to describe the principles and strategies of the Health Extension Program (HEP), to make readily available information to key stakeholders and the reproductive health community on HEP, and finally to help promote HEP to attain its set targets in the long way for achieving the MDGs.

The Health Extension Program

In Ethiopia, there exists very high unmet need for health care in rural areas of the country where close to 85 percent of the population lives. The health sector delivery system of the country has been historically unable to respond to the health needs of the people. It was highly centralized, and relied on a fragmented vertical programs delivery system with little collaboration between the public and private sectors. In spite of the past efforts made and gains registered by the health sector, it is realized that essential health services have not reached the population at the grass root levels as stipulated in the health sector policy. This was confirmed by the evaluation results of Health Sector Development Program (HSDP I). The Government of Ethiopia therefore decided to introduce an innovative community based approach aimed at creating healthy environment as well as healthful living by introducing a HEP as a sub-component of the HSDPII (3).

General objective of HEP

It is to increase access and ensure equity to preventive essential health intervention through community based services with strong focus on sustained preventive health actions and increased general health alertness. This would enable to bring about behavioral changes to ensure that communities perceive and manage their own health and health

related activities to create healthy environment as well as healthful living.

Specific Objectives of HEP

Some of the specific objectives of the HEP include, 1) providing basic hygiene and sanitation education continuously to the community in order to identify the basic health problems and take action; 2) increase peoples' participation mainly on communicable diseases which need special attention such as malaria, HIV/AIDS, TB, etc.; 3) provide basic information to women/ nmothers, youth and children about family health programs specially on vaccination and family planning; 4) promote integrated child health to prevent diseases that can cause mortality, morbidity and disability among children; 5) provide first aid service for accidents until the victim reaches the nearest health facility; and 6) increase awareness among younger members of the population about reproductive health, STDs, HIV/AIDS, abortions, unwanted pregnancies, harmful traditional practices.

Essential Elements of HEP

First of all such initiatives require strong and sustained political will and commitment by the government to improve preventive health and socio-economic condition of the population. This requirement is fulfilled by the prevailing policy environment and support being providing for this initiative. This indeed has helped in the development of a nationwide accessible, preventive, promotive and curative health services in the country. In a short period of time, it has been possible to avail provision of a system in which HEP is an integral part of overall development of the community.

HEP still requires support from and interaction with other sectors participating in health development. There is an obvious linkage between health and agriculture, health and education, health and water supply, etc., which are mutually supportive at all levels. There is also a place for key partners in development to strengthen government efforts in close collaboration and partnership. In order to maximize the impact of this initiative, utilization of

relevant and appropriate technologies that are acceptable, cost effective and affordable are desirable. Furthermore, the main trust of the HEP is to involve individuals, families and communities for their support and active participation, which is crucial for the effective implementation of the program.

It is therefore imperative that HEP should be shaped around the life pattern of the people it is serving, and should be able to meet their needs. Moreover, activities should be fully integrated with that of other sectors involved in community development activities. The people in the community should be the driving force in the formation and implementation of preventive health care activities so that the health care can be brought in line with the local needs and priorities relying on utilization of available community resources.

Within the HEP strategy the essential minimum health care program which should be made accessible to all has been identified as “Health Extension Packages”. HEP is introduced as one of the key components of in HSDPII. The core of HEP is to identify and provide a list of essential health services to households at the kebele level, and these essential packages include the following components:

Disease Prevention and Control: HIV/AIDS and other STIs, TB, Malaria prevention and control as well as first aid emergency measures. The main objectives of this component program are to reduce morbidity, disability and mortality.

Family Health Service: Maternal and child health, Family Planning, Immunization, Adolescent reproductive health, and nutrition. The main objectives of the above component program are to strengthen and gradually expand family planning, maternal and child health care, and youth and nutrition services.

Hygiene and Environmental Sanitation: Excreta disposal, Solid and liquid waste disposal, Water supply and safety measures, Food hygiene and safety measures, Healthy home environment, Control of insects and rodents, and Personal hygiene. The main objectives of the above component program are to increase coverage of hygiene and environmental health services to the population at large.

Health Education and Communication: The main objective of this component program is to increase community awareness in health through the involvement of communities and provision of continued health education to bring about positive changes in the knowledge, attitude and behavior.

Implementation Modalities of HEP

The main objective of HEP is to improve equitable access to preventive essential health intervention through community/kebele based health services with strong focus on sustained preventive health actions and increased health awareness. This service is being provided as a package focusing on preventive health measures targeting households particularly women/mothers at the kebele level. Cognizant of the fact that HEP implementation throughout the country should be consistent; the Federal Ministry of Health has developed an implementation guideline (5). The guideline is the best tool for the regional health bureaus, woreda health offices, and the health posts (HEWs) to implement community based household focused health care services.

Human Resources

First and for most, trained manpower is one of the prerequisites for a successful program. Therefore, appropriately trained Health Extension Workers (HEWs) is mandatory. Unlike the previous community health agents CHAs), traditional birth attendants (TBAs), and even community based reproductive health agents (CBRHAs), the introduction of the HEWs as community health providers is a paradigm shift, and makes it an innovative approach. Firstly, these categories of personnel are salaried, although voluntarism is still an important factor in community development. Secondly, HEWs are 10th grade complete who received one year training.

Furthermore, subsequent refresher trainings are also provided to HEWs on different RH issues including family planning, VCT promotion, etc. to improve their capacity to handle common community health problems. It involves the use of female HEWs to deliver 16 packages in four main areas such as hygiene and environmental

sanitation, disease prevention and control, family health services and health education and communication on an outreach basis. This program has been piloted over the past three years with early success, and is now being rolled out nationwide. Although conducting normal deliveries is considered one of the responsibilities of the HEWs, their midwifery skills has not been built very well during the one year training. Therefore, the Ministry of Health has a plan to conduct additional midwifery training to fill the knowledge and skills gap that is prevailing among HEWs.

The Kebele Council in collaboration with Woreda Council will recruit these female HEWs who meet the recruitment criteria set by the Ministry of Education. This is followed by one year training in vocational and technical schools (TVTS), and after graduation 2 HEWs per kebele (5000 population) are employed by the Woreda Health Office. Registration and Panel of Assessors procedures after the deployment of these HEWs to each health post. The previous frontline volunteer workers (CHAs, TBAs, etc.) will be incorporated into the system under the guidance and supervision of the HEWs.

In addition, a program to ensure the quality of and demand for clinical care particularly treatment of diarrhea, malaria in children, assisted delivery, early referral for mothers and children with danger signs particularly at the health posts will be strengthened. At the same time, HIV testing and counseling as well as prevention of mother to child transmission services in existing health centers will be made available (4).

Infrastructure

Initially, fourteen technical and vocational training centers were designated to receive the first batch of HEWs as trainees for this program. The Technical and Vocational Training Commission in collaboration with the Regional Health and Education Bureaus were responsible for initiating this program.

The Technical and Vocational Training Schools (TVTS) in seven regions of the country that served as sites for training for the first batch of HEWs were: Tigray (Axum and Mekele), Amhara (Dessie and Debremarkos), Oromia (Goba,

Shashemene, Assela, Metu, Fitche), SNNRP (Dilla, and Butagira), Harari (Harar Medhane Alem), Benshangul Gumuz (Assosa), and Dire Dawa (Dire Dawa TVTS).
Construction and equipping of health posts one per kebele has been successfully carried out, and currently we have 7,161 health posts, and 620 health centers built all over the country.

For the successful implementation of HEP, the Accelerated Expansion of Primary Health Care Coverage activities have been scaled up as an essential framework to reach blanket coverage for almost all the population by 2008. In this regard, new health posts will be constructed and equipped in order to support the provision of preventive and promotive health services to rural populations through HEP.

Training

The Health Extension Package training curriculum was developed by the Ministry of Health in close collaboration with the Ministry of Education. The curricula produced were distributed to 14 TVTS selected to train HEWs. Sixteen different Health Extension Packages were developed in English and Amharic. The first teachers for HEWs (Eighty four public health nurses, sanitarians and health officers) were nominated and received training for one month in training methodology in Addis Ababa. Two thousand eight hundred female students who completed grade ten, from six regional states were enrolled into 14 TVTS in January 2004 for one year training. At present, there are 40 TVTS in all regions of the country. The RHBs facilitated the teaching and learning process by providing logistics and appropriate teaching aids. HEP implementation guideline has been prepared by the HEP Coordinating Office and distributed to RHBs, different departments of the Ministry of Health, donor agencies, and non-governmental organizations. The total number of HEWs trained by 2005/6 was 8,901 (1), and at present this figure has reached 17,500.

Monitoring and Evaluation

Monitoring and evaluation are integral and important part of HEP, and contains both technical and managerial functions and purposes. To carry out monitoring and evaluation activities, the critical issues are setting goals, clear objectives, targets, inputs, outputs, indicators, program activities and management support and resources as well as good information network system.

It is a process of regularly reviewing achievements and progress towards the goal. In this context monitoring is the process of measuring, coordinating, collecting, processing, and communicating on the implementation of the planned HEP. It also involves the use of resource to the management and decision- making by stakeholders (5).Monitoring and evaluation are needed at federal, regional, woreda and health post levels based on the HSDP governance.

There is also a need for effective and efficient management of the program at all levels. At the Federal level, there is HEP Coordinating office, and regional health bureaus have similar offices. More importantly, there is a good monitoring and evaluation mechanism to follow closely the progress of implementation using sensitive indicators including base line surveys. It is also important to continue strengthening effective support mechanisms among the different levels of health care, which includes supervision, refresher training and the referral system.

More importantly, in the long term, the Ministry of Health would like to have the whole program to be integrated with evidence based planning and implementation, and create a strong monitoring and evaluation system with an electronic database system at the central level, as well as regional levels for the follow up of the HEP.

Conclusion

The Government will continue the emphasis of the last six years under the HSDP I and II, and now extending into HSDP III, and this health strategy has targeted the most common poverty-related diseases such as malaria, TB, childhood diseases, HIV/AIDS, and

measures to improve the health of mothers and children. Efforts will be concentrated on rural areas and on extending services outwards from static facilities to reach villages and households. In addition, and most importantly, gender will be mainstreamed at all levels of the health system.

The launching of HEP is one of the landmarks in the history of health service delivery system in the country that shifted services more to address the health needs of rural people who make up of 85 percent of the population. In other words, the HEP for the first time in the history of the country has moved services out from facilities to the household and village level.

So far over 17,500 female HEWs were trained and deployed to deliver basic sanitation, immunization, and other health services. The plan is to achieve blanket coverage in two year's time when 33,200 HEWs are deployed in 10,000 rural and 5,000 urban kebeles all over the country. There is already an increase in health budget from 12 Birr per person in 2001/2 to about Birr 19 per person in 2005, and mobilized additional foreign aid for health programs. Over 1900 new health posts and health centers were built increasing the share of the population living within 10 km. of a health post from 51 percent to 64 percent (6).

The Government's plan under PASDEP includes accelerated expansion to make sure all rural people have access to basic health care by 2010. The two major challenges are training and retaining enough health workers and ensuring there are enough resources and management capacity for recurrent operations and an adequate flow of drugs and supplies. Major efforts will include making available the necessary drugs and supplies, improving training, deployment, and retention of staff, and strengthening drug management.

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