Improving Health Extension Program in Ethiopia

Policy Dialogue

This report was prepared by Technology Transfer and Research Translation Directorate, at the Ethiopian Public Health Institute

This policy dialogue was informed by the following policy brief: Improving Health Extension Program in Ethiopia.
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Key messages

The following statements represent views, opinions and insights of individual participants in the policy dialogue.

The Problem

- Lack of coordination between the health extension program and other sectors such as agriculture, water and sanitation and education programs poses problems to the health extension program.
- Poor supplies management system should be mentioned as it is one important factor.
- In addition to their formal of the health extension program, usually one of the health extension worker is member of the community (kebele) administrative cabinet; burdening her with more duties and responsibilities negatively affecting the health extension program.
- The program gives more attention to preventive services at the expense of curative services needed by the community.
- The problem in relation to the design of the health extension program should be elaborated more. For example, Absence of pastoral health extension program strategic plan can be mentioned here.

Policy options

- The policy option entitled ‘designing tailored intervention strategies’ need more elaborations because it is a core option to solve the major problem of the program.
- Additional human resource for the health extension program in order to reduce the burden of health extension workers should be considered as one possible option to improve the program.
- The issue of providing curative services to the community by the health extension workers is one possible solution to improve the community uptake of the program.
- The supply chain management systems as well as the career development of the health extension workers are issues which should have been considered to improve the program.

Implementation Considerations

- Before considering implementing the pay for performance option feasibility further study is needed because of its potential adverse effects on the health extension program.
- Implementation of tailored intervention strategies needs the establishment of working group at national level.
- Health center staffs supervising the health extension workers lack deep knowledge and skill of the health extension packages so training supervisors on basics of supervision and health extension package is very important.
The views, opinions and insights in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue. These opinions may or may not be consistent with or supported by the policy brief that informed this dialogue or other evidence. It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated. Nor should it be assumed that they represent the views of the authors of this report.

The problem

Some documents the policy brief used as reference materials seems out dated, for example, the guide line which states health extension workers should spend 75% of their time in the community is changed to 50%. The 96 hours model family training hour is also changed to 60 hours. Health extension guide line is also revised recently. In this guide line the supervisory role of district health offices is shifted to health center staffs.

Some participants’ said lack of coordination between the health extension program and other sectors such as agriculture, water and sanitation and education programs poses problems to the health extension program. For example in a situation where there is a shortage of clean water and absence of proper waste disposal implementation of the health extension program is difficult and impossible.

Poor supplies management system should have been mentioned as it is one important factor for low performance as suggested by participants. Pertaining to quality of health extension service provision house hold training some participants said; households are reported as 'models households' without fulfilling the requirements to be one. The principle that health extension workers are supposed to be recruited from their home communities is not applied in some cases. As a result health extension workers do not stay long in the area of their deployment.

The reason for the poor community uptake of health extension program is that the program gives more attention to preventive services at the expense of curative services needed by the community. Communities value more curative services. Within the sixteen packages of the health extension program the service delivery components are very few. And sometimes the health extension workers' dress code may not be in agreement with the local community's tradition and may result in poor acceptability of the health extension worker in the community.
In relation to dissatisfaction of health extension workers the policy brief should have mentioned a study by the USAID which reported that there is 10% attrition rate of urban health extension workers. All urban health extension workers have taken competency assessment on clinical nursing which deals with hospital based care, their interest is to work in the clinical area rather than on the preventive activities. This could be one reason for the high attrition in Urban Health Extension Program. Generally there is no competency assessment designed based the role health extension workers; this affects the career development of urban health extension workers.

The problem in relation to the design of the health extension program should be elaborated more. For example, absence of pastoral health extension program strategic plan can be mentioned here. Burdening the health extension workers with more duties and responsibilities negatively affect the health extension program. In addition to their formal of the health extension program, usually one of the health extension worker is member of the community (kebele) administrative cabinet.

This policy brief gives more information on rural health extension program than the other two programs (urban and pastoral health extension program), so it is better to give further information on the urban and pastoral health extension programs too.

Policy options

Before directly going to the policy options mentioned in the policy brief, the brief should have elaborated the current policies on the health extension program in the country first and should have clearly pointed out what the new options the policy brief is trying to introduce. Among the five policy options mentioned in the brief three of them are already what the government is going through in one or the other way. For example, integrated refresher training for health extension workers, supportive supervision and community mobilization through health development army are already what the ministry doing.

The policy option entitled ‘designing tailored intervention strategies’ need more elaborations because it is a core option to solve the major problem of the program. Additional human resource for the health extension program in order to reduce the burden of health extension workers is one possible option to improve the program. The issue of providing curative services to the community by the health extension workers is one possible solution to improve the community uptake of the program. The supply chain management systems as well as the career development of the health extension workers are issues which should be considered to improve the program. Instead of the option ‘pay for performance’ other incentive mechanisms should be considered.
It is better if the term ‘continuing educational meeting and workshop’ is changed to just only ‘continuing education’ because people are exhausted with meetings and workshops. The integrated refresher training delivered to health extension workers is not need based; all the sixteen health extension program components are given to them regardless of their skill gap. In some localities the training manual is still not translated to local languages. These problems should be addressed.

### Implementation considerations

Implementation of tailored intervention strategies needs the establishment of working group at national level.

Absence of community mobilization guideline is mentioned as a barrier in this document but there is a national guideline for health development army mobilization which is equivalent to community mobilization. Rather what lacks is a community mobilization guideline for pastoralist communities which have different contexts compared to other communities, agrarian or urban.

Health center staffs supervising the health extension workers lack deep knowledge and skill of the health extension packages; even the health extension program focal persons at different level lack knowledge and skill of health extension components. In addition supervisors may also lack commitment since supervising health extension workers is considered as their major activity without additional payment. On the other hand health extension workers performance assessment is undertaken by kebele cabinet whereas the technical support is given by health center. This double chain of command may affect the communication between HEWs and supervisors. Shortage of transportation for supervisory activity is also a challenge for supervision. All these may affect the quality of supportive supervision expected to be delivered to health extension workers.

Health extension workers should be evaluated and evaluations should be connected to career development to increase their efficiency.

Because of its potential adverse effects on the health extension program, the pay for performance option needs feasibility study and monitoring and evaluation.

Before considering implementing the options, randomized controlled trials should be carried out in the country.
Appendix 1: Agenda

Policy Dialogue on Improving Health Extension Program in Ethiopia

Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems Project
(Adama, 06 June 2014)

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<tr>
<th>Time</th>
<th>Activity</th>
<th>Responsible Person</th>
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<tr>
<td>8:00-9:00AM</td>
<td>Registration</td>
<td>Wude and Ahmed</td>
</tr>
<tr>
<td>9:00-9:15 AM</td>
<td>Objective of the policy dialogue &amp; Overview of TTRTD</td>
<td>Dr. Mamuye Hadis</td>
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<tr>
<td>9:15-10:00AM</td>
<td>Going through the executive summary of the policy brief</td>
<td>Prof. Abebe G/M (Moderator)</td>
</tr>
<tr>
<td>10:00-10:10AM</td>
<td>Procedure and rules of the dialogue</td>
<td>Moderator</td>
</tr>
<tr>
<td>10:10-10:30AM</td>
<td>Tea/Coffee break</td>
<td></td>
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<tr>
<td>10:30-11:30AM</td>
<td>Problem section of the policy brief</td>
<td>Moderator</td>
</tr>
<tr>
<td>11:30-12:30PM</td>
<td>Policy options section of the policy brief</td>
<td>Moderator</td>
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<tr>
<td>12:30-2:00PM</td>
<td>Lunch Break</td>
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<td>2:00-3:00PM</td>
<td>Implementation considerations part of the policy brief</td>
<td>Moderator</td>
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<tr>
<td>3:00-3:15PM</td>
<td>Way forward</td>
<td>Moderator</td>
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<tr>
<td>3:15-3:30</td>
<td>closing remarks</td>
<td>Dr. Yibeltal A.</td>
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<tr>
<td>3:30-4:00PM</td>
<td>Tea/Coffee break</td>
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Competing interests
None
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