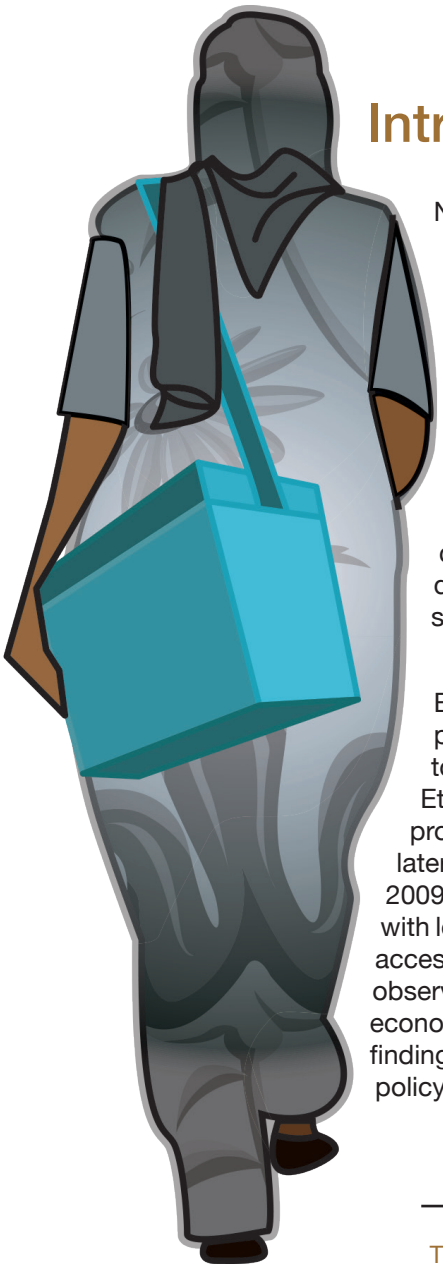
POLICY BRIEF 3

Addressing Health Equity through Health Extension program



Introduction

Nations health system are expected to be responsive to the diverse needs of communities and be inclusive of all stakeholders and equitable to various segments of the population. Planned health services should address needs of various population categories and distributed fairly without some variations of population characteristics.

In the past one and half decades' significant gain had been observed in the health outcomes of Ethiopians and the HEP has contributed to these changes. However, due to the everchanging communities demand, lack of comprehensiveness of available services and variations in distribution of services; Ethiopia is unable to meet the target set to the universal health coverage.

Equity has been one of the pillars of international and national policy goals in Ethiopia. The HEP has been primarily designed to address the health demands of grassroot communities in Ethiopia in an equitable manner. Initially the health extension program has been designed for agrarian settings in 2003 and later expanded to pastoralist (in 2006) and urban settings (in 2009). However, everchanging communities' demands combined with low intensity of implementation and variation in the coverage, access and utilization are the main gaps of HEP. The variations are observed across communities' livelihood, geography and socio-economic status. This policy brief summarized key equity-related findings from the national HEP assessment and outline important policy recommendations.

Methodology

National HEP assessment was conducted in 352 kebeles across nine regions of Ethiopia. In this study, a total of 6504 HHs had been participated and HP assessment was conducted in all HPs located in the study kebeles. An analysis was undertaken to understand variations in access and exposure to HEP by the communities by stratifying with different factors including region, livelihood (agrarian versus pastoralist), residency (urban versus rural) and income. This policy brief presented the findings on service availability and exposure by the communities disaggregated by different dimensions. It also highlights the diversification of HEP in terms of HR mix and service components. The implications and policy recommendations were also presented.

Key Findings

Overall, HEP was universally available to Ethiopians. However, there were gaps in the comprehensiveness and inclusiveness of services and wide-range of variations in the coverage, access and utilization of services. Men and youths are in general marginalized from HEP services. HEP is currently playing a very limited role in the prevention and control of NCDs and in addressing the mental health needs of community members. Low intensity of HEP implementation in pastoralist settings than agrarian settings was observed. Households in agrarian settings had a better exposure or contact to HEP/HEWs than those in pastoralist areas.

The assessment found variations in exposure to HEP/HEWs with a higher exposure was among adult women, adult men and children. Adolescents and youth boys were the least targeted household members. Progress toward full implementation of the HEP at the household level was found to increase with higher educational status and wealth quintiles.

The utilization of HEP packages of services was higher among households in agrarian settings and households with better socio-economic status (that is better income and educational status). Women in agrarian settings and from a richer household's better practices appropriate handwashing at critical times compared to those in pastoralist settings and from poorer family. The utilization of key reproductive, maternal, newborn and child health services was higher among women from agrarian areas than pastoralist settings. The use of this services also vary with socio-economic status; with a higher utilization among educated and richer women.

Policy Recommendations

Contextualization: A contextualized HEP service delivery modality need to be used for agrarian and pastoralist settings of the country. A standard should be developed that guide HEP implementation in different contexts. Different categories of health posts should be created to be efficient and address the community demands. The suggested categories can be a comprehensive HP (for HPs with communities far from the cluster HCs), HPs with basic packages of services and HPs merged to HCs.

Human Resource Mix: Human Resource (HR) mix of the health posts should be updated based on the changes made on the HP categories to meet the raising demands of the community. Suggested HR mix can be Level IV HEWs, health officers, nurses/midwifes and Environmental health professionals by considering both sex (male and female) and the variations in different contexts.

Outreach services: Outreach services should be focused and used in a way that men, adolescents and youths can be effectively targeted. For instance: schools, market places, periodic community gatherings, religious institutions and community-based organizations can be used depending on the local context. Schools are a good platform to address the health needs of adolescents and youths. Hence, HEP packages of services should be tailored to school health

services. Innovative approaches including eHealth and mHealth should be adapted to different contexts and used to deliver HEP services to youth and adolescents.

Youth friendly services: Beyond health centers, Health posts should have a separate room to deliver a youth friendly service. This can be primarily considered at comprehensive Health Posts as a pilot and expanded to other HPs based on evidence of pilot testing.

Capacity building: The health workers at Health Posts should be equipped with adequate knowledge and skills to deliver health services in all modalities (home-based, outreach-based and HP-based health services.

Adaptation of models: Behavior change models should be adapted and used for HEP package of services. The behavior change strategies should be adapted to behavioral outcomes and different contexts.

In summary, to address diversified needs and inequitable distributions of services, the following actions requires attention:

1) The health posts HR mix in terms of sex and professional category/skillset should be updated;
2) The current HPs structure should be revised, and another category need to be introduced depending on the location of catchment population to HPs and HC;
3) HEP packages of services and service delivery modalities should be tailored to various needs and contexts;
4) HEP should use various platforms (such as schools) to effectively target adolescents and youths; and
5) Use of innovative approaches such as m-health and e-health should be enhanced to deliver services to adolescents and youths