POLICY BRIEF 7

Enhancing HEP Implementation: where to focus?

Introduction

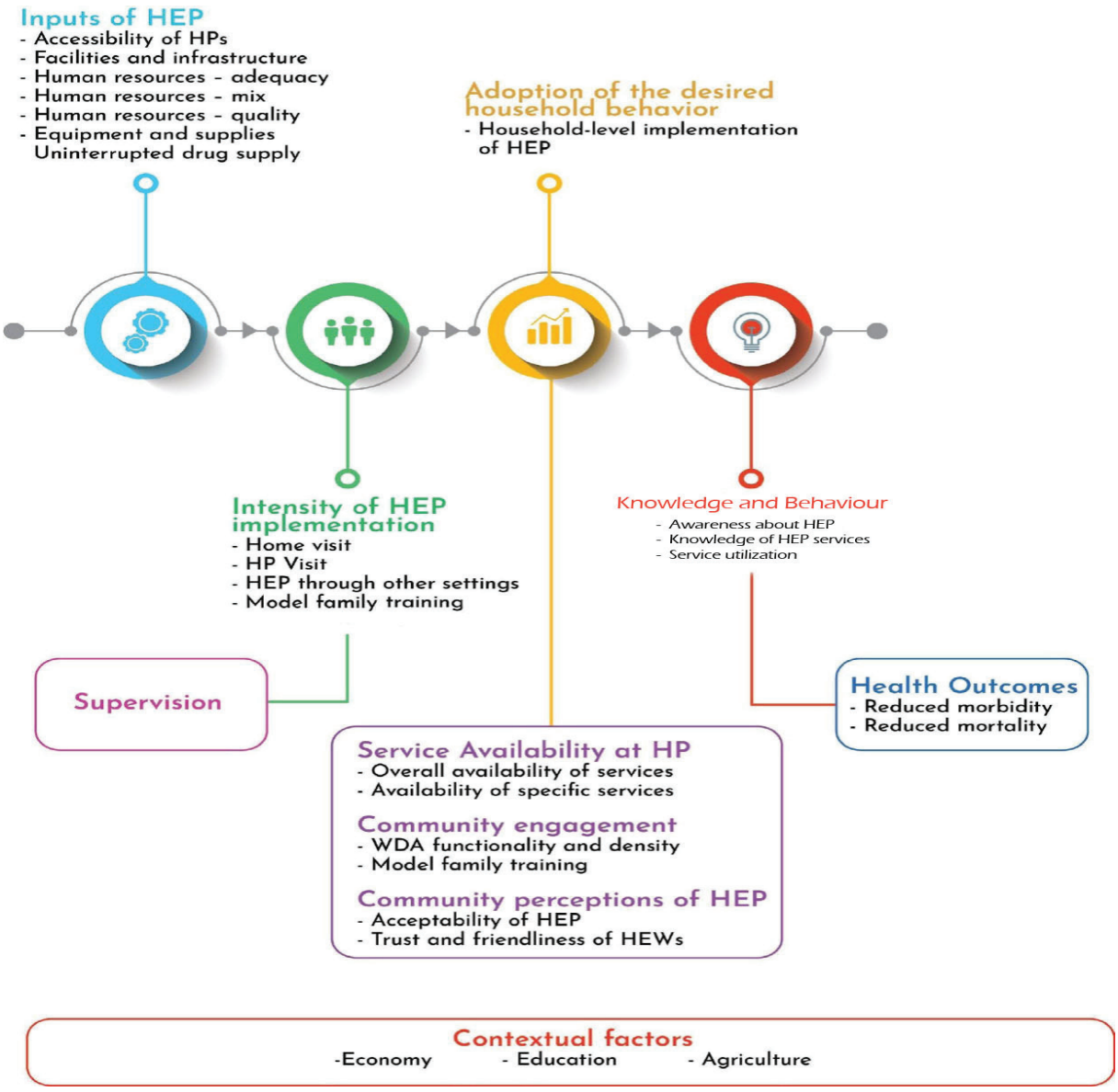
The Ethiopian Health Extension Program (HEP) is a platform of the health service delivery which is designed to access essential health services to the community. In order for the program result the expected health outcomes, the interaction of multiple health system and context level factors should be as expected.

In this policy brief, we review the findings of the National Assessment of the HEP to identify the most important components of the program that need attention during implementation (at all levels). The progress of the Kebeles towards full implementation of the HEP was considered as an outcome of the implementation.

Methodology

The key findings and recommendations are extracted from the National Assessment of the Ethiopian Health Extension Program. In the assessment, data was collected from 62 Woredas selected from all regions. Data was collected from 343 health posts, 584 HEWs and 12,868 respondents in 6430 households. The study was guided by Primary Health Care Performance Initiative (PHCPI) framework.

The Theory of Change of the HEP



Key Findings

After more than 15 years of implementing HEP, the progress towards full Implementation of HEP is sub-optimal. More specifically, the national assessment of the HEP showed that:

- The Household-level implementation of HEP showed that, on average, the level of adoption of the HEP at the household level was 40.9-50.8% (across a strong and less stringent criteria). By the same measure, households of WDA leaders were in general better at implementing the HEP; their progress, however, was much lower than was expected from a group of women selected as models and community mobilizers.
- The professional mix and level of education (availability of at least 1 midwife or nurse and of at least 1 level IV HEW), rather than the number of HEWs in an HP, are associated with better implementation of the HEP through home and HP visits.
- The progress in the household-level implementation of the HEP was significantly associated with home visits in agrarian settings and HP visits in pastoralist settings. A 10% increase in the proportion of households reached through home visits was associated with a 19% increase in household progress toward full implementation of the HEP at the household level. Similarly, a 10% increase in the proportion of pastoralist households who had interactions with HEWs through HP visits was associated with a 16% increase in household progress toward full implementation of the HEP at the household level. Only 16% and 19% of the household level adoption of desired household behavior was explained by HEP-related factors. This indicates that there are other contextual and system level factors that determine household-level adoption of desired health behaviors.

In addition to the factors described above, , the assessment empirically showed the status of the determining factors for HEP implementation.

The summary of the status of these factors, as per the theory of change, is presented as follows.

Availability and Adequacy of inputs for HEP:

- HEWS: there were 39,878 HEWs in 17,587 health posts, 87% of the HPs fulfill the minimum requirement (2 HEW/HP). This number is inadequate in relation to the increasing volume of work. There are wide gaps in knowledge and skills of HEWs which are related to the poor recruitment criteria, low motivation, limited capacity of the training institutions, limited capacity building opportunities, etc. There is high (32%) level of intention to leave among HEWs.
- Health posts: On average, a HP is serving 6057 (in agrarian) and 2919 (in pastoralist) people. About 87% of the HPs are standalone, while others are shared with other sectors. Among these HPs, 87% fulfilled the minimum standard for HP infrastructure. The HPs are in short of required facilities such as placenta pit (7%) and incinerator (12%).
- Tracer medical equipment and drugs: In general, more than half of the HPs do not have BP apparatus, delivery table and set, examination table, cold box, sterilizer, stretcher, refrigerator, dressing set and artificial light source. HPs in pastoralist communities have lower availability of all basic equipment than HPs in agrarian communities
- Tracer drugs: Stockout of drugs for long periods of time is common.
- Other infrastructure and amenities: only 59% of HPs have all whether roads. In most of the Kebeles (89%), HEWs provide outreach services by walking. Only fewer of HPs have electricity (26.5%), improved water (27.1%), and communication equipment (5.7%).

Availability of and access to Services:

- HPs are almost universally available (in 97.4% of the Kebeles). In these HPs, most of the basic services are reported available characterized by lack in comprehensiveness and interruptions.
- The average service availability score, calculated as the proportion of specific components of a service or package that were reported as available, was low for most of the packages (43.6 – 90.2%, mean: 68.1%).
- Even though awareness of the community about specific HEP services was higher (18.5-88.3%), the familiarity to these services was low (2.1-49.2%).

Program management:

- The packages have been adapted to the needs of the community, regardless to the fact that the expansions haven't received adequate guidance.
- At the lower level of the health system (Woreda Health Office to HP; Health Center to HP), supportive supervisions are usually conducted (77.8%). Only 1 in 5 (22%) HPs, however, were being supervised on a monthly basis by HCs (even though the guideline recommends the visit to happen weekly). Monthly supervision by the Woreda health office appears negligible.

Intensity of HEP Implementation:

- Overall, 61.8% of households were exposed to the HEP through at least 1 of their members. This rate ranged from 62.7% in agrarian settings to 27.1% in pastoralist settings. All respondents within 26.8% of the household were exposed to the HEP. The service delivery approach is shifting from community-based towards the facility-based. Among the HEP service delivery modalities, 55.1% of households had ever received home visits by HEWs. In these visits, adult women were the highest and adolescent and youth boys were the least targeted household members. Ever having visited an HP was reported by 58.3% of women, 23.9% of men, and 14.9% of youth girls.

Community perception towards the program:

- The program received acceptance by majority (70%) of the community, demanding additions of services (more curative services: treatment for adult and children & delivery service).
- The community accepted HEWs for being female (88%), recommending gender mix for effective service delivery.
- Households commonly bypass health posts while they seek treatment for common illnesses.

Community engagement:

- Only 14.9% of women in agrarian settings and 8.0% of women in pastoralist settings reported being aware of Model Family Training (MFT). Enrolment and graduation rates were very small, with only 2.9% of agrarian and 2.1% of pastoralist households reporting having ever been enrolled in MFT. Awareness about, enrollment in and graduation from MFT showed an increasing contribution to better household level adoption of health behaviors.
- Even though community structures are widely available (1:5 networks and WDA in 98.9% and 96.1% of Kebeles, respectively) in all regions, they have limited functionality (in 21.5% of Kebeles).
- WDA leaders are more likely to have better health behaviors, higher educational status (attendance in formal education: 40.1% vs 28%), and higher socio-economic status (Above middle wealth quintile: 57.9% Vs 42%) compared with women in the general population. There remain, however, large gaps in the health behavior of WDA leaders, given the model role they are expected to play.

Recommendations

1. Ensure the availability, adequacy and efficiency of inputs

Human Resource

Expand workforce at health posts by number and professional mix to ensure that HEWs have adequate time for home visits and outreach sessions while maintaining full time operation of health posts. In addition, include male health workers in the cadre of HEWs. Moreover, one of the essential steps include arranging flexible but regulated working days and working hours to allow HEWs to plan and reach target populations including women, men, and youth in different public gatherings such as market days, religious gatherings, and other social events.

The capacity of health work force at the health post can be improved through revising entrance criteria for HEW training to consider opportunities created by large numbers of students completing high school and university preparatory schools. Introduce entrance exams for HEW training institutions. In addition, building the capacity of HEW training institutions in the areas of involvement in student recruitment, instructors' capacity, management of practical attachment programs, and skill labs is also an important milestone. Initiating virtual learning modalities for HEWs as a continuous professional development strategy is also a relevant action.

Equipment, drugs, and other medical supplies

In order to ensure the availability and continuous supply and maintenance of inputs, strengthening IPLS implementation through regular supportive supervision and introduction of simple electronic technologies is a major step. It is also important to build the capacity of health post staff on supply chain management systems for drugs and other medical supplies.

To insure availability of medical commodities, it is relevant to explore and introduce alternative sources of funding the supply of drugs and other medical supplies for consumption at health post level. It is also important to assess the feasibility and effectiveness of alternatives for financing HP based services through mechanisms including community-based health insurance and incentivizing private sector involvement at the village level.

Infrastructure and amenities

A phased approach to renovation/reconstruction of health posts should be introduced with due consideration to: 1) the need to expand services 2) the importance of avoiding any more substandard construction, 3) the limited capacity of the country, and 4) the availability and accessibility of infrastructure and utilities within the kebele. The response to the increasing population size within a kebele should focus on expanding capacity within a health post instead of constructing additional health posts. In addition, coordination of efforts to renovate or reconstruct health posts in line with plans for expansion of services within each PHCU in important. Initiating an innovative approach to mobilize resources for renovation of health posts from government, community, and other funding sources should also be taken as an important step. Introducing enforcement of regulatory standards on future health post construction and/or renovation activities to prevent investment on sub-standard constructions should be taken as a measure.

In order to address the infrastructure challenges in the Kebeles, negotiating with other sectors is important. This will ensure that health posts are prioritized in infrastructure development projects (road, electricity, water, and telecommunication) targeting rural communities.

2. Intensify HEP implementation and diversify implementation strategies

While strengthening the static, home visit, and outreach service delivery modalities, it is also important to provide clear standard operating procedures for health post operations (health post-based activities, home visits, outreach sessions) in different contexts to guide implementation, monitoring and evaluation, and controlling of health posts. In health service delivery, enhancing the use of health post visits

as an entry point for provision of comprehensive health promotion and disease prevention services is recommended as a good initiative. As to the implementation modalities:

- Increase involvement of men and youth as targets of HEP
- The strategy for outreach modality should be designed in a way that includes social capital or indigenous social institutions like the idir, equb and others.
- Redesign pastoralist HEP by conducting more detailed analyses of experiences in addressing health and other social needs of pastoralist communities.
- Home visits and most of the outreach sessions of HEWs should focus on demand creation through health and health system literacy instead of attempting to take facility-based services to the home of potential users.
- Intensify focused outreach services to selected areas where men and youth can be targeted (markets, schools, periodic community gatherings, religious institutions, and community-based organizations) depending on local context.
- Strengthen linkage between demand creation and service provision activities by increasing availability of services at health post level and further enhancing health center – health post linkage.
- Strengthen inter-sectoral collaboration to ensure that strategies to implement HEP in pastoralist communities are integrated/ coordinated with other community-based services including villagization and animal health services.

In order to ensure the promotion of sustainable health behavior, it is important to revise behavior change theories and strategies based on variations in the needs of specific behavioral outcomes and cultural contexts. In this regard, behavior change strategies should be adapted to behavioral outcome and context specific approaches/models. Moreover, it is recommended to consider a phased approach to implementation of HEP packages through which each package that requires behavior change at community level will be a focus area of intervention. In this regard, it is also required to avoid the use of campaign-based approaches to influence behaviors that need continuous communication with household members.

3. Improve Community Awareness and Engagement

For a good health impact to be resulted, it is critical to strengthen model family training by providing clear guidelines, increasing HEWs' time spent for training of families and arranging experience sharing sessions between model families and others. All community volunteers working with HEWs should be selected only among model families. Moreover, a system that allows HEWs to track enrolment, progress, completion, and recognition of model families should be strengthened.

In order to engage communities, the most important intervention should be to redesign community structure for HEP with renewed branding, capacity, and responsibilities. In addition, consider the following features to address challenges faced by the WDA approach.

- Incentivize volunteerism and limit duration of service to a predefined period of performance.
- Make maximal use of opportunities created by: 1) relatively better availability of literate community members, 2) high level of school enrolment among adolescents and youth, and 3) increasing use of communication technologies including cell phone and the internet.
- Avoid reliance on single approach to community participation
- Avoid creating expectations of becoming salaried workers among community volunteers

4. Strengthen management and support for HEP

Strengthening the technical and administrative linkage between the HC-HP through clear lines of accountability, and alignment of priorities and targets is a critical engagement. In addition, the inter-sectoral collaboration should be further enhanced whereby social determinants of health are addressed and clear demarcations are determined to guide the involvement of HEWs in “non-health” activities. More importantly, developing a roadmap of the program should be considered a milestone engagement.