Federal Democratic Republic of Ethiopia
Ministry of Health

STRATEGY FOR REVITALISING HEALTH EXTENTION PROGRAM IN PASTURALIST AREAS

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Contents

Acronym

AMREF	Africa Medical Research Foundation
ANC	Antenatal care
APDA	Afar pastoralist Development Association
APL	Adaptable Program Loan
BCC	Behavioural Change Communication
CIF	Community investment Fund
EDHS	Ethiopian Demographic and Health Service
EFY	Ethiopian Fiscal Year
FMoH	Federal Ministry of Health
GTP II	Growth and Transformation plan two
HC	Health centre
HAD	Health Development Army
HEP	Health Extension program
HEW	Health Extension Workers
HP	Health Post
HSTP	Health Sector Transformation plant
IDA	International Development Association
IFDA	International fund for Agricultural development,
MDT	Multi-Disciplinary Team
PCDP	Pastoralist Community development
PHC	Primary Health Care
PHCU	Primary Health Care unit
PSNP	Productive Safety Net Program
RHB	Regional Health Bureau
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
SDG	Sustainable Development Goal
SoP	Standard operation procedure
SNNPR	Southern Nation Nationalist Region
UHC	Universal Health Coverage
UNICEF	United Nation Children's Emergency Fund
WHO	World Health Organization

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Preface

Despite notable progress of key health outcomes at national average, there is high disparity among different regions and population groups on uptake of key health services among which pastoralist regions are lagging behind than other regions and national average. The variation in utilization of key health services is wide among zones and woredas in the same region as well. The gap is mainly due to lack of access to and utilization of basic health service close to the community. Besides, other factors such as geographic and social distance, dispersed settlement, mobility of community, weather condition and lack of means of transportation are key barriers. Household economic status, education, gender and residence are also common barriers among different groups of population and that worsens service uptake in among pastoral community as well. The quality of primary health care service rendered at health post and health centres in terms of safety, effectiveness, efficiency and community-centeredness particularly in pastoralist areas is also sub-optimal.

As ensuring equitable access and utilization of quality basic health service for all segments of population in all parts of the country is the heart of HSTP, the ministry of health is undertaking several initiatives to narrow the prevailing gaps on key health outcomes between pastoralist regions and national average. The equity plan which is under implementation, budget subsidies, deployment of additional health human resources, the comprehensive special support provided for pastoral and underserved regions are some of examples of initiatives to address geographic inequalities in health service utilization.

Following the development of GTP II and health sector transformation plan (HSTP), the FMoH has developed and revised several strategies, programs and implementation guidelines to translate the health sector strategic plan into practice. The four transformational agendas, newborn and child survival strategy, health promotion and communication strategy, Adolescent and youth health strategy are some among others. The strategies and guidelines are not to heat shelfs but to guide executions.

As the key driver to expand basic health, nutrition and WASH services closer to pastoralist community, it is critical to strengthen the health extension program in pastoralist areas. This pastoralist HEP revitalization strategy coupled with other strategies in the sector and beyond the sector, is believed to guide the implementation of HEP and primary health services in pastoralist areas. The Federal Ministry of Health reaffirms its commitment to improve the health status of the postural population and other communities in hard to reach areas through providing the required support for execution of this strategy.

Finally on behalf the Federal Ministry of health, I would like to seize this opportunity to call up on implementers to translate the strategy into action and and partners to support in the implementation process. I also assure that the Ministry will oversee and provide guidance and the required support for regions in their endeavour to implement the strategy.

Kebede Worku

State Minster, Federal Ministry of Health of Ethiopia

Executive Summary

This strategy is about revitalizing the health extension program in pastoralist areas. The development process of the strategy was both top down and bottom up. The top down process considers the policy, strategic plans both growth and Transformation (GTPII) and the health sector transformation plan (HSTP) goals and targets and other government initiatives including transformation agendas. Whereas the bottom up process includes extensive assessment of the situation at the ground through key informant interview, observation and document review. The information obtained during field visit to Ethiopia Somali, Afar, Benshangula Gumez and Borena Zone of Oromia region from 18 November 2016 to 15 January 2017 provided basis for the development of this strategy. During the field visit, in depth interview was made with key informants using the interview guide open qualitative questions. Interviewed Government institutions include health sector from region to health post, food security office, pastoralist development office, livestock and education sector offices and woreda administration office. Few community members who were at health post or on the way during the field visit were also interviewed. From development partners experts from UNICEF, WHO, USAD and from NGOs; AMREF APDA and Save the Children were consulted. Observation of health facilities was made during the field visit. The field visit provided thorough insights for this strategy development. Relevant documents about pastoralist livelihood, health, pastoralist development programs and other initiatives were reviewed for better understanding of the context.

During the development process sequential consultation has been conducted at different level to identify and incorporate key issues. Particularly, the guidance and comments from H.E Dr. kebede Worku State Minster of Health and Mrs. Hangatu Mohamed Director, Health Systems Special Support was critical at each step. Preliminary draft was presented to State Minster of Health for programs and relevant experts. Relevant comments from State Minster, other experts and UNICEF team from country office and pastoralist regional offices included in the draft. The draft strategy document was presented to the implementing regions during consultative workshop held from 15 to 19 May 2017 in Adama. Participants from FMoH different directorates, regions, standing committee of pastoral affairs from parliament members, ministry of federal and pastoral affairs and development partners participated in the consultative workshop. Relevant comments obtained from the consultative workshop are incorporated in the document. Then improved version of the strategy was presented to Afar, Ethiopia Somali and SNNP regional health bureaus management members. Relevant comments also incorporated from the respective regional health bureau management members. The strategy was also presented to health population and nutrition (HPN) group to get inputs. Furthermore, validation was done with optimization of agrarian health extension program. This is the final draft document which is ready for implementation testing and based on findings from pilot testing, the document will be further improved.

This strategy document has three parts. In part one, the document highlighted background information of pastoralist regions and Zones, livelihood, mobility pattern, villigization status, pastoral community development, productive safety net program, health service access and utilization, and context related to

health extension program. Furthermore, key determinant factors to access and utilization of primary health service in pastoralist areas and available opportunities are mentioned.

In part two; the strategy document outlines goals, approaches and key focus areas which key interventions are listed under each focus areas. The strategy is guided by the theory of change (ToC) which is thought to strengthen the health system and local capacity in pastoralist areas. The four approaches and six priority areas are further explained to define key activities and options in some cases. The four approaches and the six focus areas are interlinked and will have synergistic effects. The four approaches include a) investing on the development of local capacity, b) stratification of woredas and zones and contextualizing implementation modalities c) Strengthening health system and d) integration within and among sectors and collaboration. The six focus area are: i) Improving stewardship ii) expand service delivery, iii) Engaging community, iv) provide special support and v) Enhance coordination and integration and vi) Monitoring, evaluation and learning. Key activities are listed under each focus areas

Part three is about roles and responsibilities to be undertaken at each level of the FMoH structure. It also provide summary of assumptions and risks and mitigation strategies. Formats and matrix is also annexed.

Cognizant to the diversity of the regions and woredas within the regions, the strategy describes options to be adapted to their specific context. The strategy is descriptive than prescriptive. It provides flexibility in implementation according to the local situation while it accentuate common approaches and focus areas to be strengthened in all context. This strategy document aims to help the regional and local government officials, health sector managers at all level, implementers and other development actors to develop strong and resilient health system in pastoral and hard to reach areas. The strategy will be further revised based on the socio-economic development status of the country, upcoming policies and strategies and level of demand and engagement of population.

Operational definition

Collaborative partnership: - strengthening alliance that are used to improve the health status of the population

Community: - a group of people living in certain geographic area sharing commonalities such as language, culture, tradition way of living

Community health workers: - selected members of community who have tacit knowledge, skills and volunteered to lead, mobilize and serve their community, deliver simple care, and strengthen the interface between the community and formal health facilities

Community organized: - working together in a way which brings people to work collectively to improve their own health status in organized manner and groups that are collaborative and inclusive

Fixed/static service: - the health services provided at health facility and/or it's compounded

Extended outreach service:- providing health care service in a temporary base in places where communities can't access health services in fixed health facilities, day or two-day long outreach services such as in internally displaced camps, temporary community concentration camps, religious or cultural pilgrims etc.

Fema: - traditional organization of peer groups in Afar which brings people who share the same gender, culture, religion, tradition and communalities to influence local decisions.

Health extension program- a program that encompasses packages of health promotion, family health disease prevention & control and essential curative health services that are provided at household, community or Health post level by trained health extension workers

Health promotion: - the process of enabling people to control over on their own healthy life style and health

"High risk community"; - communities who have difficulties in access and utilization of health service due to geographic, topographic or social and economic barriers. For example, the hard to reach, the underserved, urban poor, migrants, nomads, rural remote hard to reach populations, ethnic or religious groups, or people affected by insecurity, and others

Influential community members: - People who are respected, listened and trusted by the community and have skill and knowledge and bestowed to mobilize communities to take part in health actions, activities and influence service uptake.

Integration *The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs, over time and across different levels of the health system.*

Kebele – the lowest administrative unit in the administrative structure of Ethiopia

Mobile health and nutrition service: - A health service containing essential and lifesaving health and nutrition services provided through moving from place to place using vehicle, animal, foot or other means in hard to reach and where in areas there is no fixed or other means of health service. Movement could be continuous or at least more than fifteen days within a month

Fixed service- services refer to services offered in the health facility or in its compound.

Mobile- services usually require traveling for more than one two days or a motorized transport and a health team.

Multi-disciplinary team: - a team composed of different categories of health service providers. for example nurse, midwife, health officer, environmental health and laboratory technologist/technicians working as a team to provide basic health promotion, disease preventive and control and curative health services in fixed health facilities, outreach or by moving from place to place as a team.

Outreach service: - providing promotional, preventive and selective curative health care out of the conventional health facilities and/or its compound for communities reasonably far from health facilities usually from five to 25 kilometres away from health facilities usually for a day or overnight.

Pastoral community health extension program: - refers promoting the well-being of pastoral community (children, adolescent's, women, adults and elders) through extending promotive, preventive and basic health care using different service delivery modality

Service delivery modality: - a means of providing health service to increase access and utilization of health outcomes. Service delivery ways include fixed, family community, outreach and through moving in case where the community is mobile

Service scope: - range of service provided at each level as per the health facility standard as stipulated in 2012 health facilities standard

Special support: - support provided to the low performing and needy areas due to different circumstances to improve and further equalize performance with the average performance in the country. Special support may include monitory and non-monitory such as financial, supply and logistic, technical, management psychosocial etc.

Zoonotic diseases: - diseases that are transmitted from animals to humans

Part I

1. Background information and context

Pastoralist population in Ethiopia cover a wide geographic area and is estimated to be 10-12 million which is about 12% of the Ethiopian population. Pastoralist community live in areas with limited access to infrastructure, road, electricity and other communication means, social service institutions such as education and health services. Pastoralists are residing in arid and hot weather in sparse condition which makes fixed type of health service delivery very tough. They are seasonally mobile, well adapted to tough environment and extreme climate, living in kinship and social-network. Ethiopia Somali, Afar, and Borena, parts of Guji, Bale, parts of East Hrarerge Zones and Fentalye woreda in East Shewa Zone of Oromia regional state, South Omo and Bench Maji Zone in SNNP region are known homes of pastoralist community.

While substantial development have been attained in expansion of health services over the last decade, pastoralist community face overwhelming challenges in terms of inadequate access to primary health care. Weak institutional capacity, vulnerability due to recurrent droughts, inadequate infrastructure, increased competition for resource and associated conflicts are obstacles for access and utilization of health services and products. The health service status in brief for each region is highlighted below.

Background of Pastoral Regions
Afar Regional State:

Afar regional state is located in north-eastern part of the country bordering Eretria and Djibouti in East, Tigray in north and Amhara in North and North West, Oromia in South and Somali region in South East. Administratively, it is divided in to five administrative zones, 32 woredas, and two town administrations, which are further divided in to 420 *kebeles*. The total population based on the 2007 census projection is estimated to be 1.8 million. The settlement of population is much dispersed and seasonal movement following availability of water and grazing for livestock is common in the region. Livestock rearing is the basis of livelihood with limited agriculture along the river basins and riverine areas. The region is drought prone with the mean annual rainfall between 150 and 500mm.

The potential physical access to primary health service is estimated at 90% in Afar region. According to Afar regional health bureau, EFY 2008 annual report, the distribution of public health facilities in the region include six hospitals, 78 health centres, and 378 health posts which are rendering health services at different level. With regard to health workers population ration there are 26 Medical Doctors (1:62,846 population), 69 Health Officers (1:23,681), 684 Nurses (1:2,389), 108 Midwives (1:15,130), and 719 HEW (1:2,396). As expected health worker per population ratio is higher for lower level health workers such as nurses and HEWs while gap remain for doctors and health officers. The HEWs in the region are categorized into level II, III and IV as per their respective level of training while level II is not recognized at national health human resource standard. Nurses are assigned along with different level of HEWs in some of the health posts. In few remote areas only male HEWs trained for six months are assigned. Most

health posts are providing simple treatment for children as well as adults regardless of their level, scope and category.

With regard to social capital, the *fema* and *Liela* traditional forms of social networks exist where community members share different information and take decisions among Afar and Argoba communities respectively. *Fema* is form of traditionally organized or social network of peers in age, sex and other characteristics that is used for social and cultural influence of decisions. The *Dagu* tradition in Afar is the means of information sharing among communities to be used for dissemination of health information as well. There are existing indigenous and traditional community platforms where communities use for taking action and decision for both males and females that can be tapped for health promotion and disease prevention activities.

Ethiopia Somali Regional State:

Ethiopia Somali Regional State like Afar is homes for pastoralist community. Administratively, Ethiopia Somali region is divided into 11 zones, 99 woredas, six urban administration and 1214 kebeles. The region is the second largest region following Oromia with a total land mass of approximately 271,970 square kilometres. Based on the 2007 census projection the total population in EFY 2009 is estimated to be 5.5 million of which close to 85% are residing in rural areas. Similar to Afar Ethiopia Somali is drought prone region often challenged by recurrent droughts and frequently faced shortage of water and pasture for livestock. Water, hygiene and sanitation related disease such as acute watery diarrheal disease, measles and nutritional disorder are common health problems in the region.

According to EFY 2008 annual report of regional health bureau, there are 10 hospitals, 162 health centres (additional 48 health centres are under construction) and 1085 health posts in the region. Like Afar, the settlement of population is very scattered in Ethiopia Somali region. The physical access to primary health care service as per the norm is estimated to be 56% which is the lowest compared to other regions. Thus much remains to be done to increase access to primary health care in the region.

Somali communities tend to live in kinship and usually share resources for basic survival. They support each other and often assistance to the needy is customary religious or clan obligation. The traditional relationships are important platforms to promote health, nutrition and water, sanitation and hygiene interventions.

Benishangul Gumuz Regional State:

Benshangul Gumez is situated in Western part of the country and one of the nine regional states in Ethiopia. Administratively the region is divided into three zones, 20 woredas one urban administration and further sub-divided into 475 *Kebeles* of which 441 rural and 34 urban kebeles. Based on 2007 census projection the total population of the region is estimated to be 1.06 million. The majority of population in this region is leading mixed livelihood such as farming, animal raring and mining. About 87% of the population reside in rural areas whereas the remaining 13% live in urban areas with average growth rate of 3% and total fertility rate of about five. The region is home for various ethnic groups.

With regard to distribution of functional health facilities, there are two hospitals, 39 health centres and 402 health posts rendering service in the region. In addition, 29 health posts, 13 health centres and four hospitals are under construction. Several lower and midlevel private for profit clinics also provide curative services in different towns of the region. The ratio of health facilities to population is one hospital serving about half a million people whereas one health centre serve 25795 people and one health posts serve about 2294 people. Potential physical access to health services is estimated to be 96%.

The health extenuation program is implemented in the region since 2006. Health extension workers are deployed in all kebeles of the region. The total number of health extension workers in the region are about 991 of which 98, 663, 91 are level II, III and IV respectively. The ratio of HEW to population is one to 1,500 while the national norm is one to 2500 population. In Benshangul region, nurses are assigned along with HEWs at health post level to provide basic curative service close to community.

Despite seasonal movement for labour, the vast majority of population in Benshangul Gumez is settled. Therefore, the fixed, community outreach and family based service provision and the health development army networking platform applies in this region. In the previous settlement areas, the health development army is organized and community is networked as social and geographic proximity. According to regional health bureau administrative reports, the health service uptake in the villagized area is higher compared with dispersed settlement.

Gambella Regional State:

Gambella regional state is located in the South Western part of the country covering an estimated area of 34,063 square kilometres. Administratively the region is divided in to three zones, 13 Woredas one town administration and further divided into 262 kebeles of which 25 are urban and 237 are rural kebeles. Based on the 2007 census projection the total population is estimated to be half a million in EFY 20019. However, the region is hosting hundred thousands of refugees from South Sudan and the number of population might be under estimated. About 25% of the population is residing in urban while three-quarter of the population live in rural part of the region. With regard to distribution of health facilities, there are one hospital, 32 health centres, and 133 health posts with additional 15 health posts under construction. The physical access to primary health care service as per the norm has reached to 100%. However, some health facilities in Gambella are underutilized due to seasonal movement of the population. Besides, refugee influx from South Sudan which may put further strain on resources, health system, disease burden and host community.

Borena Zone in Oromia National regional State

Pastoralists also reside in South Eastern parts of Oromia, Southern Nation Nationalist Region (SNNPR) and Gambela regions. Borena Zone in Oromia regions is known as one of the largest pastoralist area. Pastoralism is the main source of income for the Borena people, though few community members are gradually tending to agro-pastoralism (livestock and crop production) as coping mechanism than confidently diversifying their livelihood. Livestock remains to be the vital source of food and income. Pastoralist livelihoods are almost completely reliant on water and yet water sources and supply are

extremely limited. The total population of Borena in EFY 2009 is estimated to be 774,213. Borena Zone is divided into 13 rural woredas and one urban administration and further subdivided into 144 rural and 15 urban kebeles. There are about 244,944 productive safety net beneficiaries in Borena Zone of which 211,801 are public work participants and the remaining 33,143 are direct permanent beneficiaries while temporary direct beneficiaries are not identified during the visit.

Health facilities are spread over due to dispersed settlement compared to the national and regional figure. Number of functional health facilities in the Borena Zone are 41 of which only 12 health centres have maternity waiting rooms. There are also three newly constructed health centres not yet providing service. Currently, one health centre serves for an average of 18,885 population. However, as the settlement of population is very sparse, it is hard for many villagers to access health facilities in most places. Number of health posts currently rendering service are 145 there are also eight non-functional health posts and 15 sub-kebeles supposed to have but without health posts due to various reasons. When all available health posts provide services the ratio of health posts to population will be one to 3917 population. Only 12 kebeles have residential houses for HEWs. The total number of available health extension workers in the zone are during the assessment period was 570 of which 533 are rural and 37 are urban making the ratio of HEWs to population one for 1360 people.

Unlike other pastoralist areas Borena has organized health development army (HDA). It was reported that a total of 3992 HDA groups and 20,561 one to five networks are available in Borena Zone. Borena has also structured traditional organization which governs itself traditionally. *Abba Olla* at village level is influential for any community actions and decision that can be an opportunity to influence community health issues as well.

1.1. Livelihood

Survival for rural pastoralist communities is grounded mainly on livestock raring with seasonal movement in search of water and grazing for animals. Recently, the livelihood is slowly changing due to the rapid social, and political landscape transformation. For example, in Somali region four main types of livelihoods are identified and listed below. Similar array also exist in Afar Regional State and other pastoral areas.

i. *Pastoralists* who are primarily engaged in animal husbandry and estimated to be about 60% of the rural population. Pastoralists often move seasonally in search of water and grazing for animals. Movement of community makes difficult the provision and utilization of basic services such as health and education[1].
ii. *Agro-pastoralists* who are leading diverse means of living including livestock rearing and crop production and estimated to be about 25% of the rural population. These are people somehow settled in areas where the rainfall and source of water is relatively better. These people also move whenever there is drought or food for animals is scares. But, only young and adults move with their livestock on temporary base.

[1] Field Surveys conducted by SCUK/DPPB. Food Security Monitoring and Early Warning Programme – Revised 2004

iii. *Farmers* who are leading an established existence as producers of food and cash crops for consumption as well as for selling. These people are settled in areas where adequate rainfall and water source is available and riverine areas. Sedentary and riverine population comprise about 15% of the rural population.

iv. *Urban and small town* residents whose survival is based on trade, formal and informal employment, small scale handcrafting activities and agriculture to some extent. The proportion of urban population is estimated to be about 15% in the region presumably with steady increase in recent years.

Although the majority is believed to be pastoralists, the adoption of farming particularly following vulnerary based villagization and in riverine areas of both regions is noticeable indicator of the shift from pure pastoralist to farming and agro-pastoralist livelihood. Pastoralists are opted to look for other livelihood options due to recurrent drought, competition for resource due to diminishing of grazing and water source for livestock.

1.2 Mobility pattern

Mobility for pastoralist community is a central coping mechanism of erratic rainfall, recurrent drought, livestock disease and sustain use of scarce resources. Both cross-border and internal movement is common from Somalia to Ethiopia Somali region, from Northern Kenya to Borena and SNNPR whenever Eastern Africa region is affected by drought. The internal movement of the community is predictable and unpredictable due to erratic rainfall, drought and conflict. Mobility is predictable particularly when drought occurs and sometimes unpredictable since happens due to conflict or scarcity of resources. The details of internal mobility pattern is not yet well documented. However, as per the personal communication with health workers and local community members the mobility pattern is internally known by community themselves and elders. The movement is based on kinship, families with the same clan, neighbourhood or existing social relation. The small group usually discuss and map where to go, when to go and who to go. Movement is basically selective and flexible in search of water and pasture for the livestock.

Mobility pattern takes two ways in the pastoral communities. Some pastoralists move with their families and all their belongings. This type of mobility mainly happen during tough drought period. The second type of mobility is movement of the satellite herds which adults and youth temporary move with livestock to areas where they can search grazing and water for their animals. Usually elderly, children and women stay in their permanent residential areas while young and adults move temporarily along with their livestock looking for water and grazing for animals. In some areas they settle surrounding to water points, when the rainfall starts they return to their residence place. The mobility of the community is one of the barrier for the access and utilization of health services in pastoralist community.

1.3 Villagization

Regions that require special support in Ethiopia (Ethiopia Somali, Afar, Benshangul Gumez and Gambella) are situated in peripheral areas bordering unstable and fragile countries. The regions are lowland with mostly hot and arid climate. The settlement of population in these regions is very much

sparse. The scattered location and frequent movement make the provision of basic social and economic services difficult. In addressing this challenge, the government of Ethiopia has initiated voluntary based villagization in the six regions including Oromia and SNNPR. The purpose of relocation is to improve access and utilization to basic socio-economic infrastructure and service. It is also a means of transition to secure diverse livelihood than relying on pastoralism.

The status of villagization vary among regions. Villagization is not progressed as per the initial plan of the government. In most regions, villigization is affected by several factors including inadequate preparation, planning, and weak coordination, lack of adequate dialogue, consultation and engagement of community, lack of integrated service provision, livestock size and sometimes security problem. However, overtime, it is progressing in some woredas and regions where better preparation and planning is conducted.

Voluntary Villagization has brought the basic social services (education, health) to doorsteps of villagers in areas where it is implemented and sustained. For example, essential health service coverage in Benshangul Gumez region has notably increased in the last three to five years. The increase in service utilization is attributed to villagization in addition to other factors.

1.4. Pastoral Community Development program

The Pastoral Community Development Program (PCDP) was introduced in 2003 following the approval of the Adaptable Program Loan (APL) from the World Bank's intervention to support development of pastoralist areas. The program aims to improve the livelihood of pastoralists in sustainable manner. The program includes providing basic essential services including health. The program was implemented in three phases for 15 years (from 2003 to2018) phase one from 2003 to 2008, phase two from 2009 to 2013 and phase three from 2015 to 2018. The independent evaluation of PCDP phase I and II implementation indicated that the project implementation was unsatisfactory and fairly satisfactory respectively[2]. However, the program has supported construction of health facilities particularly 338 health posts, furnishing and equipping health facilities and training of health workers in beneficiary woredas.

The third phase of pastoralist community development project has four components i) community driven service provision though community investment fund (CIF), ii) rural livelihood improvement program, iii) knowledge management and learning and iv) project management, monitoring and evaluation. It is the final phase of the 15 years program which is funded by International Development Association (IDA), International fund for Agricultural development, (IFAD), the government of Ethiopia and the local community. Local community contributes in terms of labour and material for example for construction of health posts. PCDP phase three intends to contribute towards attaining the GTP II objectives by expanding access to and ensuring quality of education and health services, and building the capacity at local level for sustainable development for provision of basic social services such as education, health care, and water supply to pastoral and agro-pastoral underserved communities. The project interventions are designed to empower local administration and communities at woreda and kebele level to better manage the local

[2] Pastoralist Community Development Project assessment report, WB, April 2016

development. The third phase of pastoralist community development program is expected to benefit about 2.6 million people in 55 woredas of Afar, Somali, Oromiya and SNNP regions.

The pastoralist community development program is an opportunity in project woredas to improve the primary health care units and improve the capacity of health workers including the health extension workers, other community level volunteers such as health development army and other networks. The project can also support the renovation and expansion of health posts, supplying essential medicines and other priority areas driven by community in target woredas.

1.5. Productive safety net program phase IV

Productive safety net program (PSNP) is a mechanism of transferring of food/cash to the food insecure community in a way that prevents asset depletion in the household and creation of community assets in turn of labour intensive public work participation. PSNP beneficiaries are also linked to social services including utilization of available health and nutrition services[3].

Link to social service including health service uptake is included as sub-component in the phase IV productive safety net program (PSNP). The inclusion of social service in productive safety net program has significant importance in improving health outcomes and addressing equity in health service uptake. The service provision builds on the existing system particularly on health extension program. The key target population groups for the health and nutrition PSNP sub-component are i) Pregnant women, ii) lactating mothers with a child under one, and iii) household with children under five identified as moderately or severely malnourished. The health sector can also benefit from PSNP to renovate and repair health facilities, construction of maternity waiting through public work support, maintenance of road and subsidizing food for maternity waiting rooms.

There are two components on implementation of link of utilization of health and nutrition service in PSNP IV[4].

1. Participation in behavioural change communication regarding health and nutrition as substitute to public work for both male and female participants
2. Introducing soft conditionality or accountability for temporary direct support of clients include pregnant women, lactating women with child under one year of age, and primary care givers of under five children severely or moderately malnourished in PSNP client household members to implement/ practice key actions of health extension program for being exempted from public works.

However, the health sector at all level is not yet able to tap the opportunities of productive safety net program to maximize health outcomes particularly for poorest people which in turn will help to address equity in health service utilization.

[3] Productive Safety Net Programme Phase IV Programme Implementation Manual, Ministry of Agriculture 2014, Addis Ababa

[4] *The Productive Safety Nets Programme IV – Baseline Survey Report 2016*

1.6. Health System Organization

The health systems in Ethiopia is organized into three-tier level of care (primary, secondary and tertiary level care). The primary health care include primary hospital, health center and health post which are linked for referral service. The primary health care is organized to serve population of about 100,000 in densely populated area and 60,000 in scattered settlements. Secondary level care is general hospital which serves for a population of 1 to 1.5 million with multi-disciplinary staff and serve as referral for primary level care. Secondary level care provides outpatient, ambulatory and inpatient, services. Besides, the second tier level of care provides support for pre-service and in-service trainings. Tertiary level care covers 3.5 to 5 million people. Tertiary level provides specialized care and receive referrals from secondary level hospitals. Tertiary level hospitals are specialized teaching and research centers in addition to service provision.

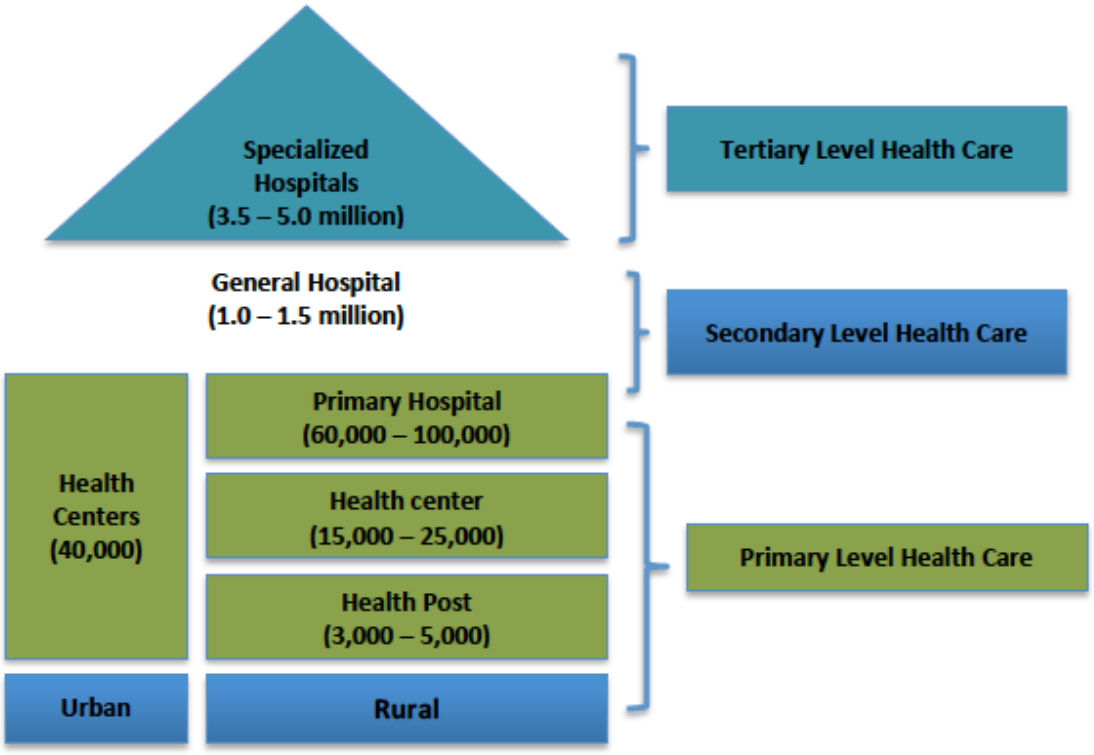


Fig 1.The health care tire system (FMoH, HSTP 2015/16 to 2019/20

1.6.1 Primary healthcare organization

The structure of the primary healthcare in Ethiopia is composed of primary hospital which is under expansion, health centre and health posts. The primary health care unit is composed of one health centre and five satellite health posts which serve all together average population ranging 15,000 in sparsely populated areas to 25,000 in densely populated areas and 40,000 in urban areas. A health centre is staffed

with mixed midlevel health professionals of about 20[5] who can provide basic curative and preventive services. A health centre may have up to five beds for inpatient service in emergency or critical conditions. The health centre provides referral, technical, administrative and logistic support to health posts under its catchment. The national norm for health post is staffing with at least two female HEWs of level III and subsequently upgrading them to level IV on merit bases. A primary hospital serves about 60,000 to 100,000 population as per the density of population in the catchment areas. Primary hospital provides ambulatory and inpatient services such as emergency surgical services including caesarean section and serves as referral centre for the nearby health centres. It has 25 to 50 beds for inpatient service and staffed by over 60 health professionals with different categories[6].

The national norm for health centre health post ties is one health centre to support an average of five satellite health posts. The health centres are accountable for providing technical, administrative and logistic support, referral service and compilation of reports from health post under its catchment. In pastoralist areas due to dispersed settlement one health centre to five health post tie is difficult. The Federal Ministry of health provided at least one Ambulance for each woreda. However, ambulance utilization is inefficient due to lack of proper management, shortage of running costs, poor road access and long distance between health posts and health centres as well as villages. Health centre and health posts offer basic health service for the majority of rural people 63% while government hospitals and private health facilities provide service for considerable number of urban population[7]. Particularly the majority of poor people use health centres and health posts while reach people tend to use private health facilities and hospitals.

1.6.2 Health Extension Program

The Government of Ethiopia (GOE) has launched the Health Extension Programme (HEP) in 2004. The program aims to improve equitable access to essential preventive, promotive and selected curative health interventions to all segments of population by extending health services to communities through the deployment of 42,336 health extension workers (HEW) in agrarian, pastoralist and urban areas. Significant improvements in health outcomes has been showed since the implementation of the health extension program in the country. The progresses are particularly remarkable in some agrarian areas while the disparity among regions, urban, rural and across different socio-economic status remains wide. Administrative and population based survey data indicated that coverage of those health services supposedly provided by HEWs remain extremely lowest in Afar, Somali and in other pastoralist areas of Ormia and SNNP regions. Perhaps this is due to the fact that these areas have weak primary health care system, lack capacity, inadequate community engagement, low implementation capacity and insufficient follow-up and monitoring of the program in addition to other barriers.

[5] Ethiopian Standard Agency; ES 3611:2012, requirements for Health centre, First edition
[6] Health sector transformation plan 2015/16 to 20120, FMoH, May 2015, Addis Ababa
[7] FMoH Health Accounts study, August 2017

Political commitment for HEP (community level health service)

Political commitment play critical role for success of any community based services including the health extension program. The commitment of Ethiopian government is an exemplary to improve health service access and utilization for all segments of population in all parts of the country through deployment of over 42,000 salaried HEWs. The Government of Ethiopia with support from development partners also equipped over 16,000 health posts. The health service at health post level is free of charge contributed to access of key services for those who cannot afford to pay. The federal and regional governments made big strides on infrastructure expansion, training and deployment of HEWs. However, task remains on sustaining close monitoring, follow-up and provision of support for HEP at implementation and management level particularly at regional, zonal, woreda, and health centre level. Due to lack of proper and organized support from higher level institutions most health workers speculate that the HEP is regressing compared with early implementation period. The irregular monitoring and support is mainly attributed to lack of resources such as transportation and shortage of payment for daily subsistence allowance. Some key informant health workers who requested for anonymity also said,

"The system in this country is campaign based. Everybody from top to dawn moves whenever some priority issue cascaded from the top level such as ruling party. Similarly, we have seen several campaign type of doing things in the health sector. For example, malaria, HIV/AIDS and TB prevention and control programs were done in campaign fashion. Then Model family graduation, community health information system, organization of health development army and skilled/health facility delivery follow subsequently. Each of the programs were key moto for a year or two then forgotten for subsequent years. This affects sustainability and strengthening system."

Others argue that doing priority activities on campaign bases has an advantage to scale up of key interventions and get results. The issue is, the lower level leadership often lack proper knowledge, skill and willingness and fail to endure to continue efforts and strategies while waiting for guidance from higher level leadership. The root cause of seeking for guidance from top level is often due to inadequate capacity to properly manage, understand roles and responsibilities, and limited motivation and accountability.

To sum up, expanding services and deployment of health workers and supplies is not adequate unless strong political commitment is ensured to provide close support and follow-up. Some of interviewed health managers and health workers were not shy to spoke out that in some cases hasty decisions influenced by political pressure without adequate participation and listening of stakeholders at lower level may lead to failure. Therefore, listening and learning from the lower level implementers and community is important to sustain and increase results.

HEP implementation status in pastoralist regions

According to the National Health Service delivery hierarchy, the health post is the lowest level of health facility staffed with at least two female health extension workers in Ethiopia. The health extension program is a vehicle for providing packages of promotional, prevention of diseases and selective curative healthcare at family, community and health post level. Following the implementation in agrarian regions,

pastoralist health extension program was launched in 2006. HEWs deployed in pastoralist areas were both males and females who completed six and eight grade primary schools and received six months of training on key health promotion and disease prevention activities. The deployment of both sex and lower grade completed HEWs was due to the scarcity of educated girls in rural pastoralist areas. Because of the low level of education, most of them lack knowledge and skill to provide essential health care. In fact, some of those lower level HEWs deployed in rural pastoralist areas are striving to improve their formal educational status through distance education for better opportunity and often get back to urban areas which caused service interruption. Thus absenteeism of HEWs from their duty is common in pastoralist regions[8]. Besides, sparse settlement, movement in search of water and grazing fields for their animals with changing seasons exacerbate access and use of static health facilities for pastoralist community.

Data of health facilities and health workers varies from different sources. As staff turnover and absenteeism is high in both regions, data on the mix and number of health extension workers who are currently available on duty considerably varies in both regions. In Afar region about 718 level II HEWs were trained and deployed of which 519 (72%) reported to be existing till EFY 2008. Recently, Afar Regional Health Bureau deployed about 176 female HEWs of them 33 were level IV and the remaining 143 were level III HEWs. The health posts are staffed with mixed first level health workers including junior nurses, frontline health workers and health extension workers, with varying educational background. Unlike in agrarian regions the scope and ranges of health service provided by health posts in both regions differ as per the available health workers in the health post.

The design and implementation modality of pastoralist health extension program was more or less similar with agrarian regions. However, implementation modality of conventional health extension program does not seem to fit to peculiar context of pastoralist community. Thus children and women in pastoralist communities likely suffer from multiple health problems while their compatriots in urban and agrarian regions benefit from the health extension program. Children in pastoralist community suffer from respiratory tract infection, eye and skin infection, measles due to low immunization service, diarrheal disease, acute febrile illness, brucellosis and other intestinal parasite, malnutrition and neglected tropical infectious diseases[9]. Women in pastoralist areas also suffer from pregnancy and birth related complications, reproductive health problems, respiratory and skin infections and other tropical infectious. The susceptibility and vulnerability is mainly due to their lifestyle and absence of safe and adequate water supply, poor hygienic condition and lack of health promotion, preventive and curative service that fit to their life style. The common remedial action practiced in the pastoralist community for health issue include suffering without treatment, self-care, including self- medication and consult traditional healers due to inadequate access to modern health care.

The scope and service packages provided at health post level are not well defined, uniform and maintained as per the national norm/standards. In some health posts where clinical nurses are assigned, they provide curatives service including delivery services. In some areas where only level II HEWs are assigned, only limited scope of services are rendered. In some cases, the level II HEWs carry out curative services which

[8] Ethiopia Service provision Assessment plus Survey, EPHI, 2014

[9] Review of good practice and lessons learned for programming ASAL population in the horn of Africa, UNICEF, ESRA, 2011

are out of their designated role. Hence the community do not have access to quality basic health service nearby. Accordingly, some problems are palpable given the situation in the pastoralist regions.

Family/household level services HDA and Community mobilization

The regularity and structure of visiting the households, villages and other community contacts differ based on settlement, weather condition, road and means of transport, terrain, population density, and security in the area, culture, and religious customs. The visit and contact patterns is not adapted and tailored to local context to fit into the local circumstances. Some HEWs are not operating the community outreach by identifying the most appropriate means and days of the week for home/community visits. Number of household or community visits HEWs are expected to make per day or week are not well defined and practiced. Thus the HEWs in a pastoralist community may not visit any households for several months. Pastoralist areas are hard to reach, off road, extremely dispersed, hot, sunny, dusty and windy climate for the health workers to provide service in outreach and family based delivery modality. Recruiting male HEWs was initiated in Ethiopia Somali and Afar regions supposedly to withstand the harsh environment. However this was not successful due to the cultural unacceptability of the males to make household visits and contact with women in some areas while key informants responded that there is such problem in other areas. Some people mentioned that they never seen the health extension workers during the past several years visiting their village. For example one resident in Harshin woredas of Somali region said that he never seen the health workers visiting his village except those coming for polio vaccine.

Social capital is the resource people use to pursue different ways of making living[10]. Social capital includes, networks, group membership, social mobilization committee structures are available particularly in Ethiopia Somali and Afar regions at all level. Pastoralist community have social capital at village community level, with different systems of indigenous social support including government instituted such as social mobilization committee. The strength and function of the social mobilization committee depends on the performance and engagement of the respective woreda health offices and health facilities. It was noted that in most cases, the social mobilization committee are actively engaged during campaigns and calm during normal circumstances. The health development army structure is in place in Borena Zone of Oromia and Benshangul Gumez regions. However, the organization of health development army is not well aligned with traditional system such as Geda system at higher level and *Aba Ohlla* at village community level in Borena and *Fema* in Afar region at village level.

1.7. Health status in Afar and Ethiopia Somali region

Persistent inequalities in reproductive, maternal, new-born and child health, nutrition and hygiene and sanitation indicators exists among regions and within regions. The health service coverage in Afar and Somali regional states lag far behind compared to the national average. For example according to the 2016 Ethiopia demographic and health survey, contraceptive prevalence rate is at 2 percent and 11.6 percent in Somali and Afar regions respectively while the national average is 36 percent and 56 percent in Addis Ababa. Percentage of women who received antenatal care four times from skilled provider was 20.6 percent for Afar, 11.8 percent for Somali whereas 31.8 percent for national. Similarly, tetanus toxoid

[10] Pastoralist Community Development Project assessment report, WB, April 2016

vaccination for pregnant women in Afar, Somali and National average is 30.2, 38.3 and 49 percent respectively. Delivery by skilled provider is also lowest in both regions 16.4 percent for Afar and 20 percent for Somali while 27.7 percent for national. Postnatal check-up for the mothers within two days after birth was 11.6, 11.9, 16.5 and 55.4 percent for Afar, Somali, national and Addis Ababa respectively. Similarly child vaccination is the lowest in both regions compared to others[11]. For instances, pentavalent three, measles and fully vaccinated children in Afar were 20.1, 30.1 and 15.2 percent respectively, and 36.3, 48.1 and 21.8 percent in Somali while the national average was 53.2, 54.2 and 38.5 percent[12]. The gap in coverage of key health services in pastoralist regions is consistent in other studies as well. A recent survey by AMREF indicated that 92% of women in zone 3 of Afar regional state gave birth to their last child at home. Of these home deliveries, 90% of the deliveries were attended to by a traditional birth attendant.

Fig 2. Key maternal and child health indicators for Afar and Ethiopia Somali compared with national average

Disparity in key health outcomes is mainly due to lack of approaches to service delivery which leads to limited health service access and utilization, sparse settlement, migratory population, lack of infrastructure, seasonal movement of pastoralist community and inadequate, maldistribution and high turnover of service providers at all level which affected the health service delivery.

1.8 Determinants and Opportunities of HEP in pastoralist areas

1.8.1 Determinants

Environment Basics

Pastoralist areas have been neglected for development of infrastructure and social services for long period of time during the previous governments. The community in pastoralist areas are sparsely settled, mobile and far from social service institutions with limited urban and semi-urban areas which can be centre for social service institutions. Pastoralist areas lack integrated infrastructure development such as road access, transport, water schemes, electrification, residential houses, food caterings and other basic services. The community also lead diverse range of livelihood. The productive safety net program is not yet well developed and implemented in pastoralist communities. Implementation of the pastoralist community development program was not as expected due to lack of capacity and close follow up. Although these are external enablers which are beyond the control of health sector coupled with other internal factors hampered the essential health service delivery in pastoralist communities.

Performance management

In pastoralist regions and low performing woredas of other regions, the capacity of health mangers particularly at woreda and primary health care unit level is limited to map and stratify the community, plan, budget, implement, supervise and monitor the health programs. Most health managers also lack to

[11] Mohammed et.al Immunization coverage of 12-23 months old children and associated factors in Jijiga District in Somali national regional State, BMC, public health, 2014

[12] Ethiopia demographic and Health Survey 2016, CSA

coordinate with other sectors that have an impact on the health and wellbeing of the community. According to the key informants, nepotism, favouritism and not abiding the guidelines and rule of low is common phenomenon particularly in some hard to reach woredas. Ensuring accountability and transparency is key challenge in all areas and at all levels and more it is more common in developing regional states. This is mainly due to lack of capacity, good governance and corruption. Hence, the assignment of leadership in most cases is not merit based and the system also favour political will than political and professional skills.

Most woreda management in the health sector engaged in serving the day to day bureaucracy of the system and routine activities than proactive and innovative thinking. Key informant health extension workers and health centre staff in some areas mentioned that hierarchical ordering and sometimes rudeness from some mangers without critically looking at the context and barriers contributed to acclimatize poor staff attitude towards service and clients which leads poor quality of services. The health sector leadership at implementation level in most woredas also lack basic knowledge and skills on health issue whilst some have notable skill in community mobilization. Balancing basic managerial skills and knowledge of health and community mobilization skill is essential for primary health care level managers.

The health Service delivery

The health service delivery in pastoralist area particularly in the primary health care level is affected by several constraints. At health post level lack of supplies, staff absence, lack of skill and knowledge and weak support, inadequate performance monitoring and follow-up, lack of accountability, motivation and retention of staff hindered the service delivery. The service packages particularly for health extension program are not tailored to the pastoralist context. Among the sixteen packages, some packages particularly hygiene and environmental health package implementation is hindered by lack of water and sub-standard housing condition. The implementation of HEP through agrarian/urban mode is not possible due to environmental condition and movement of community in search of water in most parts of the pastoralist regions. Conventional type of health service delivery at health facility is not adequate to reach pastoralist community. Innovative type of service delivery modality need to be designed to reach unreached.

The scarcity of the trained human resource in these regions is big challenge. For example recruitment of level III health extension workers was not possible due to lack of high school completed girls from kebeles and woredas. As per personal communication with health staff in both regions, high school completed girls also don't want to be level III health extension workers as they have many better opportunities where they can choose including level IV to be nurse, midwif, teacher, and many other technical and vocational training fields that enable them to get better job in urban areas. Retention of deployed HEWs in their duty is also a dare. HEWs often get married soon after they graduated from college. *When HEW get married; it is obvious that she retire from her job* said one key informant from Harshin Woreda health office. Health workers in pastoralist regions as elsewhere complain about insufficient salary, inadequate in-service training and career options and poor supervision and management mechanism.

Special Support

The government of Ethiopia through the leadership of the Federal and Pastoralist Affair's Ministry is providing multidimensional support to developing and pastoralist regions. The Federal ministry of health through the health systems special support directorate is also providing health systems strengthening special support for the four developing regions and list performing zones in agrarian regions. The support is based on the six health system building blocks. The federal Ministry of health also developed a five years plan to addressing geographic inequity in the four developing regions. Through the FMoH support the health infrastructure is expanded, the human resource deployment is improved, supply distribution is fairly close as PFSA hubs start operating and service access is getting better than before. Yet, much support requires to improve leadership, governance and performance improvement, allocating adequate budget and generating domestic resource for health, engaging the community and improving logistic supply and distribution system in pastoralist regions. Furthermore, special support need to be cascaded to the all level down to kebel by stratifying according to their respective performance status.

Community engagement

Community engagement is key factor for the success of the health extension program and primary health care. Structured community mobilization system such as women's health development army is in place in agrarian regions. While using the formal and/or informal system to mobilize all segment of population in pastoralist community is missing or insufficient. In Ethiopia Somali and Afar regions there is a government instituted social mobilization committee structure. However, these structure is functional during campaign period and whenever tasked by higher level. On the other hand, there are opportunities to explore and use the existing formal and informal social capital network/platform in pastoralist communities. For example The *Geda* system in Oromia other kinship, clan, and religious networks in Afra and Somali region can be further explored and used. The *dagu* communication structure in Afar region can be further explored and used for health information dissemination. There is an opportunity also to scale-up the health development army in some areas of pastoralist regions as well. However, in general, the voice of communities has been little heard when strategies and policies are developed. There lacks community capacity to hold service providers to account.

In general constraining factor for health service access and utilization are categorized into five:

1. Basic barriers
    - Distance between health facilities and villages mainly due to scattered settlement as cluster of few villagers far apart each other and from health facilities.
    - Movement of the community mainly to search water and food for animals as the areas is arid and hot climate
    - lack of infrastructure such as access to road, communication, water supply, residential houses to retain health workers
    - lack of integrated social service institutions in some areas
2. Inadequate Performance management and service providers knowledge, skill, motivation and accountability

- Capacity to translate and implement policies and strategies into local context is hindered by low technical, leadership and managerial competencies, high staff turnover and inappropriate assignment of mangers.
- Deployed HEWs who don't have adequate knowledge and skills as they are recruited from primary schools
- The training curriculum lacks relevance to the livelihood of pastoralist community and lifestyle as it is mainly copied from agrarian
- Integrated refresher in-service training is not tailored to the HEWs capacity and is not regularly provided except in few woredas where NGOs are operating
- Data recording, compiling, reporting, analysing and using for decision is weak and inconsistent
- Due to lack of motivation and retention mechanism there is high staff turnover at all level of health care in the pastoralist regions
- Cultural barriers for example male HEWs are not well accepted by women to utilize key RMNCH services. on the other side, female HEWs are unable to travel to distant villages to provide service and when they get married often absenteeism from job is common

3. Shortage of supplies and equipment including transportation

Shortage of supplies and equipment at health facility level due toweak distribution, handling, and reporting of medicines, supplies and equipment is more common phenomenon in these regions. Lack of skill in using available equipment and supplies and smuggling of medicines and equipment are key challenges due to inadequate monitoring and accountability

4. Inadequate community engagement/participation
    - Existing community platform and social network is not well identified and used for health promotion and disease prevention
    - Formal structure for regular mobilization of community is missing except during campaign period
    - Community representation on health facility management is missing
5. Inadequate integration within and among sectors
    - Weak service integration within the sector
    - Inadequate integration mobile health and nutrition team and fixed services
    - Insufficient integration among different programs and projects
    - Poor integration among health nutrition and Wash partners
    - Lack of integration with other sectors such as education, agriculture, livestock and productive safety net

1.8.2 Opportunities

On the other side, there are also many opportunities to address equitable access and utilization of the health services in these areas more than ever before. The establishment of Federal and Pastoralist Affairs ministry provides overall coordination and leadership for enhancing development in these regions. The presence of Pastoralist Affairs Standing Committee in parliament monitor the implementation of overall

development issues. The inter-ministerial board for pastoralist area provides guidance for implementation of integrated socio-economic development. Establishment of special support and inclusive directorates in the sector ministries helped to provide tailored support. The capacity in regions is also improving. These all demonstrate the commitment and attention given by the government to enhance the socio-economic and political transformation in developing regions. Establishment of villages in convenient areas and voluntary based villgization is and infrastructure development are underway in pastoralist areas with the objective of increasing access to and utilization of basic social and economic services

Ensuring equitable access and utilization of basic health service to those left behind is also well reflected in the health sector transformation plan. The health systems special support directorate in the Federal ministry of health developed strategic plan for addressing key barriers in pastoralist regions and other low performing zones in populous regions. The regions are also expected to develop context-specific strategic plans. There are also partners working in these regions who can provide overall support. Despite gigantic challenges persisting in these regions, there are also wide range of opportunities to improve the health service delivery and health status in these regions.

1.9 Rationale and methodology for developing strategy

Almost after a decade of implementation, it is important to revisit the health extension program particularly in pastoralist areas. Notwithstanding, from the inception, the health extension program in pastoralist areas was not as effective as agrarian areas. The Federal Ministry of Health in its strategic plan; the health sector transformation plan set out four transformational agendas of which one is ensuring equitable access to and utilization of health service and narrowing the geographic disparities in health outcomes. As part of translating the broader HSTP and equity strategic plan into action, the health systems special support directorate is tasked to prepare pastoralist health extension implementation strategy. This strategy is prepared to revisit and revitalize the health extension program implementation in pastoralist areas as per the plan in HSTP[13].

Through technical and financial support from UNICEF the team in health systems special support directorate facilitated the development of the strategy. While the State Minster for programs provided strategic direction and key areas to be included. Key informants from regional health bureaus, woreda health offices, health centres and health extension workers and experts from NGOs working in pastoralist regions provided valid inputs. Other sectors including livestock, pastoralist affairs office and education sectors were also consulted. The draft document went through serious of consultative workshops including FMoH and regional health bureau management members, health, nutrition and population (HPN) donor group, UNICEF team, stakeholders from health and other sectors, and implementing partners.

Understanding the context, gaps and opportunities through field visits observation, interview of key informants, review of relevant documents and consultation of key actors, led to the key areas incorporated in the pastoralist HEP strategy.

[13] Health sector transformation plan PP106

Part II

Strategy for Revitalizing Health Extension Program in pastoralist areas

2.1 Vision and Goals

Vision

A health extension program that addresses the gaps in access to and utilization of quality health services which contributes to achievement of UHC, the SDGs, and resilient health system.

Goals

This strategy intends to contribute achievement of two goals; i) achieve universal health coverage through strengthening primary health care and ii) contribute to reduce disparities in health outcomes among geographic areas and different population groups. Universal health coverage will be achieved through strengthening the service provided at community, health post, health center and hospitals and attaining financial protection though different initiatives such as roll out of community based health insurance and social health insurance. To reduce disparities targeted and focused support will be provided by stratifying the low performing areas and disadvantaged and deprived community groups in accessing and utilizing health services.

2.2 Objectives

The general objective of revitalizing HEP in pastoralist areas is to narrow the gap by increasing the coverage of health outcomes through designing context specific HEP strategy.

Specific objectives

- To improve leadership, governance and performance management capacity for implementation of HEP in pastoralist areas
- To increase community engagement through engaging appropriate community platform
- To develop service delivery modality that is tailored to pastoralist livelihood and lifestyle
- To establish effective follow-up, monitoring and evaluation including use of data and evidence generation

2.3 Programming principles

- Universal access for basic health service
- Community ownership
- Increase access to essential health services at scale
- Strengthen accountability at all levels
- Gender sensitive
- Contribute across the HSTP, GTP II and SDGs
- Integrate humanitarian and development programming
- Strengthen health systems and enhance resilience

2.4 Theory of change

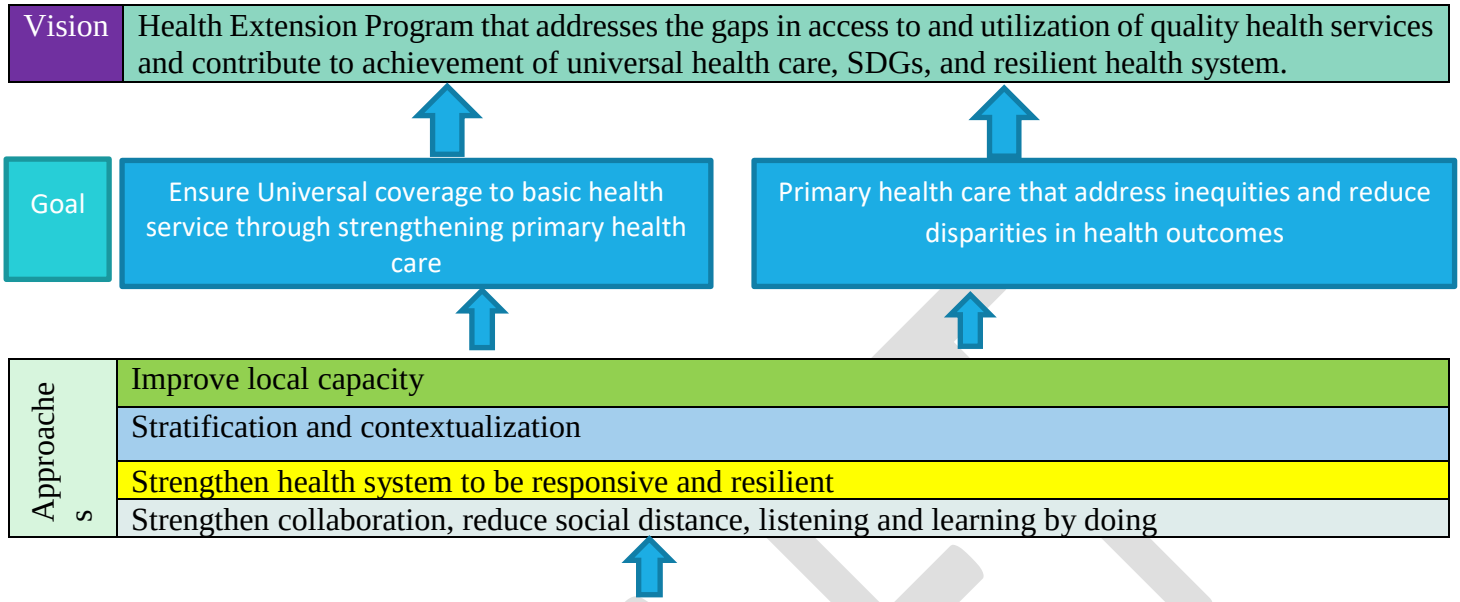
The recurrent drought, conflict and flood over the last years contribute pastoralist areas food insecure and less resilient. This in turn escalate vulnerability for various health and nutrition problems including frequent occurrences of acute watery diarrhoea, measles and sever and nutritional problems. Access to basic health service is extremely low despite the community in pastoralist areas are susceptible to complex health problems. Particularly, children and women are affected due to absence of basic health service, poor quality and interruption of key services. The health extension program apparently launched to reach the most vulnerable groups of population and provide service at door step in pastoralist area failed to achieve the anticipated result. Thus, revisiting its performance and revitalizing the HEP is required. Field visits conducted across four regions for this purpose attested the importance of revision.

A theory of change is developed to guide the revitalization strategy for pastoralist health extension program. It explains approaches to be followed, strategic focus areas that are effecting the program, and key activities that need to be done to bring change and how those inputs and activities are translated into intended results. The theory of change is believed to nurture consensus and can guide implementation sequences and help to show how the approaches and activities in each focus areas contributes to achievement of long- term goals. The theory of change stipulates four approaches and six key areas to guide the revitalization strategy for pastoralist health extension program.

The four approaches are: a) investing to develop local capacity b) stratification and contextualization c) system strengthening and d) strengthening collaboration reduce social distance and listening and learning by doing. The six major focus areas are system strengthening components which require complimentary interventions; i) improving stewardship, governance and performance management capacity of health sector managers, ii) community engagement, iii) revisiting the service delivery modality iv) providing special support v) enhancing integration within the health sector and key sectors and vi) program follow-up, monitoring, evaluation and learning.

The strategy is based on theory of change that is based on sound analysis of the situation. It is also in line with the HSTP, equity plan and other transformational agendas. Improving pastoralist HEP is not a standalone project that will be implemented separately. The revitalization strategy of the pastoralist HEP is part and parcel of the HSTP and equity strategic plan and other health sector transformational agendas. This strategy is in line with other existing health sector strategies and implementation guidelines. However, the success of the strategy depends on political and managerial commitment of implementers, capacity of health sector managers to translate into practice and above all on the political land scape and Government commitment.

Table1. Strategic framework of pastoral HEP strategy[14]



Focus areas	Improve stewardship (LGM)	Strengthen service delivery	Engage community	Provide special support	Enhance Coordination & integration	Strengthen monitoring and evaluation
Key Activities	- Implement legal & policy framework for assignment of capable managers - Build the capacity health managers and service providers - enhance accountability, transparency and rule of low -Promote evidence based planning, budgeting, supervision, monitoring & evaluation - introduce result based financing in hard to reach areas	- extend service delivery level - expand service scope - broaden service delivery modality - improve service providers capacity - Improve availability of supply & logistics	- identify & strengthen community organization, social networks - engage for demand creation - strengthen social accountability	-stratify based on implementation capacities - identify key barriers and causes -Suggest local solution for local problems -Target resources and efforts to those required	- Identify areas of coordination and integration - Integrate services within the health sector -Work jointly with other sectors -	- Conduct joint planning -supervision and capacity building -Program review, documentation of best practices and scale-up - Conduct implementation research -

[14] *Adapted from UNICEF's Strategy for Health (2016-2030), UNICEF programme division, 2015*

Approaches

Mainly four approaches will be applied for successful implementation of Health Extension Program and primary health care in pastoralist areas. First, efforts will be made to develop local capacity. Educated young health managers and service providers who know the culture, tradition and language will be trained and recruited as much as possible. In areas where there are scarcity of educated young people, affirmative actions will be applied to train local health workers. Second stratification of woredas, health facilities and communities based on health outcomes, geographic, topographic and other social barriers will be applied to provide targeted support. Third, all programs/projects, initiatives and activities should contribute to system strengthening and sustain improvement. Strengthening community platform, engaging community and risk informed preparedness will help to strengthen the system. Fourth, collaboration and coordination for common goal is critical, the health care provider at different levels of primary health care should be collaborative for common goal and listen and learn each other. Besides, reducing the social distance between health workers, local government leaders and community should be given due attention.

Priority areas

About six program focus areas are prioritized and the interventions that are intended to bring about desired results are outlined in each focus areas below. Focus areas are clarified, contextualized and indicated how each intervention is interrelated. Menu of interventions or key activities are given to select and implement based on the local situation. Interventions or activities outlined are identified on the understanding of the realities at the ground, previous experience, feasibility and believed to address key bottlenecks. Key performance measures are defined and indicated in the annex 1.

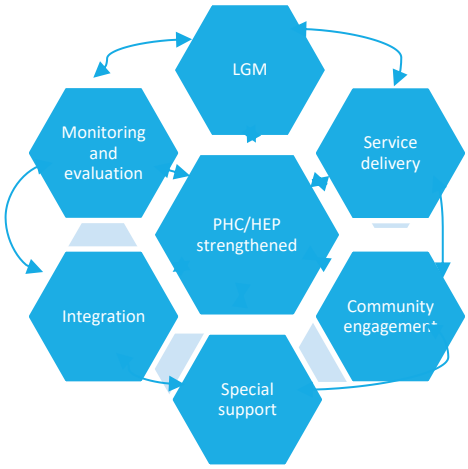


Fig. 3. Framework of priority areas for revitalizing pastoralist HEP

2.4.1 Improve stewardship and performance management of woreda and PHCU staff

Performance management/stewardship is perhaps one of the most important component because of its influence on the other health system components. Consolidation of HEP depends on the support that the health center, woredas health offices, administration and community provide to its implementation. Majority of the woreda health offices in pastoralist regions are led by low level of educational qualification or non-health trained persons. This has immense challenge on evidence based planning, budgeting, implementing, monitoring and evaluation of the health service delivery. Improving stewardship and governance enhance teams to work together to achieve a shared vision of health sector plans and its aims. Health managers at woreda and health facility level are crucial to translate policies and strategies into action. Therefore, the following actions are required to be taken to strengthen leadership, governance and result based performance:

- Implement legal and policy framework that encourages merit based assignment of health sector leadership at all level. This can be implemented through advocacy and setting minimum requirements for the leadership positions including political skills than depending only on wills.
- Encourage and motivate young educated persons to become health managers so that they can generate data, analyse and use information for action.
- Improve the capacity of health mangers through training, mentoring, experience sharing coaching and providing technical support.
- Enhance transparency, accountability and rule of low through strengthening internal and external monitoring and evaluation for better performance.
- Improve citizen engagement on health service delivery using different community platforms.
- Initiate motivation and retention mechanisms as stipulated in human resource development strategy, equity plan and other related documents. Special emphasise is required to enhance motivation, retention as well as to enhance accountability.
- Provide technical support to woreda and PHCU level health managers to be able to map and stratify community including mobility pattern and livelihood in their respective jurisdiction, exercise evidence based planning, budgeting, implementation and monitoring
- Provide intensive supportive supervision and monitoring of priority interventions.
- Commence result based financing to increase the health outcome coverage. Incentivizing for results is critical

2.4.2 Health Service Delivery

Strengthening primary health care is key factor in order to achieve Universal Health Coverage (UHC). The health service delivery should be people centered, responsive and integrated[15]. Expanding access to and utilization of basic health services to pastoralist community is recognized well in the national strategies and plans. The health extension program is the main vehicle to deliver key service at community level. The national norm for the health extension program is deployment of at least two female level III HEWs per kebele to provide service for an average population of 3,000 to 5,000. Unlike agrarian regions, the settlement in pastoral areas is scattered and population is moving. HEW in pastoralist regions are mixed gender males and females with different level of education since the context varies in these regions.

[15] Health in 2015, from MDG to SDG, WHO, 2015

Redesigning the service delivery modality that fits to the local context is crucial to improve the existing situation. Therefore, it is essential to reform the health service delivery level, package, scope, modality of delivery, the human resource, supply and logistics and monitoring mechanisms to increase access and utilization of essential health services among pastoralist community.

a) Health Service Delivery Level

The PHCU in agrarian/settled community comprises satellite health posts at *kebele* level and Health centers for an average of five kebeles. Application of similar modality in pastoral and low land areas is difficult due to distance and sparse settlement. Therefore, a three-level service delivery (health center, health post and community/village level) service delivery is suggested in pastoralist areas to strengthen PHCU service and link community and health facilities. Community/village level service includes sharing/shifting some of the tasks used to be implemented by HEWs such as health promotion, disease prevention, community mobilization and linking community and health facilities in case of access to health facilities is challenge. Examples of services delivered and activities at each level but not limited to these are highlighted below:

Health center level Health centers are key institutions for effectiveness of the health extension program elsewhere. Health centers provide preventive and curative service for the majority of poor and rural population in Ethiopia. If health centers are staffed as per the national standard, they can provide support for health posts in their catchment areas. The primary health care unit (Health center-health post) linkage can be reorganized as per the local context and feasibility than following the conventional one to five linkage. Health centers in urban and semi-urban areas of pastoralist areas are relatively well staffed while in rural areas are barely staffed. Fully staffing of remote health centers might take three to five years. Nevertheless, working on staff retention and motivation scheme is crucial to deploy and retain staff in hard to reach areas.

While strengthening the full functionality of fixed service in all health centers, it is important to establish a multi-disciplinary team from the existing staff in well-staffed health centers in pastoralist and hard to reach woredas that can provide the required services through different service delivery modality. For example, the team can soon be established at least in health centers situated at woreda towns' as these health centers are relatively well staffed. Hiring additional staff may not be required for establishment of team as long as the health center is staffed minimum as per the national standard. In case of shortage of staff in the health centers relevant persons can be included from woreda health offices. The health center and woreda health office need to work closely to extend health service to all segment of population in its jurisdiction and beyond when necessitude. The establishment of the team at health center is mainly to extend health services to hard-to-reach areas and "high risk communities." The task of multi-disciplinary team in the health center can be like special army who can respond to any health issues as required in its catchment area and provide support beyond its catchment in collaboration with woreda health office. The team can perform the following tasks but not limited to:

- Hence, the government's main strategy is encouraging pastoralists for voluntarily settlement, modernization of animal raring and to adapt diverse livelihood. Strengthening the regular service at fixed health facilities should be a priority. Once the service scope and quality improves at fixed health facility level, it is usually easy to extend those services beyond health facilities. The team will work to improve fixed service and work as change agents and innovator for PHCU service scope and quality improvement.
- Currently, there is mobile health and nutrition team (MNHT) which is supported by UNICEF in some regions as a short term transitional alternative service delivery modality to respond to health emergency and extend key live saving services to underserved population. The team institutionalized at closer health center with support from woreda and higher health facilities can replace, extend and manage key service packages to the respective woredas where population is not easily access to fixed facilities. For example;
    - The team identify and map the mobility pattern of the community, hard to reach areas, high risk communities, IDP sites and other communities affected by inequities
    - prepare annual and operational plans to extend key health, nutrition and WASH services to all communities and locate on the health center catchment and/or woreda map
    - in case of presence of health facilities (health posts) involve health extension workers and community focal persons in planning session
    - Identify sites to be reached by fixed health facilities, day or overnight outreach, extended outreach or mobile.
    - Identify and list health workers, community focal points and influential with their phone number from each site to contact and consult about service delivery
    - Hold discussion with health workers, community focal points, influential community leaders on specific circumstances and to agree on how best health and nutrition service can be provided
- The team provide a range of health services through different modalities as outlined above through fixed, outreach, extended outreach or moving from site to site in isolated and/or far located villages, temporary settlements, and new arrivals and extend key service to health posts. Vehicles/ambulances to be assigned at HC level to effectively manage service delivery.
- Build the capacity of health post and community level service providers and fill the gap whenever health post service is interrupted due to various reasons.
- Discuss with the community and consult with relevant stakeholder to establish women social network groups, social mobilization and advocacy facilitator group who can effectively link health facilities and community.
- Perform tasks that the current mobile health and nutrition team supported by UNICEF is working meanwhile the MHNT situated at regional level can focus on capacity building and supply delivery till the woreda office/health centers fully takeover the services the team used to provide.
- Establish home like maternity waiting homes at health centers and strengthen community health facilitate linkage. Health center can temporarily hire TBA to link health facility and community.

- The health center with support from woreda to prepare items required for extended outreach and/or mobile service. The items include transportation, tent, cooking utensils and mats, sleeping bag, and medical equipment and supplies
- With support from woreda health office and other partners (if available) provide extended outreach or mobile service within or out of the territory as required using the car or camel caravans as appropriate.

Health post level: Health post is the lowest health facilities in the hierarchy of public health care facilities staffed with at least two HEWs and close to community which provide health information, preventive and few selected curative services[16]. As the density of the population in pastoral areas are much dispersed, the health post are situated far apart from health centers and some villagers. For example, there are health posts 70km and 95 Km far from Harshin health center in Somali region and Guyah Health center in Kureha woreda of Afar region respectively. Thus, conventional referral link with the health center is reasonably difficult due to distance, other environmental and infrastructure barriers. Villages within the same kebele are also thinly dispersed which take hours of walking from health posts. On the other side, increasing the density of health posts and health centers will be coasty and even some of the existing rural health centers are under served. In fact, it is important to expand new health facilities in areas which are potential for future relocation. Therefore upgrading and rehabilitating the existing health posts to enable them to provide wide range of services is preferred way. Besides, construction of additional health posts particularly in isolated hand pocket areas and possible future settlement areas can be considered even if the number of population residing is less than the average norm to construct the health post.

Accordingly, the health posts in pastoralist regions need to be organized in such a way to provide basic curative service including skilled delivery and postnatal care. In some areas sensitivity to women's cultural beliefs and choices should be addressed through recruiting female health extension workers who can provide basic reproductive maternal and child health services. Deployment of diploma level (level IV) health extension workers may enable to provide key curative services including management of normal delivery at health post level. An out-reach service by health center staff can also augment range of service access and quality to "risk communities" and in remote areas. This can be achieved by:

- *Renovation of health posts*- In most places health posts do not have adequate rooms to provide range of services or some health posts constructed from wood and mud are deteriorated. The health posts in low land areas are also infested by termites and bats which may need maintenance including construction of residential houses for HEWs.
- *Construction of Health posts*- in pocket and isolated areas regardless of the national norm, construction of health posts can be considered to serve up to 250 households or 1000 people. This can be determined by respective woredas based on the existing situation.
- *Equip and upgrade health posts* with essential equipment, supplies, guidelines and lifesaving medicines as per their designated level of task. The health centres will be primary responsible institutions for continuous supplying health posts.

[16] *Ethiopian Standard Agency; ES 3612:2012, requirements for Health post, First edition*

- *Staffing health post with comprehensive level VI trained HEWs*. This is achieved in two ways. First upgrading of the existing level III HEWs on merit base enrolling annually and providing advanced training. Second through direct enrollment for generic pre-service level IV training. In areas where HEWs below level III are assigned, they will be encouraged to improve their educational background to complete at least grade 10 to upgrade their career otherwise they need to be assigned on other support staff posts.
- *Supplying with essential medicines and supplies*. Health centres to provide the required supplies to the health posts under its territory. However, support from FMoH, RHBs and partners is required to upgrade health post services.
- *Broaden service scope Enable* HEWs to provide basic curative service as per the standard so that people can access basic service without much interruption of domestic chores.
- *Integrating services* into one session is more efficient given the difficulty for users to repeatedly access health facilities.
- *Build capacity of HEWs* using different approaches including face to face, distance learning programs, availing job aids, on-site and off-site supervisor contact, and providing standard operation procedures, enhance staff motivation and performance based incentives. Regional health bureaus can collaborate with Universities and health science colleges in the respective regions to upgrade the skill and knowledge of health workers.
- *Provide solar power mobile phone that can be used to* call and skype to request advice from higher level in case of emergency

Village community level: Similarly, villages within kebele are sparsely settled which in some cases take more than three hours of travel in hot climate from health post. HEP to be effective in pastoralist low land area need to be extended beyond the health post. Therefore, it is essential to train volunteer community mobilizers/HDA as appropriate to specific context who can provide some services that can be shifted/shared from the HEWs and support to connect HEWs and or health center team and community. The community mobilizers/health workers can be clan/religious leaders' traditional birth attendant any influential persons selected from villagers as per the existing kinship or social network/hierarchy who can able to influence the community. The community level health worker can be temporarily contracted by health center or incentivized by other means. The role of HDA team leader or community health agent will be:

- Link community and health facility through information exchange
- Participate on community level planning through facilitated, structured, action-oriented process
- Support in organizing or strengthening women's groups for increased health and nutrition knowledge, care- seeking and practices and service utilization in settled and semi-pastoralist areas.
- Organize and maintain outreach posts, mobilize community for service uptake such as integrating services for example during immunization, growth monitoring, nutrition screening and promotion activities outreach service.
- Support HEWs in supply transportation such as vaccines from health facilities

- In areas where PSNP is implemented assist HEWs in identifying eligible, inform target population for service uptake, checking whether eligible and /or caretakers receive service, counsel and notify HEWs in case of nonadherence of service utilization.
    - Provide health education and arrange behavioral change communication sessions in public gatherings
    - Register and pass eligible for health facilities
    - Practice key health actions such as latrine preparation, household water treatment, personal hygiene, hand washing, nutrition etc. and demonstrate for villagers.
- Use available community/social platform to mobilize community for service uptake
- Support regular routine nutrition screening for under five children, pregnant and lactating women and adolescent de-warming and supplementation of vitamin A
- Delivering of Timely Age Appropriate Nutrition Messaging to pregnant and lactating women on maternal nutrition and Infant and Young child feeding.

Schools: There is a primary or alternative basic education centers almost in most villages in pastoralist areas. Despite that schools are key institutions for promoting health and preventing diseases, school health is not yet institutionalized and functional in Ethiopia. Schools can be health agents at least in two ways. First as school children are coming from each households, they can disseminate health messages for their families. Secondly, school children can themselves adapt key health and nutrition practices and healthy behaviors hence shaping the health behavior of school children is fundamental for creating healthy generation. Therefore, schools within the kebeles can be considered as key channels for providing health services and practicing key health actions and disseminating key health and nutrition messages. These can be done by:

- Discussion with school principal and prepare plans to promote school health, nutrition and WASH services
- Selecting health promoters from teachers and students and providing training on selected key school health activities
- Integrate health, nutrition and hygiene education with school feeding program where the interventions exist.
- Encourage the school children to tell their families and neighbors health and nutrition messages for example about immunization, engage some of the children as mobilizers during outreach session and SIAs.
- Conducting periodic outreach service provision sessions such as screening, providing simple treatment, counseling and health education by nearest health facilities
- Providing health education materials and job aids so that they can support others.
- Organizing health clubs in schools and giving assignments on health promotion activities.
- Conducting joint monitoring and support for health issues including linkage with higher level facilities in case of need of interventions beyond the nearest health facilities.

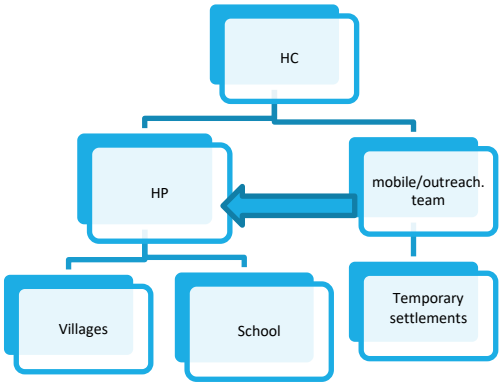


Fig.4. Primary health care unit service delivery levels

b) Service package and scope

The service mix and scope provided at health center level can be as per the national standard. Additional efforts are required to strengthen the scope and mix of service as per the national standards as many health centers in pastoralist regions are not providing services that are supposed to be provided at its level. Whereas the scope of service offered at health post level should be upgraded to include basic curative services including handling of the skilled delivery. Therefore, the range of service at health post level should be revised as per the pastoralist context to include key curative services. Thus, it is essential to develop the range of services provided at health post level in pastoralist areas. Correspondingly, the health service packages rendered at community and school level need to be developed/revised.

c) Diversify service delivery modality

Fixed or day long outreach is not adequate to extend health service in a very dispersed and mobile community and subsequently ensure universal access. Therefore, diversifying options of health service delivery is required to reach those who are left behind. In general, it is important to devise regular fixed, outreach for one to two days, periodically for extended time and mobile type of service delivery options. Each woreda and health center can map, stratify and plan where and what services to whom to be provided. Likewise, health posts can plan outreach services for villages and schools in their respective catchment areas. Each woreda together with health centers in its jurisdiction should identify and map the "high risk community" in its respective governance. Then the woreda health office with its health facilities select appropriate service delivery approach for identified and mapped community. However, the choice of approach should be based on sound analysis of the local situation and consultation with administration, respective community representatives and service providers. Sustainability and financing of the service delivery approach should be considered as well. Service delivery approaches include:

i. *Fixed facility service provision*: - in line with health center reform and quality improvement, the key focus should be strengthening the scope and quality of health care provided at health facilities and in its compound. It is important to continuously improve service at health facilities to increase public satisfaction. The community who satisfied with the service provided by health facilities will be allies and advocates for health service uptake.

ii. *Scheduled community outreach health service*- Each facility need to identify and map the hard to reach areas and "high risk community" in its catchment and plan how to extend the health and nutrition service. For example, among list of villages/community the health center identifies villages/kebeles that can be reached with a day or overnight through appropriate means of transport. Example of services include immunization, growth monitoring, vit. A supplementation, nutrition counseling, treatment of sick child, family planning etc.

iii. *Periodic intensification or Extended outreach service*- For hard to reach areas such as isolated, remote villages, seasonal inaccessibility and in case of internal displacement where more than two days of stay is required multi-disciplinary team need to prepare to provide essential services by moving to sites or mobilizing community to closer sites. Prior to travel, mapping and communication with local focal persons is critical.

iv. *Mobile integrated health service* Consider vehicle/camel caravans when circumstance such as mass mobility, high influx, outflows from the territory or health emergencies and outbreaks occurs.

Utmost preparation using checklists and service integration is important to provide basic health services out of the fixed health facility or its compound

d) Staffing

Health centre level staffing

Health human resource shortage, maldistribution, inadequate performance management and productivity, implementation of motivation and retention mechanism is lowest in pastoralist areas than elsewhere. It was noted that health centers in urban areas are over staffed while rural health centers are extremely under staffed. For example, Harshine health center in Somali regions was staffed during November 2016 with four health officers, six nurses, seven midwives, one druggist, one laboratory technician and three urban HEWs. The Health center is over staffed with midwives although the average delivery per month in the health center ranged between seven and 12. Similar scenario exists across developing regional states and in big regions as well. Thus appropriate redeployment of staff might be considered in some areas. However, redeployment need to consider improvement of enabling environment. Nevertheless, staffing the health centers as per minimum national standard is adequate in pastoralist regions. But, health centers in collaboration with woreda health offices need to increase staff productivity through designing different mechanisms including teaming and introducing motivation schemes.

Health post level staffing

The health posts need to be staffed with better qualified health workers mainly level IV health extension worker in order to improve the quality and quantity of service provided at health post level and strengthen health promotion and disease prevention interventions. Apart from upgrading level III HEWs, direct deployment of level four health extension workers will be commenced. The direct training of level IV HEWs will enable the health sector to recruit competitive and good quality health workers. Direct training of level four HEWs will reduce the cost incurred for upgrading and service interruption during upgrading training of level III. It will also reduce the current mix of staff deployed at the health posts in developing

regions. In areas where level III HEWs are working, upgrading the existing HEWs to level IV will continue. Regional colleges should be encouraged and supported to train level IV HEWs apart from other categories. The curriculum for level IV HEWs training should cover wider scope of tasks and be tailored to the livelihood and the pastoralist context. For example, the training curricula should give due emphasis on zoonotic diseases in pastoral areas. Four options are proposed for staffing health posts as per context and local suitability.

Option one Deployment of at least two to three female level IV HEWs per health post considering number of households/population and settlement density in the kebele. In addition, one HDA team leaders or community health worker with lower level education (level II) can be recruited from each villages to provide overall support and link community and health facilities. The HDA team leaders/community health worker can bridge the dispersed villages and provide information and mobilization support for example during outreach services. Support transporting supplies and logistics such as vaccines from health facility with refrigerator.

Influential community/religious leader or active TBA who can link health facility and community and more engage on health education and assist health practices in villages. The deployment of local community health worker will partially fill the key services gap created during pregnancy and maternity leave of HEWs. The community health worker can be temporarily contracted or incentivized through other means. Community health worker will not be part of civil servant or government salaried person. In well to do areas the person can be contracted by community/villagers.

Option two Deployment of at least two to three mixed (gender male and female) level four HEWs. Deployment of both sex HEWs will enable to extend service to isolated and pocket villages which are very hard to travel for females. Besides, many health managers and HEWs in pastoralist areas complain and argue that HEP services are usually compromised after HEW get marriage and birth hence they shoulder additional responsibility of caring their family in addition to the already overloaded task. Besides, availability of male HEW will fill the service gap occurred during pregnancy and maternity leave of female HEWs. Males can collect essential drugs and vaccines from the nearest health center using motorcycle or on foot. Males also preferred than female to provide mobile health services in harsh and challenging environment. Yet, about 60% to 75% of HEWs can be females based on the hardship, socio-environmental circumstances and mobility pattern of the population. Additional community/village level HDA leader/ community health worker can also be considered in health posts even male HEWs are deployed.

Option three Deployment of different categories of health workers at health post level. For example nurse along with HEWs are assigned at health post level in Benshangul Gumez region and some health posts of Afar, Somali and other regions as well. In areas where nurses are available, the HEWs focus on community health services while nurses focus on providing curative services. In some areas the HEWs as well as nurse perform the same activities including curative as well as preventive care.

Option four Deployment of lower grade health extension workers. In a very hard to reach and remote woredas where there is dearth to get 10^{th} grade completed girls to be recruited as HEWs, regions can consider recruitment of lower grade completed community health workers on temporary contractual basis.

The lower grade completed community members can be trained using contextualized and tailored curriculum. This should be implemented with careful selection training, close follow-up and mentoring. The required efforts should be made by higher level authorities and health facilities not to compromise the quality of health service in such circumstances. Meanwhile, in the future it is possible to deploy with better educated as educated young from those areas are coming. Key activities for staffing include:

- Development of tailored curricula for direct level IV HEWs training. The human resource development directorate need to work with other respective directorates at FMoH and MOE as well as health colleges to tailor curriculum for HEWs
- Regions recruit minimum 10^{th} grade completed girls for HEW at least from woredas and in case of scarcity from nearest woredas considering local language and culture appropriateness
- Regions may consider the male HEWs in areas with special circumstances.
- Support regional health colleges to train level IV HEWs than training other categories that are already saturated and trained by Universities. In some areas where already the existing diploma level health workers are excess
- Replace/upgrade the existing HEWs and other divers frontline health workers with level IV female HEWs
- Determine the minimum service year before transfer/resign after training
- Introduce retention and motivation schemes both monetary and non-monetary including career development
- Update the service scope provided by these HEWs and community level workers
- Ensure trained HEWs, deployed, motivated, managed and supervised
- In special circumstances such as very remote areas with no educated person from woredas consider temporary deployment of lower grade HEWs till 10^{th} grade completed youth available from local community.

e) Supply and logistics

Uninterrupted supply of essential drugs and logistics is key aspect of health service delivery. In most cases, the health posts are not well equipped and supplied with essential drugs and supplies. If health posts do not have adequate supplies and essential medicines as per the standard, they can't provide the required services that is supposed to be provided at their level and opted to refer to higher level health facilities. This in turn will upset the community and demotivate the health extension work. Therefore, the health centers should take the responsibilities to provide essential supplies and medicines to the health posts.

- Health centers should provide the required supplies for health posts under their jurisdiction using the appropriate logistic and supply delivery system
- The Federal Ministry of Health (FMoH) will provide support to equip and supply the health posts in the remote areas through special support.
- Respective regions to collaborate with development partners and NGOs working in their respective regions to supply health posts.

- There is possibility to tap additional budget from other sources such as PCDP, PSNP and other projects working in respective regions and woredas where these projects are being implemented.
- Implementation of health care financing strategy
- Enhance efficiency and effectiveness of the implementation including implementation of auditable pharmaceutical transaction service
- Implementation of other innovative initiatives such as result based financing

2.4.3 Community engagement

Community do many things if they are given a chance to contribute and consulted. Community has local knowledge and wisdom to solve the local problems in their respective areas. Engaging community has the capability to reach areas where formal facility based service cannot. Therefore, involving community in all process of health service delivery has significant importance in empowering them, reducing social distance between service providers and community as well as improvement of service quality and access. Community platforms if judiciously engaged can provide support for health workers, pass the health messages on throughout their neighbourhoods, contribute for health service delivery and quality of care and practice the health actions and improve health literacy, increase demand and use available services.

In pastoralist areas, identifying common events where people gather together is more difficult compared to settled population. Adult and young nomadic people meet at watering points or the encampments where the elderly and the very young may stay at shelters, but it is not common to see them regularly gather in large groups. So, it is not easy for HEWs to reach great proportion of the pastoralist population as possible. Conducting meetings with pastoralists at convenient places such as *burka* wells or other water collection areas, market places, food aid distribution centres, and at mosques require influential clan or religious leaders' involvement. The frequency of the meetings and events varies depending on the location and community. The HEWs may need to work with available social resources and religious resources such as mosques, clan leaders, *ollha* (Borena), *Fame* (in Afar), traditional birth attendants (in Somali), community animal health workers and productive safety net workers or aid food distributors and traditional healers. There is also an opportunity to integrate with pastoral community development and productive safety net program in woredas where such programs are implemented. To strengthen the engagement of community in order to own the health issues:

- Conduct further study to identify appropriate and effective community networks/ platforms which can be used to influence health service utilization
- Establish and or strengthen appropriate and contextual social networks among pastoralist communities which is similar to HDA to promote health practices and demand for services. For example the *Geda* system can play key role in Borena and similarly *Fema* in Afar region can be explored.
- Establish an advocacy and social mobilization facilitators group comprising clan leaders, religious leaders, women and youth who advise service access, advocate for health and facilitate service uptake
- Use schools as platform to disseminate health message
- Strengthen IPC for information dissemination and conduct health awareness campaigns similar to the livestock health

- Consider training of indigenous volunteer community health workers who are moving with pastoralist community preferably traditional birth attendance who are currently supporting the home delivery and other key health practices from each clans. They can also link community with health facilities. This may require development of curricula for basic and in-service training
- Use local medias to promote health messages
- Improve service quality and service delivery promote compassionate, respectful and caring professionals at all level so that satisfied clients will be key advocates for service use.

2.4.4 Special support

There are always tradeoffs in addressing an equity issue. Therefore, exceptional support is required to increase health service utilization and improve the health status in "high risk communities" including pastoralist and hard to reach areas. The health systems special support directorate in the FMoH is extending comprehensive support to the four developing regions and some low performing zones in agrarian regions. In the same way, the Regional Governments and regional health bureaus are supposed to provide special support for those woredas lagging behind for service access and utilization. The support can include but not limited to information, technical, psychosocial, financial, material such as (shelter, solar lump), transportation access, and integration. Besides, special motivation and retention monitory and non-monitory mechanism should be in place including career development opportunity by classifying hard to reach woredas. The following steps can be implemented to provide special support;

- Stratify woredas/health facilities and kebeles as per their performance level and select the list performing woredas/health facilities
- Conduct discussion with administration, service providers and beneficiaries to understand possible obstacles
- List possible solutions and define what needs to be done by whom and how
- Target resource and efforts for under-served areas
- Provide comprehensive support including local capacity building to left the performance
- Continuously monitor progress and adjust accordingly

2.4.5. Coordination and Integration

Integration is usually easy to say nonetheless hard to practice. Health sector can benefit from multiple sectors if pro-actively work with other sectors. There are opportunities and guidelines to work together to enhance livelihood of the community and increase access to and utilization of basic services including health and nutrition. Health sector at national and decentralized level will strengthen the collaboration and coordination with education, agriculture, livestock, women and children's affair and other relevant sectors. Likewise HEWs will be supported to collaborate with sectors who are operating at kebele and village level such as school teachers, animal health technicians, women's affair focal persons, kebele administration and executive officer, productive safety net workers and other influential community members.

Information exchange and working towards common goal among sectors will help to increase service access and utilization.

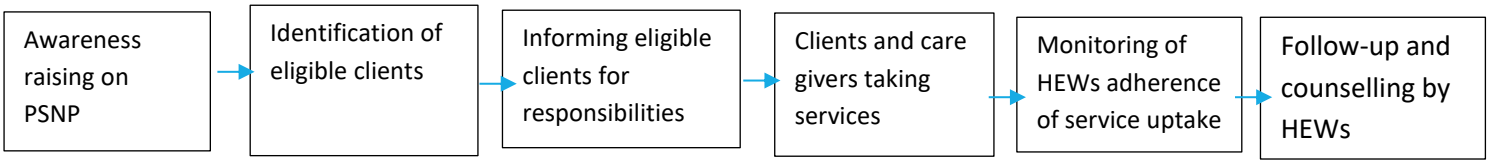
For example the national productive safety net program phase IV and national nutrition policy spell out opportunities which health sector can benefit to increase service utilization. More importantly, PSNP and PCDP target the poorest households which is important to address the equity agenda which is the core principle in the health sector transformation plan. In the fourth round national productive safety net program, beneficiaries can contribute to the health sector and increase health and nutrition service uptake at least in the following ways[17].

a. **Through Public work contribution to construction and maintenance of health facilities** adults and young able people can engage and contribute for public work activities where the health sector can benefit from maintenance of health facilities, construction of maternity waiting, water and sanitation facilities and improve road access to health facilities.
b. **Link to health and nutrition service** temporary direct support beneficiaries groups are pregnant women, lactating mothers with under one year age children, women with under five children identified as suffering from moderate or severe malnutrition. These target groups are supposed to be linked to health and nutrition services. They get direct temporary support for utilizing health services and participating in behavioral change communication session instead of public work.
c. **By identifying permanent direct support beneficiaries** who are elderly, disable and poorest people who earn permanent support for 12 months in a year as part of social protection where also can be considered as indigents to address equitable access to basic health services
d. **Increase health awareness, care seeking and practice** HEWs will get the opportunities to meet poorer households to disseminate key health messages, to provide services and to link with higher level health facilities which otherwise difficult to reach them.
e. **Construction of health facilities procurement of supplies and essential medicines** The pastoralist community development program phase three is also an opportunity in project woredas and kebeles to extend the health access and utilization to the community through supporting construction and maintenance of health facilities and procurement of equipment and supplies.
f. **Capcity building and system strengthening** The programs PSNP and PCDP are mainly manged by local government (woreda and kebele level) and integrated on already existing structure. Therefore, there is an opportunity to strengthen the existing system through local capacity building

The health sector at all level will further explore and use the PSNP opportunities to increase the coverage of maternal, newborn, child health and nutrition outcomes. Hence participation on health and nutrition behavioral change communication, practicing key health actions and using health and nutrition interventions are considered as substitute for public work in phase four PSNP. Ensuring collaboration with PSNP task force at woreda and kebele level is important. Woreda health officers are responsible to develop the capacity of health workers at health center and health extension workers. The HEWs are supposed to provide behavioral change communication, link beneficiaries with service and PSNP

[3] Productive Safety Net Programme Phase IV Programme Implementation Manual, Ministry of Agriculture 2014, Addis Ababa

beneficiaries is key. The flow chart below highlights key elements and steps in linking the health service with productive safety net.



The health extension workers and the village level volunteer health workers perform the following activities;

- identify eligible women such as pregnant, lactating and household with malnourished children by screening refer them to temporary direct support through development agent
- provide health and nutrition counseling for temporary direct support beneficiaries as per the manual
- Arrange and facilitate regular behavioral change communication sessions for temporary direct support beneficiaries and encourage service uptake
- Negotiate in case of service interruption and notify the development agent
- Provide service uptake report to relevant stakeholders and monitor coverage as per plan
- HEWs need to work with school, women affair, agriculture development agent and animal technicians as well as community level workers
- Work with animal health team to prevent zoonotic diseases
- Immunization sessions can be integrated with livestock vaccination and serve as gateways for information dissemination can be facilitated along with livestock immunization program
- Appeal for maintenance, fencing, cleaning and gardening of health posts through public work

2.4.6 Monitoring, evaluation and learning

Regular supportive supervisor, follow-up, monitoring and evaluation of the implementation is essential component for the success of programs. Joint planning and monitoring among different stakeholders increase implementation synergy and effectiveness. Health workers, community members and administration has stake on follow-up and monitoring of implementation. Development of monitoring and follow-up mechanism is critical at all level. Social and pastoralist standing committee at federal and regional level can play key role in monitoring the health sector progress. The following key actions are required to strengthen monitoring, evaluation and learning;

- Involve stakeholders starting from planning stage
- Agree and set reporting template, reporting period and reportable scopes and items

- Set periodic supportive supervision/inspection mechanisms quarterly, monthly as per the context and norm in the region
- Provide on the job training and feedbacks during supportive supervision and comprehensive written feedback and agree on the next action points and milestones
- Conduct operational/ implementation research to inform policy and programs
- Conduct periodic review meeting, experience sharing
- Recognition of best performers at all level is one of the key motivational aspect.
- Conduct periodic tri-party dialogue and monitoring with administration, health mangers and community representatives.
- Document best practices and disseminate lessons

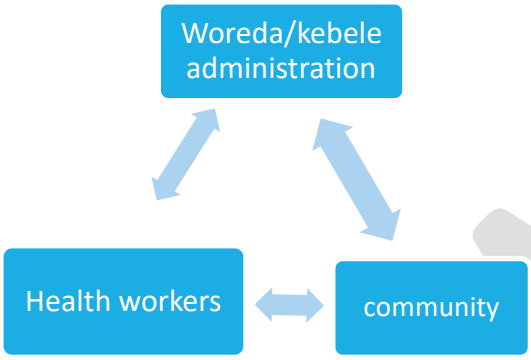


Fig 5. Monitoring and accountability framework

2.5 Cross-cutting

2.5.1 Basics

Recent studies indicated that many pastoralists are changing the mobility pattern from traditional 'highly mobile' forms to seasonal and engaging into semi-pastoralism, settlement or other livelihood options[18]. Integrated infrastructure development along with re-settlement is key to enhance broad based development in pastoralist areas.

The Rio Political Declaration of Social Determinates of Health spell out, health equity as a shared responsibility and requires the engagement of all sectors of government, all segments of society and all members of the international community[19]. Status of individuals or groups with regards to their wealth,

[18] Pastoralism demographics, settlement and service provision in the horn and East Africa, transformation and opportunities, HPG, May 2010

[19] http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf

education and access to basic utilities such as water, electricity and road determines their access to health care and ultimately, their health outcomes. Implementation of the following comprehensive development activities are expected to increase health service coverage and utilization.

- Expand voluntary re-settlement or villageization and provide access to road, water, electricity and other infrastructure
- Establish semi-urbans in convenient areas and fulfill infrastructure
- Increase access to telecommunication
- Diversify livelihood schemes and employment opportunities in semi- urban and settlements
- Sectoral integration in development of social service institutions and residential houses for service providers

2.5.2 Complementarity with health transformations agendas

Revitalization of health extension program in pastoralist areas is spelled out in the health sector transformation plan and it is part and parcel of the health transformational agendas. It should be implemented under the principle and in line with the HSTP and its transformational agendas. Implementation of transformational agendas; such as woreda transformation, ensuring equitable access to quality health care, information revolution and creating compassionate, respectful and caring health workforce contribute to effectiveness of the health extension program as well as the entire health service provision. All transformational agendas have complementarity in implementation and synergetic effect in health outcomes. While the framework and implementation arrangement remain the same, implementation modality of pastoralist health extension program will be based on the specific context in pastoralist areas as per stipulated in this strategy. However, working with respective lead directorates of each transformational agendas in the Ministry of health is critical. Some of the activities to be performed include:

- Cascading joint orientation of transformational agendas at all level
- Conduct joint implementation monitoring of transformational agendas
- Use each transformational agenda, guide, manual or strategies and complement each other and avoid fragmented implementation
- Establish transformation taskforce who can monitor the implementation of transformation agendas in the regions.

2.5.3 Partnership

Health sector has a comprehensive framework and cooperation with multiple stakeholders. For instance development of HSTP was extensively participatory and transparent process which helped effective coordination among international donors, civil society organizations and private sector. The implementation of HSTP, transformational agendas and revitalizing HEP in pastoralist requires collective efforts of various stakeholders in the framework of one plan, one report and one budget as per the international health partnership and aid effectiveness principles. Establishing/strengthening partnership

and networking among health and nutrition, WASH partners operating in pastoralist areas entails the pro-active leadership of the respective regional health bureaus and commitment of partners. Partners will continue to play important role in providing multi-dimensional support. The following actions are required to strengthen partnership;

- Identify potential partners operating in the region and their capacities conduct partners mapping by the area of work, geography, capacity willingness etc.
- Develop terms of reference for building partnership in participatory and inclusive manner
- Conduct periodic consultative workshop and organize best experience sharing
- Mobilize to get support and work together
- Focus on investments that strengthen the existing system
- Collaborate with relevant Universities in the region to enhance evidence generation, capacity building including HEP curriculum revision/development and service provision
- Involve community representatives partnership at all level and in all stage of program implementation and delineate roles clearly

Part III Implementation arrangement

3.1 Roles and responsibilities

Roles and responsibilities of FMoH and its structure down to the community level are listed below but not limited to the lists.

FMOH

- Provide overall policy guidance, leadership and capacity building
- Mobilize resource and subsidize budget for implementation
- Prepare, familiarize and disseminate strategies, implementation guideline and packages
- Coordinate regions and support adaptation of strategies into regional context.
- Advocate regional governments to implement the strategy and to ensure equitable access and utilization of health services
- Ensure intersect oral coordination and collaboration at higher level
- Coordinate development partners and Mobilize resources
- Provide technical support to regions
- Coordinate implementation and/or operational research, documentation and learning

Regional health Bureaus/Zonal health department

- Adapt the strategy to the regional context, familiarize and disseminate the strategy and lead the implementation
- Closely support, monitor implementation of the strategy
- Lead the implementation of the strategy in their respective regions

- Collaborate with FMoH, Universities and Health Science Colleges to train health extension workers
- Stratify woredas according the capacity, performance and accessibility and provide support for needy
- Coordinate with other sectors develop SoP and MOU for implementation of health service
- Build the capacity of woredas and health facilities
- In collaboration with partners and NGOs conduct evidence generation through qualitative and quantitative operational/implementation research
- Facilitate experience sharing within and with other regions

Woreda health office

- Allocate budget for deployment of HEWs and running cost for health facilities under its jurisdiction
- Design the health service modality and plan, budget, implement, monitor and document the health service provision
- Negotiate with concrete evidence with woreda cabinet for increased allocation of public budget for health
- With sound judgment determine the number of health facilities required by type
- Coordinate proper selection and recruitment of HEWs in kebeles
- List hard to reach kebeles and communities using geographic, topographic or social classification and provide special attention to reach the disadvantaged groups of population
- Coordinate with other sectors, programs and projects to support the implementation of the HEP and primary health care
- Implement and monitor translation of health sector transformational agendas into actions and results
- Deploy health workers, build their capacity and enhance individual and team productivity through close follow-up, motivation and guidance
- Conduct periodic follow-up through supervision, review meeting and verification
- Coordinate and link the primary health care including primary hospitals, health center, health post and community/school level health service provision
- Coordinate with PFSA and other vendors to ensure uninterrupted supply
- Support health centers to establish multi-disciplinary team which will work to extend service access and improve the quality of health services
- Perform other innovative tasks and other initiatives when cascaded from higher level

Health center/Health post

- Identify and map kebeles, risk community/villages in its catchment areas including focal points from community
- Prepare plan and service delivery approach for population in their respective catchment areas

- Organize multi-disciplinary team from the existing staff and prepare standard operation procedure
- Provide health services through different approach
- Hold discussion with community representatives
- Improve service range and quality
- Capacity building of HEWs and community health workers
- Perform other duties and responsibilities as stipulated in different guidelines

Community health workers

- In close collaboration with influential community members, plan health actions, advise community to implement HEP packages and utilize health service.
- Identify target groups support registering community/households in remote villages
- Know key target groups such as pregnant women, newborns, under one children, under two and under five and other target groups
- Support HEWs in disseminating health messages
- Link community with health facilities
- Arrange outreach sites and support HEWs in transporting vaccines and other supplies
- Inform in case of any outbreak or manifestation of any health problems in the village
- Support in Organizing and mobilize community
- Perform any actions that will be passed from health facilities and health workers
- Support in mobilizing for regular routine nutrition screening of children under five and pregnant and lactating women, children and adolescent de-worming, vitamin A supplementation for children under five.
- Follow up of severely malnourished children under treatment and tracing of defaulters.

3.2 Assumptions and Risks

Assumptions- The success of this strategy depends on the Government's political commitment. It also depends on the local capacity to translate the strategic document into practice. It is hoped that health budget will increase from domestic and external funding. The stability of the country and implementing regions in particular is critical for achievement of results. Community engagement will be enhanced and partners support will be sustained and increased to implementation of this strategy. Economic growth will be continuing at least with current pace and infrastructure will be improved in hard to reach areas. Improved governance and accountability.

Risks- the recurrent drought, increased internal conflict, refuge influx, health emergencies and inadequate economic growth will be key are key challenges. Reduction of funding from external sources and inadequate allocation of domestic resource. Inadequate capacity of implementers will be risk for implementation.

Risk mitigation strategies

Risks	Mitigation measures
1. Recurrent drought	Strengthening local capacity, preparedness, pre-position of supplies, surveillance, early warning and response
2. Internal conflict and increased internally displaced persons	The government will provide priority attention to improve stability and security
3. Refuge influx cause stress on local capacity and host community	Government will work with partners to strengthen the capacity and improve development of infrastructure
4. Financial reduction	Health care financing strategy will be implemented and additional resource will be mobilized for external and internal sources
5. Inadequate capacity among implementers	Local capacity development will be enhanced through training, mentoring, supportive supervising and by providing standard operation and job aids

Annex Table Strategic objectives, initiatives, main activities and indicators

Priority Areas	Target	initiatives	Main Activities	Indicators	Responsibility	Implementation Period in EFY			
						2011	2013	2015	2017
improve leadership, governance and performance management capacity for implementation of HEP in pastoralist areas	100% of woredas and HCs led by 1st degree holder professional	- implement merit based assignment of health managers -commence motivation and retention mechanism - implement result based financing	-Advocated for merit based assignment policy/legal framework -provide training, mentoring and coaching through deployment of capable TAs -provide job aids and SoPs -program review through supportive supervision, review meeting, and experience sharing - initiate motivation and retention mechanism -pilot result based financing in hard to reach areas	Proportion of woredas/HCs led by at least first degree level educated mangers	FMoH /RHBs	5%	25%	50%	100%
increase community engagement	Level IV HEWs deployment 100% -Level III and lower HEWS deployment in selected areas HDA/Social mobilization network 100%	-Initiate direct level IV HEW training -Establish/or strengthen HDA/ appropriate community platforms -Ensure appropriate representation of community members on health facility management/board	-curriculum development for generic training Identify appropriate community level platforms/social networks -organize the HDA/social mobilization networks -provide training for network/clan leaders -provide job aids -institute follow-up and monitoring arrangement	# of level IV and level II HEWs enrolled, graduated & deployed Number and proportion of social networks organized and functioning	RHBs, Woredas, PHCU, HEWs, administration	3% 10%	10% 40	30% 70	100% 100
Improve tailored service delivery modality to	Ratio of key RMNCAH & N coverage between pastoralist	-policy framework to revise service delivery, task shifting, scope and	-stratify service delivery, scope and packages - build capacity thought on the job and in-service training, and supportive supervision	Ratio of deliveries assisted by Skilled Birth Attendants and Pentavalent 3 coverage between	FMoH, RHB, woredas,	0.67	0.50	0.35	0.25

pastoralist context	and national average less than 0.25	packages per context -Strengthen facility based service delivery -increase outreach service including extended outreach and camel Canavero as appropriate -train and deploy appropriate HR	-provide job aids -establish multi-disciplinary team that can offer key services at fixed, outreach and mobile -revise and tailor HEWs training curriculum -commence level IV HEW training	pastoralist and non-pastoralist regions Difference of Pentavalent 3 coverage between agrarian and pastoralist regions	University	33	28	20	10
provide special support for hard to reach areas	Low performing region, zone & woredas	-Stratify woredas as per performance and hardship -Design targeted support as per the context	-Identify low performing areas -provide targeted technical, financial, capacity building support -implement incentive packages	# of woredas provided special support	FMoH, RHB	20	35%	60%	80%
Increase effective follow-up, monitoring and evaluation	Federal/ regional level monitoring biannual, zonal woreda level quarterly, PHCU monthly	-initiate result based financing -strengthen data and evidence collection, analysis and use -Strengthen program monitoring and review	-prepare detail SOP on result based financing -capacity building on RBF -institutionalize follow-up and monitoring by: - data collection form all types of sources -support for data use at the point of generation -conduct regular supportive supervision, review meeting and experience sharing -recognize performance improvement	# and % of regions/woredas conducting M& E as outlined in the HSTP	FMoH, RHBs, Woredas (administration, finance &economic cooperation offices and Health	20%	40%	60%	80%

					offices)				
Enhance integration within the sector and with other sectors	All woredas	-Enhance service integration -Increase sectoral integration Example PSNP,PCDP	-Prepare service packages to be integrated at each delivery level and mode -prepare memorandum of understanding among health, agriculture/food security, education, women's affair and other relevant sectors at woreda and kebele level outlining each sectors role to increase health service uptake -monitor implementation as per the	# of woredas outlined service packages and strengthen integration	RHBs, Wordas and HPs	0	20%	50%	100%

Budget distribution

	Focus areas	**Key activities**	**Budget in ETB 000s by year**						
			2011	2012	2013	2014	2015	Total	Remark
1	improve leadership, governance and performance management capacity for implementation of HEP in pastoralist areas	Training, mentoring, experience sharing	1000	1500	1500	2000	1500	6500	
		Technical assistance	2400	2700	3000	1500	1400	10,000	
		Motivation and retention	2000	2000	3000	2500	2500	12,000	
		Citizens engagement	300	400	500	600	500	2300	
		Supportive supervision	700	800	900	1000	900	4300	
		Piloting PBF/RBF	0	10,000	15,000	30,000	25,000	70,000	
	Sub-total		**6400**	**17,400**	**23,900**	**37,600**	**31,800**	**105,100**	
2	Service delivery	Training of health center team	5000	7000	10000	15000	20000	57,000	
		Operational cost for health center team	20000	30000	50000	75000	90000	265,000	
		HEWs training	10,000	20,000	15000	15000	10000	70000	
		Renovation and construction of health posts	50000	75000	80000	60,000	45000	310000	

		Equipping health posts	25,000	25,000	30,000	20,000	10000	110,000	
		Operational cost for health posts	10,000	15000	20000	25000	30000	100000	
		Compensation for community volunteers	3000	5000	7000	8000	10000	33000	
	Sub-total	**Sub total**	**123,000**	**177,000**	**212,000**	**218,000**	**215000**	**945000**	
3	Supply and logistics	Consumable	6000	7000	8000	9000	10000	40000	
		Non-consumable	12000	15000	20000	10000	5000	62000	
		Sub total	**18000**	**22000**	**28000**	**19000**	**15000**	**102000**	
4	Special support	Technical assistance	4000	5000	5000	4000	3000	21000	
		Budget subside	10,000	8000	6000	4000	2000	30000	
		Supply including transportation support	5000	7000	9000	7000	4000	32000	
	Sub-total		19,000	20000	20000	15000	9000	83000	
5	Coordination and integration	MoU preparation joint monitoring and evaluation	200,	250	250,	150	150	1000	
	Sub total		200	250	250	150	150	1000	
6	Monitoring, evaluation and learning	Program monitoring (supervision, review meeting	1000	1200	1500	1700	1900	7300	
		Research and evaluation	500	0	750	0	1000	2250	
		documentation	200	0	250	0	300	750	
	Sub total		1700	1200	2500	1700	3200	10300	
	Total		168,300	237,850	286,650	272,450	274,150	1,246,400	

Annex II Framework of Roles and responsibilities to implement HEP strategy at each level

Priority areas	National Level	Region/Zone	Woreda	Health Centres	Kebele Health post /community
Stewardship performance mgt	- Development of policies, strategies, and guidelines, - provide technical support -Advocate for policy & legal framework for assignment of competent leadership, -capacity building, -introduction of result based performance in low performing areas	-Lead implementation as per the regional context, -provide orientation, training, monitoring TA support and budget and performance management Support assignment of competent managers, orientation for woreda and health centres levels to conduct equity assessments and barrier analysis & suggestion of appropriate solutions	Lead implementation of the primary health care at health facilities, outreach, mobile and performance management. Support organization of team Stratify and map "risk community" Develop plan, budget implement and monitor appropriate strategies to extend health services to high risk communities	Provide services in diverse modality including fixed, outreach and mobile. Organize team, Improve performance, engage community in HF management, Provide services in high-risk community,	Provide service at health post, community, villages and elect community contact persons, register targets, mobilize, follow up in community Provide curative and preventive services at health post level link communities with health facilities
Service delivery	Develop policies and strategies on different and efficient service delivery modality	Provide training for service providers. Monitor implementation of service delivery to high risk community.	Stratify kebeles/villages as per the hardship prioritize and select appropriate approach	Organize MDT, plan and monitor Provide support for HEWs provide service as per SoP.	Support the involvement of communities in local micro-plan development
Community engagement	Develop advocacy & communication plan specific to the needs of high risk communities identified	Advocate with local political leaders to gain support for health centres to engage high risk communities	Organize regular meeting with high risk community focal points during outreach and at health centre	Identify community representative in hard to reach communities. Reduce social distance Hold discussion with community representatives Engage community	Support demand creation within high risk communities and mobilize population health service provision such as immunization session
Special support	Develop SoP for special support Target support for under served	Stratify woredas which need special support	Stratify map & map the high risk community	Stratify kebeles and communities and map the areas which need special support. Organize Reduce social distance	Reduce social distance, discuss with community representative. Provide quality services

Integration	Policy direction for service integration and coordination	Strengthen integration within the sector and among the sectors	Coordinate with other sectors. integrate services	Service integration, coordinate with other sectors.	Integrate with sectors at kebele level such as DA, civil registration officer, teachers and others
Monitoring, evaluation, documentation learning	Support evidence generation, documentation of best practice and enhance learning	Conduct implementation research, supportive supervision, and review meeting, document best practices	Conduct Supportive supervision, provide support for low performing areas,	Engage community during monitoring and evaluation	Engage community during monitoring and review

Annex three

FORM 1. Information on distribution of villages/community, population, distance from health facility in KMs and list of contact person in health centre catchment area

	Kebele/Village/community name	**Total population**	**Distance from HF in kms/hours**	**Means of transport**	**Name of community focal person/CHW**	**Phone number**	**Service deliver modality**

Annex IV : Example of Template for mapping hard to reach areas and budget estimate for ___ year)

Kebele/COMMUNITY NAME (a)	High Risk (√) (b)	Distance from HC (c)	# Sessions per year (d)	# Staff per session (e)	Staff costs (#staff x per diem) (f)	Means of transport per session (g)	Estimated cost for transport per session (h)	Allowance for comm. workers (j)	Cost for one session (k) =f+h+I+j	Total costs for all sessions (l)
Outreach for a day/ overnight										
Sub TOTAL OUTREACH										
Extended/Mobile service sites										
Sub Total Mobile sites										
Over all Total										