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## **Executive Summary**

Recognizing the urgency of dealing with the HRH problem in the country and the constraints in the training of high level health professionals, the Ethiopian government has launched a new program for 'Accelerated Expansion of Primary Health Care Coverage' with the health extension program (HEP) as its centerpiece. This implies the training and deployment of over 33,200 health extension workers (HEW) for more than 15,000 health posts (HP) and the construction or upgrading of 3153 health centers (HC) by 2009.

The main objective of HEP is to improve access and equity to preventive essential health interventions provided at village and household levels with focus on sustained preventive health actions and increased health awareness. It also serves as effective mechanism for shifting health care resources from being dominantly urban to the rural areas where the majority of the country's population resides. Therefore, HEP is considered as the most important institutional framework for achieving the MDGs.

The government has now trained 2,612 and 7,000 HEWs in 2005 and 2006 respectively and assigned them to about 5000 Health Posts (villages).

Working conditions are important in terms of creating the conditions for effective and efficient work, boosting morale of the workforce, reducing turnover and attrition. The importance of community-based health workers has been well recognized but promising starts have often foundered on working condition issues.

This study focuses on those deployed in early 2005and have worked for over six months, with the overall objective of assessing the working conditions of HEW and their job satisfaction.

An in-depth field study was carried out on 60 HEW in 51 health posts (HP) from six regions, 23 zones and 26 woredas.

The need for community based health workers is well established. Placing HEW at community level is a commendable undertaking but fulfilling favorable working conditions is an important challenge which is compounded by long distances and poor transportation and communication facilities. There are challenges in harmonizing the staffing pattern at the HP level, guiding time-use, work schedule and relationship with the community (leadership). There are no clear guidelines on relationship with other health workers at the community level, on career structure, transfer, leave absences etc. Reporting and health management information system in general is weak and the referral system is almost inexistent. An important challenge is the request for curative care by the communities.

## Based on these findings, it is recommended to:

- Avoid repeated shortage/lack of equipment and supplies; build commensurate capacity in equipment maintenance and repair capabilities in the sector; ensure adequate availability and sound management of basic supplies, drugs and vaccines in anticipation of the greater demand of servicing over 15,000 HP; and initiate studies on appropriate and sustainable transport and communication facilities for HEW;
- HPs should develop work plans as much as possible in consultation with major stakeholders; and establish mechanisms for regular reporting, feedback and sharing the report with the community;
- ♦ The capacity of the woreda health office (WHO) need to be strengthened in way that HEP focal persons as well as other technical staff of the WHO have adequate understanding of the program and capability to provide supportive supervision;
- ◆ The Health Extension Program (HEP) should be the concern of the whole Woreda Health Office. The importance of active participation of the community in its own development should be prioritized. There should be a guideline on the major principles of the relationships between HEW and other community based health workers including traditional practitioners. Operational research should be undertaken to strengthen supervision practices;
- Ensure adequate time and attention to knowledge and skill development in health education (HE) during training; reference materials, upgrading, new and improved

- approaches and technologies should be introduced through more flexible formats (Continuing education, Newsletters, leaflets...); explore the possibility of preparing a newsletter dedicated to HEW;
- ◆ Demand for curative care is an important challenge to HEP. Graduated inclusion of selected procedures with the appropriate (in-service) training through HEW and intensive health education to the population on appropriate drug/injection use seems the most likely avenue. In delivery services, measures should be taken to increase the confidence level of both HEW and the community on the delivery skills of the HEW; and increase the awareness and service seeking behavior of the population. Prepare formats for referral with inbuilt mechanism for feedback; orient and continuously sensitize the relevant staff on referral;
- ♦ Housing should be provided in or very close to the HP compound by all kebeles. Availability of safe water supply and toilet facilities (pit latrine) in or near HEW residence should be the priority of priorities. The possibility of providing HEW with a small credit for installation (acquiring essential commodities) should be explored.

# Assessment of Working Conditions of the First Batch of Health Extension Workers

## 1. Background

Achieving the Millennium Development Goals in Ethiopia could be severely handicapped by the shortage of human resource for health (HRH). It is now recognized that HRH is a major bottleneck to the attainment of development agendas including the MDGs and the Plan for Accelerated Sustainable Development to End Poverty (PASDEP) as well as priority health programs and interventions in Ethiopia. Lack of adequate resources for training, imbalances in distribution (Urban/Rural) and brain drain are among the major underlying factors for the shortage of the workforce for health.

Recognizing the urgency of dealing with the HRH problem in the country and the constraints in the training of high level health professionals, the Ethiopian government has now launched a new program for 'Accelerated Expansion of Primary Health Care<sup>1</sup> Coverage' with the health extension program as its centerpiece. This implies the training and deployment of 33,200 health extension workers (HEW) for some 15,000 health posts (HP) and the construction or upgrading of 3153 health centers (HC) by 2009.

## 2. The health extension program

The health extension program (HEP) is a new initiative developed as one of the components of HSDP-II. It is introduced in recognition of the failure of essential services to reach the people at the grassroots level. As such, it constitutes all the key activities necessary for rapid development, particularly primary health care. It is an innovative community based health care delivery system aimed at creating healthy environment as well as healthful living. The main objective of HEP is to improve access and equity to preventive essential health interventions provided at village and household levels with focus on sustained preventive health actions and increased health awareness. It also

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<sup>&</sup>lt;sup>1</sup> In the incessant shift of paradigms, developing countries are subjected to, the current buzz phrase is 'health sector reform' (HSR) which purportedly negates Primary Health Care (PHC). However the Ethiopian policy, strategy and program (HSDP) documents, while seemingly espousing HSR, maintain strong political commitment to PHC.

serves as effective mechanism for shifting health care resources from being dominantly urban to the rural areas where the majority of the country's population resides. Therefore, HEP is considered as the most important institutional framework for achieving the MDGs.

The Primary Health Care Service is designed to include preventive, promotive and basic curative services. In order to realize this, the Health Sector Development Program introduced a four-tier system for health service delivery, characterized by a primary health care unit (PHCU), comprising one health center and five satellite health posts. Since the curative service rendered at the health posts is limited the health centers will serve as the first referral point for the health posts. The HEP was initiated towards the end of 2004 with the construction of health posts and training of Health Extension Workers. Since then, a total of 4,211 health posts have been constructed representing 28.1% of the total need (about 15,000). The community is actively participating, by contributing labor and local materials for the construction of the health posts. The community also bears the responsibility of building the housing for the health extension workers. The government has now trained and deployed 2,612 and 7,000 Health Extension Workers (HEWs) in 2005 and 2006 respectively. These HEWs have been assigned to about 5000 Health Posts (villages). In 2006, the total number of students admitted for training is 7,138. More than 16,000 HEWs will be deployed by the end of the year and this comprises about 50% of the planned 33,200 HEWs. The number of government health centers has increased from 243 in 1996/97 to 600 in 2004/05 in order to strengthen the curative services and support the health posts.

The Health Centers are expected to be staffed by health officers who are in short supply to meet the expanded services. To fill the gap in mid level health professionals at the health centers, about 2,000 candidates have been enrolled in October 2005 for health officers training program (a first degree in health science). This number is in addition to the routine intake of the colleges under the Ministry of Education. The venue for the training of the 2,000 health officers will be several hospitals in the regions and the process is part of the accelerated program that will be coordinated by the FMOH.

There has been an encouraging result in the implementation and outcome of the Health Extension Program. Encouraging results were seen in terms of community's acceptance and demand for services provided through HEP. Improvements were seen in construction and utilization of latrines, utilization rate of contraceptives and vaccination services in areas where the program has been implemented so far.

Working conditions, part of the broader human resources management (HRM), are important in terms of creating the conditions for effective and efficient work, boosting morale of the workforce, reducing turnover and attrition. Lack of proper working conditions have, in the past, been associated with large number of absenteeism, serious mishandling of clients, poor quality of work and overall underutilization of services. Creating adequate working conditions to ensure that workers are retained in a sustainable way is at the core of creating a sustainable health system.

The importance of community-based health workers has been well recognized but promising starts have often foundered on working condition issues. While resource constraint and the generally underdeveloped environment could explain part of the failure, it has been shown that lack of attention to the details of working conditions, to HR management in general have been important factors.

The third Health sector Development Program (HSDP-III) recognizes incentive packages; trainings and career structures; participatory planning, monitoring and evaluation of sectoral activities; and dynamic and responsive organizational structure as appropriate institutional responses in HRH. The Civil Service Reform Program (CSRP) introduced in February 2002 has a human resources management component which could be highly relevant to Health Extension Worker (HEW) concerns.

There are now (end of 2005) 2,612 health extension workers (HEW) working for over 6 months in a number of woredas all over rural Ethiopia and another 7100 deployed beginning of 2006. This study focuses on those deployed in early 2005. It is important to study how this first batch have fared, the strengths and challenges in their work

conditions and, based on our findings and international experience, indicate where strengthening, remedial measures and improved preparations are required. It is important to take measures as early as possible before the sheer large numbers (more than double of the existing human resource in four/five years) overwhelm the management system.

The Center for National Health Development in Ethiopia (CNHDE) views its mission as a constructive engagement, not fault –finding, geared towards identifying challenges early and drawing attention to remedial measures. Preparatory/remedial measures should be taken as early as possible before the more than 30,000 HEW are deployed. Their sheer number, the high expectation from their deployment and the circumstances of the current democratization process are bound to give high resonance effect to any mishaps in the implementation of this innovative and potentially break-through process. The importance, therefore, of anticipatory and appropriate measures now.



HEWs teaching a mother on latrine use

A preliminary assessment, carried out by CNHDE, of the preparation for the support (budget, supervision, logistics etc) of HEW at the district, health center (HC) and community levels has raised some concerns about the preparedness at the woreda and other levels to support the work of HEW. Preparations in terms of sensitization at all levels, the woredas and communities in particular, financial and

logistic support, the overall management process were minimal (CNHDE 2005 a & b). It is therefore important to assess conditions about a year later, once a number of HEW have been working in communities for about 9 months.

## 3. Objective:

The **overall objective** of this study is to assess the working conditions of the first batch HEWs providing service at the health posts

## Areas of assessment:

• The living conditions of HEW; housing and availability of certain amenities

Table1: Numbers of zones, woredas and health posts visited and HEWs interviewed by region							
	Amhara	Beni/G	Harari	Oromia	SNNP	Tigray	Total
Number of Zones	6	1	-	7	5	4	23
Number of Woredas	7	1	1	7	5	5	26
Number of HP with HEW	46	2	3	24	33	28	136
Number of HP visited	13	2	2	14	10	10	51
Number of HEW							
interviewed	15	3	4	18	10	10	60
•	15	3	4	18	10	10	,

- Conditions in the HP (building and facilities, equipment and furniture, supplies)
- Availability of reference/reading materials
- ♦ Conditions for salary and operational budget
- Working hours and other duties, rights/privileges
- ♦ Transportation and communication
- ♦ Administration, monitoring and supervision
- Relationship with communities
- Perceived accomplishments and future aspirations

#### 4. Method

This is the first study of HEW carried out in the field. Knowledge and experiences are very limited and there are virtually no previous studies on the subject. The study was, therefore, exploratory and essentially qualitative to pave the way for future more systematic (representative sample based) studies.

In-depth study was carried out in 26 woredas, 51 HP and 60 HEW using different sets of questionnaires (pre-tested in a woreda in Oromia) and through visits to the sites. The selection of woredas was purposive in each region with the aim of making them as

diversified as possible (different zones etc). The list of sites visited is indicated in table 1. In each region, discussions were held with the Regional Health Bureau (RHB) (mostly focal person), the Woreda Health Offices (WHOs) in the selected woredas and the HEW in the selected HP/kebeles. In addition, secondary information was obtained on 85 other (non-visited) HPs with HEW in the study woredas through interviews of the WHO heads and HEP focal person as indicated in table 1.

## 5. Results of the Assessment:

## 5.1 Characteristic of Respondents

At HP level a total of 60 HEWs were interviewed, separately. All were young, 87% single. Only 8 were married – 3 in Amhara (one with a child), 2 in Oromia, 1 in SNNP and 2 in Tigray with a child each. One in Harari was a single mother.

- All respondents could speak, read and write Amharic and, between them, some 9 local languages. All could read English but only about 50% claimed the ability to speak it. In this sample, the preferred language for continuing education was the local language followed by English.
- ◆ At woreda health office (WHO) level, the Head and/or the focal person for HEP filled the questionnaires followed by discussion.
- ♦ At regional level the relevant /focal persons in RHB and Technical and Vocational Education and Training (TVET) Commission were interviewed.

#### 5.2 Health Post: Resources

**Proximity to Administrative/supervisory bodies:** Distance of the health post (HP)/kebeles visited varied from 1 hour to seven hours on foot from the woreda capital and therefore from the Woreda Health Offices (WHOs). Many HPs are accessible at least by dry weather roads while a number are only accessible on foot. Forty eight percent of the HPs were at more than 10km distance from the nearest HC/clinic.

In the context of poor transportation and communication systems, distance could have an important impact on logistics, monitoring/supervision, referral and the overall motivation of the HEW.

## Building, Equipment and furniture: The regions often classify a Health Post as:

- Functional i.e. if building completed and reasonably equipped and furnished
- ♦ Non-functional i.e. if building not completed and/or not equipped or furnished Health extension workers (HEW) have been posted both in functional and non-functional HPs. In kebeles without HP building, they often worked from the kebele administration office. The structure and size of HP buildings were found to be variable. Almost all in Tigray − two rooms − and Harari − 3 rooms, are the standard cement block with corrugated iron roof and cement floors. In most others, the most recent HPs are made of wood and mud and may have up to 4 rooms (e.g. Amhara). For a purportedly 'health facility' 11 out of the 50 HPs visited have no protected source of water aand 9 out of 50 were without latrine. The possible impact of these on the credibility of the health

Building is only the first step to effective coverage; it has little value if it does not have the appropriate equipment. Equipment and furniture procurement effort by the regions is commendable. Almost all equipment and furniture for the available HP (e.g. SNNP) seems to have been procured. Distribution seems to be a problem as there were a number of empty HPs.

messages conveyed by the HEW should not be underestimated.

Even where there are reasonable numbers of equipment, they are sometimes not utilized or, in the case where there are senior health workers in the HP, not used by the HEW. In some cases even when the delivery kits and couches are available, it is not being utilized because almost no one comes for delivery at the HP.

It is important to complete HPs before the arrival of the HEW or, at least, as soon as possible there after since it could impact on effective work and the motivation of HEW (convenient working place, possible housing). It should also be seen as a measure of commitment of the woreda and kebele officials and the community. While variation and the perceived low quality of some of the buildings might not matter in the short run, availability of the minimum standard of equipment and furniture is critical both for

motivation of the HEW and acceptance/perception of the communities. Repeated shortage/lack of equipment and supplies could lead to under-use of HEW with ensuing problems. Measures taken in procurement at the regional level are commendable but all, the Woreda health offices (WHOs) in particular, should ensure that the items effectively reach the HP. The rapid expansion of HP (and consequently HC etc) is bound to strain equipment maintenance and repair capabilities in the sector. Measures should be taken immediately to build commensurate capacity in this field.

Staffing: Health Extension Program (HEP) Implementation Guideline stipulates a staffing pattern of two HEWs per HP. Actual staffing however varied a lot. While Amhara region adheres closely to the guideline, most other regions (Oromia, SNNP, Tigray...) have opted for the placement of one HEW as a transitional arrangement until the full complement of HEW is available. Some regions (Oromia, Benishangul Gumuz, Harari...) assign one or two other health workers, mostly Junior Public Health Nurses in addition to HEW. This is usually as a response to curative demand but often places the HEW in an ambivalent situation. There are also a number of community based workers (Community Health Agents, Traditional Birth Attendants, and Community-Based Reproductive Health Agents etc).

The placement of more senior health workers (nurses) with HEW in the HP seems to alleviate the demand for curative care but raises a number of questions for more thorough studies and decisions including:

- ♦ Is it sustainable i.e. could the regions/country afford to place additional 1 or 2 nurses at the kebele level? (Their placement is only seen as a transition arrangement in Oromia, what will be the implication of their eventual withdrawal?)
- Their relationship with and impact on the motivation of HEW.

**Supplies:** The supplies situation seems erratic. Few HPs have no supplies at all (e.g. Akuda, BeniG). Where there are supplies

- ♦ Some major items/drugs may be missing, e.g.
  - Contraceptives
  - o Oral rehydration salt (ORS)
  - o Anti-malarial drugs, CoArtem in particular. On the other hand the supply of malarial drugs in many HPs in Tigray and Amhara is commendable.

• Available drugs may not be used by HEW because HEW do not feel competent to use them or are not allowed access to the drugs where there are senior health workers in the HP.

Continuous availability of basic supplies, drugs and vaccines in particular, is a defining criterion for the effectiveness, efficiency, acceptability and overall sustainability of Health Services Extension Program. Immediate measures should be taken to ensure adequate availability and sound management of these supplies in anticipation of the greater demand of servicing over 15,000 HPs.

Reference and reading materials: The reference materials prepared by the Ministry of Health (MOH) are now available in almost all the HPs visited. These materials are in English and Amharic and some in local languages. Materials prepared by Carter Center, in more advanced English, have reached TVETI but not HPs. There are practically no other reading materials at the HP level. They do not get any newspaper, newsletter or journal. Filing facilities being almost nonexistent, most documents are scattered haphazardly and had to be retrieved for inspection by the study teams with some difficulty.

Reference materials are important and the effort so far is commendable but more adapted versions might be required. More importantly, upgrading, new and improved approaches and technologies should be introduced through more flexible formats (Newsletters, leaflets etc).

*Transport and communication:* None of the HP had any means of transport except in Harari and Oromia where two HP visited each had motorcycles. These were not however used by HEW but the nurses in the HP. Most HPs have no means of communication as telephone, post office etc are at quite a distance.

It has not been possible to obtain estimates of kebele sizes. However, distances are bound to be considerable in most (of the less densely populated) kebeles. Distances from the woreda capital/WHOs, the nearest HC etc are bound to be great. Thus the need for a means of transport and communication for HEW is clear. It might be reasonable to accept that in most of the remote highland areas travel will only be on foot for sometime to come. However, given the diversity of Ethiopia, it would be necessary to explore what is feasible and affordable. Few woredas provide HEW with umbrellas and raincoats. In view of the great distances they have to travel and the difficulties they have to face, this seems to be a

practice that merits to be emulated by others. Given the rapid evolution in information and communication technology (ICT) in the country, strategic thinking on alternatives in communications (two-way radios, mobile phones etc) should be initiated as of now.

#### 5.3 Health Post: Finance

Budget: Invariably, the HP does not know its budget. They are not told of the amount of recurrent operational budget they have for the year. They could ask routine supplies such as stationery, soaps etc and would be supplied as much as possible on ad hoc basis. HPs are competing for such items with HC in a very uneven and opaque field. Operational budget at the woreda level is very limited. There is no budget for program activities e.g. environmental health (EH), nutrition education. The budgeting process merits a closer scrutiny. In most cases WHOs do not have direct representation in the Woreda Executive Council and the Woreda Council where decisions in the allocation of the limited woreda budgetary resources are made. Thus the health sector budget, operational in particular, tend to be relatively meager. Under these circumstances, operational budget to HP will continue to suffer.

No HP knows its budget. Even at the WHOs level, there is no clear indication of what the operating budget for HPs is. If all operational budgets are to be derived from the community, this should be clearly articulated and the necessary guidelines, rules and regulations established. Otherwise, it will be clearly

very difficult to prepare work plans. HEP entails a major shift of resources to rural areas in terms of salaries. This should be matched by a comparable operational budget if it is to be effectively used.

Salary, per diem: All get their salaries regularly at the end of the month. This seems to be the only item in the budget that is guaranteed. All get the 381Birr stipulated by



HEW visiting a mother in her house

<sup>&</sup>lt;sup>1</sup> The possibility of introducing community-based health financing schemes (CBHF: cost recovery, community insurance etc) could be explored.

MOH; however, Amhara Region has decided to raise it to Birr 426 on appropriate scale considerations. Salaries are collected most often at the woreda capital from the Woreda Finance Office or from WHOs. Some collect their salaries from the nearest health facility mostly HC. HEWs thus spend at least a day in the woreda capital each month. The WHOs could plan to use this opportunity partially for professional and/or administrative purposes. HEW get per diems for participation in some of the 'vertical' programs such as polio campaigns, trachoma control or de-worming and also when they attend meetings or workshops. This could amount to a substantial sum in some areas and certain periods<sup>1</sup>.

None of the HEW interviewed reported any additional source of income other than their



HEW consulting rural couples at their home

wage in the HP. Though a more through economic study might be needed, HEW seem to attain a reasonable income level by rural standards with their salary, various per diem and housing (where provided). However, high proportion perceives their salary/income level as

less than most of the community based public employees. None-the-less, their remuneration level seems, for the moment, enough to keep them motivated.

The salary level and regular payment seems adequate and is appreciated by the HEW. The pay differential between Amhara and the other regions should be assessed as soon as possible in view of possible harmonization as privileges in one region are bound to trigger similar demands in others as seen for stipend for trainees and top-up for trainers. Almost all HEW spend, at least, one day in the woreda capital to collect their salary. WHOs should explore the possibility of using these occasions for a programmed contact with HEW in order to give feedback on reports, in-service training, discuss work plans etc.

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<sup>&</sup>lt;sup>1</sup> In areas where HEW have worked for some 6-9 months (Amhara, Oromia, SNNP and Tigray) each HEW had received perdiem ranging from Birr 500- 1500.

## 5.4 Health Extension Worker: Routine work activity

*Work schedule/hours:* Work patterns varied. Where there are two HEW, programs could vary<sup>1</sup> as follows; some:

- Alternate every day, one working in the HP and the other in the field;
- Work, together, half a day, usually in the morning, in the health post and the other half in the field;
- ♦ Work a number of scheduled days in HP and in the field;
- ♦ In one HP field/community work was only done on Saturdays, Sundays and holidays to accommodate busy farmers.

A down-sized variant of this pattern is carried out when there is only one HEW. In cases where HEWs are placed with (PH) nurses, they are confined to field work.

Most HPs do not have formally developed work schedule and, what ever schedule there is, is rarely posted for consultation (by community, supervisors etc)<sup>2</sup>. Most of those who had written programs have not discussed these with neither the relevant kebele officials nor with WHOs let alone with the community at large.

In Tigray and Amhara, the HEW focus on 50 selected, closely grouped households (HH) for what is called the 'Family Package' i.e. the whole HEP package. These HHs get intensive exposure, are evaluated at the end of the period and 'graduate'. The HEWs then move to the next batch of households. Those HH not included in the 'Family Package' are involved in a more toned down, follow up program.

Most HEWs claim very long hours of work including Sundays (e.g. Amhara, Oromia, Tigray).

While variations in work schedule should be expected because of the differing local conditions, some principles should be adhered to including:

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<sup>&</sup>lt;sup>1</sup> SNNP Guideline prescribes 75% of time should be spent in the field.

<sup>&</sup>lt;sup>2</sup> Only few HP in our study - Leka Dulecha, Mana, Gorogotu, Ameya in Oromia and Gedeba in Kobo had posted their program. In one HP visited, Gorogutu, the duties and responsibilities of HEW was posted.

- ♦ Work plans should be developed for each HP/HEW
- ◆ These should be prepared as much as possible in consultation with kebele officials/ the community and WHOs or, at least, these bodies should be duly notified
- ♦ The agreed upon work plan should be posted in the HP.

*Time utilization:* Almost invariably, HEWs indicate that the highest proportion of their time is spent on health education followed by environmental health. Very little time is used for community documentation, family health and diseases control and prevention.

The Community Documentation component seems to be given the least attention. In fact, few have done the kebele census and rapid assessment they are expected to do. Some, as in Tigray and Amhara, have limited the community documentation work to the 'Family package' group; others have done a survey of every 10<sup>th</sup> house holds. One issue is that the

HEW do not have a standard format for the census and rapid appraisal they expected to do or any guideline on what data should be routinely collected and what on

Co	urse Title	No. of Hours	%
1.	Main Courses	912	65.5
	1.1. Community Documentation	60	4.3
	1.2. Family Health Care	340	24.4
	1.3. Disease Prevention & Control	205	14.7
	1.4. Environmental Health	307	22.1
2.	Supportive Courses	150	10.8
	2.1. Health Education	30	2.2
	2.2. Others (7)	120	8.6
<i>3</i> .	Common Courses	330	23.7
	Total	1392	100

periodic/survey basis. Apparently, HEWs currently spend little time on Family Health and Diseases Prevention and Control in spite of the fact that most spend quite a high proportion of their time in the HP<sup>1</sup>. The findings are confounded by the fact that quite a number of HEW, in Oromia in particular, work in HP with public health nurse (PHN) who handle most of the activities in these components. However, given the high proportion of time allocated to these components in the curriculum and the high expectation on the impact of these interventions towards achieving development goals, the situation merits close monitoring.

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<sup>&</sup>lt;sup>1</sup> For 5000 people, one HEW does not have to spend more than half a day to cover HP visits including the paper work.

On the other hand, Environmental Health and Health Education (HE) seem to be getting the due attention they merit. All HEW confirm that they spend a high proportion of their time on HE. However, HE, one of the triumvirate of public health interventions, is only considered a 'Supportive Course' in the curriculum and given only 30 hours of training or 2% of the total training hours; much less than mathematics or English (75 hours each, civics or introduction to Information Technology (50 hours each) and Entrepreneurship.

Health Education, quite understandably, occupies a considerable amount of the time of HEW. It is, therefore, important to ensure adequate time and attention to knowledge and skill development in health education (HE) during their training. It should probably be given a job title and given more time as a main course. For those who have already graduated, it should be one of the priorities for continuing education (CE).

Overall, it is important to closely monitor trends in Community Documentation, Family Health and Diseases Prevention and Control and take measures to promote them. There seems to be no common format for community documentation. MOH should lead in developing one with core/mandatory information and with flexibility for local adaptation. (The format being prepared by SNNP could serve as a basis) <sup>1</sup>

**Leave, absence ...:** HEW do not seem to know specifically their rights and privileges regarding leave, absence etc. None of them seem to have been given specific information on this during training or induction into service. This is not surprising as written information (rules and regulations) on these is not available even at the WHO-level. Only a vague notion that the civil service regulations should apply prevails.

Remarkably very few (unauthorized) absences from work are reported. In addition to the regular 1 or 2 days per month to collect salaries, HEW have spent some 3 to 20 days out of their kebeles to attend meetings or training sessions since their assignment. Some have taken, usually short, 3 - 5 days of sick, compassionate (mostly bereavement<sup>2</sup>) leave. One each from Oromia (Mana) and Amhara, had taken maternity (the majority are still single) leave.

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<sup>&</sup>lt;sup>1</sup> This could go a bit beyond lay reporting and include simple data on morbidity and mortality, birth and death (other pop movement) registration etc. Central guidelines would ensure collection and comparability of core data. Local (Butajira, Dabat and Jimma) and international experiences in community level data collection should be reviewed.

<sup>&</sup>lt;sup>2</sup> One in SNNP has reportedly taken over two months leave for bereavement!

The rules and regulations on leave, absence and other conditions of work should be clearly known (in writing) to HEW. This would help avoid arbitrariness and subsequent conflicts. If the general civil service regulations apply, copies of these should be available and communicated to HEW.

*Uniform:* The situation regarding uniforms varies. Tigray and Amhara have decided to introduce uniforms probably white gown for work in the HP and another color for field work but have not fully introduced them yet. Harari provides white gowns. In Oromia, some HP have white gown while others do not.

## 5.5 Living conditions of HEW

Housing: A number of HEW live in one of the rooms of the HP (Tigray, Amhara, Harari and some in Oromia), others in a separate unit in the compound of the HP. The kebeles provided housing, sometimes built for other purposes (teachers, DAs etc). Some were obliged to rent a house in the kebele. There was even a case where the HEW commuted daily from her house in the nearest town. Most of the houses were a one room unit often shared with the other HEW. They were mostly built of mud and wood in the traditional manner. Those in the HP shared the water and toilet facilities. Those living in the community seem to adapt to the coping mechanisms of the community

Housing is very important in motivating HEW and possibly, in lengthening their stay in the communities. The trend in our sample is encouraging. Those kebeles who have not done so to date should be encouraged to provide housing in or very close to the HP compound. Availability of safe water supply and toilet facilities (pit latrine) is very important not only as basic need, but also because of the wrong message conveyed to the community by their absence in or near the HP and/or the residence of the HEW. Making these available should be the priority of priorities.

Access to information: HEWs have very little access to information. Most have their own radio and almost all listen to radio quite often at neighbors. They have almost no access to newspapers or television. They do not get any professional information material (e.g. Newsletter). As some kebeles are distant from woreda towns this leads to a sense of complete isolation.

This isolation could have a negative effect on the quality of work and motivation of HEW. The possibility of preparing a newsletter dedicated to HEW to periodically present news on exemplary activities, innovations, problems and solutions, best practices, new developments etc should be explored. It would be also important to encourage all HEW to have a radio.

Access to other amenities: Most of the kebeles are at considerable distance from the woreda capital (some over 7 hours walk). Of the visited HPs for example, three each in Amhara and Oromia and two in SNNP were over 20kms distance from the woreda capital); therefore, interaction with the WHOs and other offices is limited. Post offices, telephone, health center, hospital, food markets (for items not available at community level), secondary school (for extension education) are often very far. Road conditions differ. While almost all kebeles are accessible by, at least, dry weather roads, some kebeles are only accessible by foot in the big regions (e.g. Amhara, Oromia).

*Ownership of selected items:* HEW own very few items<sup>1</sup>: a bed (38/60) one or two chairs (23/60), plates (59/60), cups (59/60). They do not have (at the kebele level) any 'major' property e.g. cupboard (4/60).

Owning some property could be important in improving their living conditions and also motivating and anchoring them in the kebeles. The possibility of providing them with a small credit for installation should be explored.

#### 5.6 Administrative Issues

*Organizational structure and accountability:* At WHOs level the position of the HEP seems to be evolving. All except two of the visited woredas have a focal person in the WHOs, most often the environmental health technician on the team. Patterns of organization and responsibility include:

- ♦ Directly under the Head
- ♦ Under the DPC desk
- Under Health Programs (Health Services and Training) desk
- ♦ Own unit (under study)

<sup>&</sup>lt;sup>1</sup> One, close to a major town, had her own mobile phone, the shape of things to come?

At the **kebele level**, conditions are even more fluid. In most no clear link with kebele institutions have been established.

- ♦ Kebele Health Committees are supposed to guide health work at the community level (Health Policy and Strategy etc). This has been stressed in the HEP Guideline¹ however very few have established such committees.
- ♦ In some HEW sit in the Kebele Council.

Most HEP are not formally anchored in the kebele structure yet. In most cases the plan of the HP, the work program of the HEW and even the selection for 'Family Health Package' seem to be drawn without clear notification let alone consultation at the kebele level.

Inputs (buildings, equipment, supplies, human resource...) are not enough; how they are planned, allocated, organized, managed etc determines cost-effectiveness and sustainability. At the WHOs level, while the final organizational arrangement has to be flexible to take account of local conditions and resources, the tendency to leave the Health Extension Program (HEP) to a focal person alone should be rectified. It must be understood that all desks, teams and experts have a role in HEP in their respective competence and responsibilities. The focal unit, team or person's role should be, essentially, to facilitate and coordinate information flow and actions.

The importance of active participation of the community in its own development, including the choice of priorities, objectives and actions to be taken for health through a functioning community organization has been recognized since the early 1970s but has in practice remained illusive. The modalities of participation could vary. In the Ethiopian context, the Health Committee model, promoted over several decades, seems inoperable since it has not taken root in almost all regions (Only 40% of the kebeles with community health agents (CHA) had Health Committees at the height of Derge's comittization process and have also proved problematic in a number of other countries). Even though its theoretical merits seem compelling, the reasons for the lack of up-take should be explored; in our sample, only 14 of the 50 kebeles had more or less functioning Health Committees. In the meantime, the participation of HEW in the Kebele Council should be strongly promoted so as to strengthen the health agenda and ensure intersectoral measures. Through this and other means, the HEW should be prompted to ensure a high level of effective community participation. Along side this, a measured effort of 'deprofessionalizing' HEW

<sup>&</sup>lt;sup>1</sup> The Guideline calls them Kebele Health Council.

should be considered. As is, HEWs are more of the health sector/civil service employee rather than of the community. A priority continuing education (CE) theme could be principles and practices of community participation.

Supervision/monitoring and logistics: Encouragingly, a lot of attention seems to be given to supervision at all levels. The data shows that there have been quite a number of supervision visits to the HP/HEW visited/interviewed. Only the three HP in Benishangul Gumuz just started and two each from Oromia and SNNP had not had any supervision prior to our visit. Supervision was by WHOs, except for a few supervisions by a HC in SNNP and a large number in Tigray. However supervision is considered to be poor with a lot of technical inadequacies, limited learning process and deficient feedback (none gave written feedback). Varied approaches are evolving:

- Some are working on the principle that only WHOs should be involved (e.g. Amhara, Oromia);
- Others tend to involve the closest health facilities, HC in particular (e.g. Tigray, SNNP);
- ◆ Kebele officials are involved in supervision in some woredas. 12 (20%, 6 in Amhara,
   5 in Tigray and 1 in SNNP, say they are responsible to the Kebele Chairperson;
- ◆ The Guideline envisages (only) team supervision, with wide participation, coordinated by WHOs;
- ♦ In some case the focal persons/supervisors at the WHOs complain that they were not given enough orientation about the HEP that should have helped them provide effective guidance and supportive supervision.

This and previous studies show that both the WHOs and HC are usually understaffed. Orientation on HEP (compounded by high turnover of staff e.g. Kobo) and supervisory skills are limited. Proper monitoring/supervision are the linchpin of a successful community-based program. The paramount need is for better supervision at the woreda level. The principles of monitoring/supervision sketched in the Guideline are sound. However, they require more elaboration in view of the large number of stakeholders and limited resources at the woreda level in particular. While ultimate responsibility should rest on WHOs, greater participation of all stakeholders and delegation to some, e.g. health centers

(HC)<sup>1</sup>, NGO, should be explored. Practical training in supervisory skill will be required.<sup>2</sup> Since this is a critical issue, it is advisable to undertake some operational research and discuss its findings in a highly participatory process before up-scaling.

Relationship with other health workers: A number of community-level/based health workers exist in most kebeles: community health agents (CHA), trained traditional birth attendants (TTBA), community-based reproductive health agents (CBRHA), malaria, trachoma agents, Health Promoters (mostly SNNP and Amhara and a few in Oromia). Most of these started as NGO projects with their own chain of command. The relationship between these workers and HEW are not clearly established yet. There is bound to be conflicts as HEW become more seasoned unless duties and responsibilities are more clearly defined. In principle, there seems to be a consensus that the HEW should at least have an oversight role<sup>3</sup>.

In some HPs, HEW are placed with other health workers, mostly junior public health nurse (JPHN). Relationships in most of these cases are ambivalent with HEW excluded from any activity (even immunization) in the HP. In some of these cases, the HEW has no direct link with WHOs.

The relationship of HEW with other community based health workers is critical for improved coverage and improved quality of services. All HEP documents<sup>4</sup> are mute on traditional practitioners and they were not raised in our interviews. However, it is well known that they exist in most communities. It will be in line with the country's policy to map out ways and means for their interaction with HEW. Otherwise, it could lead to unhealthy 'competition' and lost opportunities for cooperation in improved health care in the communities. The Guideline is mute on the subject of relationship with other community based health workers<sup>5</sup>. While local conditions and the status of the different stakeholders, e.g. NGOs, might dictate the details in each woreda and kebele, there should be a guideline on the major principles of such relationships: coordination of and ultimately responsibility for all health work in the kebele is the mandate of the HEW; they should, therefore, be in a position to get all the necessary information and the communication line to fulfill these functions. Such a guideline should be prepared as soon as possible with the active participation of all stakeholders.

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Assuming that its staff will continue to have public health oriented professionals (environmental health technician and PHN...)

<sup>&</sup>lt;sup>2</sup> The possibility of upgrading selected HEW as supervisors should be explored.

<sup>&</sup>lt;sup>3</sup> There are reports of community health agents (CHA) referring cases (malaria in particular) to HEW in Tigray.

<sup>&</sup>lt;sup>4</sup> SNNP Guideline mentions stopping harmful traditional practices (HTP) and illegal practices

<sup>&</sup>lt;sup>5</sup> The SNNP Guideline specifically put all community-based health workers under the 'guidance' of HEW but in practice, a number of problems are reported.

Career structure, upgrading, promotion, transfer and rewards/continuing education:

The career structure for HEW has not been formally established yet (to our knowledge). The indication from interviews at different levels and the aspirations of the trainees is for upgrading into the nursing and environmental health categories. But how and at what level<sup>1</sup> they will fit into this scheme has not been elaborated. The Ministry of Education (MOE) strategy and curricula foresee discrete training paths for different vocational groups (nurse, environmental health, and laboratory, x-ray, and pharmacy technicians) but has not envisaged HEWs and how they will fit into this scheme.

There is a high anticipation among HEW of **upgrading** their status soon (most say this has been promised during recruitment). Most expect this after two years of service. However, there does not seem to be any clear guidelines and preparation on this at any level. What are the requirements (years of service, quality of performance ...), how many would/could be upgraded each year, what would be the selection process, who would be involved in the selection, where will upgrading training be given ...? This could be one of the most important challenges to the governance of the Health Extension Program.

**Transfer** of HEW is a delicate issue. Selection from the kebele in which they will be working after graduation was assumed to guarantee a reasonably long service to the community at the kebele level<sup>2</sup>. However because the selection was flawed for the first intake in almost all regions and the inherent difficulty of finding qualified candidates at the kebele level coupled with the relatively high level of education and the youthfulness of HEW, transfer requests are bound to become major concern in the future. It seems that little thought has been given to this aspect of HEW management to date and there are not yet any clear rules and regulations<sup>3</sup>.

<sup>&</sup>lt;sup>1</sup> The decision in Amhara Region to raise their salary to B 426 seems to equate them to Assistant/Junior Nurses/Technicians.

<sup>&</sup>lt;sup>2</sup> A few HEW indicated preference to placement outside their kebele of origin; probably an inclination towards public employee rather than a community worker.

<sup>&</sup>lt;sup>3</sup> The SNNP Guidelines categorically states that HEW will not be placed in any facility except HP

A system of **rewards** for commendable performance has not yet been formally established. It could be that there are some initiatives at the woreda and kebele levels. However modest, recognition of a few regularly at the regional and central levels could have a major impact on the motivation of HEWs. Recently, some HEWs have been selected to participate in MOH annual review. These kind of initiatives could, in addition to other objectives, be systematized (with clear and transparent procedures) to serve as part of a reward system. Continuing education could also be built into the reward system.

Clear and properly/transparently implemented/enforced career structure plays a critical part in the motivation and retention of staff. Immediate clarification on the career structure will have an important impact on the motivation of HEW and future planning including promotion and upgrading. This should include not only the conditions and paths of upgrading, but also the evolution over time of those who remain HEW. The way transfers¹ are handled could be critical to the future status of HEW. Selection criteria might need revision to ensure availability at the kebele level. However, transfer should be handled in a way that is transparent and reinforces appurtenance to the community. Overall, a manual on HEW workforce management should be developed and applied consistently and transparently.

**Reporting/administrative documentation:** All HPs send regular reports to WHOs some every two weeks but all at least once a month<sup>2</sup>. Some also report to the nearest HC/clinic (Tigray and SNNP). Most HPs do not have a format for reporting; the RHB in SNNP and Amhara have prepared formats. The report is essentially routine and the HEWs rarely receive any feed back. Even though some HPs report a registry book in their supplies, registry of daily activities is hardly practiced. Thus reports are not based on clear source document and are difficult to verify. Reports are not sent to the kebele.

Reporting is an essential management tool but has to be used effectively. There is need to:

- Prepare a format for reporting containing core elements but flexible enough to accommodate local variations and new events/actions
- ♦ Institute a registry of activities in all HP

<sup>1</sup> Transfer poses the same problem as high level attrition for voluntary workers – lead to lack of continuity in relations between the community health workers (CHW) and the community, lost opportunities to build on experience etc.

<sup>&</sup>lt;sup>2</sup> These are 'routine' reports. A number also send weekly malaria etc ('epidemic') reports

- ♦ Ensure feedback, not withstanding overburdened and understaffed WHOs (use monthly presence in the woreda capital for collecting salary?)
- ◆ Device ways of sharing (the contents of) the report with the community (Health Committees/ Kebele Councils).

**Referrals:** HEWs report very few referrals. In total, about 40% in our sample have not reported any referral. Contact with HC/nearest health facility (HF) seems very weak. There are no referral forms and those who have sent referred patients use pieces of papers. Referral papers rarely confer any privilege. HEWs almost never receive feedback on their referral from HF and very rarely from the patients. There is also no report of HC/hospitals referring patients to HEW for follow up. The referral process seems to be handicapped by constraint in physical and material resources (long distance, poor roads, scarcity or high cost of public transport...).

The referral arrangement should be seen as a serious issue. It is inadmissible to place HEW at community level for simple (curative and) preventive services and let them work almost in isolation from the rest of the system. Admittedly conditions (transport and communication in particular) are not conducive but the basis for a clear link between the different levels of care should be laid as of now. There should be commitment at all levels to start the referral system rolling and achieve a two way flow. To this end:

- ♦ Prepare formats for referral with inbuilt mechanism for feedback
- Orient and continuously sensitize the relevant staff on referral.

## 5.7 The community

Community participation/expression: Communities are, in general, reportedly well disposed to HEWs. They readily participate in HP building even though there are resistances in few places. However, there is very little participation of communities in planning and programming and management of HP/HEP in general.

There have been very few complaints by the community, except for the absence of curative care. Communities participate in HEP actively except for some reluctance during busy farming periods.

Currently, most HPs do not seem to have an active system of soliciting community reflection on their activities. It is recognized that 'good health results from a process over which people themselves need to take charge and not a product that can be delivered in discreet package'. Community participation is also an important element of staff motivation especially in rural areas. Some of the complaints from the communities, e.g. involvement during peak farming periods, could be avoided if communities are involved in program development.

The Curative Care Challenge in the Health Services Extension Program: Health care<sup>1</sup>, as close to those who need it ('patients', vulnerable groups etc) as possible, has been the goal of modern health services. Even though promotion of health and prevention and control of diseases have been the priority policy concerns of the health (public) leadership, the demand for curative care has been in the forefront of the demands of the people. Consequently, meeting this demand and using it as an entry point for promotive and preventive work has evolved as an accepted strategy in most health care programs. However, the Health Extension Program (HEP) started off with the concept of drug/curative-care-free health service by HEW. The rational for this was apparently to ensure that priorities in prevention and control are given exclusive attention and the concern that curative activities could overshadow these priorities if HEWs are involved in curative care.

## The context for curative care

Rural Ethiopia suffers mostly of infectious, parasitic and nutritional diseases. The disease burden is very high. Therefore, the demand for curative care is potentially very high and beyond the means of the public health sector alone. They are therefore met in a number of ways including (in the Ethiopian context);

Self/lay care: This covers the largest, the most immediate and 'simple' needs. The mother is, after all, the first care provider for the family using traditional and/or modern medicines. While commendable, unless supported by the formal sector, the modern drugs used could be of dubious benefit.

<sup>&</sup>lt;sup>1</sup> Taken in the broader sense including health promotion, diseases prevention and control and curative and rehabilitative care.

- ◆ Traditional practitioners: These are pervasive, easily accessible (proximity, low cost...) and acceptable because they are familiar. Shrouded by secrecy and therefore vulnerable to charlatanism, they have not been 'integrated' in the mainstream health care system to date. However, their potential to mitigate the curative care challenge could be high.
- ◆ Transitional/informal practitioners/injectors: These are mostly those who have rubbed shoulders at one time or another with formal modern medicine/health care providers and use/abuse this association to 'treat' patients in both urban and rural areas. They most often give injections of clearly dubious indication and quality. They are often mobile in order, among others, to avoid legal pursuit.
- Rural drug vendors and other drug outlets: There are relatively large number (about 1880 in 2005) Rural Drug Vendors and even though licensed as drug retailers, they give a whole range of curative services, including antibiotic injections. They are mostly confined to rural towns.
- ◆ The formal modern health care service: The modern health care service is of limited accessibility even though potential coverage is estimated between 43-72%. Currently the closest public health services are health centers (HC) and health stations (HS). As is well known and our studies document, HC are at relatively great distance from most kebeles with often very bad road and transport conditions. Distance for most rural kebeles could be 20km or more from a HC. Even HS are distant and, anyway, the policy is to upgrade them to HC or downgrade them to health posts (HP).

This is the context within which the curative challenge for HP should be viewed. Rural communities are faced with dubious choices when faced with health problems. Understandably, they aspire for a more reliable, accessible and trustworthy service. The presence of a HP triggers high expectations along this line when, in particular, the community is a major contributor to its construction.

Our study shows that there is a pervasive request in almost all communities dictated by the long distance and high cost of traveling to HC or hospital. During one visit (Chiro), for example, the study team found the community at a meeting in the HP and the



HEW providing first aid care treating a child sustaining burns

dominant issue was the provision of curative services.

The push for some/additional curative services is also promoted by several Woreda Health Offices (WHOs). Even though provisions/logistics might be erratic HEW have started providing first aid, ORS and malaria drugs (including

CoArtem in some and soon probably in all malarious areas). The demand seems to be for antibiotics and probably injections. Even though HEW may soon carry antibiotics as part of the Child Survival/community Integrated Management of Childhood Infections (IMCI) strategy, the demand for more/better curative services is a challenge to the HEP.

In the condition where HEW is the only health care provider for kilometers, the preventive/curative dichotomy seems untenable. If communities are involved in the decision making process, the demand for curative services would be inevitable. This should not however mean that all community demands have to be met but, with clear discussion of the implications (cost etc); these are amenable to reasonable proportion (within the essential health services package, for example). Experience shows that "...when patients do not receive therapeutic drugs, they have little incentive to seek public health care". A number of options are being experimented in the regions:

Few seem to continue to toy with the no-drug model. This is most probably untenable with other woredas even regions introducing curative services. The resonance effect even form 'far away' regions is bound to be high. Particular attention should be paid in areas where health stations (HS) (which gave curative care) are downgraded to HP as there is a real possibility of uproar from the community;

- ♦ Some have placed junior nurses in HP. The long term perspective and the resource implications of this approach as compared to in-service/continuing education of HEW does not make it a feasible alternative;
- Others give training and continuing education on new introductions and expand the curative role of HEW. A woreda in Tigray, for example, has already introduced this on its own initiative;
- ◆ There are also considerations (though we have not noted any field/woreda level practice) of using intermediate level curative services between the HC and the HP. These will be units encompassing 3-5 kebeles manned by a nurse. However, such an intermediate unit will only add an additional layer (and the resulting management burden) without resolving the problem as long as there is a HP at the kebele level. People will continue to expect a 'reasonable' package of curative care from the HP.

Further analysis of current experience is warranted but graduated inclusion of selected procedures with the appropriate (in-service) training, through HEW, seems the most likely avenue. Concurrently, intensive health education should be given to the population on appropriate drug/injection use.

It seems to us that the solution should focus on what could/should be delivered at the HP level and apply a multi-pronged strategy to ensure a legitimate level of community satisfaction while safeguarding the promotion, prevention and control priorities.

#### This implies a number of measures including:

#### 1. Expanding judiciously the curative role of HEW

Introduce gradually (as part of the Essential Health Services Package) a selected number of curative services through the HEW who would be given the appropriate in-service training. Malaria treatment has been already introduced in a number of woredas. Antibiotics for child pneumonia and other respiratory infections seem good early candidates.

#### 2. Introduce cost-recovery methods

Curative care could be a bottomless pit, therefore some cost-recovery mechanisms should be introduced probably as fee-for-service. A way of backing this up with, for example, a community-based financing scheme should be explored. (The Health Care and Financing studies could be adapted to this end). Seed money could be solicited from donors on the "Bamako Initiative' lines.

#### 3. Education of the people

Beyond the usual health education (HE)/IEC topics, people should be educated on appropriate health seeking behavior, rational drug use and related issues. An important goal of the education should be people's involvement in the planning, implementation and monitoring and evaluation of

their health services. Experience elsewhere has shown that participation could reduce undue demands for curative care.

#### 4. Strengthen supervision and logistics

The introduction of curative procedures through HEW presents a number of challenges. An important concern is distortion of Health Services Extension Program (HSEP) from the priority promotion and prevention activities. For two (2) HEW working in a kebele of 5000 in a densely populated area, there should be ample time to carry out their promotion and prevention activities along side a limited curative care in the HP. However, experience shows that health workers could easily be distracted by curative care. This could be alleviated by close, educative and supportive supervision. At present, supervisory capacity at the woreda level in particular is highly inadequate and poses a real threat to the development of HSEP. The addition of more curative services risks derailing the whole process if the supervisory mechanisms are not strengthened.

Another challenge is the possible abuses/corruption of the curative services (unnecessary injections, pilfering of drugs etc). This could be attenuated by a sound logistics system and close supervision. Community involvement (see above) is also an important antidote against abuse by providers.

#### 5. Strengthening the referral system

For HEW to provide any credible and effective (in terms of health impact) curative service, they should be supported by a meaningful referral system. Our and other studies show that this is almost non-existent even for HC let alone HP at present. Strengthening implies among others:

- ♦ Creating a workable system clearly integrating HEW in the health (curative) care hierarchy
- ♦ Developing the required regulations/guidelines, formats etc
- ♦ Endowing those who are referred through HEW with clear incentives (privileged access to the referral facilities, ensured follow up etc)

#### Looking into the future:

In deciding on alternatives, it would be good to look into the future as far as possible. If the promises of our development goals (ADLI, SDPRSP/PASDEP, MDGs etc) hold, we should anticipate, in the not so long future, a rise in the standard of living and the effective (economic) demand for improved health care. For example, by 2010 (two-third of the way to MDGs) some achievements, even if not at par with MDGs, will be made. These will require a revision (upgrading) of the services at HP levels. HEW could ideally be upgraded to nurse practitioners with experience and expertise in community level promotion and prevention health work. Their community health work experience and the in-service/continuing education efforts during their HEW years should prepare them more adequately for this upgrading.

**Delivery service:** Very few delivery service by HEW is reported in the study woredas even though a number of HP have delivery kits and couches (e.g. Amhara) <sup>1</sup>. This may be related to the fact that:

- Very few deliveries (normal in particular) are brought to health facilities in general (most health centers (HC) are under utilized in this respect);
- There is competition from traditional birth attendants (TBA) in home delivery and;
- ♦ Probably most HEWs do not feel confident enough to undertake delivery independently because of limited practice during the training.

Reduction of maternal mortality, one of the main goals of the Health Sector development Program (HSDP) and MDGs, has remained illusive to date. 'Professionally' attended delivery is considered an important factor in reducing maternal mortality rate (MMR). HEW could/should - given the appropriate training/retraining and support – play an important role in this connection. Measures should be taken to:

- ◆ Increase the confidence level of both HEW and the community on the delivery skills of the HEW;
- ♦ Increase the awareness and service seeking behavior of the population.

## 5.8 Job satisfaction/motivation, future aspirations

**Perceived standard of living:** Even though their standard of life could be considered relatively modest, HEW seem to have no demonstrated complaint along this line. The reward package is new and for most of HEW a very important step out of the jobless (income less) status they were in previously. They consider their incomes/living standard better than the better-off farmers, more or less equivalent to kebele officials but lower than teachers and agricultural extension workers in their community.

**Accomplishments:** Most have been on the job for over 6 months and, therefore, in a position to assess their accomplishments:

- ◆ Community Documentation appears to be a relatively weak link. Except for Analysis and Sending Reports, most of the other jobs Preparing Plan of Action and Maintaining Stock seem to lag behind.
- ♦ In *Family Health Care* accomplishment in providing FP Services, Immunizing Children, and Enabling Mothers to Prepare Balanced Diet are considered high while

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<sup>&</sup>lt;sup>1</sup> The only exception is a HEW in Mana who has carried out one home delivery.

nothing or very little has been accomplished in Providing Nursing Care, Employing Universal Infection Precaution, Providing Home Delivery and Providing Care to Children with Common Childhood diseases.

- ◆ In *Disease Prevention* and *Control and Environmental Health*, almost all jobs get good accomplishment rating.
- ♦ Almost all rate their accomplishment in *Health Education* as very high.

**Empowerment:** Most find their work fulfilling. They work quasi-independently and take most decision on their own. All HEW interviewed are still highly motivated and continue to see their job as a mission to improve the health of the population.

Future aspirations: Very few expect to stay in the kebele of their present assignment or even as a health extension worker for more than two years. The majority would like/expect to upgrade to nurse (about 70%) and the rest to environmental health. Few mention pharmacy technician, administrative positions and, interestingly two mentioned upgrading to diploma in HEW.

There is a quasi-universal and very high level of expectation of upgrading/moving out of the HEW status in a very short time. This is bound to raise a number of serious management problems unless handled promptly and with sensitivity. A prerequisite for achieving the minimum level of acceptable performance is an adequate reward package, i.e. a living wage (otherwise personnel must devote their energies to 'moonlighting' in order for them and their families just to survive). The salary level seems adequate for the moment. The emerging discrepancy on salary (Amhara 426, the rest 381) should be rectified as soon a possible as it could be a bone of contention later.

## 6. Summary of Major Recommendations

## 1. Facilities, equipment and supplies

- It is important to complete health posts (HP) before the arrival of the health extension workers (HEW) or, at least, as soon as possible there after since it could impact on effective work and the motivation of HEW.
- Avoid repeated shortage/lack of equipment and supplies which could lead to underuse of HEW with ensuing problems. Measures should be taken immediately to build commensurate capacity in equipment maintenance and repair capabilities in the sector.

- ◆ Immediate measures should be taken to ensure adequate availability and sound management of basic supplies, drugs and vaccines in anticipation of the greater demand of servicing over 15,000 HP.
- ♦ Initiate studies on appropriate and sustainable transport facilities for HEW; provide raincoats and/or umbrellas; initiate strategic thinking in the use of information and communication technology (ICT).

## 2. Administration and supervision

- HP should know their operational budget and plan accordingly. Harmonize salary of HEW.
- ♦ Work plans should be developed for each HP/HEW, as much as possible in consultation with major stakeholders and posted in the HP.
- Prepare a format for reporting, institute a registry of activities in all HP, ensure feedback and devise ways of sharing the report with the community.
- ♦ The rules and regulations on leave, absence and other conditions of work should be clearly known (in writing) to HEW. A manual on HEW workforce management (career structure, promotion, upgrading, transfer etc) should be developed and applied consistently and transparently.
- ◆ At the Woreda Health Offices (WHOs) level, the tendency to leave the Health Extension Program (HEP) to a focal person alone should be rectified. It must be understood that all desks, teams and experts have a role in HEP in their respective competence and responsibilities. The importance of active participation of the community in its own development should be prioritized. The modalities of involvement should be revisited. In the meantime, the participation of HEW in the Kebele Council should be strongly promoted so as to strengthen the health agenda and ensure inter-sectoral measures.
- Current supervision practices are weak and since this is a critical issue, it is advisable to undertake some operational research and discuss its findings in a highly participatory process before up-scaling.
- ♦ There should be a guideline on the major principles of the relationships between HEW and other community based health workers including traditional practitioners.

#### 3. Training and access to information

- Ensure adequate time and attention to knowledge and skill development in health education (HE) during training. For those who have already graduated, it should be one of the priorities for continuing education (CE). Overall, it is important to closely monitor trends in Community Documentation, Family Health Care and Diseases Prevention and Control and take measures to promote them.
- ♦ Reference materials, upgrading, new and improved approaches and technologies should be introduced through more flexible formats (continuing education newsletters, leaflets...).
- ♦ The possibility of preparing a newsletter dedicated to HEW to periodically present news on exemplary activities, innovations, problems and solutions, best practices, new developments etc should be explored.

### 4. Curative and delivery services

- Demand for curative care is an important challenge to HSEP. Further analysis of current experience is warranted but graduated inclusion of selected procedures with the appropriate (in-service) training through HEW seems the most likely avenue. Concurrently, intensive health education should be given to the population on appropriate drug/injection use.
- ♦ The placement of more senior health workers (nurses) with HEW in the HP as seen in some regions requires more thorough studies and decisions.
- In delivery services, measures should be taken to increase the confidence level of both HEW and the community on the delivery skills of the HEW; and increase the awareness and service seeking behavior of the population.
- Prepare formats for referral with inbuilt mechanism for incentive and feedback;
   orient and continuously sensitize the relevant staff on referral.

#### 5. Living conditions

- ◆ Those kebeles who have not done so to date should be encouraged to provide housing in or very close to the HP compound. Availability of safe water supply and toilet facilities (pit latrine) in or near HEW residence should be the priority of priorities.
- ◆ The possibility of providing HEW with a small credit for installation (acquiring essential commodities) should be explored.

# 7. Annexes

Annex 1: Places Visited

Annex 1: Places Visited	ı		
Region	Zone	Woreda	Kebele/HP
Amhara	S Gondar	Dera	Dembeza
			Gelawdios
	E Gojjam	Dejen	Chercher
			Borber Chenecha
	W Gojjam	Bahir Dar Zuria	Adele
			Wonjeta
	N Shoa	Baso/Warana	Bere Ager
			Aba Mote
	Oromia Special Zone	Dawa Chefe	Shekela
			Herensa
	N Welo	Kutaber	05 Elssa
		Kobo	Jarota
			Gedeba
Beni/G	Assosa	Assosa	Akuda
			Abramo
Harari	-	Errer	Dodota
			Ulan
Oromia	E Shoa	Boset	Borchota
			Amecha
	Arsi	Gedeb-Assasa	Wekachela
			Kakawa Welkite
	W Shewa	Ameya	Gombore
			Bereda
	W Haraghe	Chiro	Ulakuni
			Yabdo Shembeko
	E Haraghe	Gorogotu	Errer Mendechin
			Werji
	E Wellega	Leka Dulecha	Karo Negesso/Busano
			Bedho
	Jimma	Mana	Gudeta Bula
			Sumbo Mana
SNNP	Gedeo	Bule	Herede
			Suko
	Wellita	Boditi/Damot Gale	Adiaro
			Zamne Sibay
	Gamo	Arba Minch Zuria	Chano Mille
	at t	** **	Genta Bonkie
	Sheka	Yeki	Shusha
			Adiss Berhan
	Sidama	Hula	Getama

Region	Zone	Woreda	Kebele/HP
			Wetiko Wedi
Tigray	Eastern	Atsebi	Hadnet
			Ruba Felege
	Central	Weri Leke	Mignai Aweli
			Segun
		Lay Maichew	Dereka
			Dura
	S. Western	Laylay Adiabo	Adi Nigisti
			Tsaeda Midri
	South	Rayana Azebo	Ebo
			Beiru

## 8. Acronyms

ADLI Agricultural Development Led Industrialization
CBRHA Community Based Reproductive Health Agent

CE Continuing Education
CHA Community Health Agent
CHW Community Health Worker

CNHDE Center for National Health Development in Ethiopia

CSRP Civil Service Reform program
DPC Disease Prevention and Control

EH Environmental Health HC Health Center HE Health Education

HEW Health Extension Worker

HF Health Facility
HH House Hold
HP Health Post

HRH Human Resource for Health HRM Human Resource Management

HS Health Station

HSDP Health Sector Development plan HEP Health Extension Program

ICT Information Communication Technology
IEC Information Education Communication
IMCI Integrated Management of Childhood Illnesses

JPHN Junior Public Health Nurse MDGS Millennium Development Goals

MRR Maternal Mortality Rate
MOE Ministry Of Education
MOH Ministry of Health

NGO Non Governmental Organization

ORS Oral Re-hydration Salt

PASDEP Plan for Accelerated Sustainable Development to End poverty

PHN Public Health Nurse
RDV Rural Drug vendor
RHB Regional Health Bureau

SNNPR Southern Nations Nationalities & Peoples Region

TBA Traditional Birth Attendant

TTBA Trained Traditional Birth Attendant

TVET Technical, Vocational and Education Training

WHO Woreda Health Office