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PUBLIC HEALTH PICTURES

Community-based health extension policy implementation in Ethiopia: a policy experience to scale-up

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Abstract
Ethiopia has launched innovative community-based health policy in 2003. It was designed to accelerate the expansion of community-based health facilities and basic health services. The program established a health post at the lowest administrative unit level to serve in the villages. The policy implementation was supported by many stakeholders to improve the health indicators of the country. All the concerted efforts and public participation has helped the implementation of the policy and improvement of primary health services in rural communities. Thus, participating communities through grassroots mobilization in similar resource limited settings as experienced in this policy review could be scaled up to other health policies for its successful implementation.
Keywords: Policy implementation, Community-based health extension, Ethiopia.

INTRODUCTION

Context and nature of the policy

Ethiopia, home to more than 112 million people as of 2019,[3] has passed through various political transitions that caused health policy inefficiencies. Ethiopia had bad core health indicators at the beginning of 1990s with a high child mortality of 204 per 1,000 live births,[4] high maternal mortality with 1250 maternal deaths per 100,000 live births[5] and low overall life expectancies (47.7 years) with one of the lowest in the world.[6]

After the fall of the military regime in 1991, the transitional government of Ethiopia formulated a health policy in 1993 articulating the vision for health sector development focused to more promotive, preventive

Supplementary information The online version of this article (Tables/Figures) contains supplementary material, which is available to authorized users.

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and selective curative health services in equitable and accessible manner.[7] It acknowledges the policy initiatives of the previous two regimes while criticizing the weakness of the past leadership to implement it.[7] In pursuit of this, the government developed a 20-year Health Sector Development Plan (HSDP) in 1997 which proposes long-term health sector goals and mechanisms to achieve successively in every five-year.[8]

Community-based Health Extension Policy introduction

Ethiopia has launched an innovative community-based health policy in 2003 which is also known as health extension program (HEP).[9] This program was designed to accelerate the expansion of community-based health facilities and provision of basic health services in the rural community that have limited access to healthcare facilities otherwise.[2,10] (Table 1).

Content of the policy

The program established a health post in each kebele, the lowest administrative unit, to serve between 3,000 and 5,000 villagers. Each health post employs two female health extension workers (HEWs)[11] who deliver basic health education through home visits and outreach services. In health posts, basic promotional, curative, and preventive health services are provided.[12,13]HEWs represent the health sector and collaborate with representatives of other sectors (such as education, agriculture, and community members) under the kebele administration's leadership.[13] This community-based health extension policy was implemented by recruiting 10th-grade-educated females from the community and training them to be HEWs after a year of formal training on 16 health packages, which they then implemented through home visits and outreach services during their deployment.[13] Consequently, the sixteen health packages were divided into four major components: family health, disease prevention and control, personal and environmental hygiene, and health education. To accomplish this, over 42 thousand HEWs were trained and deployed across the nation.[2] For its effectiveness and long-term viability, this community-based health extension policy is structured as a joint government-community program. The government pays for the construction of health posts and HEWs' salaries, while the community is responsible for the construction and renovation of health posts and the provision of housing for HEWs[13] (Figure 1).

POLICY DEVELOPMENT PROCESS

Problem identification

The first five-year health sector development plan (HSDP I) (implemented from 1998 to 2002) brought in the overall improvement of health sector performance. Despite the progress made, the targets set in HSDP-I were not met and a new strategy suggested for HSDP-II (2002/03– 2004/05).[8] During the HSDP I evaluation, major gaps were identified in the delivery of essential services in rural areas where 85% of the Ethiopian population lives and prompted the need to significant human resource reforms.[14] Only one from four pregnant women received antenatal care, and only one-third of children were fully immunized.[15] Distances to health facilities were also identified as a main barrier to the use of health services.[16] After the implementation of HSDP I in 2002, the physician to population and nurse to population ratio were 1:35,604 and 1:5,613, respectively.[14] This was far behind the standard health workforce to population proportion recommended by the WHO and led to looking for an affordable approach to develop a health workforce with less intensive training (unlike doctors and nurses) tailored to preventive and health promotion services.[14]

Actors involved in shaping policy agenda and development of HEP

There were recommendations from international agencies (e.g., WHO, World bank) and development partners to accelerate improvements in the country's healthcare system to reach the health targets and the Millennium Development Goals (MDGs).[17] The donors and funding agencies had the interest to increase primary healthcare access through institutionalized community-based approach to achieve universal health coverage.[12,18,19]

The government evaluation of its HSDP I performance, the country's prevalent health problems, high maternal mortality, low socio-development index,

international agencies recommendation and donors interest enabled the health issue to reach the policy agenda of the government. Therefore, it opened the policy window for the development of community-based HEP in Ethiopia.

There have been consultative meetings to provide policy input prior to its formulation. The Federal Ministry of Health and Ethiopian Public Health Institute have summarized evidence on the country heath data, policy briefs and prepared draft documents.[20] While the UN agencies like WHO provided technical support and other development partners pledged to fund the system and capacity building of HEWs which strengthened the governments financial capacity. The policy triangle depicted in Figure 2 has summarized the policy actors and context of the health extension policy development in Ethiopia.

The policy development process of HEP in Ethiopia satisfies both Kingdon 2014 and Hall et al 1975 models.[21,22] The Kingdon model is satisfied as described in Figure 3.

As per the Hall et al. model, access to primary healthcare is a legitimate concern fully recognized by the government's HSDP I performance evaluation. HEP is also accepted as a feasible program to address the issue with a limited resource and less intensive 1-year training of HEWs with basic health service education as compared with more intensive training of doctors and allied health workforce for curative services. The HEP had wider public support and the community was a part of the program to partly cover the expenditures for constructing health posts and providing residence for HEWs.

Policy solution and transfer

The components of the health extension package were determined after identification of major public health problems of the population living in the rural areas.[23] The chosen policy is synthesized and transferred voluntarily considering the 1978 Alma-Ata declaration of primary health care to attain health for all, lessons drawn from the experiences of previous HSDP I implementation, Ethiopian health policy history and policy recommendations of interest groups to conform with the national health policy and its HSDP objectives.[7,9,24] The HEP is shaped to the societal context and cultural sensitivity of the Ethiopian population. Female HEWs recruited since the cultural acceptability of females is better to conduct home-to-home visit and outreach services. Therefore, this policy is chosen considering the feasibility, country's population context, resources, available healthcare infrastructure and recommendations from interest groups such as world bank, WHO, other UN agencies and charity organization.

CONCLUSIONS AND IMPLICATIONS

The policy development of community-based HEP in Ethiopia was the government's political commitment to increase promotive and preventive health services to the less privileged rural population. The policy process supported by public, international development partners and funding agencies to improve the health indicators of the country. Generally, it was designed to address the health access inequalities caused by the shortage of health workforce and health facilities in rural parts of the country by increasing the number of health posts and trained health workers. Thus, harnessing and participating communities by grassroot mobilization to common health development objectives as experienced in this policy review could be scaled up to other health policies for its successful implementation.

INFORMATION

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TABLE 1: Ethiopia's three-tier healthcare system.

Health tier level	Health facility type		Population estimates served by a health facility
Tertiary level	Specialized Hospital		3.5-5 million people
Secondary level	Generalized Hospital		1-1.5 million people
Primary level	Urban	Health Center	40,000 people
	Rural	Primary Hospital	60,000-100,000 people
	Rural	Health Center	15,000-25,000 people
	Rural	Health Post	3,000-5,000 people
			Health Development team (20-30 households) --> One-to-five networks (six-households) --> Households

Source: adapted from Federal Ministry of Health, Health and health related indicators 2012/2013.[1]

Family health services	Hygiene and environmental sanitation	Disease prevention and control	Health education and communication
• Maternal and child health • Family planning • Immunization • Adolescent reproductive health • Nutrition	• Proper and safe disposal system • Proper and safe solid and liquid waste managment • Water supply safety measures • Food hygeiene and safety measures • Healthy home environment • Arthropods and rodent control • Personal hygiene	• HIV/AIDS prevention and control • TB prevention and control • Malaria prevention and control • First aid	• Health education and communication

FIGURE 1: Health packages interventions for HEP to be implemented in rural Ethiopia. Source: Yibeltal Assefa et al. Community health extension program of Ethiopia, 2003–2018:success and challenges.[2]

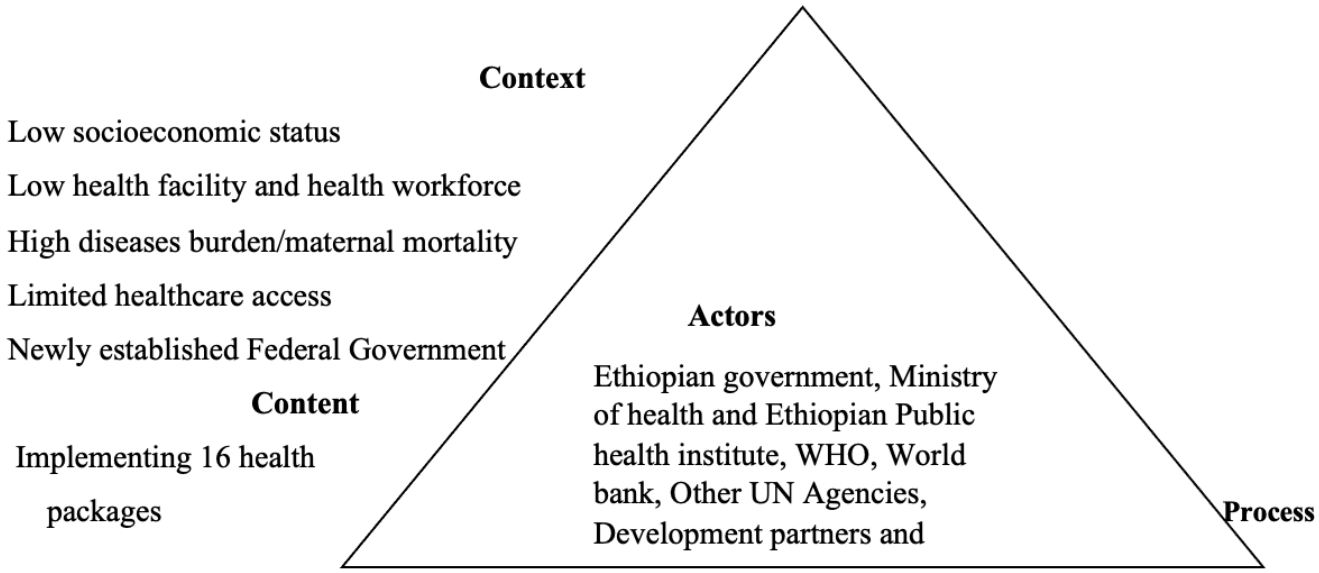

FIGURE 2: Policy triangle of Health Extension Program in Ethiopia.

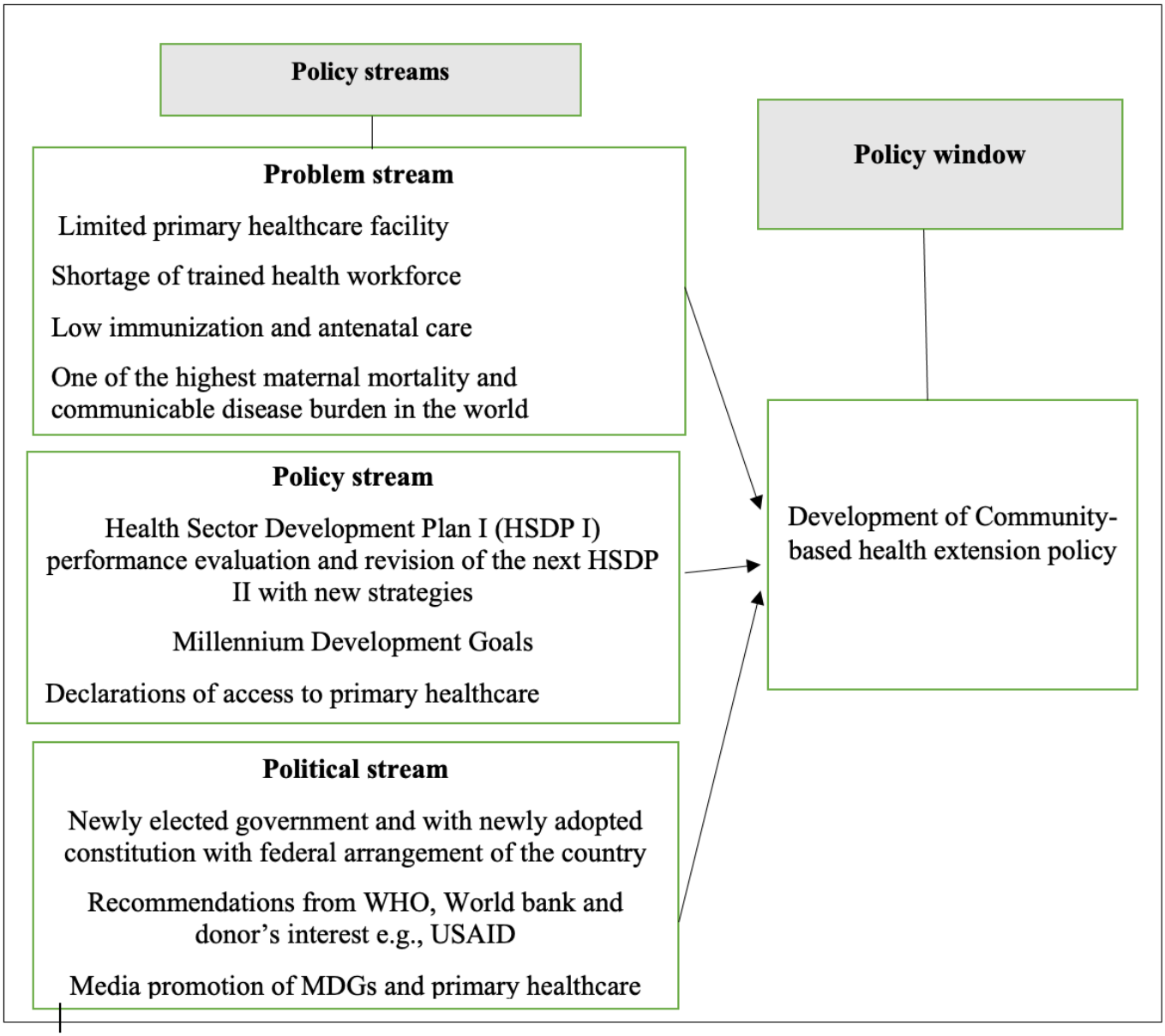

FIGURE 3: Policy development of HEP in Ethiopia from Kingdon model perspective.