

Full Length Research Paper

Ethiopia's health extension program: Opportunities and challenges of its implementation in Shiromeda¹

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This study assesses the opportunities and challenges of implementing health extension program in Shiromeda Health Center, Addis Ababa, Ethiopia. It has three key objectives: to examine prospective and retrospective views of health extension workers towards health extension program; determine the challenges faced by clients in their health service utilization and examine the challenges extension workers face during provision of services. The study employed cross sectional research design and qualitative methods. Data were collected from health extension workers and residents using interview and focus group discussions, respectively. Accordingly, while four health extension workers were interviewed, two focus group discussions, each consisting of six discussants, were conducted with members of the community based on the objectives of the study. The study found that health extension program has become a hit- or- miss phenomenon for health extension workers are fed up with the routine, tiresome work of increasing health seeking behavior of people and keeping personal hygiene and environmental health with poor salary and other compensations. Though implementation of health extension program is considered as the right action for Ethiopia, except one, all interviewees have no interest to stay as health extension workers. It is also found that on top of limited number of toilets and other health promoting establishments, politicization of formation and implementation of community based health development army has severely limited the success of health extension program. Therefore, appropriate remuneration for health extension workers; establishment of health promoting infrastructures; deployment of senior and male health professionals as health extension workers should be considered.

Key words: Health extension program, health development army, health extension workers, public health, opportunities, challenges.

INTRODUCTION

Context of health extension program

Though substantial efforts have been made during the imperial (1931 to 1974) and regimes, and the transitional

government (1991 to 1995) of Ethiopia to improve the health status of Ethiopian people, basic health services have not yet reached, as envisaged, those in need (FDRE, 1993, 2005, 2008; MoH, 2005; FDRE MoH,

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2005). To address these situations, the current Ethiopian Government, Federal Democratic Republic of Ethiopia, has formulated a series of Health Sector Development Programs (HSDP I, II, III and IV) to be implemented from 1997 to 2015. Recognizing low performance of HSDP I, the government also initiated what it called an innovative program-Health Extension Program (HEP) in 2003 in its HSDP II to accelerate utilization of primary health care services mainly in rural communities (Federal Democratic Republic of Ethiopia, MoH, 2010). Its objective is to improve equitable access to mainly preventive health services through community based services which focus on health promotion and preventive health activities, and increased community health involvement by deploying two trained Health Extension Workers (HEWs) to each health posts (MoH, 2013).

With the aim of ensuring health equity by creating demand for essential health services through the provision of health information at the household level, and access to services through referrals to health facilities on four package areas of intervention, urban HEP began in 2009. This is realized by deploying thousands of nurses to serve as community health workers who provide house-to-house health services to upgrade not more than 34% health service coverage of the city (Addis Ababa Health Office, 2009) though their merits have not been well addressed (Awash et al., (2007).

However, there have been no scientific studies on the opportunities and challenges of implementing HEP in Shiromeda even though a plethora of these have been found in the current study. Therefore, this study aims to assess the level of implementation of the program, in Shiromeda Health Center (SHC), Gulele Sub-city of Addis Ababa. This is done by taking the width and breadth of service provided by HEWs, and levels of adoption of the program by the community.

Statement of the problem

Prior to HEP initiative, provision of health care services in the country was characterized by very few health facilities (hospitals, health centers, clinics), and inadequate number of physicians, nurses and other health workers. (MoH, 2010; Netsanet and Ramana (2013). As a consequence, Ethiopia has hosted high levels of maternal and infant mortality rates, and low rates of immunization. Preventable diseases such as malaria, tuberculosis and human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) have been common causes of morbidity and mortality.

By bringing healthcare down to the household level, the HEP has been designed to provide a number of health packages which are categorized under four main themes:

- (1) Disease prevention
- (2) Family health service

- (3) Hygiene and environmental sanitation, and
- (4) Health education and communication.

These packages have been developed to tackle the main health problems of the rural and urban areas of the country, such as tuberculosis, HIV/AIDS, malaria, and maternal and child health as part of its Millennium Development Goals (Health Extension and Education Center 2007).

However, about 60 to 80% of the health problems in the country are still caused by infectious and communicable diseases. In addition, the national adult HIV prevalence is 2.4%, and the country ranks 7th out of the world's 22 high burden countries for tuberculosis (WHO, 2013).

Currently, national and international media reports reaffirm the country's success not only in health but also in many other socioeconomic indicators. As a result, the country's success in health is quite often attributed to successful implementation of series of health sector programs and strategies, of which HEP is the top priority. However, the success of HEP in achieving its set goals and objectives could be affected by plethora of complex factors which need to be proved by collecting empirical data from concerned bodies (clients¹, HEWs, etc.).

This article is, therefore, devoted to evaluate the level of implementation of the program by empirically assessing reflections of extension workers and the public on the objectives, past performance results, current status and future prospects of the program in-terms of achieving the objectives it was instituted for.

Objectives of the research

General objective

Generally, this research aims to assess the current status of HEP implementation in SHC of Gulele sub-city using empirical data collected from extension workers, and clients.

Specific objectives

The following specific objectives will be addressed so as to achieve the general objective:

- (1) Assessing the views of HEWs towards HEP, and its past and current implementation as well as prospects.
- (2) Determining the challenges faced by clients in their health service utilization.
- (3) Determining the challenges extension workers face during provision of health services.

¹ In this paper the term 'clients' was used to refer to members of the community in general and /or leaders of NHDA or members within that group depending on the context of the text.

METHODOLOGY

This study employed cross-sectional research design and qualitative data collection methods. Both quantitative and qualitative methods were used to elicit extensive, adequate and in-depth data on the issue. However, as a result of time constraint and simplistic nature of assignment, only qualitative methods, that is, in-depth interview, focus group discussion and observation were employed to collect primary data. In-depth interview was conducted to elicit information on overall objectives, success stories, and future prospects of HEP with regard to HEWs understanding and knowledge of their duties in the study area. Observation was made on office duties (plans, execution of activities and reports) and by visiting model households created. Focus Group Discussion (FGD) was also employed to understand the insights, trends in the level of awareness and health seeking behavior of communities from their perspective. It is also meant to know the level of changes in their health lifestyles.

Sampling population and technique

The study site, SHC, was selected purposively due to its proximity for the researcher and with the rational that it has been implementing HEP for the last 5 years. In addition, simple random sampling was used to select 4 out of 15 HEWs working in the health center while one FGD consisting of 7 members was conducted with members of the community that are currently leading 1 to 5 and/ or 1 to 25 'Network of Health Development Army' (NHDA).

FGD was supported by the opportunistic data the researcher has got by fully attending and participating in all the discussions made between three HEWs and 12 members of such community (1 to 5 and/ or 1 to 25 leaders) on the successes, challenges and future plans they envisioned to implement for additional one and half hours. It is possible to see this as another focus group discussion. This has given the researcher the opportunity to cross-check the points raised during FGD, adding additional and new insights.

While random selection of HEWs was made with the rational that there is little variation among all HEWs, as they are similar in terms of sex and one year training they took before starting their job, the selection of leaders of 1 to 5 and 1 to 25 was due to the fact that these leaders are better implementers of HEP, as they are selected based on who can provide more in-depth insights of both their own and those sought by their group members. As a result, 7 focus group discussants can represent the views of 35 to 175 community members.

Obviously, it is difficult to bring such individuals together for FGD without the help of HEWs. The strategy the researcher used to approach focus group discussants was by availing himself of the appointment they have with their HEWs to discuss the achievements, challenges and ways to be rectified. Accordingly, as 25 leading members of NHDA of the community are expected to attend the meeting, the researcher went ahead of time to the meeting place (kebele 19 of district 3 youth center), the researcher managed to conduct one FGD with 7 participants that came early for an hour. Finally, thematic and content analysis was made to present the findings.

DISCUSSION

Seen ethically, consent letter was obtained from the Department of Sociology in Addis Ababa University. Research participants were also briefed about the objectives of the study, and the intimate nature of the

issues/questions to be raised; they were further informed about the confidentiality of all the information and its exclusive use for research purpose. Furthermore, they were also told the immense benefits of their factual responses both for the accomplishment of the paper, and any further investigations and interventions that are going to be made in the area. Guides on interview and FGD were used to collect views and opinions of HEWs from community members broaching the following issues:

- (1) Objectives
- (2) Past experiences,
- (3) Current realities and
- (4) Future prospects of HEP.

Both discussions were conducted in Amharic, national language of Ethiopia, with the rational that everyone can easily communicate the issues. In addition, the validity and accuracy of the data were checked using different methods. Accordingly, the following results were obtained from interviewed HEWs whose names are mentioned in the text pseudonymously.

Interview

Interviews from four HEWs using grounded theory approach revealed that except one of the interviewees, all the three have appreciated government's use of HEP as a tool to maintain and improve the health status of Ethiopian people in general. Three of the respondents also believed that HEP has brought progressive changes that, if appropriate support, encouragement and advertisement was made, it can bring valuable and accelerated changes in the health sector. All the interviewees are clinical nurses who possess a very good knowledge of the objectives of HEP and communication skills. They are aged from 26 to 28, and have worked in the study area for 2 to 4 years. All have conducted mapping of health profile of their respective working sites as per the objectives of HEP.

For the question one, the researcher raised to understand their feelings if they are told to keep working as HEWs for the next 10 years, except one, all were not interested to stay in the work given tiresome work and poor benefits as their reasons. Moreover, for the question one the researcher posed, "why fast food preparation and selling was allowed in notoriously smelling places along the streets and near school gates" and "their role with respect to this problem, all HEWs pointed their tremendous attempts to create awareness beyond which the responsibility of punishing those who are involved in those activities is given to other body (Legal protection unit).

All of them have also described that they have been making maximum efforts without reservation and have created many model families. Moreover, they also aggressively mentioned that owing to financial constraints

both on the side of the government and of the public, HEWs are powerless in solving problems related to toilet, hygiene and other issues related to environmental pollution that require funds. They also raised the importance of male HEWs and involvement of male members of households as one of the active participants in implementing packages of HEP. The details of interview results showing different views of HEWs are shown below:

With protestant religious affiliation, the first interviewee, Beletu, has four years of experience as HEW. The following is the way she expressed the problem in implementing HEP on the side of community members and HEWs:

Though increased changes have been registered in the number of children taking vaccination and mothers taking regular pregnancy checkups, delivering in health centers etc, there are many who retreat back after graduation pointing that HEWs resemble the urban and rural people by encouraging and forcing them to put cans near the toilet for washing dry wastes. HEWs, too, are only theoretical as there is nothing we can do to practically help members of the community during our outreach services except encouraging them to visit health centers both because of not only our knowledge gap but we are also not allowed to do so. Indeed, despite the tiresome and challenging nature of the work, members of the community do not want to give time for their health related discussion and activity and do not also value it.

Fatuma, 28 years old, and orthodox Christian, has served for a total of five years as HEW, of which 4 years is in SHC. She is the only respondent who indicated her definite interest to work as HEW even if 'the government stops it'. As a challenge, she mentions settlement patterns, toilet distance, and disorganized waste disposal system people experience that are beyond their level and potentially contributing people to be bored with HEP. She described her overall view of HEP as follows:

I am backbone of HEW and never think of to stop doing it even when the government stops not because of salary but because of the basic satisfaction and relief I can get by helping people. While health extension work in general and health extension development army network in particular is usually attached with politics, it is actually not. It is a tool not only to carry out our duties but also to evaluate the performance of each other regularly and learn one's weaknesses from others easily.

Abebech, the third respondent, is 28, an orthodox Christian and has served 4 years in HEW in SHC. Her overall view is expressed as follows:

I do more than what I expect and the government expects by investing more extra time and weekends. The

problem is that society wants to visit the health center after being faced with critical illness than protecting themselves from being caught by the illness. Though change exists (roughly 50%), this is extremely below what I do and what the government expects to be achieved. Change can be brought but HEWs are dissatisfied because of low salary, absence of offices problems of good governance (many employees are fined being late for even up to 5 minutes). The performance of HEP in SHC registered the ranks of 1 up to 3 in the sub-city for the last 3 years, but achieved 10th last year. Government has not given adequate attention to the program as administrators work political activities and we are also forced to mobilize people during periods of election. This has created HEWs to be viewed by the public as implementers of government's politics. Because of financial constraints, people cross/pass their toilet, whose roof cannot protect rain, to prepare food near it; nor can they be shifted to other houses.

Tirunesh, the fourth respondent, 27 years, a protestant and has served for the last 2 years in SHC. She is the most critical of HEP as non-need based. The following is taken from her Saying:

It is the government, not the society that needs HEP; people basically need what to eat not where and when they eat, urine, recreate. They say, we are still alive, nothing happened hitherto while we have been living the way you suppose us to change now. HEWs are the most disadvantaged with no/little short term training, no educational opportunities at all, no corresponding salary increment even if we upgrade our qualification privately, and so on. Furthermore, while the duty of HEW is tiresome and challenging as it requires home to home outreach activities, we are equally paid with those with the same qualification but simply employed to inject people with needles being in office. Amidst these, creation of model families is a big challenge as communities do not want to be always asked to change their lifestyles.

I believe, it would have been better if communities demand the service than being served without demand. I said this because they show discomfort with HEWs by saying: "you come today, too, to me?", "you don't have other people to go?" Indeed many also insult, but we become quiet so as to do our task that we frequently evaluate. In the real sense of the term, it is HEWs who apply the principle of 'customer is king'. Amidst such situations, HEWs can bring change (create model families) to 5 out of 500 families. But does this make sense given our tiresome efforts? Media coverage of the government on HEP is indeed poor.

Focus group discussion

For the sake of brevity, ideas, views and reflections of

clients during both FGD and their forum on performance evaluation were merged and presented together below. Discussants have made lively debates by frequently interrupting one another and arguing over controversial issues.

Discussions indicated that there are appreciable successes in training members of the community by HEWs. Many leaders of NHDA indicated encouraging successes in changing clients' views on healthy lifestyles though they, however, indicated little realization of HEP by the clients. Regular environmental sanitation campaign; coffee ceremony aimed at increasing solidarity and common understanding among clients; village level saving aimed at solving some of the common problems such as light, toilet and water; increased follow up of clients with pregnancy, the sick and children that need vaccination, etc by villagers and reporting of the issue to HEWs when necessary are among the strategies clients use to lead healthy lifestyles.

Change in its implementation greatly varied from few early adopter model families to majority late adopters and completely resistant members of the community. Discussants have raised critical problem of some members of their respective communities who go to the extent of not only criticizing leaders of 1 to 5 and/or 1-25 NHDA but also dropping their own wastes near the homes of those leaders. And discussants are dissatisfied by the government and/or HEWs for not taking appropriate and strict legal measures on those clients despite them being reported repeatedly.

The pre-existing difficult settlement patterns; shortage of enough spaces to construct toilet, shower and kitchen rooms; use of a single toilet by many villagers are among the critical problems faced by clients in their attempts to lead health lifestyles. The focus of non-governmental organizations to construct toilets only when there exists a situation where 10 or more households can use it is also another issue raised by the discussants. Therefore, implementation of HEP in Ethiopia has its own challenges and prospects hypothesized in the paper. Thus, more researches need to be conducted to play their part to the resolution of the problem.

CONCLUSION AND RECOMMENDATION

This study not only indicated the need to further critically assess the implementation of HEP in SHC but also in different health posts/centers and regions of the country so as to take immediate remedies without which continuity and sustainability of the program with accelerated improvement will be at stake. Based on the data obtained during this study, the following conclusions and recommendations were made.

Generally, attribution of all improvements in the health sector to the effective implementation of HEP is difficult to acknowledge as HEP has not yet stood with two feet as there exists plethora of hitherto unsolved critical

challenges impeding its implementation. HEP is facing problems and challenges of continuity and sustainability owing to ambivalence of both the clients and HEWs on motivation and committed implementation of HEP though they differ in the factors that can play for both. While issues of incomparable salary to what they actually do, lack of further educational opportunities, absence of clear career structure even when HEWs improve qualification by their own, created not only intrinsic demotivation and reduced commitment but also blocked future hope to stay in the job on the part of HEWs; by attaching the program with issues of politics, settlement patterns of the population, issues of governance problems with delayed or totally absent solutions, financial constraints and above all limited practical behavioral changes have contributed to resistance to less participation of the public.

Clients have not yet owned creation of healthy lifestyles as part of their life as seen from responses of clients who stated to the researcher that even from twelve 1 to 5 and/or 1 to 25 leaders of NHDA that attended the 'forum', only one has got sub-city level prize as model family for achieving the packages of HEP. Indeed, their lively discussion has clearly indicated strong resistance of even trained members of the community to the extent of dropping their wastes near the gates of their leaders by informing them to observe while dropping. There is a tendency to view households as model when they just meet medical model (when they test their HIV/AIDS status, follow up physicians to check their pregnancy situations, take their children for vaccination or immunization and /or any sick person of the family to immediately visit physicians) while other aspects of health lifestyle are given low attention.

In addition, there is loose coordination among different government bodies to take concerted measures as seen with issues of fast food preparation along the roads. Discussions of many families also revealed that some of their tasks are unrelated to health issues.

Study limitations

This study has been limited methodologically to qualitative one that does not give the chance for generalization. In addition, since, there are no accessible articles on the subject in the study site, the researcher failed to make retrospective analysis, and have a base from which comparison can be made with previous studies.

CONFLICT OF INTERESTS

The author has not declared any conflict of interests.

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ⁱ Shiromeda is the name of an area covering north East of the city of Addis Ababa immediately above Addis Ababa University, sidist killo campus, covering areas where the French and US embassies exist.