Building a Resilient Health Extension Program

Introduction

Resilient health systems detect and control infectious disease outbreaks quickly, continue to function effectively, and prevent shocks to the health system from impacting other sectors of society. They are characterized as aware, integrated, diverse, self-regulating, and adaptive. These features need a strong local and national leadership, a committed health workforce, sufficient infrastructure, and global support in order to be realized.

The Health extension program which operates at the primary level of Ethiopian health system was launched with the goal of improving health outcomes at community level. As part of this, health extension workers are also expected to undertake disease surveillance activities in collaboration with other community network leaders at community level for selected priority public health problems by using community case definitions.

According to the national assessment, the role of the health extension program in mitigating public health emergencies was found to be suboptimal. Multifaceted factors ranging from low political leadership involvement to lack of capacity building activities for health posts and health extension workers impacting on the program.

The aim of this policy brief is to provide policy makers and public health experts a glimpse of the existing health extension program's capacity and ability in preparation, responsiveness and mitigation of public health emergencies, the key problems that were found

by the national assessment in doing so, the resilience of the health extension program in relation to the aforementioned capacity and its adaptability and flexibility with the advancement of time technology and increasing community demands. Furthermore, it will also highlight policy directions that could help in building a much stronger, resilient and proactive health extension program that ensures the wellbeing and protection of the community.

Methodology

The national health extension program assessment assessed the existing public health emergency management activities using standard indicators across different levels of the health system. The health extension program disease surveillance system's structure, core components, support functions, data quality attributes and knowledge level of health extension workers on public health emergency management were assessed. Data on these attributes were collected at community, health post, health center and district health office levels using both qualitative and quantitative approaches.

Key findings of the assessment

The link between community and health post was weak due to low attention given by political leaders. More than half of HEWs in each region reported they have no emergency coordination platform at kebele level. There was low involvement of stakeholders and politically appointed leaders in the community level surveillance platform. Moreover, budget allocation and implementation for community level surveillance activities was low.

There was limited training and orientation given to the HEWs and Women development armies on handling emergency cases. Health extension workers understanding of reportable diseases or events was low. Health extension workers' knowledge scores differed between woredas and among regions. There is a high level of work dissatisfaction, the retention of only less competent staff over time, and the high risk of losing a large number of HEWs if alternative job opportunities emerge. Gaps in the competence of HEWs are primarily linked to sub-optimal pre-service training in the 1) recruitment of trainees, 2) medium of instruction in colleges, 3) training capacity of institutions as opposed to large class sizes, and 4) limited compliance of trainings with training curricula

Poor availability and accessibility of locally translated guidelines and protocols, lack of emergency medications and other logistics reserved for emergency response purposes. District level experts blamed a poor governance structure, low participation in capacity building activities and poor community coordination for their poor response to emergency situations. As a result, the high community demand for more comprehensive services at the HP level has not been adequately addressed.

Limiting HEWs to women only could be difficult due to geographic barriers, security and sustainability issues that could arise from not involving men in patriarchal society. In pastoralist communities, the Health Extension Program requires a different arrangement of service delivery that addresses challenges related to the sparse population settlement and mobile lifestyle. The professional mix and levels of education, rather than the number of HEWs, in a Health Post, are associated with better implementation of the Health Extension Program through home and HP visits.

Conclusion

Although the national Health Extension Program is not contributing greatly to addressing basic components of Public Health Emergency Management as per the standard, this study has shown that it plays a significant role and has great potential in detecting, reporting and responding to Public Health Emergencies at community level.

Recommendations

Coordination platform: There should be a functional emergency coordination platform at kebelle level; political leaders should lay an example for the community by proactively engaging in community level surveillance system. There is a need to enhance the use of health post visits as entry point for provision of comprehensive health promotion and disease prevention services.

Earmarked budget: There should be a budget that is earmarked for public health emergency management and response at kebelle level; due emphasis should be given to emergency forecasting and preparedness.

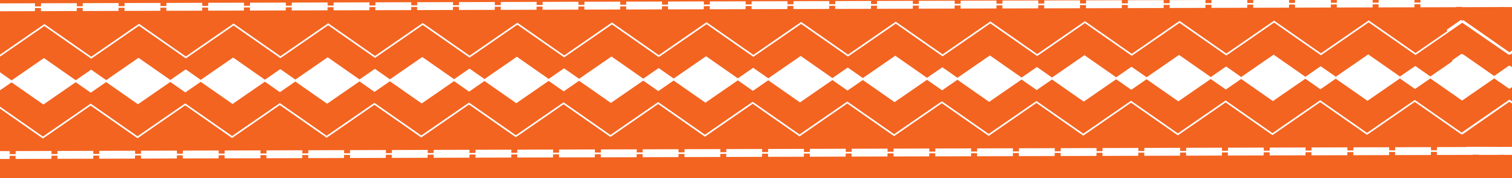
Capacity strengthening: Comprehensive trainings and workshops that could build the capacity of health extension workers to mitigate emergency conditions should be in place. A well trained and equipped health extension worker would be an entry point to engaging the community in emergency preparedness.

Standardized guideline: A standardized and universal guideline on reportable diseases and events should be in place and available to all health extension workers. Efforts to improve health extension workers' knowledge and understanding of reportable diseases should be made.

Leadership and governance: Leadership and governance of public health emergency management task force should be strengthened. Experts at all levels should participate and get involved in capacity building activities.

Health workforce: Inclusion of male health workers in the cadre of HEWs and increasing involvement of men and youth as targets of HEP are needed. Expanding workforce at health posts by number and professional mix is also recommended. Besides, revising entrance criteria for HEW training to consider opportunities created by large numbers of students completing high school and university preparatory schools, and opening career development for HEWs to allow them grow in a more diversified areas of specialties allowing competent HEWs to compete and occupy positions in other levels of health institutions need to be considered.

Collaboration: Strengthen inter-sectoral collaboration to ensure that strategies to implement HEP packages in the pastoralist communities are integrated / coordinated with other community-based services including villagization and animal health services.



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