



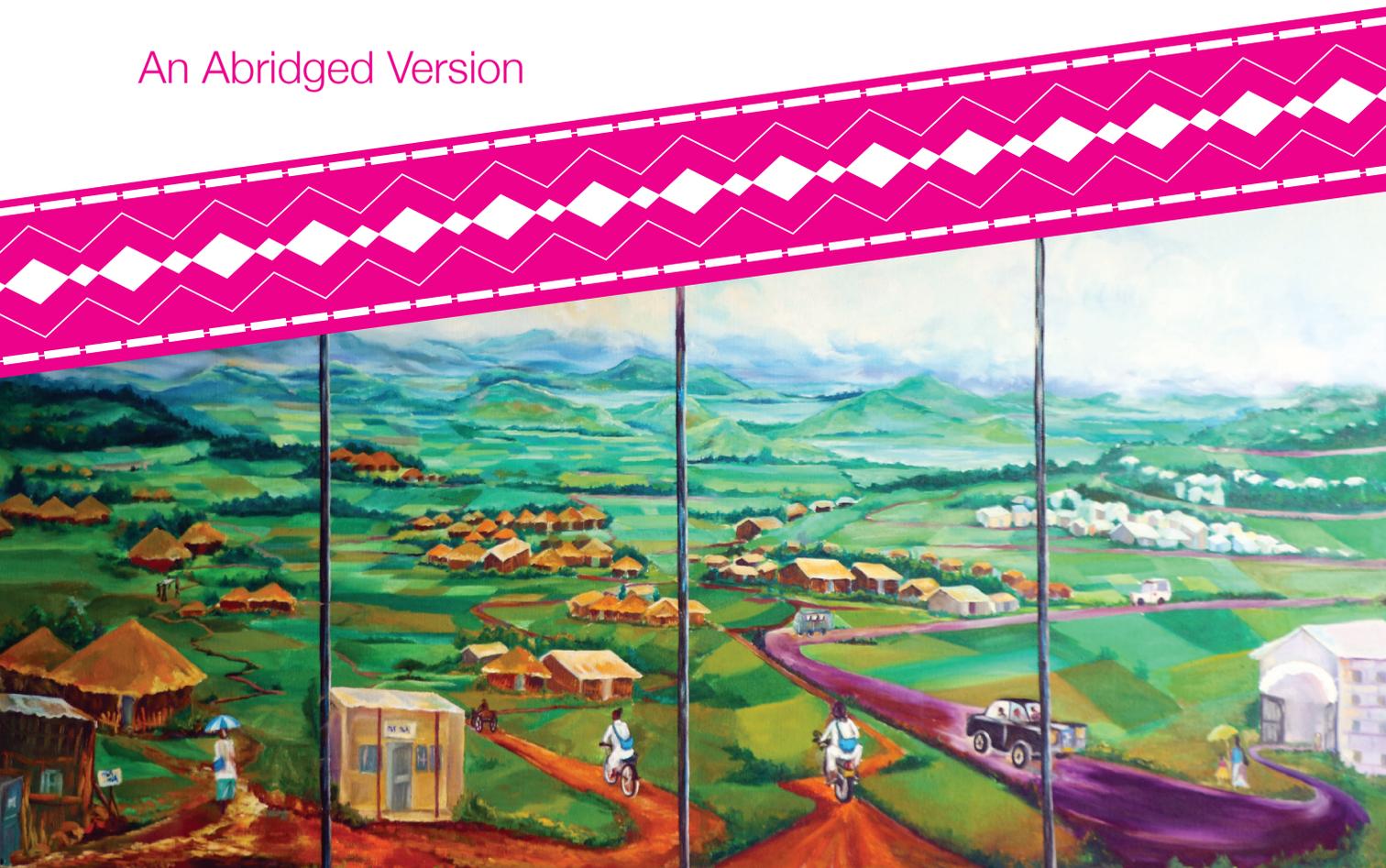
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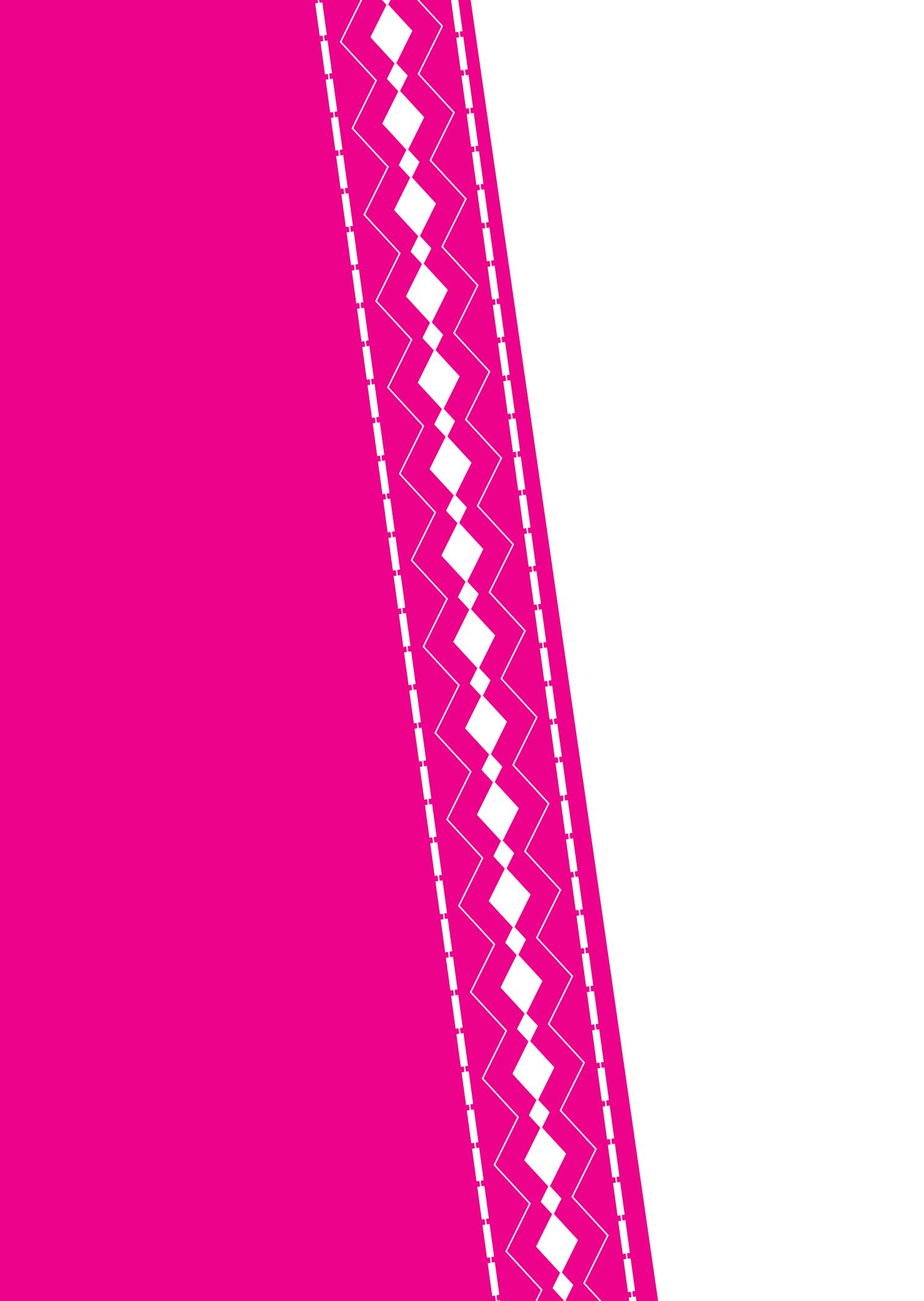
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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

REALIZING UNIVERSAL HEALTH COVERAGE THROUGH PRIMARY HEALTHCARE

**A Roadmap for
Optimizing the Ethiopian
Health Extension Program
2020 - 2035**

An Abridged Version







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1st Edition
June, 2020
Addis Ababa, Ethiopia



ACKNOWLEDGMENTS

The 2019 National Assessment of the Ethiopian Health Extension Program (HEP) provided tremendous insight into the current status of the program, pinpointing to key areas of intervention needed to optimize the HEP in a way that maintains its flagship status as a driver to ensure universal health coverage (UHC). The need for a document that gives an overall direction was found to be critically important. As such, a multi-stakeholder engagement model was employed to develop this high-level trajectory for the HEP from 2020 to 2035. It has been developed by employing rigorous methods inclusive of situational analyses, benchmarking, forecasting and projections, and identification of key strategic priorities.

The Ministry of Health would like to express its heartfelt appreciation to the Health Extension and Primary Health Care Directorate for leading the preparation of this roadmap. Our appreciation goes to the Bill & Melinda Gates Foundation for financially and technically supporting the development of the roadmap and to MERQ Consultancy PLC for carrying out the assessment and for playing a pivotal role in the preparation of this document.

The preparation of the roadmap wouldn't have been successful without the continued commitment of the Steering Committee. I was privileged to chair, with the Directorates of Health Infrastructure; Health Service Quality; Health System Special Support; Human Resource Development; Maternal Newborn and Child Health and Nutrition; Strategic Planning, Policy, Monitoring and Evaluation; Public Relation and Communication; Resource Mobilization; Women and Youth Affairs as well as the Ethiopian Health Insurance Agency and the International Institute for Primary Health Care.

The technical support provided by health sector development partners including: JSI/ L10K2020, USAID, UNICEF, JHU-CCP, USAID-Transform PHC, Yale University, CHAI, JHPIEGO, AMREF, and PSI as members of a technical working group was instrumental in bringing this document to its current status.

The Ministry of Health extends its thanks to all stakeholders.

Dereje Duguma, MD, MPH
State Minister, Ministry of Health



FOREWORD BY MINISTER OF HEALTH

With a population of over 100 million, Ethiopia is the second most populous country in Africa, with a diverse range of people speaking over 80 languages. Ethiopia has the fastest growing economy in Africa, with an average gross domestic product (GDP) growth of 9.0% between 2000 and 2019. This economic growth has led to a reduction of poverty in the country, from 38.7% in 2004 to 23.5% in 2015. The country's human development index has also improved over the same period, increasing from 0.283 in 2000 to 0.470 in 2018¹.

Ethiopia has also registered remarkable achievement in the health sector in the last 15 years, including elimination of neonatal tetanus; increased care seeking for acute respiratory infections, from 18% to 34.1%; a decline in Under 5 mortality from 166 per 1000 to 67 per 1000 in 2016 and 55 per 1000 in 2019. Institutional delivery and receipt of antenatal care (ANC) has gone up from 5% and 28% in 2005 to 48% and 74% in 2019 respectively. Stunting has also gone down from 51% to 37% in the same period, while malaria and HIV related deaths have also fallen by 92% and 90% respectively².

One of the major contributors to the gains in the health sector is the Health Extension Program (HEP), our flagship of community-based primary health care (PHC) delivery platform. HEP was introduced in 2003, in response to the findings of an evaluation done on the country's Health Sector Development Plan I (HSDP-I) which found that access to health care for most Ethiopians was limited. Over the last decade and a half, HEP has proven to be an effective intervention by serving as the largest component of Ethiopia's health care delivery system and thus transforming access to health care services.

In order to ensure its responsiveness, the program has undergone various changes since its inception including expansion to pastoralist and urban settings in 2006 and 2009 respectively. Its implementation approach has also been revised from a model family training approach to a scaleup approach where women development army (WDA) members were used to enhance community engagement.

The HEP, like any major system, requires maintenance and modification over time to be able to perform at optimal level. After a 15-year of its journey, and with the ever-changing socio-economic, epidemiologic and demographic landscape in Ethiopia, the program was facing challenges in terms of its momentum and the relevance and appropriateness of its implementation strategies given the changing population needs and demands. Cognizant of the importance of periodic appraisal and in response to the need to address the mixed opinions about the status of the program, a comprehensive national assessment was done. One of the key findings of this assessment was the need to develop a roadmap for the next 15 years of the HEP, designed to support Ethiopia's journey to join the lower middle-income countries by 2025, and middle-income countries by 2035.

1 UNDP, 2019. Human Development Report 2019. Available at http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ETH.pdf

2 Ethiopia Mini-Demographic and Health Survey 2019.

This roadmap has been developed through a rigorous, multi-stakeholder consultative process and was primarily informed by the findings of the 2019 national assessment. Key lessons were sought for forecasting by benchmarking countries which recently joined the middle-income countries category.

This roadmap has various transformative initiatives which are expected to be rolled out over the coming 15 years. It is intentionally aligned with the Health Sector Transformation Plan II (HSTP-II) as well as with global milestones including the sustainable development goals (SDGs). This roadmap calls for evidence generation, coordination and periodic appraisal during its implementation. Its implementation must also be guided by more detailed implementation manuals which should be customized to contextual circumstances.

I would like to use this opportunity to express my heartfelt appreciation to all who participated in the development process. Going forward, I would like to ask all partners, governmental and non-governmental organizations, funding agencies and others who have any role in the HEP, to use this roadmap as the only source for strategic planning and engagement. The ministry will appreciate all efforts to improve the effectiveness of the HEP. The rollout of the interventions proposed in the roadmap will require periodic review, and alignment with the review periods for the next three HSTPs (HSTP II to IV). These periodic reviews may call for modifications to or revisions of the roadmap using implementation evidence to inform course correction. The Ministry of Health will lead a consultative process where rigorous reviews of any proposed revisions are conducted and decided upon at the ministry level, with the ministry making the final decision on revisions.

The revitalization of the HEP is one of the most essential engagements we will take on in the years ahead. It is critical that all stakeholders remain engaged and aligned on this 15- year vision for how the HEP, and the broader health system, can be organized, governed, financed and monitored to better meet the health needs of Ethiopia's diverse population. There is still much to be done to help the HEP meet its highest potential. I and my team look forward to a continued collaborative engagement with all our partners as we take on this very important work.



Lia Tadesse, MD, MPH

Minister, Ministry of Health of Ethiopia





FOREWORD BY HEALTH EXTENSION AND PRIMARY HEALTH CARE DIRECTORATE DIRECTOR

Ever since its inception, The Ethiopian Health Extension program has been the core component of the Primary Health Care Unit (PHCU), which has made preventive, promotive and curative services more accessible to the residents of rural Ethiopia since 2003, to the pastoralist communities since 2006 and to the urban population since 2009. Over the course of fifteen years, the program has grown to encompass 18 essential health service packages with a work force of 39,878 health extension workers (HEW) working from more than 17,587 health posts (HP).

Detailed evidence about the effectiveness of the program was generally insufficient because available research would tend to focus on standalone components of the program which did not allow us to draw conclusions about the program as a functional whole. This led to the call for a national assessment of the program, conducted in 2019.

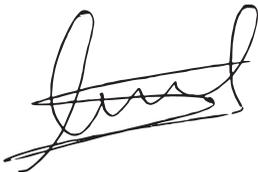
The national assessment - the first of its kind in terms of comprehensiveness, responsiveness, focus on utilization and independence - was carried by an independent research firm (MERQ Consultancy PLC) and comprised an agreed upon list of objectives which included: assessing the relevance of the HEP's essential health service packages, determining the implementation status of the HEP, estimating population coverage of essential health services, assessing the adequacy of resources, characterizing the determinants of implementation, exploring the contributions of the HEP and identifying key areas of intervention for future improvement.

The assessment found out that the HEP is being implemented through HPs which are present in more than 97% of kebeles and interventions are being implemented using diffusion of innovation theory and scale-up approach as the main accelerator of the program. The current packages were found to be relevant, but the delivery of the packages requires a set of expertise which may not be adequately addressed by the health extension workers (HEWs) alone. The assessment also found that only a third of households received at least one visit by HEWs and only 37% of HPs fulfill building standards. HPs are not providing uninterrupted services and level four HEWs were found to be better at delivering services. Communities also tended to bypass HP for services because of lack of confidence in HEWs or due to the presence of a health center (HC) at a close distance. The role of HEP in public health emergency management (PHEM) was not well defined and the monitoring and evaluation, which includes data use and supervision, were sub-optimal. The other key finding was that the program was being led by short term plans, which resulted in the absence of longer-term visioning, which in turn limited timely customization of the program to meet the evolving needs of the community.

This roadmap, which is expected to guide all programming for HEP in Ethiopia for the coming 15 years, has pointed out key transformative strategic objectives to address the challenges identified by the assessment. These areas include stratification of HPs into three categories, redefining the health

service packages, changing the professional mix, rethinking community engagement strategies, using innovative methods to ensure sustained financing, and ensuring resilience of the HEP to maintain essential service delivery during public health emergencies.

We have a long road ahead of us to make this 15-year vision a reality, kicking off the process through the development of implementation manuals, which will translate the proposed strategic priorities into actionable items. It is my strong belief that all interventions, strategies and studies will be geared towards the ultimate goal of revitalizing the HEP to meet the needs and demands of Ethiopia's diverse and evolving community. I thank all the stakeholders who have been on this journey with us, and I look forward to our continued partnership as we move into the new era of the HEP.



Temesgen Ayehu, BSc, MPH

Director | Ministry of Health | Health Extension Program and Primary Health Care

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1

INTRODUCTION

1.1 BACKGROUND

Ethiopia achieved remarkable improvements in health indicators over the past two decades. Between 2007 and 2019, life expectancy at birth increased from 58.5 to 66.34 years; substantial changes were also achieved in reducing maternal mortality, child mortality, and mortality from major communicable diseases.¹⁻³ Major causes of morbidity and mortality in the country remained to be communicable, maternal, neonatal and nutrition diseases. The burden of non-communicable diseases and injuries is also increasing alarmingly leading to a triple burden. Behavioral, environmental or occupational, and metabolic risk factors are major contributors to the leading causes of morbidity and mortality.⁴

Guided by the health policy of the country and health sector strategic plans rolled out every five years, the health sector of Ethiopia provides health promotion, disease prevention, curative, and rehabilitative health services through a network of health facilities organized in a three-tier health service delivery model. At the bottom of the tier system are primary health care units (PHCUs) supported by a primary hospital (PH). A PHCU is composed of one health center (HC) serving 25,000 population (in rural settings) to 40,000 population (in urban settings) and five community health posts (HPs) each serving 3,000 population (in pastoralist settings) to 5,000 population (in agrarian settings). A PH provides comprehensive primary level care for 60,000 to 100,000 populations. The second level of the tier system includes general hospitals each expected to serve 1 to 1.5 million people. The top-tier, tertiary level consists of specialized hospitals each serving 3.5 to 5 million people.⁵

The Health Extension Program (HEP), introduced in 2003, is one of the major platforms for the delivery of high impact priority health promotion, disease prevention, and selected curative services to the community. The program was designed to address challenges related to the limited number and uneven distribution of health facilities that highly limited the performance of the first phase of the Health Sector Development Program (HSDP). The second phase of the HSDP expanded and scaled the HEP and formalized it as a major strategic initiative in the health sector.^{7,8} Over subsequent phases of the HSDP, the HEP expanded in geographic coverage, infrastructure development and service delivery. The number of HEWs and HPs increased from 2,737 and 4,211, respectively in 2004/5 to 39,878 HEWs and 17,587 HPs in 2019. In addition to expanding in size and coverage, the program has undergone several changes over time. Pastoralist and urban HEP models were developed, and service packages were expanded from solely promotive and preventive services to a more comprehensive package including selected curative services.

1.2 RATIONALE FOR THE DEVELOPMENT OF HEP OPTIMIZATION ROADMAP

Changes in the needs and expectations of communities and the different components of the health system have led to the evolution of several challenges and opportunities for the delivery of primary healthcare services through the HEP. The development of the HEP Optimization Roadmap 2020-2035 has become a major milestone in the history of the HEP, outlining the major changes the program requires to serve as a major strategy for achieving UHC in Ethiopia. The roadmap has systematically appraised findings and recommendations of the 2019 National HEP Assessment and recent attempts to optimize the HEP.^{9,10} It responds to the following needs of the program:

- A. Providing structured guidance to an evolving HEP
- B. Addressing socio-economic changes in the population
- C. Responding to epidemiological shifts
- D. Meeting community expectations
- E. Expanding essential services and achieving UHC
- F. Improving and sustaining HEP performance
- G. Adjusting HEP service delivery model

A. Providing structured guidance to an evolving HEP

The HEP has been the major platform for the provision of PHC services for Ethiopians, particularly for rural communities. The program has undergone substantial changes during its lifetime. However, many of these adaptations have been taken on without clear or evidence-based guidance, leading to uneven rollout and stalled implementation. The Roadmap uses data and evidence about the HEP to present clear recommendations on how a more structured approach to decision-making can lead to stronger and more sustainable implementation of future HEP reforms.

B. Addressing socio-economic changes in the population

Socio-economic changes during the period of the HEP implementation have created challenges and also have brought tremendous opportunities for the program to evolve to a new level. Agriculture and availability of food, education and adult literacy, access to information outlets, access to road and other basic infrastructure, and overall economic status have improved in many parts of the country. Migration patterns – especially for youth populations – have created small urban and semi-urban centers along major roads and investment sites, altering the demographic profile in urban environments.

Availability of trained health professionals in the market and increasing literacy rates among rural populations create opportunities to easily acquire the needed human resources for health. Increased access to and familiarity with telecommunication technology in rural settings creates opportunities for digitization of information systems, electronic data sharing, and possibilities for virtual trainings. Changes in healthcare financing including the introduction of community-based health insurance (CBHI) and government commitment to allow health facilities to retain and use revenue has also created opportunities for considering new ways of financing HEP as services expand in the future.

C. Responding to epidemiological shifts

The HEP was initially designed with a focus on maternal, newborn and child health (MNCH), communicable disease prevention and control, hygiene and environmental sanitation, and health education and promotion. Even though there were recent additions to HEP packages to address NCDs and mental health, HEWs did not have the training to deliver them, and thus implementation was suboptimal. Addressing the changing population health needs, including the growing burden of non-communicable diseases and injuries will require a nimbler and more responsive HEP in the future.

D. Meeting community expectations

Community engagement is vital to its success: high performing HPs consistently demonstrate strong community engagement compared to lower performing ones. However, communities have greater expectations about the kinds of care they would like to receive from HPs, and failure to meet these expectations, particularly for curative care, has been a source of dissatisfaction. If communities cannot have their

needs and reasonable expectations met, the resulting implication is a loss of trust in the HEP and the broader PHC system. The 2019 National Assessment of the HEP revealed that communities would like to receive more comprehensive services at the HP level, particularly in areas where access to higher levels of the health service delivery system is limited.

E. Expanding essential services and achieving UHC

The need to ensure universal access to PHC has been a global priority since the adoption of the Alma Ata Declaration in 1978.¹¹ The world is now backing to this important agenda under the third Sustainable Development Goal (SDG) that entails to ensure healthy lives and promote well-being for all at all ages includes a target to achieve UHC. Increasing equitable access to essential health services has been a major strategic objective throughout the period of HSDP and HSTP-I.¹²⁻¹⁴ The revised Essential Health Service Packages (EHSP),¹⁵ which includes 1019 evidence-based interventions, reaffirms Ethiopia's commitment to ensuring universal access to a wider range of healthcare services.

F. Improving and sustaining HEP performance

The 2019 National Assessment of the HEP and previous studies, including the 2018 HEP Optimization Assessment identified challenges that hindered implementation of the HEP.^{9,10} These include challenges in the areas of infrastructure, human resource, medical supplies, information systems, governance and leadership, and community engagement resulting in suboptimal coverage and quality of services.

G. Adjusting HEP service delivery model

Increasing numbers of schools, youth centers, and institutions and workplaces where people with special needs congregate presents both a burden and an opportunity for the provision of PHC services. The commitment of the Government of Ethiopia to UHC also requires reaching all segments of the population. The HEP, which focused mostly on addressing married women in their homes, is not adequate to address different categories of target populations in different settings. As Ethiopia moves forward in its journey to leaving no one behind, it is important that HEP service delivery points expand to reach all segments of the population as close to where they live and work as possible.

1.3 ROADMAP DEVELOPMENT PROCESS

The development of the HEP Optimization Roadmap was initiated with the objective of providing clear and evidence-based guidance to the evolution of HEP in Ethiopia by setting long-term goals and strategic objectives aligned with the vision and mission of the health sector. With guidance and leadership from the ministry, two teams were established to follow the proper preparation of the roadmap. A steering committee chaired by the State Minister and a technical working group chaired by the Director of the Health Extension and Primary Healthcare Directorate led the process. The HEP Optimization Roadmap technical working group (TWG) was overseen by the HEP Optimization Roadmap steering committee (SC), and charged with developing the roadmap through a systematic process informed by evidence about the current situation of the program and predictions of possible changes expected in the coming two decades. The process for the development of this roadmap included situation analysis, local and international benchmarking, projections and modeling, consultative workshops, and a costing exercise.

2

HEALTH EXTENSION PROGRAM SITUATION ANALYSIS

This section describes the current state of the HEP primarily based on the report of the 2019 National Assessment of the HEP, review of program documents, and other relevant studies. The section is organized into eight sub-sections related to different components of health system building blocks, including: 1) HEP infrastructure, 2) Service delivery through HEP, 3) Human resources (HR) for HEP, 4) Drugs and other medical supplies, 5) Financing of the HEP, 6) Community engagement and ownership, 7) Governance and leadership of HEP, and 8) Information systems and M&E.

2.1 HEP INFRASTRUCTURE

Since the introduction of the HEP in 2003, Ethiopia has managed to establish 17,587 HPs, reaching close to the target of one HP per 3,000-5,000 rural population. Data from a representative sample of kebeles in Ethiopia shows that the HP to population ratio among rural communities in Ethiopia was 1:5760 (1:6057 in agrarian and 1:2919 in pastoralist areas) in 2019. Most HPs are located in rural settings, where access to higher levels of the health system is limited. However, in recent years, expansion of HCs to rural places has created a new combination of health facilities where both HC and HP may be located within the same rural kebele. In recent years, the MOH has developed a plan to renovate and expand these HPs as part of the second generation HEP. A new standard design of HP was launched to improve infrastructure of HPs; however, it is perceived unrealistic by stakeholders, including RHBs. To date only less than 200 HPs are under construction based on the new design.

Despite certain improvements in recent years, a substantial proportion of HPs have limited access to all-weather roads, lack basic

infection prevention facilities (only 12% of HPs had incinerators and 7% had placenta pit in 2019).^{9,16} Lack of basic amenities has been a persistent problem of HPs since the inception of the program.¹⁶⁻²¹

2.2 SERVICE DELIVERY THROUGH HEP

Health Posts represent a substantial component of PHCUs.¹⁴ The PHCU is the platform through which around 70% of essential health services are delivered. The original HEP included 16 preventive and promotive packages, which grew to 18 packages in subsequent years. The packages include categories of programmatic areas: family health, disease prevention and control, and hygiene and environmental sanitation. The current packages of HEP are relevant to address the disease burden of the largely rural-dwelling Ethiopians. Recent changes, including the two additional packages on NCDs and mental health and inclusion of additional interventions under the original packages were effective in increasing care seeking behavior among rural communities.^{22,23} Yet, expansion in health service packages

has not kept pace with the needs arising from changes in disease epidemiology and expectations of communities. This mismatch has been particularly significant for communities living in villages far from HCs.

The expansion of service packages, as part of the second generation HEP also required investments in trainings and competencies, new equipment and supplies, reconfiguration of existing health infrastructure, institutionalization of CHWs, and shifting some basic services to community health workers. Apart from upgrading training for HEWs, the required equipment, supplies and space for second generation HEP have not been in place, limiting the readiness of HPs to provide more comprehensive services.²⁴

The HEP provides health services at the household, community and HP levels. Health Extension Workers provide home visits and outreach services. Most HEP services were reported available in the majority of the HPs. However, objective evidence of service availability indicated lower service availability and readiness.²⁴ Comparison of data on availability of essential services at HPs across time indicated declining trends for many services. Between 2014 and 2018, availability of ANC, preventive and treatment services for under-five children, child growth monitoring services, and most components of maternal and child health services declined substantially.^{20,21,26}

Uptake and quality of care is also sub-optimal. Community's awareness on available HEP service packages was only 58.8% in 2019. Home visits had been considered the primary modality of HEP implementation. In recent years, the focus of HEWs has shifted from home- and community-based to HP-based services. In 2019, only 31.2% of rural households reported at least one visit from a HEW in the year preceding the survey. HP visits have become the predominant means of exposure of women to information and services from HEWs, as compared to home visits and outreach sessions. Data on the quality of HEP services are limited: what's available suggests that HEWs do not have sufficient knowledge of the services they are supposed to provide. They also lack appropriate amenities and supplies required for service delivery. There is also some evidence to suggest that HPs are mostly bypassed by the community due to limited trust of clinical skills of HEWs and limited awareness about available services. As a result, service uptake and effective coverage

of HEP-related interventions have been consistently low despite efforts to increase service utilization during the last 14 years.⁹

2.3 HUMAN RESOURCES FOR HEP

The number of HEWs trained and deployed has mostly reached the intended target of two HEWs per HP. As a result, recent efforts have been mainly directed at upgrading training of current HEWs and recruiting new HEWs to replace HEWs who have left their jobs. In this regard, 22 health science colleges in different regions of the country are involved in HEW training. Recently, a new scope of practice and curriculum for HEWs to pursue a degree program in family health is also launched in five Universities. Limited capacity and motivation of HEWs is a major area of gap. The health science colleges are resource constrained. Inadequate focus on practical aspects of the training and difficulties in practical placements for graduating HEWs are also major challenges of the institutions. Low level of readiness of trainees to receive the training, including inadequate language skills in the medium of instruction (English), is among the major challenges leading to compromised quality of pre-service trainings.

Inclusion of additional HEP packages and services has added to the mismatch between the skill sets of HEWs with the skill sets required to effectively implement HEP. Provision of in-service trainings has not adequately addressed this mismatch indicating that training HEWs alone may not solve the problem; it may require assigning a multi-disciplinary team of health professionals in addition to HEWs.

2.4 DRUGS AND OTHER MEDICAL SUPPLIES

Expanding HEP services has brought with it the need for a strong pharmaceutical logistics system. However, the system has been struggling to cope with the rapid expansion of HEP and provide regular supply. As a result, interruptions in the supply of drugs, medical equipment and

supplies have been common challenges for HPs.^{16,27} Health posts and supervising health institutions also fail to request their requirements in a timely manner, due to knowledge gaps in logistics and drug supply chain management. In addition, absence of standard drug lists and different forms for requesting drugs further exacerbates shortages at the HP level.

2.5 FINANCING OF THE HEP

The HEP was initiated as an exclusively government-financed program with communities being asked only to contribute in-kind through providing building materials and supporting construction of HPs. As government commitment continued and the program started to demonstrate its potential, it attracted more resources from development partners' financial and technical support. Between 2010/11 and 2016/17, total HEP spending increased from 70 million to 148 million USD. The share of government spending in HEP financing increased from 20.8% in 2010/11 to 40.4% in 2013/14. However, it stagnated at this level since then. The program is still heavily donor dependent with the external assistance accounting for 59.7% of HEP spending in 2016/17. Between 2010/11 and 2016/17, the share of HEP spending from total health expenditure and total PHCU level spending declined from 8.9% to 7.1% and from 25% to 22%, respectively.⁹

Currently, all HP services are provided as exempted services, meaning free of charge to households financed mainly through donors and the government. Expansion of HEP service packages to include additional curative services will require revisiting how alternative financing mechanisms like CBHI and social health insurance (SHI) can help recover some of the costs of services at the HP.

2.6 COMMUNITY ENGAGEMENT AND OWNERSHIP

The community engagement platforms under use at present are primarily the WDA in agrarian and to some extent urban settings, and Social Mobilization Committees (SMCs) in pastoral

settings. The functionality of these structures was however limited in most places because of a number of reasons, including but not limited to inadequate capacity of voluntary community health workers. In 2019, only 21.5% of WDA structures met basic criteria for functionality. WDA leaders also lacked the model behavior required to positively influence the behavior of their network members.⁹ Competency-based training (CBT) has been designed and implemented to address this gap in competencies of WDA leaders. So far, over half a million WDA leaders attended the training. However, there is a lack of evidence of its effectiveness in bringing about behavior change among leaders and members of WDAs.

Training of model families has been an effective strategy to empower households in producing their own health. However, the coverage of model family training has been very low, particularly in recent years.

Reliance of the HEP only on WDA structures as its community engagement strategy has resulted in inadequate utilization of existing communities and exclusion of men and youth from community health services.

2.7 GOVERNANCE AND LEADERSHIP OF HEP

The HEP has been a flagship program for the Ethiopian health sector. Integration of planning, monitoring and evaluation, and reporting arrangements for the HEP with the functions of the broader health system at the earliest stage of the program allowed seamless integration of the program at all levels of the system. The program has also received greater emphasis in macro plans, including HSDP, HSTP, and GTP. The program is led by a directorate at MOH, sub-processes at RHBs, and a focal person at zonal health departments (ZHD)/WoHO and PHCUs. A strong commitment of the government at all levels during the early phase of the HEP enabled the program to expand throughout the country.

Governance and leadership challenges in recent years, however, have become a source of deteriorating performance of the HEP. A declining commitment to the HEP has also been reflected in relative size of investment;

government health expenditure on HEP as a share of total government health expenditure has been declining in recent years. Inadequate intersectoral collaboration has been a source of slow progress in promotion of hygiene and environmental sanitation. At lower levels, lack of clear HP governance structures, dual accountability of HPs to kebele administrations and HCs, human resource management practices compromising the rights of HEWs, and lack of accountability for performance of HPs are among the major challenges. Inadequate back-office support and weak mentorship from HCs are also among the major challenges.

2.8 INFORMATION SYSTEMS AND M&E

Monitoring and evaluation of the HEP is an integral part of the overall M&E system of the health sector. Community Health Information System (CHIS), initiated in 2008 as part of the reform on HMIS and recently digitized to eCHIS, is the major platform for the collection, analysis, management, and use of data on the performance of the HEP.

Assessment of CHIS, as part of the 2019 National Assessment of the HEP, showed that there are limitations in the design, quality, and use of CHIS. The current health information/M&E system focuses only on outputs of specific programs implemented through HEP with very limited attention to monitoring the process of HEP at lower levels. In addition, kebele level indicators directly linked to the performance of HEP lack the ability to show progress of HPs/HEWs. Over-reporting is a common phenomenon. Implementation of CHIS was partial and inputs for its implementation were inadequate. As a result, information use and usefulness at HPs is limited.⁹

3

PROJECTION OF KEY POPULATION AND HEALTH SYSTEM CHARACTERISTICS

The HEP Optimization Roadmap 2020-2035 intends to guide the evolution of the program with a primary purpose of meeting the current and future health needs of individuals, households, and communities through health service delivery predominantly at the kebele level. Understanding changes expected during the timeframe of the roadmap is critical for making appropriate planning decisions. Key population and health system characteristics for which projected data was considered in the preparation of the roadmap include population size and composition, burden of disease, fiscal space, and other social determinants of health including economic growth opportunities, education, and infrastructure.

3.1 POPULATION PROJECTIONS

The latest census in Ethiopia was conducted in 2007. Projections based on data from this census estimated the population of Ethiopia to be 100.8 million in 2020 and 136.8 million in 2037. The population is also expected to undergo major changes in age composition leading to a youth bulge during the coming two decades. The proportion of people living in urban places will also rise from the current 22% to 25.3% in 2027, 28.1% in 2032, and 31.0% in 2037. Increasing urbanization and fast population growth will rise Ethiopia's urban population to 42.4 million by 2037.

3.2 CHANGES IN MORTALITY AND MORBIDITY

Ethiopia has experienced a substantial reduction in morbidity and mortality in the last two decades reaching average life expectancy at birth of 65.5 years in 2019. This gain has been a result of improvements in social determinants of health and increased access to health services.³ The burden of NCDs is expected to increase further in the coming years. By 2030, mortality from NCDs is expected to exceed the combined mortality from CMNNDs to become the most common cause of death in Ethiopia. By 2040 more than 65% of DALYs lost in Ethiopia are expected to be due to NCDs.²⁸

3.3 FISCAL SPACE AND HEP FINANCIAL RESOURCE AVAILABILITY

The path to UHC will require both domestic resources mobilization and equitable and efficient utilization of these resources. A 2019 analysis of HEP financing showed that 60% of HEP financing is dependent on external assistance. Changes in the funding landscape paired with substantial decline in external assistance will present major financing challenges in future years, especially as the country moves towards middle-income country. To provide greater insight into the current and future resource requirements for the HEP, the roadmap includes a high-level fiscal space analysis for the HEP (2020 to 2035), using estimates for the various sources that currently contribute to the program. Methods and results of the fiscal space analyses are presented in Section 8 along with the cost estimates of the roadmap.

3.4 CHANGES IN OTHER SOCIAL DETERMINANTS OF HEALTH

Other social determinants of health also play a vital role in the implementation and effectiveness of the HEP. During the period of the HEP Optimization Roadmap, the country is expected to undergo substantial economic growth, improvement in literacy and formal education, and improved access to basic infrastructure. Environmental changes, including climate change, are also expected to have increased pressure to the health of Ethiopians and the health system.

4

BENCHMARKS, GUIDING PRINCIPLES, AND BASIC ASSUMPTIONS

4.1 BENCHMARKS

According to WHO, UHC means that “all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.”²⁹ Reaching the global targets of 80% coverage of health services and 100% financial protection from catastrophic and impoverishing healthcare costs are critical for achieving UHC by 2030.^{30,31}

4.1.1 Lessons from international benchmarks

Literature search for benchmarking across the five countries (Thailand, Bangladesh, Rwanda, Sri Lanka and India) allowed identification of key lessons for Ethiopia. The major ones are organized and presented based on the WHO’s health system building blocks.

Service delivery

- Extensive geographical coverage of health facilities is a foundational factor leading to successful progress towards UHC.
- Pro-poor health policies and strategies supported by public subsidies facilitate access to and utilization of PHC services by people with lower socio-economic status.

Health workforce

- Champions with pro-poor ideology and rural health background serve as “policy entrepreneurs” liaising with and influencing politicians and influencing legislation supporting investments in the deployment of the sufficient quantity of health workforce at PHC facilities.
- Requiring health science graduates of public universities to serve in the public sector or pay a significant penalty fee after graduation facilitates availability of adequate health workforce in the health system.

Access to essential medicines and technologies

- Investment in local production of essential medicines and technologies may not only serve the needs of PHC but may also generate economic gains from substantial substitute of imports and increase of exported items.
 - Bangladesh was the most prominent scenario in medical products and technologies, the growing pharmaceutical sector has cemented its achievement by successfully exporting its products to countries of Asia, Africa, Latin America and Europe (from 37 countries in 2004 to 84 in 2011).

- The pharmaceutical industry in Bangladesh now contributes about 1% of the country's total GDP and it is the third largest contributor of government revenue. Bangladesh is now fulfilling 95% of its demand from indigenous sources.
- Public-private partnership, with a clear target of making quality assured generic drugs available to communities, increases the affordability and continuous supply of essential drugs and supplies.

Health care financing

- Increased government spending is a critical success factor for achievement of UHC.
- Strong political leadership and commitment and adoption of a legal framework making health insurance compulsory facilitates insurance coverage for all.
- Performance-based financing (PBF) facilitates performance improvement and efficiency in resource utilization.

Leadership and governance

- Commitment of leaders plays a critical role in making UHC a priority agenda. Commitment to address urban-rural and socio-economic disparities in health service delivery is a primary driver to invest in UHC.
- Good governance, political leadership, and strong management lead to stronger health systems and thus better outcomes with or without health financing reforms.

4.1.2 Lessons from local benchmarking visits

The local benchmarking was conducted in nine regions focusing on six thematic areas providing additional evidence on recommendations of the 2019 National Assessment of the HEP. The synthesis of findings from these benchmarking visits affirmed the roadmap's recommendations. Lessons from local benchmarking visits include:

- Having a HP and a HC in one kebele resulted in duplication of effort and confusion amongst staff. In these settings, it is recommended to merge HPs with the HC and provide HEP services as one function of the HC.
- Assignment of nurses or midwives at HPs has brought about improvements

in clinical service delivery, service use by the community, and satisfaction among community members.

- HPs with high volumes of deliveries tended to be correlated with communities that lacked access to roads or were in distant locations far from higher level care options. However, quality is a concern. HPs providing delivery need to fulfill minimum requirements for the service.
- Factors that contributed to better performance of HPs include multi-sectoral collaboration, strong HC - HP linkage, leadership support, and strong community engagement. Manageable catchment population size, convenient topography and favorable view of the local community contribute to better performance of HPs. HEW-related factors that contribute to better performance were the skills of HEWs, motivation and commitment, number of years and level of education, and having professional mix and enhancing teamwork within the HP.
- High performing PHCUs are characterized by strong engagement of HCs with multisectoral approaches, high degrees of community engagement, organizing and implementing experience sharing among cluster HPs and between WDA structures in the kebeles, and strengthening public-private partnerships (in big cities like Addis Ababa).

4.2 GUIDING PRINCIPLES AND KEY ASSUMPTIONS

The guiding principles which governed the development of the roadmap were: Universal access, self-reliance, multisectoral approach, equity, efficiency, informed decisions, and contextualization. Key assumptions involved in the design of the HEP Optimization Roadmap 2020-2035 were made by reviewing strategic documents of the health sector. These include: expansion of HCs, commitment to PHC, continued commitment to the plan to construct one PH in each district, and decentralization and task shifting.

5

ROADMAP FOR HEP OPTIMIZATION 2020-2035

5.1 STRATEGIC OBJECTIVES OF OPTIMIZATION

In this section, the key strategic objectives are listed and further described in the sections that follow. All the strategic objectives of optimization are given under each of the six interrelated objectives.



Figure 5-1: the strategic objectives

5.2 THEORY OF CHANGE

The strategic recommendations given below are expected to facilitate the transformation from the current sub-optimal situation, further compounded by COVID-19 and other global and national threat, into a pathway which leads to achievement of UHC within the coming 15 years.

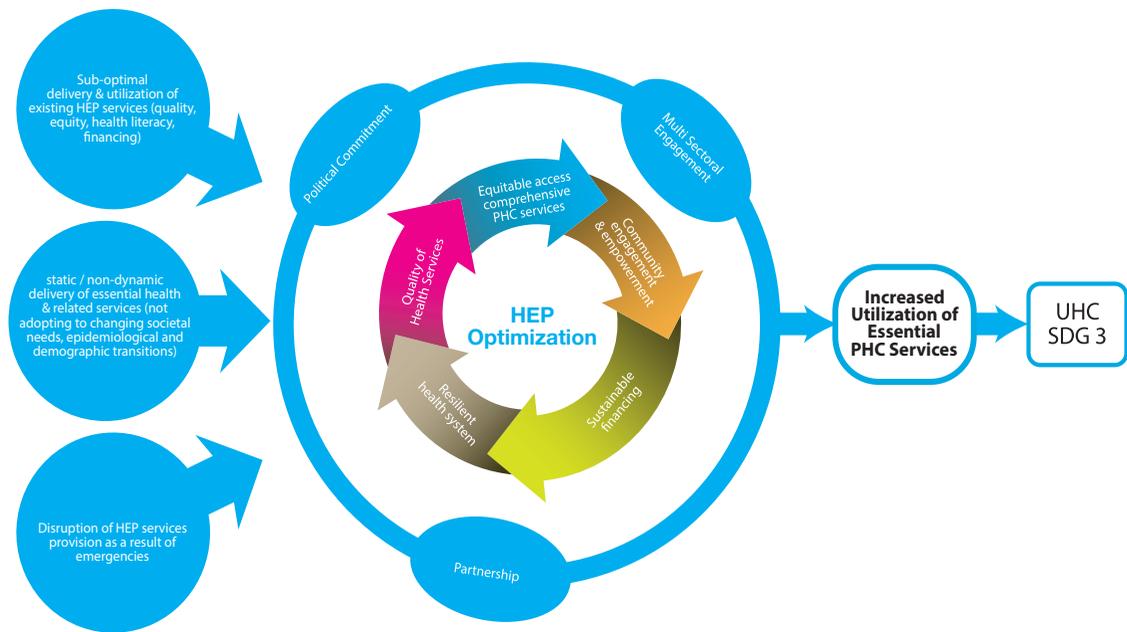


Figure 5-2: theory of change

5.3 DESCRIPTION OF STRATEGIC OBJECTIVES OF OPTIMIZATION

Strategic Objective 1. Ensure equitable access to essential health services

1.1. Expand HEP service packages

Health Extension Program packages will be expanded to ensure that all health promotion and disease prevention services and majority of outpatient department (OPD) visits for curative services are provided to communities within the kebeles they reside in. This will be achieved through strengthening of the current 18 packages of HEP by addressing issues in quality of care and adding services to provide curative services for top causes of OPD visits.

A list of interventions under each variant of HEP packages is outlined in Table 5-1. A detailed list of packages will be provided as part of HEP implementation manuals that will be prepared to operationalize the roadmap.

Table 5-1: Variants of HEP packages

| HEP Packages | Brief description of contents | Targets |
|--|---|---|
| Comprehensive HEP Packages | Comprehensive maternal health care for normal pregnancy, childbirth, and postpartum period, treatment of common childhood illnesses through integrated management of childhood illnesses, treatment of common adulthood illnesses, and prevention and treatment refill for chronic illnesses. | Communities in kebeles that have limited access to a HC or PH (more than one-hour distance) |
| Basic HEP packages | The current HEP packages will be provided by addressing issues in quality of care, strengthening referral linkages with catchment HC, and outreach health services to communities living far from the HP. | Communities in kebeles that have access to a HC or PH within a reasonable distance (within one-hour distance) |
| HEP for communities with access to HC & PH | Community-based health promotion and disease prevention packages linking communities with HC and PH for clinical services. | Communities in kebeles that already have either a HC or a PH. |

1.2. Establish community health program at all Health Centers and Primary Hospitals

The provision of several health promotion and disease prevention services in settings where there are no HPs and HEWs has mostly been either ignored or provided on ad hoc basis. This strategic initiative will make PHCUs responsible for delivery of HEP packages for their respective catchment populations.

1.3. Restructure service delivery platforms for HEP

All existing HPs will be mapped in relation to their nearby HCs/PHs, communities they serve, and their nearest access to paved roads. HPs will be classified based on their relative distance from the nearest HC or PH. Those located in kebeles where there is already a HC or PH will be merged with the HC or PH and become a unit in the facility; those within a reasonable distance will continue as Basic Health Posts; and those far from HCs and PHs will be expanded to Comprehensive Health Posts. Prioritization for upgrading to comprehensive HPs will be based on assessed need and feasibility. HPs with the highest needs to expand services (e.g. those that are physically distant from other PHC facilities) and fulfill most of the input requirements of comprehensive service delivery will be given priority for upgrading.

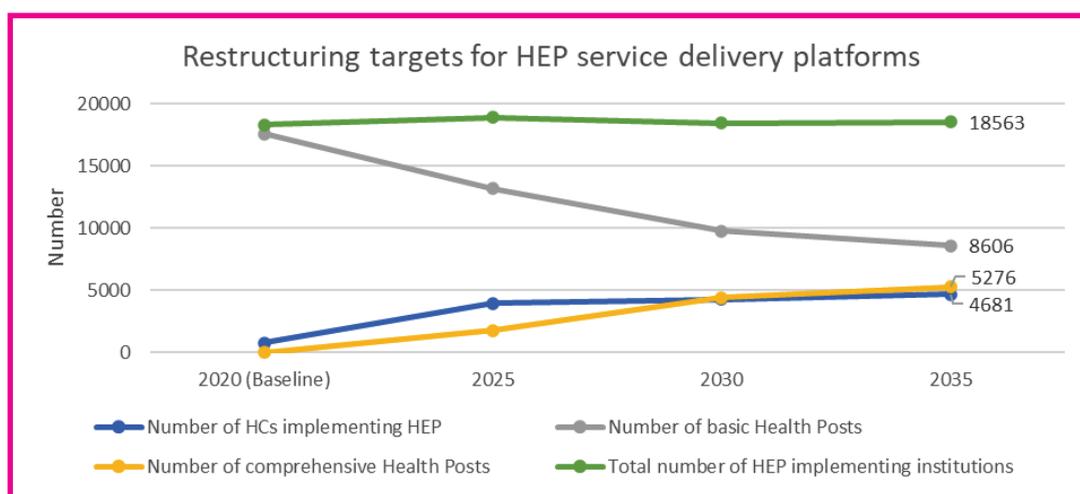


Figure 5-3: HEP Restructuring Targets, 2020-2035

1.4. Contextualize service delivery modalities for communities in pastoralist and urban settings

HEP for pastoralist settings: Construction of HPs for communities with sedentary lifestyles will be supplemented by expansion of mobile health services for communities with semi-sedentary and mobile lifestyle. A model for mobile HEP service delivery will be developed based on lessons from previous experiences of NGOs working in pastoralist areas of Ethiopia and others working in the areas of livestock and education.

HEP for urban settings: Unlike in agrarian and pastoralist settings where physical access is a major challenge, urban dwellers have relatively better proximity to HCs and hospitals, including private health facilities. Barriers to adoption of health behaviors and health service utilization in urban settings are related to social determinants of health.

1.5. Introduce a system to monitor and regulate addition, modification, and removal of packages

The HEP has suffered from loosely regulated expansion and modification of services that resulted in compromised quality of care. In the coming 15 years, the HEP is expected to evolve in terms of all its aspects; this evolution will be in a controlled manner. Additional services will be provided through the HEP only after ensuring the service is part of the EHSP; a pilot study is conducted to determine the feasibility, effectiveness and resource implications of providing the intervention through the HEP; and an implementation plan including commitment for resource allocation is prepared and endorsed by decision makers at federal and regional levels.

Strategic Objective 2. Improve the quality of health services provided through HEP

This strategic objective will improve and assure the quality of HEP services by introducing changes in the areas of HEP workforce, supplies management, infrastructure and basic amenities, service delivery processes, and governance and leadership.

2.1. Workforce

2.1.1. Introduce professional and gender mix among HP staff

Staffing of HPs will be revised to ensure that each category of HP is staffed with the adequate number and mix of professionals allowing implementation of respective HEP packages with acceptable quality. An incremental approach will be implemented to continuously build human capacity at HP level until the appropriate number and mix of health professionals is reached.

Table 5-2: Description of targets on staffing pattern by year

| | Description of staffing pattern by year | | |
|-------------------------|---|---|--|
| | 2025 | 2030 | 2035 |
| Basic HPs | 2 level 4 HEWs 1 Nurse | 1 level 4 HEW 1 Family Health Prof 1 Nurse 1 Environmental Health | 2 Family Health Professional 1 Nurse 1 Environmental Health |
| Comprehensive HPs | 2 level 4 HEWs 1 midwife 1 Health Officer | 1 level 4 HEW 1 Family Health Prof 1 midwife 1 comprehensive nurse 1 Environmental Health 1 Health Officer | 2 Family Health Professional 1 midwife 1 comprehensive nurse 1 Environmental Health 1 Health Officer |
| HEP unit in HCs - Rural | 2 level 4 HEWs | 1 level 4 HEW 1 Family Health Prof | 2 Family Health Professional |
| HEP unit in HCs - Urban | 2 HEPr | 2 HEPr | 2 HEPr |

2.1.2. Build the capacity of HP staff

Actions will be taken to improve the overall training program starting from entrance through to graduation and deployment. Specific initiatives that will be implemented during the first five years of the roadmap include: revising entry criteria to HEW training program, curriculum revision and improvement in implementation of practical attachments, improving lab skills, building the capacity of instructors, ensuring practical attachment sites represent actual working environment of HEWs, improving student assessment, and conducting continuous assessment and improvement of training institutions.

2.1.3. Advance a career path for HEWs

The current HEWs will be provided opportunities to upgrade their educational status in the fields of midwifery, comprehensive nursing, environmental health, health officer (public health), and family health. Training institutions will have independent power to assess and determine entrance of a HEW for post-basic trainings. HEWs who cannot qualify for post-basic trainings will, in the long run, be allowed to take administrative, clerical, and other positions at different levels of the health system.

2.1.4. Introduce comprehensive benefit and performance-based incentives packages to HP staff

The revised salary scale of HEWs, which take into consideration hardship postings, will be fully implemented. In addition, performance-based recognitions and incentives will be explored and implemented to ensure that staff are motivated to better implement HEP. A new system will also be introduced to provide healthcare services for HP staff. Performance-based recognition and incentives will be introduced to keep HP staff committed.

2.2. Supplies

The supply chain management system will be designed to respond to the major changes in service delivery and other components of the HEP.

2.2.1. Implement pharmaceutical supply chain improvement initiatives at HP level

Alternative ways of financing HEP services including CBHI and user fee will be considered to partly cover the cost of drugs at HPs. Integrating training content on supply chain management in to in-service and pre-service curriculum of health professionals will be considered to build supply chain management capacity at HP level. The HP infrastructure standards will be revised to ensure appropriate storage, safety, maintenance and use of pharmaceuticals.

2.2.2. Introduce a system of accountability to supply chain related problems

Efforts to establish an appropriate system of accountability on the supply chain will include: the use of technology and information system for supply chain management, involvement of the community in evaluating health service delivery, building the capacity of the workforce at the HP, and ensuring checks and balances in the workflow at HPs.

2.3. Infrastructure and basic amenities

Actions in the area of infrastructure development will include upgrading and renovation of existing HPs, enforcement of standards on construction and basic amenities, and establishing a reliable system for regular preventive maintenance of HPs. Health posts will be renovated through a phased approach. All health posts will fulfill basic amenities and infrastructure standards.

2.4. Improve service delivery processes

HEP services are provided through home visits, HP visit, and outreach sessions. Harmonizing and ensuring standards for service delivery through different modalities will ensure the HEP delivers better quality while at the same time allowing for contextual adaptation of services and procedures. Strategic actions in this regard include:

- Revise social and behavior change communication strategies
- Introduce standards for HEP service delivery modalities
- Introduce internal quality improvement processes at HPs
- Strengthen referral linkage

2.5. Revise and digitize health information system and M&E for HEP

Introduction of the community health information system (CHIS) has improved the relevance and coverage of health information collected through the HEP. Further improvement of the components of the information system for informing local decision-making processes and improving the capacity of HEP staff to utilize available information will be priorities in transforming the information system at the level of the HEP. CHIS will be revised and digitized with the intentions to improve the relevance and comprehensiveness of indicators and data elements, address issues in quality of data including sources of inaccurate reporting and strengthen data use capacity at local levels. Data use capacity will be built among potential information users. Information systems of HPs and HCs will be integrated in the long term.

2.6. Improve governance and leadership processes

Changes on different aspects of the HEP proposed for implementation during the 15 years period of this roadmap can be effective only if they are appropriately led and governed. Changes are required in the areas of: technical and administrative structures; cross-sector collaboration and functioning at different levels (kebele to federal levels); how and whether resources are mobilized and channeled towards the program; the degree to which the HEP is responding to community needs; the adaptability of the program to social, political and economic dynamics; and responsiveness to the needs of its own workforce. Actions to realize these changes include:

- Enforce standards of HPs
- Establish HP administrative structure at HC which involves the community
- Strengthen HC – HP linkage
- Strengthen HEP leadership at all levels of health administration

**Strategic Objective 3.
Ensure sustainable financing and eliminate financial hardship from HEP services**

Expanding HEP services in the face of shrinking financial resources requires careful consideration to craft and design financing mechanisms. The

overall effect of changes proposed in the HEP Optimization Roadmap will hopefully reduce waste and redirect saved resources towards more effective service delivery models. However, in the short term, the proposed recommendations will require significant resources. This strategic objective focuses on how the proposed changes will be financed and how services will be delivered under these new arrangements.

3.1. Prioritize government spending at PHCU level

During the timeframe of this roadmap, research and advocacy will be done to reverse the direction of investment in the health sector. A comprehensive policy analysis will be done to initiate discussions on where Ethiopia has been investing on and where it should be investing its limited resources. Guided by the policy analysis, revisions will be made on how the health sector allocates resources at all levels.

3.2. Cover the cost of curative health services at HPs through user fee and CBHI

During the first five years of the roadmap, a user fee will be introduced for curative services provided at HPs. The user fee will allow recovering costs of drugs and other medical supplies while at the same time preparing communities for CBHI contributions to cover the cost of HP level services. In the subsequent strategic period, CBHI will start to cover the cost of HP level services.

3.3. Formalize and strengthen community contributions for HEP services

Standard methods of valuating in kind contributions will be introduced to allow accurate tracking of community contribution in different settings.

3.4. Introduce earmarked budget for HEP

Currently HPs are budgeted under HC, which makes them dependent on the HC and denies them the ability to plan for their community in a predictable way. HEP budget will be earmarked at all levels, including the consideration of HPs as cost centers.

3.5. Enhance resource mobilization from non-government sources

Actions to mobilize resources from external sources will include allocating adequate portion of already available funds (SDG pool fund, Global fund) to the HEP and soliciting additional sources of funding. A PHC financing strategy will be developed with greater attention to HEP resource mobilization mechanisms.

3.6. Expand social marketing for the supply of HEP related supplies

The experiences of Ethiopia on the use of social marketing strategy for condom promotion and recently for the supply of sanitation supplies and equipment will be further expanded to ensure continuous supply of supplies required for implementation of HEP at household levels.

Strategic Objective 4. Strengthen community engagement and empowerment

This strategic objective of the HEP Optimization Roadmap intends to strengthen community engagement and empowerment by redesigning its current structures and functions. These features will be promoted further to initiate the adoption of a broader strategic document for community engagement in the Ethiopian health sector.

4.1. Redesign community engagement mechanisms for HEP

The current community engagement platform is not adequately functioning in supporting the implementation of the HEP. Alternative options will be developed, tested, refined, and scaled-up during the early phase of the HEP Optimization Roadmap. Revision of community engagement strategy will focus on putting in place a system that optimizes mobilization of community capacities towards self-reliance in the production of their own health.

4.2. Introduce incentive mechanisms for voluntary community health workers

Keeping the balance between volume of work expected from voluntary community health workers and the volume and type of incentives provided to them will be a critical consideration

in the design and implementation of any motivational intervention. This will be realized by introducing a mechanism through which volunteers will work only for a fixed term before they pass their role to their successors.

4.3. Design, test and scale-up capacity building strategy for voluntary community health workers

Different capacity building approaches, including the current CBT, will be tested for their effectiveness in building model behavior among volunteers and their ability to influence their households, neighbors, relatives, and communities. Effective, efficient, and sustainable approaches will be scaled up. An important consideration in the identification of the best approach is that volunteers work for a defined term.

4.4. Enhance the role of multi-sectoral institutions in the implementation of HEP at kebele level

Guided by the principle of “health in all policies and practices” and existing frameworks for intersectoral collaboration at federal, regional, zonal, and woreda levels, the HEP at the community level will promote institutionalization of positive influences on health by other sectors. Specific initiatives to promote the engagement of other sectors in the implementation of HEP at the community level will include integration of school health services with HEP, introduction of regular advocacy sessions with community leaders, and creating multisectoral platform for urban water, sanitation and hygiene (WaSH).

Strategic Objective 5. Ensure resilience by maintaining the provision of essential services during any health emergency

Capacity building trainings will be provided to HP staff on the topics of preparation, detection, and response to crisis. While the Public Health Emergency Management (PHEM) system will be the major area of emphasis, HPs should also be ready to address locally relevant sources of disruption. In this regard, the health sector will:

- Define and standardize the role of HEP in emergency preparedness and response

- Strengthen PHEM capacity at the kebele level
- Strengthen resilience of HEP to administrative changes

Strategic Objective 6. Strengthen political leadership, multi-sectoral engagement and partnerships

The lower level political leadership, who will have the opportunity to closely work with the HP and PHCU should be involved. Development partners' engagement should also be coordinated centrally to prevent duplication of efforts.

6.1. Create clarity and commitment through promotion and advocacy

The ministry and the regional health bureaus are expected to play a critical role in the initial phases of the introduction of this roadmap. Thus, the political authorities at all levels will have defined roles and responsibilities including roles in the introduction, mobilization, monitoring and follow up of progress.

6.2. Promote multi-sectorial engagement using existing platforms

The woreda transformation agenda uses the Woreda as a point of intersection for the various sectors. Implementation of the HEP Optimization Roadmap will also use this platform to engage the different sectors for the successful transformation of the health extension program. The health sector will work with the other sectors at the ministerial, regional, and woreda levels.

6.3. Foster Development Partners' engagement and coordination

Identification of alternative resources through engagement of partners will be geared towards materializing the transformation of HEP. This will be achieved through promotion of adherence to the priorities of the health sector and joint programming. Efficient and optimal use of the resources is expected to have a significant contribution for the successful execution of the roadmap.

6

PRIORITIZATION AND MILESTONES

The HEP Optimization Roadmap lays out a high level, 15-year vision for how the HEP and the broader health system can be organized, governed, financed, and monitored over three phases, which correspond to the HSTP periods starting in 2020 and through to 2035. Recommended actions are prioritized to serve as an important bridge between the Roadmap and its eventual implementation. The theory of change described in Figure 5-2 is used as a frame for the prioritization.

The prioritization process for the HEP Optimization Roadmap was assisted by the 2X2 grid method³² of prioritization. The 2x2 prioritization matrix uses need and feasibility criteria to determine which priorities yield the greatest results. “Need” could be defined in terms of addressing equity dimensions, maximizing health gains, and financial risk protection. “Feasibility” could be seen in terms of operational, technical, schedule, and economic feasibility of the proposed action. This process is also recommended to be used in subsequent efforts to improve the HEP through monitoring and continuous improvement.

The roadmap considers the fact that ensuring optimal utilization of existing packages by providing enhanced access and by preventing any disruptions in service delivery should be maintained while the transformative interventions are implemented.

Realizing the broad goal and strategic objectives of the HEP Optimization Roadmap also requires setting realistic and evidence-based milestones arranged in a logical framework that prioritizes results. Coordination between investments in different components of the health system building blocks is vital to maximize efficiency. Major milestones of the roadmap expected during the periods 2020-2025, 2025-2030, and 2030-2035 are described in Figure 6-4. Detailed targets are presented in Table 6-4.

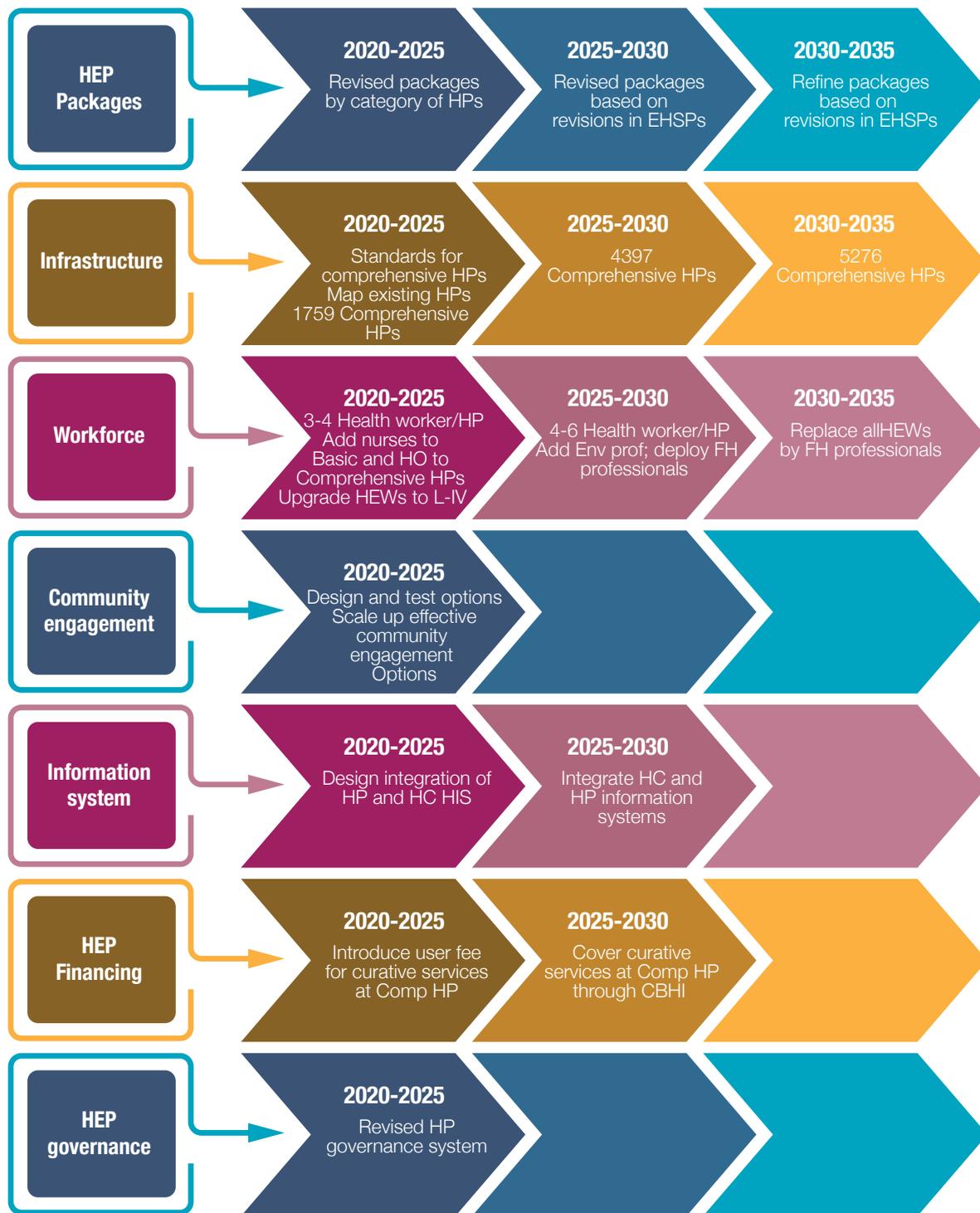


Figure 6-1: Calendar of major events of the HEP Optimization Roadmap by health system

7

IMPLEMENTATION ARRANGEMENTS, MONITORING, EVALUATION, RESEARCH, AND LEARNING

7.1 GOVERNANCE STRUCTURE

HEP optimization will be a priority agenda at Federal, Regional, Zonal/Woreda, and Kebele levels. Milestones and targets of the HEP optimization roadmap will receive substantial emphasis in the preparation of annual core plans, regular meetings of joint decision-making forums, and annual review meetings.

7.2 STAKEHOLDER ROLES AND RESPONSIBILITIES

Optimizing HEP is a multi-year and multi-stakeholder program for transforming the component of the Ethiopian health system that encompass majority of the population in the country. Under the leadership of the public sector at federal, regional, zonal, woreda, and kebele levels, diverse groups of actors will be involved in the implementation of the HEP Optimization Roadmap.

7.3 PLANNING AND IMPLEMENTATION

The HEP Optimization Roadmap outlines what health system actions are needed to ensure the platform can meet community needs and help to achieve UHC. Similarly, annual plans for implementation of the HEP Optimization Roadmap will be developed and aligned with annual plans developed through Woreda-Based Annual Planning processes.

7.4 MONITORING AND EVALUATION OF PROGRESS

The roadmap's monitoring and evaluation plan includes three important categories of processes for evidence generation and utilization: 1) Routine Progress Monitoring, 2) Implementation and Evaluations, and 3) Evaluation of Strategic Initiatives.

7.5 RESEARCH AND INNOVATIONS

Primary health care is one of the most widely researched areas in public health. Community-based innovation incubation labs (community labs) will be identified and used for testing future changes in the HEP. New ideas related to service packages, technologies, service delivery modalities, and other dimensions of the HEP will be tested through rigorous evaluation methods in these communities prior to large scale implementation.

7.6 PROCEDURES FOR MAKING ADJUSTMENTS TO THE ROADMAP

All monitoring, evaluation, and research activities will have a common goal of informing how the HEP is structured and how it functions. Evidence regarding the feasibility, effectiveness, and sustainability of strategic initiatives introduced as part of the roadmap will be continuously compiled and synthesized. Strategic actions and/or targets will be officially amended every five years depending on evidence on their feasibility, effectiveness, and sustainability or emergence of new health technologies.

8

HEP OPTIMIZATION ROADMAP COSTING AND FINANCING

The HEP Optimization Roadmap is costed using the OneHealth Tool. The resulting cost estimates for the first five years of the roadmap and indicative costs for the remaining ten years were compared with three scenarios of projected financial resources. Financing gaps are then estimated for the three scenarios. The three scenarios are:

Scenario 1: Maintain the current share of HEP from the total health expenditure (THE) at baseline (low case scenario); include community contributions projected from the HH survey.

Scenario 2: The share of HEP from the total expenditure at baseline is maintained and user fees are introduced in the comprehensive HPs (medium scenario). Community contribution will be included as above. However, retained revenue from comprehensive HPs will not exceed 20% of the HPs budget (share of retained revenues is about 35% of total budget/spending at higher level facilities (HPs will have few services to charge for and their average fees will be lower).

Scenario 3: Current share of HEP from THE will increase (government will allocate more resources to HEP) and HPs will begin charging user fees for the additional services they deliver (high scenario)

The introduction of innovative financing mechanisms including the introduction of user fees at the HP level and the potentials of using prepayment mechanisms (CBHI) are not included as available resources and will be advocated to fill part of the financing gap.

8.1 AVAILABLE FINANCIAL RESOURCE FORECAST

A financial space analysis for HEP (2020 to 2035) was estimated from various sources for HEP. In the analysis, international fiscal space analysis framework was adapted to Ethiopia local context and Ethiopia's local and international health financing commitments take into account.

Table 8-1. Financial resource forecast for health (in USD million)

| Scenarios | Year | Government | External source | Total-HEP |
|----------------|------------------------|------------|-----------------|-----------|
| Low variant | 2020-2025 (Estimated) | 495 | 933 | 1,428 |
| | 2025-2030 (indicative) | 750 | 1,412 | 2,162 |
| | 2030-2035(indicative) | 1,082 | 2,039 | 3,121 |
| Medium variant | 2020-2025 (Estimated) | 637 | 1,200 | 1,836 |
| | 2025-2030 (indicative) | 982 | 1,850 | 2,832 |
| | 2030-2035(indicative) | 1,422 | 2,680 | 4,102 |
| High variant | 2020-2025 (Estimated) | 761 | 1,434 | 2,195 |
| | 2025-2030 (indicative) | 1,188 | 2,239 | 3,427 |
| | 2030-2035(indicative) | 1,725 | 3,251 | 4,9767 |

ESTIMATED AND INDICATIVE COSTS OF HEP OPTIMIZATION ROADMAP 2020-2035

The total cost of implementing the HEP Optimization Roadmap for 15 years – including cost of human resources, infrastructure, medicines and medical supplies as well health system cost - is estimated to be US\$ 12.6 billion. The major drivers of the cost of implementation of the HEP Optimization Roadmap are infrastructure and medicines and medical supplies cost, as their share from the total cost ranges from 74% to 87% over the three 5-year periods.

Table 8-2. Total cost of HEP Optimization Roadmap implementation, 2020-2035 (% share in parenthesis)

| Type | 2020-2025 (Estimated) | 2025-2030 (indicative) | 2030-2035 (indicative) | Total |
|---------------------------------------|-----------------------|------------------------|------------------------|-------------------------|
| Human resource costs | 455,159,853 (3.6%) | 533,045,292 (4.2%) | 648,531,101 (5.1%) | 1,636,736,247 (12.9%) |
| Infrastructure costs | 1,024,316,471 (8.1%) | 1,904,459,284 (15.1%) | 2,317,065,915 (18.3%) | 5,245,841,671 (41.5%) |
| Medicines and supplies | 1,229,523,229 (9.7%) | 1,645,620,829 (13.0%) | 2,369,545,190 (18.7%) | 5,244,689,248 (41.5%) |
| Other HEP Health system related costs | 321,520,859 (2.5%) | 142,890,675 (1.1%) | 52,251,237 (0.4%) | 516,662,771 (4.1%) |
| Total HEP all-cost | 3,030,520,413 (24.0%) | 4,226,016,079 (33.4%) | 538,7393,444 (42.6%) | 12,643,929,937 (100.0%) |

Comparison between estimates of the cost of HEP Optimization Roadmap and forecast of financial resources indicated a financing gap ranging from 28% to 53% in the first five years, with substantial decline in the subsequent periods.

Table 8-3. Resource Gap for HEP – Resource Need versus Available (Amount and Percentage), 2020-2035

| Gap - resource needed vs. available | Planned expenditure in millions USD and % | | |
|-------------------------------------|---|------------------------|------------------------|
| | 2020-2025 (estimated) | 2025-2030 (indicative) | 2030-2035 (indicative) |
| | 3,031 | 4,226 | 5,387 |
| Low | 53% | 49% | 33% |
| Medium | 39% | 33% | 11% |
| High | 28% | 19% | -7% |
| Average (%) | 40% | 34% | 12% |

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