

Summary

Background: Improving access to health care services through efforts to provide services closer to the place where people live and work has been advocated widely since the Declaration of Alma-Ata. Despite the efforts to realize this in Ethiopia, it is only in the year 2003 that the intention to take a package of essential health services to the kebele (village) level was realized. This was done through the introduction of the Health Services Extension Program (HSEP).

Objective: To explore whether introduction of the HSEP in Jimma Zone has improved coverage and comprehensiveness of primary health care services delivered to the population in the rural areas of the Zone.

Methods: A cross sectional study was conducted in three randomly selected Woredas (districts) of the Jimma Zone of Southwest Ethiopia. The data collection was undertaken during the months of May, June and July of 2009. A structured questionnaire was used to interview female heads of sampled households of nine kebeles randomly selected from the three Woredas. In-depth interviews and (focus group discussions) FGDs were conducted with purposively selected health extension workers, voluntary community health workers, members of kebele health committees and health managers from Woreda Health Offices and the Jimma Zonal Health Department. Data obtained was analysed and triangulated to meet the objectives of the study.

Results: It was only 64.0% of the kebeles which had functional health posts although about 32% of the kebeles in the Jimma Zone have got health posts being constructed. However, it was noted that most (93.7%) of the kebeles in the Zone already have two HEWs assigned. Vaccination coverage as measured by DPT3 was 67.9% and 10% of the under two years children included in this survey had diarrhea. Regarding coverage of maternal health services, 53% of the women use family planning methods, 72% of pregnant women received at least one ANC, 8 % of women gave birth at health institutions, and 15% of the mothers were visited by the HEWs. Assessment of environmental and personal hygiene showed that only 10.2% of households dispose excreta on the open field and only 13.2% and 10.4% of the households their members do not practice hand washing with soap after using the latrine and before main meals, respectively.

In-depth and FGD participants witnessed that improvements have been observed after the arrival of the health extension workers (HEWs) particularly in relation to access to health services, acceptance of latrine construction and use by the community, environmental and personal hygiene and immunization. The HEWs work with almost all social, cultural, religious and administrative structures available in the kebele to effect community involvement and intersectoral action for health. Except schools and to some extent agricultural development agents working with the HEWs at the kebele level there is no much intersectoral action for health at higher levels.

Conclusions: Physical access to primary health care services including family planning, antenatal care, environmental and personal hygiene, and provision of health information on the prevention of common health problems were found to have remarkably improved in the study kebeles as per the time of introduction of the

HSEP. However, unlike the improvements in coverage the comprehensiveness of the approach to health services is not to the expected extent particularly at the district and zone levels. More specifically, intersectoral collaboration for health appears to be existent at the kebele level. However, the absence of any sign of intersectoral collaboration at higher levels will ultimately affect what is happening at the village level.

Recommendations: On top of efforts to sustain the achievements in improving coverage, there is a need to make sure that activities are linked with favourable health outcomes such as use of family planning methods, early treatment seeking and proper home management of diarrhea, use of ITNs, and institutional/skilled attendance of delivery. Community participation at the village level among all stakeholders should be sustained by support and follow up from the district health offices, supervising health centers and zonal health department. Creating a working mechanism to initiate and sustain intersectoral action for health at higher levels should also be a concern to the district health offices, zonal health department and the Oromia regional Health Bureau.