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Implementation of the Health Extension Program Optimization Roadmap: The Case of Shashemene Wereda, Oromia Region, Ethiopia

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Abstract

Background

The Ethiopian government had revised the Health Extension Program (HEP) after 15 years of its application, resulting in the Optimization of the Health Extension Program (OHEP). This optimization developed a roadmap to guide HEP from 2020 to 2035, which has been in operation for nearly five years. Thus, this assessment aims to document progress, obstacles, and lessons learned in the process and provide evidence for consideration in informing subsequent years.

Methods

An exploratory design was employed in Shashamane Wereda (district) of the Oromia region in Ethiopia from May 22 to June 1, 2025. The study conducted key informant interviews and focused group discussions among 40 participants from various health structures, community leaders, village health leaders, and stakeholders who contribute to the optimization agenda. Data saturation was observed at each level of participant category. Findings were transcribed, coded, and analyzed thematically.

Results

At policy level, our study revealed that the optimization was ambitious but short-lived, with early political advocacy driving its rollout. In the wereda, 13 Basic and three Comprehensive Health Posts are operational, with multidisciplinary teams in comprehensive posts; however, service delivery is inconsistent due to supply shortages and staff grievances in duty and workload. Although community-level health service delivery could thrive with structured multi-sectoral collaboration, this was grossly missing.

Conclusion

While the optimization roadmap offers opportunities to extend health services to end users at the community level, its success within the remaining timeline calls for charting mechanisms on how to ensure consistent availability of medical supplies and equipment and motivate the health team at the health post level. Furthermore, the Ministry of Health should define how to ensure support for primary health care and health service delivery at the community level by all sectors, with defined accountability for multisectoral collaboration.

Background

The Ethiopian health care system follows a three-tier model: the primary health care system (PHC), the secondary health care system, and the tertiary health care system [1]. At the PHC level, the system

provides community-based services emphasizing preventive care and basic treatment. The secondary level serves as a referral center for the primary level and training centers for health officers, nurses, and emergency surgeons. The tertiary-level system with highly specialized and subspecialized experts and advanced diagnostic and therapeutic services serves as a referral center for the general hospital from the secondary level [2], [3], [4]. Thus, the country's health care system is a reflection of a continuum of care connecting the community-based services with advanced interventions, reflecting a commitment to access equity, which was reflected through the health care system's introduction of the Health Extension Program (HEP) in 2003 [5], [6].

HEP, an indication of Ethiopia's commitment to the PHC and to meeting global health indicators, introduced sixteen packages of health services [7], [8]. Those packages were categorized under Hygiene and Environmental Sanitation; Disease Prevention and Control; Family Health Services; and Health Education and Communication [8], [9]. The program assigned two trained health extension workers (HEWs) to work within their home communities serving around 5,000 people in the community. Although references vary, the optimization roadmap reported that 39,587 community health extension workers in 17,587 community health posts were deployed to provide health services at the community level [10].

This strategic investment in local health workers aimed to improve household behaviors and provide essential, cost-effective health services, including sanitation, personal hygiene, childhood vaccinations, family planning, and the prevention and treatment of malaria, diarrhea, and pneumonia in children under five. HEWs spend about 75% of their time in the community, visiting families to promote healthcare demand and educate them on good health practices, such as exclusive breastfeeding, family planning, maternal and child health, and hygiene [2], [11].

Evidence revealed that HEWs were the source of information for a substantial proportion of modern contraceptive users and individuals seeking antenatal care and treatment for common illnesses, particularly among less educated and rural populations [12], [13]. Such household and community-level interventions have served as an important vehicle for improving PHC coverage and meeting the Millennium Development Goals (MDGs). Remarkable contributions were evidenced in improving access and coverage of maternal health service utilization, HIV/AIDS, tuberculosis, and malaria prevention, and improved waste disposal behavior during the last 15 years [14].

Despite its contribution to the MDGs [6], [15], [16], [17], there were steady concerns that compromised the smooth implementation of the health extension program. The years of investment in demand creation by HEWs have resulted in enhanced public demand for quality and comprehensive curative, promotive, and preventive services, while demotivation by HEWs in connection to lack of commensurate professional development has challenged the implementation of HEP [18], [19], [20], [21]. In 2015, the ministry launched the Second Generation HEP that intends to address outstanding demands from social, demographic, and epidemiological transitions. It builds on the initial HEP program but with a phased approach to upgrade HEWs to level IV, through providing them with an additional one-year training, and

improving the capacity of health posts with equipment and supplies that ultimately expand basic health services to the community [22].

In order to capture the evidence that was documented by a number of individual research studies on specific areas, HEP evaluation of the 15 years of accomplishment, including the short-lived Second-Generation HEP, was conducted in 2020. The findings revealed multiple challenges in relation to the service, HEWs' interest, community engagement, and health care [23].This has led to the launching of the Health Extension Program Optimization (HEPO) roadmap.

The HEPO has an overarching goal of ensuring equitable and quality health services, multi-sectoral engagement, along with resilient community engagement, and preventing financial hardship associated with the service, thereby meeting universal health coverage [2], [14].The roadmap introduced six strategic objectives; 1) Ensure equitable access to essential health services, 2) Enhance the quality of health services provided through the HEP, 3) Secure sustainable financing and reduce financial burdens associated with HEP services, 4) Strengthen community engagement and empowerment, 5) Ensure resilience by maintaining the provision of essential services during health emergencies, and 6) Foster political leadership, multi-sectoral collaboration, and partnerships [24]. Thus, this study aimed to explore lessons learned from HEPO since its introduction in Shashemene rural Woreda, West Arsi Zone of Oromia region.

Authors consider this the first exploratory assessment after the launch of the HEP optimization roadmap in 2020, and the first five years of the program are due to be completed in a few months; the findings may help the Oromia regional health bureau, as well as the Ministry of Health, to take measures to optimize program implementation.

Methods

Study design and period

The study employed an explorative study design in the Shashemene rural woreda, West Arsi Zone of the Oromia region, from May 22 to June 1, 2025.

Study Setting

Shashamane Zuria Woreda is one of the 15 woredas of the West Arsi zone found in the southeastern part of the Oromia Regional State. The woreda is located about 250 km south of Addis Ababa. The woreda has a total of 37 rural kebeles and is bordered by Shala Woreda, Bishan Guracha town, and Sidama regional state in the south, Negele Arsi Woreda in the west, and Kofale Woreda in the east. The woreda is known to be highly populated in the zone. The total population is estimated to be over 300,000. There are seven functional health centers and 29 community health posts.

Study participant and participant recruitment

The study purposively recruited 40 participants who have a stake in rolling or operationalizing HEP optimization at federal, regional, zonal, wereda, and community levels.

Data Collection and Analysis

Data were collected using a checklist developed in line with the research questions. Twenty-three key informant interviews (KIIs) and three focused group discussions (FGDs) were completed. Key informant interviews targeted leaders and advisors of the HEP at different levels, while FGDs targeted health team members, including village health leaders. Data was collected by a senior qualitative researcher, a native speaker of the local language (Afan Oromo). Data were collected at participants' natural settings, health posts, health centers, and respective offices, which, on average, lasted 1:20 – 1:45 minutes.

The data were transcribed by a research assistant and checked for consistency and completeness. Transcriptions were read and re-read to extract codes that were put into the code book to guide the pulling of codes to themes (Supplement I). Findings were presented in line with the themes, and outstanding verbatim quotes were considered to illustrate the findings.

Data quality assurance

A checklist was developed in relation to the research questions and was further enriched with additional probes during the data collection. During the data collection, consensus was built with participants on the data generated through a debriefing technique. During analysis, additional clarification was sought from research participants who are at the federal and regional levels.

Results

Profile of participants

Forty people who are active at different levels in HEP optimization and with different profiles participated in the assessment. Of these, eighteen were female, twelve were community members, including village health leaders, four were health sector leaders at different levels from federal to *wereda* (district) level, and twenty were frontline health team members, including HEWs, as exhibited in the Table 1.

Table 1
Profile of participants

Profile	Male	Female	Total
Advisors of HEP optimization	4	-	4
Leaders of health sector including HEPO	2	2	4
Members of VHL	4	1	5
Members of health team	8	12	20
Influential community leaders	4	3	7
Total	22	18	40

Theme I: Acceptance and commitment for the optimization

Subtheme 1. Political Commitment and Leadership Support

The federal ministry of health considers HEP optimization as a critical strategy to meet Ethiopia's commitment to Universal Health Coverage (UHC) indicators. In view of this, the ministry believed political commitment and leadership support are critical success factors to roll out the HEP optimization roadmap. Following a participatory approach in the development of the HEP optimization roadmap with an active role of regional counterparts and development partners, the ministry launched the roadmap by the Deputy Prime Minister of Ethiopia in the presence of ministers, regional authorities, and development partners. Regional leaders have shown commitment to facilitate the optimization agenda. One of the participants pointed out that,

"Regions show commitment to implement HEP optimization in line with the regional contexts, including translation of the documents to local language" (KII, FMoH).

The Oromia region followed suit and launched the roadmap at regional and zonal levels, led by key political leaders. It was argued that,

"The HEP roadmap and its details were tailored to local circumstances, emphasizing cultural relevance, and launched by top political leaders of the regional state" (KII, RHB).

Subtheme 2. Resource Mobilization and capacity building to implement HEP Optimization

The Federal Ministry of Health (FMoH) took steps to mobilize financial resources to facilitate the implementation of HEP optimization in the regions. Such an endeavor targeting international organizations and other stakeholders demonstrates commitment to the success of the optimization roadmap. One of the participants at the policy level argued that,

"…the Ministry raised quite a substantial sum of money which is invested to procure medical supplies and equipment" (KII, FMoH).

The ministry has also developed and distributed operational guidelines and training programs to ensure that service provision at health posts is guided and that providers have relevant competence. Participant at the ministry pointed out that,

"*We developed several guidelines and manuals, including quality improvement guide, redefinition of Community Health Information systems, Integrated Refresher Training (IRT), etc., which were shared with the regions"* (KII, FMoH).

Besides, mobilization of resources at the operational level is extensive. In Shashamane, community support for HEP optimization has included non-monetary contributions of goods such as corrugated sheets and cement that were raised during local events organized by zonal and wereda leadership to mobilize resources for HEP optimization activities at the community level.

Despite the expectation of sectors to contribute to the success of the HEP optimization roadmap within the principles of multisectoral collaboration, neither the agriculture, education, nor women's affairs sectors have been found to have a structured contribution to the optimization plan. Yet, it was learned that some of the sectors have indirectly contributed to the success of the health sector. One of the participants at the wereda health office indicated that,

"*Although our public sectors did not contribute in cash or in kind to the HEP optimization, Corridor Development, rural road construction, rural water construction, and electrification attempts by the respective sectors have facilitated the optimization work of the health sector*" (KII, Shashamene Wereda HO).

Theme II: Current state of health extension program optimization

Sub-theme 1. Health Facility Structure

In the Oromia region, 36 Comprehensive Health Posts (CHPs) were built in 2022, while construction of such health posts has increased over the years, with 94, 72, and 48 new CHPs built in 2023, 2024, and 2025, respectively. Currently, of the total of over 600 CHPs, 130 are functional, while nearly 100 Basic Health Posts (BHPs) are built with additional blocks for staff residences. In the West Arsi zone, 49 merged, 43 comprehensive, and 221 basic health posts are currently in operation. By "merged" we mean the existing health post is merged with the nearest health center because of proximity. Shashamene wereda has constructed 2 CHPs, which are currently functional, and one is expected to become operational during the third quarter of 2025. The cost of health posts was found to range from 25 to 30 million birr. The money was mobilized from stakeholders, including the community at different levels. While the health authorities at zonal and wereda levels are worried not only about the fact that

mobilization efforts may not help generate any resources due to fatigue from such demands, there is also the lack of infrastructure and medical equipment, which is not made available even for the functional ones. One of the participants highlighted the concern that,

“There are new health posts currently under construction to meet the goals in the HEP optimization roadmap in our zone. Ten CHPs are expected to be operational starting the Ethiopian New Year in September. Our concern is that they may not function due to the outstanding problems of infrastructure, medical supplies, and equipment. The other challenge is that it may not be possible to mobilize money to construct a health post for a cost of 20–25 million birr. In fact, the number of CHPs at the end of the first five years is still much less than the plan” (KII, health authority).

Subtheme 2. Health service provision

Following the PHC structure, health posts, health centers, and primary hospitals are serving the public with different health services. As such, CHPs refer patients for better services to health centers, and similarly, rural hospitals receive patients from health centers for specialized services. As part of data collection, however, it was realized that there was no clarity at the operational level on referral pathways between health posts, health centers, primary hospitals, and referral hospitals in line with the referral algorithms. At least during data collection, clarity was lacking among the health team, both at the BHPs and CHP levels, in terms of what health services are expected at their level, given the limitations of infrastructure and supplies.

A nurse participant expressed that she was providing comprehensive family planning service, including insertion of Intrauterine Contraceptive Device (IUCD) and implants, post-abortion follow-up and referral, referral management of laboring mother and postnatal care, essential newborn care, Integrated Management of Newborn and Child Illnesses (IMNCI) and EPI, HIV testing and Counseling, and Community Direct Observed Therapy (DOT) for TB, which is not the case here at the BHP level. She explained that,

“Since I came here, I have not been helping people with my profession as I did when I was at the health center. I know even HEWs used to do clean and safe delivery within the health post. Here, I can’t even do that because this health post is empty, as you can see [showing around]. All I can do for a laboring woman is to call for an ambulance, and at times the woman may deliver on the way to the health facility” (KII, Health team, BHP)

Similarly, the health team member at CHP argued that,

“When I was assigned to this health post, I was so happy because I could serve the community much closer. At the beginning, the motivation and encouragement from the local community were amazing. Unfortunately, such hope eventually waned, for I am not serving them as much as they needed since the health post does not have the needed medicines. I do not think I will stay here with the current state” (FGD, Health team, CHP).

The community members have also expressed their frustration with the services at CHP. A participant argued that:

"In this community, we did all we could to see this health post here in our community. The entire community hoped to be relieved to travel as far as about 10 kms to the Hurraa Health Center. Since the Elemo Abiyu health center, which is close to us and used to provide us with health services, was unfortunately clustered under Shashamane town. Thus, our hope was in this health post, which failed to help us. We understand it is not the problem of the new nurse here. We were betrayed, and we voiced our concern, but we were told to wait. How long do we wait?" (KII, community leaders, BHP)

The concern about the closest HC failing to provide health services to its usual clients due to restructuring is the case at two of the sites visited, without exception. Community members argued that,

"Chabi HC, which used to serve seven kebeles, was moved under Shashamane town with two of the kebeles. The remaining five kebeles are now without a health facility. As a result, in addition to the kebele that hosted this CHP, we are serving five more kebeles, and we have to travel more than 13 kms to the Faji Gole HC to seek support, report, and refer clients. This could have been much easier if Chabi HC remained under the wereda instead of restructuring it under Shashamane town" (FGD, community leader, CHP).

In all the visited facilities, service provision was argued to be hampered due to the limitation in medical equipment and supplies at the health post level, mainly the CHP. The FMoH indicated that there are challenges in the timely procurement and distribution of medical equipment and supplies for CHPs. The problem is widely recognized by health authorities at regional, zonal, and wereda levels. However, what such a challenge would mean will not be glaringly clear until one listens to the voices of frontline health team members who explained the problem and its implications. One of the health team members explains that,

"Nothing is more embarrassing than telling your client that the health facility [CHP] doesn't have the medicine your client wants. We have to, at times, cover up by counseling the patient on the health problem of complaint and giving them other medicine that is not effective. We can't continue doing this. People are conscious of our limitations. We are increasingly getting confronted" (FGD, Health team, Gonde Karso).

Concerns over medical supplies and equipment are a common problem in all health posts, for which health centers are blamed for failing to facilitate a timely response. It was argued that,

"We keep sending our request regularly to the health center. While for the last six months we did not get any medicines, the last time they sent us medicine, it was only part of what we requested" (FGD, Health team, CHP).

Participants at the CHP level argued that,

"Health centers obtain medicine from Ethiopian Pharmaceuticals Supply Agency *(EPSA) regularly and additional such supplies from the Dhaabata Biiftu Adugna (DBA) [regional supplier]. It does not seem EPSA and DBA recognize health posts in their distribution plan, nor HCs seem prepared to share 'their' supplies and equipment with CHPs. In my opinion, CHPs are not considered a priority in the procurement and distribution of medical supplies and equipment. Yet, these facilities, particularly CHPs, function more or less the same as health centers" (FGD, Health team, CHP).*

Although 25 medicines are expected to be available at the CHP level, most are not consistently available, while five were not available for a year, and eight were absent for at least a couple of months.

Subtheme 3. Human resources (Health team at the health post level)

According to the roadmap, the staffing pattern follows a phased approach. By 2025, the BHP will be staffed by 2 level-IV HEWs and a nurse. The staffing will expand to 2 family health professionals, a nurse, and an environmental health expert by 2035. Similarly, by 2025, a CHP will have 2 level-IV HEWs, one Health Officer, and one midwife, which will increase to 2 family health professionals, a nurse, one environmental health expert, a midwife, a comprehensive nurse, and one additional health officer in 2035. Despite this, findings show that on average, there were six health team members composed of a health officer, nurse, pharmacist, lab technician, and two HEWs at Gonde Karso and Kore Rogicha CHPs. At the BHP level, six of the thirteen BHPs (Meraro, Culule Habara, Xaxessa Dadessa, Fiji Gole, Odesso Jalo, and Danisa) were found to have one nurse in addition to the two HEWs. All participants, irrespective of how they argue about the challenge, pointed out that the number of health team members is still limited, compelling them to stay within the facility since there is no replacement for each category. So, every staff member is expected to stay at the facility 24/7, irrespective of whether a full-service package is available or not. The argument reveals that:

"I am surprised how those who developed the roadmap have neglected consideration of the number of health human resources needed at the health post level. For each of the service areas, only one expert was planned, who may have completely forgotten the need for a replacement in case one goes on leave, gets sick, or encounters a problem. This compromises consistency of service provision" (FGD, health team, CHP)

Similarly, the health management team felt that the design of HEP optimization has inherent problems,

"The Oromia Civil Service has been allowed to fill in the allowed posts both at comprehensive and basic health posts. However, getting such human resources is not easy. We managed to get whatever number of professionals at health posts, mostly on transfer from health centers. As a result, each of the health posts is operating with limited human resources. Yet, even if we could complete the boxes, it is still one person per area of expertise, which may not solve the overarching problem of the limited number of health teams and consequently compromised consistency of service delivery. Getting professionals from the market was also found to be challenging" (KII, health authority).

Findings show that the health team has to do administrative functions in addition to their routine technical roles, including cleaning, guarding, serving as a receptionist, documenting, and compiling Community-Based Health Insurance (CBHI) in a rotation arrangement. It was found that the community, at times, assists voluntarily in some of the health posts.

“Currently, there is no formal payment structure in place for security and cleaners at the health post. Community members are volunteering their time and effort to provide security services without any compensation. Similarly, the Village Health Leaders (VHLs) and Health Extension Workers (HEWs) have been taking on cleaning duties without payment.” (FGD, VHL, CHP).

Secondly, duty payment schemes for staff members at the CHP level were found to be an outstanding concern. The health team members stay within the health facility through the week and provide services with no replacement; they do not get their duty services paid. The health team complained that,

“Although a staff member accrues a total of 338 duty hours during a month, payment is only for time within the range of 180–198 hours. Even that is not properly recognized and allowed at the national level. The health authorities at the zonal and wereda level tried to help us” (FGD, Health team, Gonde Kerso).

The health authorities argue that the roadmap does not provide legal ground and commensurate guidelines to compensate duty payment for the health team at the CHP level, which may challenge the sustainability of the optimization endeavors. One of the participants pointed out that,

“The health team at CHP cannot receive night duty compensation due to a lack of a clear legal provision. Although there is some money allocated for this purpose by the wereda health office, it is not paid in full and depends on the goodwill of the health center leader, as this may have accountability if an auditor finds it out” (KII, health authority)

The inconsistency of how HEWs are managed and treated at the different health posts was found to be a major concern. While HEWs in the merged and comprehensive health posts are happy for, they consider themselves as members of the health staff of the facility with learning and mentorship opportunities, the health centers that merged health posts are happy to have additional health human resources. One of the participants argued that,

“The fact that HEWs at the health center are now members of our health team means they rotate to participate in most of the curative services within the facility. Since both of them at our facility are now at level-IV and they have demonstrated to be more competent than graduates with a few years of service, they have become an additional workforce for us. At our health center, the current EPI coordinator is an experienced HEW, and she is really very good” (KII, Health authority).

Theme III. Community Engagement and Financing

Subtheme 1. Community engagement

Community engagement at the village level was organized to constitute volunteers composed of men and women, of different ages, who have completed at least 6th grade formal education and are recognized as models in their community, named Village Health Leaders (VHLs). They join voluntarily and receive a six-day training on their roles, which among others is to liaise between the health post and the community, track health-related issues in their village: record death, birth, pregnancy, immunization, hygiene and sanitation-related information, and emerging health complaints. They do home visits and report to the health post every month. VHL are considered

"*Treasured social structures at the community level that have remained to play an important role in keeping community members to support each other*" (KII, health authority).

A VHL is responsible for 80–100 households (HHs). One of the participants reported that,

"Currently, Shashamane wereda has around 300 VHLs with 7 to 24 members in each kebele. They work with local women, youth, men's groups, and Idirs to execute their roles" (KII, health authority).

Village health leaders, who participated in this assessment, argued that they are happy providing such service, although it is not clear how this could continue, given that some of the members are not taking responsibility, and some have to bear much of the responsibility. Furthermore, concerns were flagged by some of the VHLs:

"*We did not get any additional training other than the initial six-day training to improve our skills, nor do we receive any compensation for our continued support to the community and the health post" (KII, Community leader, CHP).*

Subtheme 2. Community health financing

Community health insurance coverage in Shashemene wereda is reported to be 100%. Every household has paid 1710 Birr/year for health insurance. This contribution is meant to cover the cost of health services at the CHP level, while services at the BHP are free of charge. Since community members have paid for their health insurance, they expect to get all forms of health services at any community health post and/or be referred for specialized health care, if that is required based on screening at the CHP level. However, community members were found to have been consistently complaining about the lack of regular health services at CHPs. One of the community participants argued that,

"The health team members are all active, sympathetic, and are always keen to help us within the community. Unfortunately, their effort is limited by a lack of necessary support from authorities. Medicines are often missing, and we are not getting the service we deserve" (FGD, community leader).

Both woreda and zonal health authorities felt that CHP was the first level of contact, by community members, for specific health problems; the health post, however, failed to respond to the health needs of the community. It was emphasized that,

“Community members do not understand our internal bureaucracies, but would like to get health services of interest. A collection of health insurance and getting the authority to procure medicines would have eased the problem and strengthened the credibility of health posts. With the current structure, health insurance is managed by its own structure, on which we do not have any stake” (KII, health authority).

It was further argued that CHPs provide services to clients with CBHI cards from any kebele visiting the CHPs. However, since CHPs do not have budget codes of their own, they can’t procure medicines of common interest in the community. This is found to hamper their operational capacity and affects their service delivery. CHPs often struggle to maintain adequate stock levels of medications and medical supplies. As explained by one of the participants,

“CHPs collect CBHI claims and submit to the Health Center (HC) to procure supplies and provide to CHP. Unfortunately, the HC doesn’t procure and supply in time. This is the cause of service interruptions and compromise quality of services to the community and demotivation of the health team at the CHP level” (KII, Health authority).

The health team in the community complained that community members don’t understand how the primary health care units are structured. For them, visiting the nearest CHP is normal. Although the available health service is provided to the clients irrespective of catchment designation, at times, HCs do not replenish supplies used. One of the participants argued that,

“Community members visit health facilities they thought were the closest. They don’t understand catchment-related bureaucracies. For us in this health post, we provide the service, while getting our claims from the HC is not easy. Such artificial divide affects the relation between the community and the health post on the one hand and challenges us on the other” (FGD, health team, CHP).

In summary, evidence generated from different sources and levels has demonstrated that the rollout of HEP optimization is encouraging despite concerns over the investment the initiative may require. The last four years of operation witnessed that commitment of political leadership at different levels facilitated the mobilization of resources to successfully construct health posts at the community level. It is important as well to recognize that the essential health service delivery kicked off in the functional health posts. The community’s interest and visits to the health posts witness the community’s interest in health services in their village. The community’s growing interest in services and political commitment to the HEP optimization roadmap helped to meet substantial structural plans, while much more remains to be given attention.

Discussion

The HEP optimization roadmap (2020-35) sets out to ensure access and quality of health services at the community level by upgrading health posts, improving the professional mix of health post staff, and enhancing the community health information system, thereby meeting universal health coverage

indicators [25]. The roadmap is expected to mobilize more resources for the construction of the health posts and procurement of supplies, equipment, and furniture on the one hand and deploy more health human resources. Although this is a thoughtful plan to expand service to the community, challenges remain vivid. The short-lived advocacy and commitment by both health and political leaders have helped to create an effective rollout of the optimized agenda to the community level, as well as set shared accountability by political leaders [26], [27]. Such organized advocacy for the optimization of HEP has certainly facilitated the mobilization of support in the form of financial resources, equipment, and supplies from the community, health facilities, and private sectors. Nonetheless, such an effort was short-lived.

The HEP optimization roadmap is taken seriously in Shashamane, where construction of basic and comprehensive health posts is well underway. However, the cost of such construction casts a grim cloud on whether the rest of the weredas in Oromia and Ethiopia at large could meet the cost of constructing health posts and a specialized professional mix [28]. According to the HEP optimization roadmap, equitable access to essential health services is considered critical. As such, depending on how close or distant to health centers, basic or comprehensive health posts were planned to be constructed within the community. While communities with limited or remote access to health centers will have comprehensive health posts, communities with access to health centers will have basic health posts[29]. This is believed to expand service delivery to the community level; presumably, such a constellation ensures continuity of the service delivery.

Primary health care-oriented service delivery is linked and improves health equity, reduces health disparities, and produces better outcomes [8], [30]. The finding, however, reveals that the health team at comprehensive health posts, composed of at least a health officer, nurse, pharmacist, and lab technician, is believed to provide as comprehensive health services as health centers do. This clearly shows either the referral pathways and roles of primary health care units are not clarified in the first place, or the health team at different levels did not get proper orientation on the roles and accountability [31]. Moreover, home visits that were practiced by health extension workers[29] could face diminished attention in areas where comprehensive health posts are located.

Finding unequivocally demonstrated that despite the service they offer, which they believe is as comprehensive as the health center, they were found to be demotivated. Compromised motivation was due to limited opportunity for refresher training and duty payments and failure to meet the expectation of community members for services due to inconsistency in the availability of supplies, medical equipment, and furniture. This is contrary to the commitment of the optimization roadmap to address such challenges widely reported from the HEP during 2003–2019 [7], [32]. Overworking with barely one expert in every discipline, and not being treated the same as those with the same competence, but working at the health center, detracts from the motivation of the health team.

The community’s contribution to health insurance was found to be 100% in all the villages visited, which is encouraging. Community members are happy to have contributed to covering the health service

needs. However, there were two outstanding concerns that community members flagged. Firstly, they cannot get health services in health facilities other than those found within their cluster, and secondly, since comprehensive health posts are not cost centers, the health center responsible for the comprehensive health post does not provide supplies as quickly as desired, resulting in services being interrupted. The authors believe that such problems are unfounded and could have been resolved. Residents close to a health center couldn't access the service since their catchment areas are geographically rearranged, i.e., being artificially placed in another cluster. Similarly, providing supplies regularly from the health center or ensuring that health centers immediately respond to replenishment requests of the comprehensive health post is critical.

Although it is useful to clarify the basic rubric of community engagement in connection to health extension program optimization, it was interesting to find a functional team at the village level with the title of "village health leaders." They joined voluntarily and have basic minimum criteria to serve as such: a sixth-grade formal education, demonstrable role as a model in the community, and interest in serving voluntarily for two years. Their role is to mobilize the community for prevention activities and document any health event, including emerging epidemics, to report to the health post every month. Addressing their training needs and keeping them motivated is crucial for strengthening the community health program. The engagement of other development sectors at the community level was not visible, with a clearly defined structural alignment of their efforts. This is a critical limitation for primary health care services, where multi-sectoral collaboration is believed to have a multiplier effect for success [7].

Conclusion

The evidence reveals that the implementation of HEP optimization is well underway despite concerns about the continuity of political support that may facilitate successful expansion of PHC services to the community, on the one hand, and multi-sectoral collaboration for improved access and quality of services. Besides, it is critical to ensure staff demotivating factors are addressed and community health workers (VHL) are kept supported and motivated. It's also essential to continue home visits as a foundational element of the health post activities. The health teams at the health post level should be treated the same way as those in the health center. Furthermore, ensuring the availability of supplies, equipment, and furniture at the comprehensive health post is critical. Finally, it is useful to strengthen the community's trust in the health structure, allowing holders of a health insurance card to access services in any primary health care unit by addressing structural barriers.

Abbreviations

BHPs (Basic Health Posts); CBHI (Community-Based Health Insurance); CHPs (Comprehensive Health Posts); EPSA (Ethiopian Pharmaceuticals Supply Agency); FMoH (Federal Ministry of Health); FGD (Focused Group Discussion); HC (Health Center);); HEP (Health Extension Program); HEPO (Health Extension Program Optimization); HEWs (Health Extension Workers); HHs (Households); IUCD (Intrauterine Contraceptive Device); Device);IMNCI (Integrated Management of Newborn and Child

Illnesses); KII (Key Informant Interview); MDGs (Millennium Development Goals); PHC (Primary Health Care); Care);RHB (Regional Health Bureau); UHC (Universal Health Coverage); VHLs (Village Health Leaders)

Declarations

Ethical approval and consent to participate

The study was conducted in compliance with the protocol and local authority ethical standards in public health research. The protocol is designed to ensure adherence with the ethical principles of the Declaration of Helsinki for ethical conduct of such studies. Accordingly, ethical approval for this research was granted from the ethics review board of the Oromia regional health bureau under protocol number BFI/HQ/227/17. During data collection, participants were briefed on the purpose of the study, the right to decline participation, ask for clarity on the purpose as well as the process etc. The participants were informed that participation was voluntary and that they could withdraw from the study at any time without providing a reason. They were also informed that their answers would remain confidential and that identifying information would not be added to transcripts or the report. All the participants agreed to have the interviews recorded and provided written informed consent before data collection begins.

Consent for Publication

Not Applicable

Data availability statements

The datasets used and analyzed in the current study are available upon request from corresponding author

Competing Interests

The authors declare no conflict of interest

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Authors Contributions

MK, GM, and KS designed the research, developed assessment methods and tools. MK and ST have collected and analyzed the data and drafted the manuscript. MK, GM, and KS reviewed the tools, methods, and draft while MK finalized the manuscript

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