Working on Fostering Community Engagement Towards Achieving Universal Health Coverage in Ethiopia

The Federal Ministry of Health
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Acronyms

AEW	Agriculture Extension Workers
ARI	Acute Respiratory Infection
BMGF	Bill & Melinda Gates foundation
CBNC	Community Based Newborn Care
CBDDM	Community Based Data for Decision Making
CHW	Community Health Workers
CSO	Civil Society Organization
EPHI	Ethiopian Public Health Institute
FHG	Family Health Guide
FMOH	Federal Ministry of Health
HDA	Health Development Army
HEP	Health Extension Program
HEW	Health Extension Workers
ICCM	Integrated Community Case Management
IIfPHC – E	International Institute for Primary Health Care - Ethiopia
JSI	John Snow, inc.
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millennium Development Goals
MOE	Ministry of Education
MOP	Ministry of Peace
MNCH	Maternal, Newborn, and Child Health
MWH	Maternity Waiting Homes
O-HEP	Optimizing the Health Extension Program
SBCC	Social and Behavior Change Communication
SNNPR	Southern Nations, Nationalities, and People's Region
PHCU	Primary Health Care Unit
RHB	Regional Health Bureau
SDG	Sustainable Development Goals

UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
WCA	Women's Collective Action
WDA	Women's Development Army
WDG	Women's Development Group
WHO	World Health Organization

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On June 14, 2019, the Federal Ministry of Health invited public health professionals and researchers for a workshop to discuss community engagement and participation within Ethiopia's Health Extension Program. As the nation's flagship community based health program, the HEP has been instrumental in providing affordable and accessible health services to Ethiopia's rural population. Since its implementation in 2004, HEP has expanded primary health care coverage, transferred health knowledge and skills to the household level, and improved multiple health indicators leading Ethiopia to meet many of its health related millennium development goals. Community engagement and participation are pillars of the HEP and crucial to its continued success. Participants of the forum gathered to evaluate the sustainability of current community engagement platforms and weigh options for a way forward.

Section I: Introduction and Historical Background on Community Engagement

Dr. Hibret began the workshop by outlining the day's purpose and objectives. He highlighted Ethiopia's historical achievements in meeting health related MDG targets and the HEP's role in improving health outcomes throughout the country. Now, Dr. Hibret stressed, Ethiopia is at a critical and defining moment where the continued improvement of health depends on an evaluation of community engagement strategies.

Opening speeches continued with Dr. Yekoyelegn, Director General of the FMOH, providing brief remarks. He called for a more robust regulatory system, social accountability, intersectoral collaboration, and greater public-private partnership. He also urged for an urban community program, because the urban has become exemplary to the rural. Finally, he challenged the understanding of what it means for a community to be engaged. He explained that community engagement is tied to information, that is a community is not engaged until it has accurate and timely access to information. In addition, community members are fully responsible. Although community engagement in HEP has been good so far, greater progressive information is necessary.

Next, Dr. Hailom Banteyerga began his presentation entitled: The Historical Background of Community Engagement in Health – Ethiopian Context. Dr. Hailom viewed Ethiopia's commitment to primary health care and creation of the HEP through the lens of global trends in health theory. Worldwide, there was a transition from human security to health security. The Ethiopian People's Revolutionary Democratic Front, led by Prime Minister Meles Zenawi, brought a human centered approach to Ethiopia's health system. Many doubted whether the HEP could unload Ethiopia's health burden, noting the lack of curative services offered in the packages. However, HEP not only cultivated strong community engagement but also fostered community empowerment. Dr. Hailom highlighted that the key ingredient to Ethiopia's success was strong political commitment from the highest level of government to the lowest. In addition, Dr. Hailom emphasized, community engagement requires strong political security. However, Dr. Hailom highlighted that HEP had faced some challenges in improving maternal, newborn and child health. In order to further strengthen HEP, the structural arrangement of the Women Development Army was introduced.

Section II: Women's Development Army

Success and Challenges of the Women's Development Army

Next, Dr. Fisseha Ashebir gave a presentation entitled: Community Engagement in Public Health: The Case of WDA Experiences from Ethiopia and Experiences from Other Countries. Dr. Fisseha began by recognizing the importance of community health workers (CHW) for achieving universal health coverage (UHC) and the Sustainable Development Goals (SDG) outlined in 2015. Thus, investing resources into CHWs and integrating them into Ethiopia's health system is paramount. Knowing this, in 2010, the Ethiopian government established the Women's Development Group/Army to support the program and encourage community ownership. While trends show that WDG has improved achievements in maternal and child care, the FMOH has recently reported that less than 19 percent of 1 to 5 networks are functional. Since 2015, the performance of WDGs has also been declining. Dr. Fisseha's literature review aims to act as evidence to fuel progress towards community engagement as a means to achieving UHC.

Dr. Fisseha's research showed four major successes of the female-centered approach. First, WDGs provided better dissemination of sexual and reproductive health messages for women. Secondly, WDGs helped increase health service utilization by identifying and linking pregnant women to skilled delivery sites. Thirdly, the inclusion of the WDG increased the participation of married women in HEP. Fourth and finally, women more freely discussed health issues with the WDG, improving communication.

On the other hand, challenges also persist. Namely, motivation for the WDG remains low. Members exhibit poor training conduct such has developing training manuals late and holding irregular training sessions. There is little to no supervision and feedback. In general, the lack of incentives (financial or otherwise) and recognition mechanism has led to low motivation. In addition, there are challenges related to the structure of the system. For one, there are multiple names to describe the group of women completing the same function: women's development army, women's development group, health development army, and so on. This incoherency causes confusion. Another example is the fact that these groups have trouble reaching all parts of the community, and many are left without a WDG at all. Another challenge the research raised is that, with WDA leaders engaged with multiple sectors, there is a lack of clarity as to who is responsible for leading the group. Additionally, WDG members perform a heavy burden of work daily, without pay. This in turn, affects their social and economic status.

Based on their findings, Dr. Fisseha and his team make a number of conclusions and recommendations. First, they recommend a mixed gendered group that includes female adolescents, youth, and adults as well as male youth and adults. Another recommendation is to develop a community health strategy that clearly defines the roles and responsibilities of the WDG. Also, the government should design a motivation package based on altruism (feedback given in front of supervisors, recognition ceremony) as well as intrinsic (regular training and

feedback) and extrinsic (salary for minorities and rural workers) motivation. In addition, there must be a career progression members of the development group can look towards.

Evaluation of Women's Development Army Implementation

The next speaker, Dr. Alula, presented his national assessment on HEP. He used a systematic synthesis of previous studies, primary qualitative and quantitative data, and evidence to both determine the state of HEP and identify the factors related to that status. The research was conducted across all regions in agrarian, pastoralist, and urban communities with over 13,000 individuals, 7,000 households, and 344 health posts from 64 woredas. After analyzing these and over 310 interviews with key informants at all levels of the health system, researchers walked about with enlightening evidence. First, the existence of community structures supporting the HEP varied between agrarian and pastoralist populations. For example, 96 percent of agrarian communities have WDAs or at least one 1:5 network as compared to 44 percent in pastoralist communities. Though the latter is bolstered by social mobilizations committees, pastoralist communities are more likely to have no community structure for HEP as compared to agrarian communities. Moreover, the functionality of these community structures varies between agrarian and pastoralist communities. For instance, 83 percent of agrarian communities have at least one functional WDA or 1:5 network whereas pastoralist communities have just 40 percent. Another key findings regards the educational attainment of the members of WDAs, of which 68 percent have no formal education compared to 75 percent of nonmembers.

This finding led Dr. Alula to ask the questions of how different, in fact, are members of the WDA from nonmembers in terms of their health behaviors and health outcomes. On child health indicators, both WDA members and non-WDA members achieved comparable levels of health seeking behavior for children with Acute Respiratory Infection (ARI) and diarrhea. On family planning and maternal health services, non-WDA members had similar levels of knowledge and use of modern family planning methods to WDA members. In addition,both WDA members and non-WDA members had similar rates of birth at home and health posts, with the latter exceed the former in percentage of births at health centers. In conclusion, these findings prompt further investigation into the role of WDAs as health information sources and the health impact of functional WDA structures on HEP implementation. Upon completion of the data analysis of this research, Dr. Alula expects to make qualitative conclusions on the role of WDAs in implementing HEP, the perception of community members on WDAs, and the WDAs own reflections on their role in the program.

Section III: Optimizing the Health Extension Program

Optimizing HEP by Mr. Bizuhan

The final presentation was given by Mr. Bizuhan on the O-HEP initiative, which focuses on addressing critical demand bottlenecks and increasing the use of community based newborn care (CBNC) and integrated community case management (ICCM) of childhood illness. Led by Bill and Melinda Gates Foundation (BMGF), UNICEF, PATH, and the London School of Hygiene

and Tropical Medicine (LSHTM) and implemented by JSI/L10K, Save the Children, EPHI, and four universities in Ethiopia, O-HEP addresses the issue of low ICCM/CBNC service uptake at primary health care units (PHCU). Through a barrier analysis conducted in four region and an FMOH led stakeholders consultative meeting, the initiative made key findings, developed a theory of change, and created an intervention package.

The barrier analysis revealed both demand and supply side barrier towards ICCM/CBNC uptake. On the demand side, barriers include: misconceptions and myths related to childhood illness and cause of disease; lack of awareness of ICCM/CBNC services; preference for traditional healers or home remedies; perceived poor quality service and capacity of HEWs; cost of care and distance; existence of religious and traditional beliefs discouraging health seeking behavior for newborns; and a lack of adequate knowledge and skills. Supply side barriers include weak ownership of ICCM/CBNC programs, service interruption, drug stock-out, the limited skill and confidence HEWs have in treating newborns, and the lack of appropriate renovation in health posts.

The theory of change suggests that a combination of community education and mobilization, capacity building, and ownership and accountability interventions will create greater awareness, training, and integration. This in turn, will result in improved child health practices at the household and community level, improved availability of quality ICCM/CBNC services, and improved ownership and accountability of such programs. The outcome, then, will be the increased use and coverage of high impact CBNC and ICCM, which will contribute to the reduction of under-five mortality. This all rests on four key assumptions. The first is that multi-sectoral political commitment at all levels will support project interventions. Secondly, that there will be strong coordination and partnership among stakeholders at all levels. Third, that community influences such as traditional healers and religious leaders will promote the proposed services. Finally, that the public sector and supply chain partners will ensure drug and service availability.

Some of the interventions themselves include the following:

Community Education and Mobilizations

- Health Post Open House
- Engaging Agriculture Extensions Workers (AEWs) to reach male partners
- Engaging School Communities
- Engaging Religious and Traditional Leaders
- Projecting Health Videos, Radio Spots, and Programs
- Providing Low Literacy tools (books, posters, brochures)
- Support Community Based Data for Decision Making (CBDDM) and level one training to strengthen WDA

Capacity Building

- Provide ICCM/CBNC training to fill in gaps
- Print and provide ICCM/CBNC register and chart booklet to fill gaps

- Strengthen HEWs outreach services

Ownership & Accountability

- Advocacy meetings with decision makers and influential bodies
- Integration of ICCM/CBNC
- Community forum with kebele community leaders/stakeholders
- Biannual kebele community feedback meetings

The intervention was phased-in within a two-year period, and several key lessons and recommendations for scale-up were made. The first lesson is the importance of government ownership and leadership, as an up-close, good working relationship between the FMOH, the Education Bureau, and mass media agencies made all the difference. The second lesson is the need for continued engagement to improve quality of care in order to alleviate provider and facility side challenges. Third, the researchers recommend holding community engagement activities using available opportunities. The fourth recommendation is innovation for projecting health. For example, using maternity waiting homes (MWH) to deliver health messages, as mothers send a lot of time there already. Fifth, the researchers recommend using schools as a site to promote health. For example, establishing health clubs to send messages to school children or engaging teachers on the family health guide (FHG) messages. Finally, O-HEP showed that key Maternal, Newborn, and Child Health (MNCH) service utilization improved at the PHCU level, and this is with final evaluations still coming from LSHTM.

Among their key findings, discussions at the forum highlighted the following. First, multi-sectoral community mobilization and engagement of non-health platforms were raised as promising approaches for service promotion. Also, the name change of the HDA to the WDA caused fatigue, lack of attention, and poor functionality at all levels. In addition, the mandate for WDAs and their role in supporting health activities at the community level must be made clear.

Section IV: Group Activity and Presentations

Following individual presentations, the workshop continued by randomly assigning participants to groups to discuss issues related to community engagement in HEP.

<u>Group 1: Selection Criteria</u>

Group one was tasked with outlining what criteria should change as qualifications for CHWs. First, they identified who they are concerned with for this activity. They identified CHWs as any entity under the HEW. This includes the HDG, women development leaders, 1:5 and 1:30 network leaders. They recommend that qualifications for CHW should be local context specific, and thus members of this group had differing ideas of what qualified for selection criteria. First, some suggested that all persons above 18 years old should be eligible. Other members noted that 10 to 14-year-olds do not have a platform on which they can discuss health issues, and because engaging the youth for health purposes is important, there should not be an age criteria. Members also suggested that WDG members should be over 36 with experience.

In terms of educational attainment, the group agreed CHWs should have completed grade 4 and are literate. They decided that community leaders must select and accept all CHWs. In terms of gender equity, the group explained that while it is understandable why the current model focuses on female health workers, engaging men can also be beneficial, especially in pastoralist communities. For criteria concerning personal attributes and values, selected individuals should be willing to serve as leaders.

In terms of structural changes, the group suggested the inclusion of religious leaders, social groups such as *eder*. This idea of changing the HEP structure to fit the multisectoral idea and adding a lower structure below the HDA. The group also suggested that the concentration of these criteria should be on the 1:30 network rather than the 1:5 network. Most important, the group emphasized, selection criteria must be able to adapt to local contexts.

Group 2: Scope of Work

This group focused on the scope of work of HEWs as it is currently and any recommendations for change. The participants listed the scope of work in seven categories: information, care, data recording/reporting, tasking sharing, target population size, CHW's service linkages with essential health service package, and leadership and coordination. The group listed these activities as HEW's current scope of work.

Information:

- Pregnancy care, newborn and child health, hygiene and sanitation, nutrition, PNC
- Community mobilization
- Coordinate and mobilize the community construction of communal latrines
- Health education
- Distribute Social and Behavior Change Communication (SBCC) to FHG

Care

- Early identification of pregnancy
- Organize meetings with members
- Household visits
- Facilitation of ambulance service
- Birth notification
- Linkage of households with HEWs
- Referrals

Data Recording and Reporting

- Update CBDDM (surveillance of health status of households under their jurisdiction)
- Verbal reporting on health status of households

Task Sharing

- Provision of limited information

Target Population Size

- 1 to 80 (which is not in compliance with the 1 to 30 networking scheme)

CHW's Service Linkages with Essential Health Service Package

- Health promotion and education

Leadership and Coordination

- Chair meetings
- Grade members
- Political leader (leader of women league)
- Collect contributions (tax, grain, etc.)
- Engage in education, agriculture (animal and fish), women and children affairs
- Savings
- Oversee 1:5 networks

Then, after deliberation on the challenges HEW's face with their current scope of work, the group came up with recommendations that could unload their burden while also providing more comprehensive health services.

Information

- Provide information to HEWs about the community and convey key messages
- Good communication and facilitation skills

Care

- Identify danger signs
- Essential Newborn Care
- Postnatal Care
- Provide cooking demonstrations
- Screen for malnutrition
- Provide pre-facility emergency care
- Follow adherence to treatment

Date Recording and Reporting

- Simple recording and reporting (pictorial)

Task Sharing

- Health promotion
- Identification of target groups for difference services
- Referral linkage

Target Population Size

- Scattered areas: 1 to 10-15
- Dense areas: 1 to 30

Leadership and Coordination

- Facilitation skills
- Role models

The group made a final remark that though multisectoral collaboration is important, the health sector should organize its own community structure so that it is committed to health activities only.

Group 3: Training

Group 4: Organizational Structure, Governance, and Support Systems

This group focused on four topics related to organizational structure, governance and support systems, outlining the current situations and brainstorming recommendations for improvement.

Current Situation:

Organization and Leadership

- Nationally lead by multi-sectoral steering committee (WCA, MOP, MOH, MOE)
- Steering committee led by the WCA state minister, technical committee where HEP director is represented which reports to the steering committee, and a director at minister of WCA that organizes associations structures
- Regionally, there is a women's association which serves as the secretary for the steering committee
- Kebele members leads at the kebele level, women's affair/HEW is secretary led in SNNPR and Tigray and health sector led in Amhara and Oromia
- Political party leaders are involved at all levels to play a coordination and oversight role, leading the public to believe the program is politically heavy

Support System

- Irregular, inadequate, and disintegrated
- On a quarterly basis, the steering committee supervises the WDA teams in the Me'erab Azerent according to the standard
- When they face resistance, they refer to the health post and they are handled by the HEW or people from the administration or higher level
- The HEW provides some incentives by their own (at the PHCU and woreda levels)

Planning and Reporting

- Report is submitted to the kebele manager and also the health sector
- Plan multi-sectoral activities

Performance Review

- Performance of the WDA is appraised by visiting the households (each household of the networks), verification
- HEWs give WDA leaders feedback

The group made the following recommendations in response to the current situation.

Organization and Leadership

- Steering committees should continue to lead
- There should be accountability and performance appraisal, a clear line of accountability, and a platform that involves all Civil Society Organization (CSO) at all levels to ensure social responsibility
- Steering committee should be responsible for recruiting and organizing women and other community members while the CSO provides oversight and monitors the group's performance

- There must be a community engagement strategy that clearly indicates how CHWs are managed and what role they play in community engagement
- Support System
- Supportive supervision should be integrated across sectors
- Referral System
- Should be linked with hospitals
- Planning and Reporting
- Planning exercise should also involve all sectors
- Performance Review
- Joint Reviews of the performance (through multi-sectoral approach)

Group 5: Motivation Mechanisms and Career Pathways

The final group focused on the motivational mechanisms and career pathway options that are currently imbedded in the HEP. Like the other groups, this one listed recommendations to improve this aspect of HEP.

Current Situation:

- Questionable social perception of WDAs impacting their acceptance in the community (marital status, socioeconomic position, lack of political neutrality)
- Majority are not functional and unmotivated, though there are some with altruistic motivation
- Most WDAs are not well trained
- Lack of performance management and decision making/ punishment
- No clear pathway for promotion (who becomes a 1:30 leader)
- No clear classification of roles – everyone has similar responsibilities
- Huge burden on WDAs that impact their livelihoods (meetings take too long and are not effective)
- Supervision and training is at kebele center, which is distant
- No recognition mechanism in place – they are taken for granted and when recognition is done, there were no criteria used with unintended consequences
- Some areas have experiences of social recognition event (e.g. in Tigray)
- Other social networks not well engaged in health activities (traditional leaders, Eders, etc.)

Recommendations

- Systematic approach needed for motivation and career pathway
- Engage and strengthen KCPs kebele leadership, supervision, and recognition
- Clear structures and lines of accountability including relationships between and with other community groups and structures
- Role of HEWs and other sectors in supporting them
- Explore in-service training packages for WDAs, availability of tools and job aids
- Set standards for meetings and timelines, frequency and location (e.g. meetings guides for effective sessions already available)

- Building the community health workforce as politically neutral or impartial
- Need community level recognition which is systematic (engage men, their husbands where they are supported and recognized by their own with family)
- Create bonds between WDAs in order to establish teamwork and build status (e.g. mahaber for WDA only, but similar uniform for their mahaber (HEW included)
- Free health insurance at least for 1:30 and fees
- Ensure they are compensated for their service and time (in-kind incentives) and social contract as part of the package (e.g. debo-mares)
- Lower level tasks shifted from HEWs – standards for each level in line with experience, performance, and service
    - Level 1 – all
    - Level 2 – after 8th grade (HAD team leader/supervisory role and other services)
    - Level 3 – after 10th grade (HEW)

Section V: Options Going Forward and Closing Remarks

Dr. Sintayehu

After group presentations, Dr. Sintayehu, an advisor at the FMOH, gave brief remarks. He began by supporting the underlying thread of the workshop, that is multi-sectoral collaboration. Multi-sectoral collaboration is crucial, he said, because health problems are often a result of non-health root causes. Meeting the MDGs and SDGs requires an investigation of the social determinants of health. Even though an indicator may be sector specific, the intervention required is often multi-sectoral. Dr. Sintayehu used the example of school dropouts, which on the surface seems like an issue only for the MOE, but the causes of dropouts can be linked to disease outbreak, drought, or child marriage, and solving these issues requires collaboration from multiple health sectors. Community diagnosis, then, is the first task of any intervention. Such a coordinated effort is necessary to achieve effectiveness and efficiency. Dr. Sintayehu warned against looking at issues through a narrow lens. Community engagement in itself, he warned, is a provider-side perspective. He challenged the group to look at the demand side of all problems. Finally, Dr. Sintayehu brought to the group's attention the fact that macro-level achievement such as economic growth may not reflect in the micro-level realities of people's lives. Thus, we must always dig deeper and look more holistically at the issues we are trying to tackle. He final takeaways also related to the day's reoccurring mentions. First, political commitment does not mean a project is politically leaning. We must find a way to communicate and pursued members of the community that government involvement is not a inherent indicator of politics. Second, he reminded the group that interventions must be customizable and modifiable, always. Finally, Dr. Sintayehu emphasized that multisectoral collaboration does not mean sectors do each other jobs for one another, but that collaboration where appropriate makes all the difference.

Options for Organized Community Mobilization Approach

In closing, Mr. Temesgen, HEPHCD Director at the MOH, led the workshop through a final exercise. He listed four options for how community mobilization should move forward, and in light of today's discussion, participants explained which one they would recommend.

Option 1: Continue WDA Approach with Modification

Option 2: Re-Design Independent Community Structure and Activate Ground Level Multisectoral Platforms

Option 3: Continue with the WDA Approach

Option 4: Create a New Proposal

Most participants opted for the first approach, modifying the existing structure to address key issues. They preferred this because the HEP has largely been a success, and disrupting the scheme could prove more detrimental than making slight adjustments. The importance of continuity was raised as an argument for option one, suggesting that the international attention HEP has received is too great to completely uproot the structure.

Some participants, still, favored option two because they believe the existing challenges are fundamentally an issue of how HEP is designed. To address this, HEP's structure must be changed from the ground-up.

In conclusion, Dr. Hibret restated the mission of the day's workshop, which was to grapple with the question of whether the current structure of HEP can provide and sustain health for Ethiopia's population. Multiple concerns and ideas were raised, and although they did not always agree with each other, participants concluded that the HEP at all levels must be aware of the local context and interventions must always be context specific.

Section VI: Questions Raised

For each presentation, participants raised several questions and made relevant comments. Due to restricted time, not all questions were answered. Nevertheless, they are worth mentioning and keeping in mind for the future.

Historical Background, Dr. Hailom Banteyerga

1. We have come a long way to create community awareness. Which action do you think we should strengthen and follow up at this point? In other ways, what is Ethiopia's best way forward?
2. Does the HEP structure work for all settings?

3. What is the likelihood of forming incentives for WDAs?
4. Have we built on the past community structure prior to HEP or replaced it?
5. What was the health professional view of community health in the past and what is it today?

Dr. Yekoyen Worku

1. Should we think of the business concept of health?
2. What is the difference between community engagement and community empowerment?

Women's Development Army, Dr. Fisseha and Dr. Alula

1. The Amhara region has high functionality due to the existence of community based health insurance. How is CBHI and functionality related? How is functionality measured?
2. What is the functionality at the household level?
3. What is the knowledge and skills of HDA members and ordinary households?
4. Why are HDAs delivering at home?
5. How do we define functionality?
6. What is the linkage between HEWs and WDAs? There should be a systematic analysis, and a linkage where if HEWs perform well, WDAs perform well, too.
7. What are the indicators of functionality?

O-HEP

1. Do religious platforms and other traditional platforms have the influence necesary? Are they hindering progress or are they advantageous? What do the study show in this regard?