Facilitating accessible community-oriented health systems: the Health Development Army in Ethiopia

A new force in health development

Ethiopia has achieved remarkable improvements in reducing maternal and child mortality. A major strategy that led to this was the establishment of the Health Extension Program, which has led to the training and deployment of community-based primary health care (PHC) staff in the form of health extension workers (HEWs). However, rural health care coverage in the country remains poor. The work of the HEWs has been challenged by vast catchment areas with highly dispersed populations.

Major health reform plans have focused on strengthening local PHC systems. Thus, a new initiative was launched in 2010/11, comprising community volunteers known as the 'Health Development Army' (HDA). While similar to community health workers (CHWs) in other low- and middle-income countries (LMICs), these volunteers (primarily women) differ in that they are 'multi-purpose', and are not formally integrated within the health system. In addition, their activities are often seasonal and time-limited. Most importantly, they see themselves as representatives of their communities, rather than the health system itself.

The initiative is now estimated to involve some 3 million women, who promote the uptake of key programmes by mobilizing the population and supporting the HEWs. The model reflects the government's vision to devolve responsibilities for health to individuals and local communities. There is an intention to professionalize selected HDA leaders so that they will become HEWs. The overall aim is to improve the motivation of community-based staff and ensure that PHC involves individuals at the grassroots level. The results from pilots of this initiative in 2016 in the woredas (districts) of Tigray and Oromia were reported to be successful.

The Oromia qualitative study

The project explored the role of the HDA in Ethiopia as community volunteers, service providers and intermediaries between the population and the health system. It asked: Faced with scarce resources, can community health volunteers make a meaningful contribution to the appropriateness and acceptability of health services, improved access, and greater uptake and, if so, under what conditions and how can their contribution be optimised?

An exploratory qualitative study was carried out between 30 June and 7 September 2016 in the Jimma zone of the Oromia region, one of the first locations to implement the HDA programme. Three districts were selected, aiming to capture diverse health system performance and population characteristics. The study comprised:

- 17 focus group discussions with community members and HDA leaders
- 34 semi-structured and key informant interviews with HEWs, managers and policy makers
- video diaries (using Videovoice) with 28 HDA volunteers, providing authentic narratives of their experience
- a systematic literature review of the role of community health volunteers (CHVs) globally.

Emerging themes

The analysis revealed the following themes relating to HDA governance and the HDA contribution to community-based PHC.

HDA governance and contribution to PHC

The HDA (working in synergy with HEWs and PHC management teams) places significant emphasis on improving the health and wellbeing of community members. Being involved in health, education, agriculture, financial support and 'peace-keeping', the HDA constitutes an excellent platform from which to enhance the implementation of key principles of PHC: equity, community participation and intersectoral action for health, among others.

Despite the top-down nature of the HDA initiative, we found strong participatory focus and interaction between actors at the community level, reinforced by existing and traditional mutual help arrangements within communities.

The examination of the organizational and structural arrangements in the HDA revealed a highly organized and well-functioning system of one to five groups (led by a leader) which support effective implementation of Ministry of Health and woreda-led programmes.

We found that the HDA volunteers are effectively organized, with clear lines of interaction with the PHC system in their communities. The volunteers gain skills and capabilities as a result of twinning with the Health Extension Program, with regular bi-weekly meetings, joint planning and implementation of essential programmes. This in turn enables them to execute and support a wide range of activities, including education and communication of health-related messages, mobilization of communities (supporting clinical activities such as immunization), referral to health facilities, problem solving, representation of communities, serving as liaison points between formal and informal structures.

Volunteers also benefit from exposure to existing community-based self-help programmes such as Idir, Ikub, Dado and Afosha, many of which are informal and reflect long-standing traditions. A strong attribute of the volunteer programme in Oromia is a reasonable level of cohesion between the volunteers, as well as between the volunteers and their communities. Their multi-purpose profile opens up a pragmatic opportunity for intersectoral action, which is facilitated by trust from the community and a clear linkage to formal administrative, health and political structures.

The mechanisms employed by the volunteers to discharge their responsibilities include persuasion, linkage/leveraging with other groups and enforcement and modelling to influence others.

Key messages

- HDA volunteers have significant potential to improve access to PHC in Ethiopia, and support the work of the HEWs in a context of vast catchment areas and dispersed populations.
- HDA volunteers are 'multi-purpose' and cohesive, enabling community participation in improving their health and wellbeing in a holistic manner.
- HDA volunteers are not institutionalized into the health system; they regard themselves as community representatives.
- Barriers to the success of the initiative include illiteracy, lack of training, resources and time, some opposition from local communities, poor supervision and weak collaboration between some sectors.
- Overcoming these barriers would involve a management and human resource policy rethink. This is particularly critical given the plans to professionalize key HDA leaders to develop their capacity and become HEWs.
- Urgent research in more than one region is needed to capture geographic variations in operating practices among HDA volunteers and identify context-specific strategies and opportunities.

Challenges and gaps

The key areas in terms of barriers to success include the fact that many HDA volunteers are illiterate, and lack assertiveness and confidence. They receive little training beyond that supplied by their local HEWs. Volunteers face both a lack of practical resources (e.g. basic stationery and leaflets) and a lack of time to conduct the full range of activities they are expected to deliver. In some cases they experience opposition and insufficient cooperation from families and communities.

There is somewhat weak supervision and a lack of clear guidance at the district and kebele (neighbourhood) levels, along with gaps in terms of leadership skills throughout the system. Despite some strong examples of effective collaboration, in some cases there is duplication, and stated aims can come into conflict, as a result of an inability to always achieve 'joined-up working'.

Finally, while formal policy is conveyed in a consistent manner, there are variations in the way HDA volunteers operate between geographic areas, which highlights the importance of local tradition, community leaders and the strength of the HEW programme.

Future outlook

Investment in the management capacities of woreda health offices, health centres and health posts will significantly improve implementation of accessible PHC. The HDA offers significant potential when building PHC systems, provided that there are effective management practices and feedback loops (from communities to regional/national level) in place to refine policy.

While the HDA initiative has much positive potential, it may require some rethinking in terms of broader system-related issues, such as the PHC delivery models, human resource training, supervision and motivation. A crucial research need is to understand what impact management structures, communication systems and, crucially, the fostering of trust within individual communities, all have on the HDA's work. It is also essential to fully understand the extent to which the Army's work reflects the priorities and values of the communities it serves.

The HDA plays an important role as a service provider and an intermediary between the community and the health system. The study suggests that HDA volunteers have significant potential to improve access to PHC, but more benefits can be gained by strengthening routine supervision of HDA leaders, introducing guidelines and protocols, providing suitable materials to support HDA work (in particular visual aids), and promoting better collaboration between sectors.

This work has demonstrated that intersectoral models can work at grass roots level but that they require commitment to intersectorality at higher levels of administration as well.

Further reading

Please contact Prof. Woldie (mirkuzie@yahoo.com) and Dr Dina Balabanova (dina.balabanova@lshtm.ac.uk) to request project papers and presentations.

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