TECHNICAL BRIEF

An Evidence-Based Participatory Process to Inform Policy Decisions and Re-Design Community Engagement Strategies

INVOLVING COMMUNITY MEMBERS, HEALTH CARE WORKERS, AND POLITICAL LEADERS IN DEVELOPING SOLUTIONS

ABSTRACT

PROBLEM: Ethiopia's community engagement strategies have been associated with impressive achievements in improving access to and use of primary health care services aligned with the millennium development goals (MDGs). However, progress has slowed due to increasing demand from the community, coupled with demotivation and attrition of community health workers.

APPROACH: The Ethiopian Ministry of Health (MOH), with support from the Last Ten Kilometers (L10K) project implemented by JSI Research & Training Institute, Inc., orchestrated a participatory, iterative process to optimize community engagement approaches comprised of evidence-based advocacy, policy dialogue, and co-creation sessions that culminated in two policy options described in this brief. Human centered design principles were used to understand stakeholder desires and contexts and to co-create alternative approaches.

LOCAL SETTING: In rural Ethiopia, the woreda (district) is the lowest government structure with an average population of 100,000 people residing in about 20 kebeles (villages). The woreda health system is composed of one primary hospital and four primary health care units (PHCUs), which include four health centers and 20 health posts and serve about 25,000 people. As part of the Health Extension Program (HEP), each health post is staffed with two health extension workers (HEWs) who deliver packages of primary health care services to the people living in a kebele. Based on the diffusion of innovation theory, the HEP was designed to train model households that practice the HEP and share their skills and knowledge with other households in the community to bring them to model status. To produce model households at scale, the government introduced the Women's Development Army strategy in 2011, through which women are organized and mobilized in groups that work in tandem with HEWs to motivate each other to adopt and practice healthy behaviors.

RELEVANT CHANGES: The beneficiaries and implementers of proposed HEP interventions played a major role in designing the interventions. The process involved various stakeholder groups ranging from community members to the high-level political leaders.

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LESSONS LEARNED: The iterative, participatory, evidence-based advocacy and policy dialogues were crucial to achieve stakeholder support and ownership of the proposed interventions and the process. The in-context interviews and immersions were pivotal to exploring desires, contexts, and insights of the target population that informed intervention design.

INTRODUCTION

Community engagement has been recognized as a fundamental component of primary health care (PHC) since the Alma Ata Declaration in 1978 [1, 2]. Many countries have developed and implemented community health worker programs to nurture community participation to improve health outcomes over the last four decades [2-4]. The impact and sustainability of these programs varies between countries as a result of not only how well they are tailored to community needs and cultural context, but also to how well multi-sectoral responses are coordinated and how governments respond and adapt to community needs, local cultural practices, and changing disease patterns and emerging challenges [4, 5].

Ethiopia has embraced community engagement as a pillar of its pro-poor policies and strategies in line with the millennium development goals [6, 7]. The Government of Ethiopia (GOE) has employed various community engagement approaches through voluntary community health workers with various titles and scopes of practice, including community health agents, community-based reproductive health workers, community health promoters, traditional birth attendants, and malaria agents [8]. Community engagement in Ethiopia's primary health care (PHC) system has been fundamental since the beginning of the Health Extension Program (HEP) in 2003 [9]. The HEP is a GOE flagship program and was pivotal in improving health outcomes and meeting MDG-4 (reducing child mortality) three years ahead of the schedule, largely through increasing demand for and expanding access to basic curative, preventive, and promotive PHC services. In 2011, the Women's Development Army (WDA) strategy was launched to reinforce the HEP's role in engaging communities in PHC.

Despite these gains, recent HEP evaluations reveal challenges to engaging communities and sustaining momentum in community participation in health. HEP performance has been hindered by demotivation and growing attrition of health extension workers (HEWs) and WDA leaders; failure of the HEP service package and coverage to meet increased community-level demand for curative services; epidemiologic transitions; and increased demand for health services for non-communicable diseases [10]. To address these challenges, HEP platform strategies need to be adjusted to meet growing demand, leverage the increased capacity and transitions of local health workers, and sustain the momentum in community participation and demand for services.

LOCAL SETTING AND PROBLEM

Ethiopia is the second-most populous nation in Africa with an estimated population of 109 million as of 2019. About 20% of the population resides in urban settings and the majority live in rural areas leading agrarian (65%) or pastoral (15%) lifestyles. The country is a federation of nine regional states and two administrative cities with the rural agrarian population largely residing in four regional states: Amhara; Oromia; Southern Nations, Nationalities, and Peoples; and Tigray [11]. A woreda (district) is the lowest government structure, with an average population of about 100,000 people who live in 20 kebeles (villages) of about 5,000 people each. In rural agrarian settings, the woreda health system is composed of one primary hospital and four primary health care units (PHCUs). Each PHCU serves about 25,000 people through one health center and five satellite health posts located in kebeles [7]. Each health post is staffed with two HEWs and serves a kebele through delivering the

HEP's 18 packages of basic promotive, preventive, and curative health services to households. HEWs are female frontline health workers with at least a 10th grade education, plus one or two years of theoretical and practical training on providing basic curative services and engaging communities [10, 12, 13].

Based on the diffusion of innovation theory, the HEP was designed to produce model households by training them on the skills and knowledge required to practice HEP service packages and promote healthy practices among their neighbors [14]. HEWs reinforce healthy practices during service provision at health posts, household visits, and community meetings. They also facilitate group meetings including pregnant women conferences, family-based conversations, and other platforms to disseminate actionable health messages to communities [14].

HEWs are supported by the WDA to sustain the gains of the HEP program and increase service converge. WDA members are organized and mobilized in 1-to-5[1] and 1-to-30[2] groups that work in tandem with HEWs to share actionable messages and motivate each other to adopt and practice healthy maternal and child health, hygiene, and sanitation behaviors and practices [10, 15, 16].

THE PROCESS: RE-DESIGNING COMMUNITY ENGAGEMENT

Between May 2017 and February 2020, the MOH collaborated with L10K and other stakeholders in an iterative participatory process to re-design community engagement interventions to address community engagement challenges in agrarian settings.

The process included the following steps:

1. **HEP review** (May 2017): the MOH conducted a rapid assessment to gauge HEP performance status and explore implementation successes and challenges.
2. **Advocacy on the need for optimization:** informed by the assessment, three national consultations were conducted:
   a. **A national advocacy workshop** (September 2017) convened political leadership, including the Deputy Prime Minister and parliamentarians, and health sector leadership at all levels. Findings from the rapid assessment and anecdotal evidence on the evolution of HEP were presented to set the agenda to address emerging challenges.
   b. During the **health sector annual review meeting** in Gondar (October 2017), the findings of the program review were discussed among a wide range of participants including HEWs, public health experts, health managers, and political leaders.
   c. **Regional level advocacy** was conducted in all agrarian regions to obtain support from regional political leadership including regional presidents, public health experts, and HEWs. Leadership decided to optimize the program through quickly designed and implemented administrative adjustments.
3. **Literature Review** (May-July 2019): To deeply understand the current situation, an extensive literature review[3] was conducted to synthesize evidence of the challenges and successes of community engagement strategies in agrarian settings in Ethiopia and other resource-limited countries.

[1] A woman from a household is designated to lead women from other five households in the neighborhood to form a 1-to-5 group

[2] About five 1-to-5 groups (i.e. thirty households) is led by a woman leading one of the five 1-to-5 groups to form a 1-to-30 group

4. **Collaborative and iterative co-creation of interventions with end-users** (April-July 2019): L10K and the regional health bureaus (RHBs) of the four agrarian regions applied Human-Centered Design (HCD)[4] techniques to understand the desires and insights of community members and to co-design alternative community engagement approaches for rural agrarian settings. During the inspiration or learning phase of the HCD process, data were collected through empathetic, in-context interviews and immersions with frontline health workers, community representatives, and experts in community engagement. The ideation or co-creation phase included a series of brainstorming and iterative rapid prototyping sessions to craft alternative community engagement options. Lessons from the inspiration and ideation phases were presented and discussed in policy dialogues to formulate policy options.

5. **Evidence-based policy dialogues:** Three rounds of national level policy dialogues were conducted for multidisciplinary experts in community engagement to discuss how to re-invigorate the PHC community engagement strategies in rural agrarian settings. The dialogues were informed by findings from the literature review, recent studies on the HEP and the WDA strategy, and lessons from the HCD process to develop context-tailored community engagement interventions.

6. **Consultations with national and regional level leadership and policy-makers** (September 2019): The prototype policy options and implementation considerations were discussed during the Joint Steering Committee (JSC) meeting. Leadership from the MOH and RHBs participated and provided feedback and direction on the subsequent steps. The policy options were also discussed with a wide range of participants during the national annual health sector review meeting in Addis Ababa in October 2019. In addition, four consultations with RHB management teams were conducted in each of the agrarian regions to solicit feedback from wider regional audiences and to understand regional contexts to further shape the policy options and implementation considerations.

RESULTS

Findings from Evidence Synthesis and HCD Exercise

EVIDENCE SYNTHESIS: The evidence from rapid program reviews and assessments revealed that the HEP has not been as effective as it was at the beginning of implementation in producing model households, and the WDA mechanism has become increasingly non-functional over the years. The momentum in community engagement has declined due to several factors:

1. **Suboptimal implementation of HEP and WDA strategy:** HEWs have become increasingly fatigued and dissatisfied as a result of serving for long periods of time in rural and remote areas. This erodes their motivation to fulfill their roles in implementing community-based activities including household visits, facilitating community meetings, and providing support to WDA leaders. This de-motivation is compounded by increased community demand for more curative health services, which is

[3] A literature review was conducted using the Problem or population, Intervention, Community or control and Outcome (PICO) method. About 42 relevant research articles were reviewed and a summary report was developed.

[4] Human-Centered Design is a solution-designing process based on user empathy, purposeful design, rapid successive prototyping and iteration, integrating user feedback to generate feasible, desirable, and viable solutions.

a positive outcome of the HEWs' work, but the current HEP structure is unable to meet this growing demand. Communities are also experiencing an epidemiologic transition, where health services for non-communicable diseases are increasingly needed and requested. This increased burden on the HEP, HEWs, and health facilities has contributed to community dissatisfaction with the health system's ability to meet their needs [17-21]. Other limiting factors include community scepticism and low acceptance of the WDA strategy; low capacity and motivation of WDA leaders to mitigate and negotiate these factors with their families and neighbors and limited WDA educational and health literacy capacity to communicate and model best practices [16, 18, 19, 22-24].

2. **Exclusion of population segments:** Women's empowerment has been a pillar of Ethiopia's poverty reduction strategies since 2000 [25, 26]. As such, the community engagement strategies have been women-centered, all HEWs workers and WDA leaders are women, and community-based activities mainly target women [16, 27-29]. However, men are in a critical position to contribute to the improvement of the health status of their communities. Husbands and fathers are the lead decision-makers and income earners in most households. Adolescent boys and young men comprise the more formally educated segments of the rural population in Ethiopia [10, 30-32]. In addition, community health worker programs with mixed-sex CHWs have been proven to be effective to forging strong community engagement in several countries [21, 22, 33, 34].
3. **Limited multi-sectoral coordination at the kebele level:** The kebele administration has a cabinet[5] which includes one HEW from the catchment area. The cabinet coordinates the activities of multiple sectors in addition to those of the HEWs and WDA leaders. Anecdotal evidence indicates that effective coordination by this cabinet is limited.

HUMAN CENTERED APPROACH: The HCD exercise explored how well existing community engagement strategies are working, how they address the desires and contexts of communities, and what they lack. The exercise identified the same gaps described in the literature review as well as the following issues and suggested solutions.

1. **Current status of WDA strategy:** The participants of the inspiration and ideation phases described several challenges related to the current WDA structure:
    - There are too many WDA leaders per kebele for HEWs to adequately support
    - Recruitment criteria for WDA leaders has not been endorsed by the communities
    - Families and communities tend to see WDA strategy as a political mechanism
    - WDA leaders and women in the community face opposition from their husbands to participate in WDA activities
    - WDA activities don't adequately involve men, the youth and existing social structures
    - WDA leaders lack requisite negotiation skills to facilitate interactions with their neighbors

[5] The kebele cabinet is composed of seven representatives from seven sectors. Members include an HEW, women's and children's affairs representatives, an agricultural extension worker, and a school director.

To address these challenges, a rebranding and restructuring of the WDA strategy was suggested during the co-creation session.

2. **Community trust in the health system:** The inspiration phase revealed that the communities' trust in the health system depended on transparency about community contributions including financial and material contributions and the health system's ability to meet expectations. Suggested solutions include increasing community involvement in planning and monitoring activities and sharing information publicly using existing platforms.

3. **Motivation mechanisms:** Currently there is no clear set of criteria for recognizing high-performing CHWs. Existing criteria are not endorsed by the community and community actors have limited involvement in identifying high performers. There is no joint planning of recognition activities nor collaborative resource mobilization for incentives. Identifying and implementing innovative financial and non-financial mechanisms in collaboration with communities were suggested solutions.

4. **Appeal and convenience of community meetings:** The inspiration and ideation phases revealed that community meetings were not arranged through discussions with communities and thus timing, location, and duration of the meetings were not convenient for the participants. Agendas are not determined in consultation with community members and therefore do not reflect community priorities. In addition, the WDA leaders lack the meeting facilitation and management skills to create engaging and informative discussions and need training to vary communication. The meetings also were not tied to valued activities like community savings activities, coffee ceremonies, and dramas which could attract participants.

THE POLICY OPTIONS

Based on evidence syntheses, consultations with stakeholders, policy dialogues and the co-creation sessions, the team proposes the following two policy options for pilot testing.

Policy Option 1: Optimize existing community engagement approaches

Under this option, a range of strategic activities were identified to further develop the WDA strategy, including more purposeful engagement with men and youth through existing community structures.

- **Optimize the WDA strategy:** This includes working with the MOH and communities to re-brand the WDA structure to avoid political connotations and perceptions that the WDA is politically motivated; re-consider selection criteria to recruit well-respected and accepted leaders; restructure the 1-to-5 groups to 1-to-10 to decrease the number of WDA leaders per kebele; provide certification based on WDA leaders' training completion and household practices; and integrate WDA activities into other community platforms. In addition, the following two sets of interventions have been proposed to further optimize the strategy.

  > **Capacity building to increase the confidence of WDA leaders:** This intervention includes providing quality and tailored competency-based training to WDA leaders to increase their confidence, building trust between WDA leaders and communities through transparent community meetings and interactions, and strengthening the support provided to WDA leaders.

  > **Tailoring activities and motivation mechanisms and redefining roles of WDA leaders:** This includes tailoring activities to the desires and contexts

of WDA leaders while sustaining the strength of implementation of WDA activities, providing an incentive to communities based on performance in achieving jointly-set targets, limiting the time a WDA leader serves as a volunteer, and adapting national implementation approaches or guidelines to local contexts to embrace diversity.

- **Integrate innovative engagement approaches for men, women, and youth:** This intervention aims to re-invigorate existing or establish new social structures for men and youth in harmony with the WDA strategy.
- **Improve coordination of activities and alleviate systemic barriers:** This includes revitalizing and strengthening kebele steering committees, community scorecard use, participatory community solutions approaches, performance-based incentive mechanisms, and coordination of kebele community-level activities.

Policy Option 2: Create a new cadre of Village Health Leaders

Under this option, a new community engagement cadre of Village Health Leaders (VHLs) would be formed as a structure between the WDA and HEWs, alongside optimizing existing strategies. The proposed mix of male and female VHLs would be have a grade six or above literacy level, and one VHL would be responsible for an average of 100 households. The VHLs would be organized in a team of three (one man and two women) to coordinate activities at a sub-kebele level along with an average of 300 households and their 10 1:30 WDA leaders. All three members would share roles in community engagement, with one VHL coordinating activities for adolescent and youth health and school linkages. The second VHL will be responsible for engaging with groups for men, and the third would coordinate activities targeting women of all ages but particularly mothers and younger children.

PROPOSED INTERVENTIONS

Once the final policy options were selected and outlined for pilot testing, the MOH organized two rounds of six-day workshops held between November 2019 and January 2020 to develop the tools, implementation guidelines, and manuals for each of the interventions. These materials are in line with the WHO guidelines for optimization of recruitment, training, management, and motivation in CHW programming [35]. Experts and representatives from the MOH, RHBs, woreda health offices, health centers, HEWs, and implementing partners developed the guidelines and materials for six interventions: **1) Adding village health leaders as a new community engagement cadre; 2) Optimizing the WDA strategy; 3) Expanding the male engagement strategy; 4) Harnessing local social structures to enhance community engagement; 5) Implementing innovative approaches to engage the youth in health activities; and 6) Implementing innovative and sustainable motivation schemes.**

LESSONS LEARNED

The main lessons learned from the community engagement process are summarized in Box 1. The participatory process informed by concrete evidence was instrumental in galvanizing support from political leaders and other stakeholders and ownership of the inquiry into improving the HEP, the discussion and iteration process, the proposed policy options, and subsequent steps. In addition, the evidence-based advocacy opportunities were instrumental in gaining the buy-in from political leadership on the need for optimization and support for the exploration of alternative strategies to improve the existing ones. These policy dialogues have been pivotal to forging strong collaborative relationships among political leaders, multidisciplinary experts from academia, non-governmental organizations, and implementers at the grass-root level in order to frame policy options for revitalizing community engagement strategies.

The HCD techniques were instrumental to understanding the desired characteristics of effective community engagement approaches through an empathetic, immersive process to collaboratively co-create prototype solutions tailored to the contexts, aspirations, and desires of frontline health workers and communities. The iterative co-creation sessions harnessed the insights and creativity of all involved, fostered ownership of the process and the proposed interventions, and informed further refinement and tailoring of the policy options based on regional contexts. The implementers of and participants in the HCD techniques will also be able to use the methods to identify and develop solutions to future challenges.

BOX 1. SUMMARY OF MAIN LESSONS LEARNED FROM THE COMMUNITY ENGAGEMENT APPROACH

- Evidence-based advocacy involving government officials and politicians was instrumental in gaining political buy-in for optimizing existing community engagement strategies.
- The consultations and evidence-based policy dialogues that involved multidisciplinary experts, implementers, and health managers galvanized support and ownership of the process and proposed interventions.
- The HCD techniques provided an effective, cutting-edge approach to exploring desires, contexts, and insights of individual, families, communities, and implementers to inform the design process.

THE WAY FORWARD

The MOH intends to pilot test the proposed interventions through a phased process informed by developmental evaluation design through which evidence will be generated at each phase and inform subsequent piloting steps. The pilot phase will be implemented in four groups: one group for policy option one, one for policy option two, one using both options combined, and a control group. The pilot will determine the feasibility and acceptability interventions and evaluate the effectiveness of the options through operations research. Findings will inform a final policy response for the program.

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