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TECHNICAL REPORT

Improving Community Support for Health Extension Workers in Ethiopia

SEPTEMBER 2014

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SEPTEMBER 2014

Ram Shrestha, University Research Co., LLC

DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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Abbreviations

ANC	Antenatal care
CHW	Community health worker
FMOH	Federal Ministry of Health
HC	Health center
HCI	USAID Health Care Improvement Project
HEP	Health Extension Program
HEW	Health extension worker
HH	Households
HIV	Human immunodeficiency virus
MNCH	Maternal, newborn, and child health
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization
ZHD	Zone Health Department

EXECUTIVE SUMMARY

Introduction

Quality improvement (QI) methods have been successfully applied in developing countries to improve facility-based services for maternal, newborn, and child health, malaria, tuberculosis, and HIV. But as the complex needs of people facing the double burden of health issues and socio-economic difficulties are increasingly identified and addressed, there is a growing need for applying QI methods to community-level health and social services. Community-level health services include health education, referral, follow-up, and links to the health facilities and are often provided by community health workers (CHWs) who often work alone or in pairs. But such community level agents are often overburdened with too many tasks, and CHW programs are frequently inadequate to provide the full range of needed services to all households.

A promising model for leveraging informal community health and social welfare groups to work together to improve the health of the community was proposed by the USAID Health Care Improvement (HCI) Project. The *Community Health System* model links CHWs with the network of existing community groups and social structures to mobilize these groups and increase their capacity to work as a system to effectively reach all households in the community with needed health education and services. Because of urgent need for new models of care to extend community-level prevention of HIV transmission, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) agreed to support a pilot project to develop and apply the Community Health System model to improve the performance of CHWs in Ethiopia.

Health Extension Program in Ethiopia

Since its inception in 2003, Ethiopia's Health Extension Program has deployed over 30,000 health extension workers (HEWs) to rural communities across the country. HEWs are paid government health workers who deliver some 17 different services covering disease prevention and control, hygiene and environmental health, family health, and health education and communication at the village level. In order to extend coverage of the government health system, each rural administrative area (*kebele*) is expected to have one health post staffed by two female HEWs; however, this is not universal, as some kebeles have only one or no HEW.

A 2008 evaluation of the Health Extension Program found that while community demand for HEW services was high, improvements were needed. HEWs had too great a workload and inadequate skills to address all the health issues they faced. To address these challenges, in 2011, the USAID Health Care Improvement Project (HCI) was invited to work with the Federal Ministry of Health (FMOH) to implement a community health worker (CHW) improvement collaborative to bolster linkages between the informal community system and the formal health system, improve the effectiveness of HEWs, and improve the capacity of community groups to take ownership of health programs. The collaborative was supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) because of PEPFAR's interest in developing promising strategies to extend community-level services for prevention of HIV transmission and care for people living with HIV.

Intervention

Implemented in Illu and Tole districts (*woredas*) of Oromia Region, the community improvement collaborative brought together key stakeholders to form improvement teams focused on strengthening the community health system, with particular attention to HIV/AIDS and hygiene services. These improvement teams, made up of key community stakeholders and representatives of key community groups, formed the foundation of a community health system to support HEWs in service delivery.

HCI used a community health system strengthening approach to address these issues and focused on the following objectives: 1) Improve the competence and performance of HEWs; 2) Strengthen the linkage between the community and the health post; and 3) Improve the capacity of community groups

to take ownership of health programs in their catchment areas and strengthen the existing community health system. The improvement collaborative was implemented between November 2011 and September 2012.

Results

Before the community improvement teams were established, HEWs were going house to house to identify pregnant women and provide basic ANC information and services. Since they were not able to go to every household, the number of pregnant women identified by HEWs was low. But after community groups started sensitizing their members' families, the number of pregnant women identified by the community groups and number of pregnant women who visited the health post for antenatal care increased. For example, nine health posts in Illu district were able to identify 259 women in an eight-month period and get 86% of them to register for antenatal care at the health post. The changes that led to improvement were house-to-house visits, and mobilization of Idir (community funeral cooperative) and other community groups to support the identification of pregnant women. Similarly, another health post community improvement team in Illu increased the number of households with latrines from 30% to 60% and the proper use of latrine from 36% to 76%. The change ideas that led to this increase were utilizing community leaders, funeral cooperatives (*Idir*), savings and credit groups, and religious group to reach out to the community. The nine health posts participating in the improvement collaborative in Tole were able to increase the number of pregnant women tested for HIV from 11 in July 2011 to 191 in June 2012.

Community improvement teams began focusing on improving postnatal visits by new mothers after January 2012. Within six months of the intervention, the number of postnatal women who were visited by the HEW for postnatal care increased, reaching 181 by June 2012, representing coverage of 91% of postnatal women in the communities.

During the final month of the improvement collaborative's implementation, a retrospective cross-sectional qualitative study was conducted in three out of the 18 health posts to document the impact of the collaborative improvement approach on the community health system and its management, linkages between the community and the health system, and support offered to HEWs.

HEWs and improvement team members expressed satisfaction with services they provided, contending that over the course of the intervention year the community had taken greater ownership over its own health. Respondents observed that HEW workload had decreased but coverage of services increased. Additionally, communities had more confidence in HEWs and increasingly sought their services. While the study was limited by its small size and retrospective design, it provides evidence that a community health system can be strengthened to improve health services utilization and quality. The findings are consistent with other studies which have documented that supporting community health workers can strengthen the health system and improve efficacy.

"There is not member of a household who cannot be reached now. Each improvement team knows who is pregnant, who is lactating, who has a latrine, who sleeps under an [insecticide treated bednet]."

--HEW interviewed in qualitative study, September 2012

Participation on improvement teams raised members' awareness of and respect for the services HEWs provided, which was seen as positively impacting the coverage of services and referral of those in need to HEWs for care. The improvement teams also offered a venue for HEWs to raise concerns or challenges with service delivery and receive support and guidance.

Conclusions

While more needs to be done to improve access and quality of community-based health services, this improvement project demonstrated that supporting the community health system can positively impact the work of HEWs.

I. INTRODUCTION

A. The Community Health System Model for Improving CHW Performance

Quality improvement (QI) methods have been successfully applied in developing countries to improve facility-based services for maternal, newborn, and child health, malaria, tuberculosis, and HIV. But as the complex needs of people facing the double burden of health issues and socio-economic difficulties are increasingly identified and addressed, the need for applying QI methods to community-level health and social services is amplified.

Community-level health services include health education, referral, follow-up, and links to the health facilities and are often provided by community health workers (CHWs) who often work alone or in pairs. But such community level agents are often overburdened with too many tasks, and CHW programs are frequently inadequate to provide the full range of needed services to all households. In addition, although CHWs are usually linked to facilities, facility-based health care teams often do not have the time or the capacity to support CHWs to fulfill their expected role.

Programs that do address community health problems often work with only one or two community groups. Yet communities typically have many groups and structures in place that, if well organized and linked to appropriate resources, could be leveraged to address key health issues of community members.

A promising model for leveraging informal community health and social welfare groups to work together to improve the health of the community was proposed by the USAID Health Care Improvement (HCI) Project. The *Community Health System* model links CHWs with the network of existing community groups and social structures to mobilize these groups to support CHWs to address the needs of every family in the community. The model provides an opportunity to sustainably strengthen existing community groups and organizations and increase their capacity to work as a system to effectively reach all households in the community with needed health education and services.

Because of urgent need for new models of care to extend community-level prevention of HIV transmission and care for the growing numbers of people living with HIV, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) agreed to support a pilot project to develop and apply the Community Health System model to extend community-level services for prevention of HIV transmission and care for people living with HIV. In consultation with the USAID Mission and the Federal Ministry of Health of Ethiopia, HCI proposed to pilot the community health system using a collaborative improvement approach to improve the performance of health extension workers.

B. Health Extension Program in Ethiopia

Ethiopia's Federal Ministry of Health (FMOH) launched its Health Extension Program (HEP) in 2003, designed to improve access to and utilization of "quality promotive, preventive and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children". The purpose of HEP is to enable households to maintain their own health. Since its inception, the program has deployed over 30,000 Health Extension Workers (HEWs) to rural communities across Ethiopia. HEWs deliver 17 different services covering disease prevention and control, hygiene and environmental health, family health, and health education and communication.

Each rural *kebele*, the smallest administrative unit in the government system and typically consisting of 3,500-4,000 inhabitants, is expected to have one health post staffed by two female HEWs; however, this is not universal as some *kebeles* have only one or no HEW. HEWs are expected to spend at least 75% of their time conducting outreach health services and delivering health messages at community meetings.

They also provide selected primary health services such as antenatal care, delivery, immunizations, growth monitoring, family planning, and referrals.

A 2008 evaluation by the Center for National Health Development in Ethiopia of the HEP found that while community demand for HEW services was high, improvements were needed in the performance and management of these frontline health workers. The HEWs had too great a workload and inadequate skills. One study revealed that while HEWs visited households less frequently than once a week as stipulated by policy, recipients viewed their services positively, and some expressed a preference for HEWs over traditional birth attendants, despite the fact that HEWs were not trained in midwifery.

Another study found HEWs had limited contact with other *kebele*-level government institutions and other health care workers, suggesting that they function in isolation. HEWs reported it was challenging to visit and provide primary health care services to all households in their catchment area. Since the HEWs were spending most of their time in the field visiting patients, the health post remained closed so patients were not coming to the health post for health services, leading to underutilization of health posts.

While the HEP has been acknowledged as setting a strong foundation for Ethiopia to achieve the Millennium Development Goals, particularly around maternal health and hygiene and sanitation, it is also recognized that more effort is needed to accomplish these goals.

To address these challenges, in 2011, the USAID Health Care Improvement Project (HCI) was invited to work with the FMOH to implement a community improvement collaborative to bolster linkages between the informal community system and the health system, improve the effectiveness of HEWs, and improve the capacity of community groups to take ownership of health programs. Implemented in two districts (*woredas*) of the Oromia Region of Ethiopia, the collaborative brought together key stakeholders to form improvement teams focused on strengthening the community health system, with particular attention to HIV/AIDS and hygiene services.

HCI used a community health system strengthening approach to address these issues and focused on the following objectives:

1. Improve the competence and performance of HEWs;
2. Strengthen the linkage between the community and the nearest health facility;
3. Improve the capacity of community groups to take ownership of health programs in their catchment areas and strengthen the existing community health system.

Supported by PEPFAR through the USAID Office of HIV/AIDS, the demonstration project was expected to further develop the community health system model for application in other high-prevalence settings.

II. INTERVENTION

A. Understanding Community Systems

Modern quality improvement focuses on systems and processes of delivering health care. Years of experience working in communities have shown us that while they are not always visible to outsiders, there are systems and processes at the community level which are used to communicate and allow inhabitants to support each other. Community members and groups are constantly working together, making decisions about community welfare, and supporting each other.

Development programs tend to work with one community group, such as a savings and credit group, a women's group, or a religious group, to improve health at the community level. In fact, everyone in the community is linked into one or more groups; addressing only one of them will not reach everyone across the community. By tapping into a network of existing community groups (e.g., schools, religious

groups, income-generating groups, savings and credit groups, women's groups), a program could reach every household.

Communities have their own systems to provide care, both for health and social services. Community level health care can involve health education and awareness, advocacy and behavior change, and provision of basic health care services and social support. Some of this health care may be part of a formal government health, education, or social service system represented by paid or volunteer community health workers (CHWs). Care may also be provided by a formal organization such as a women's or farmer's group or by informal means of providing health care such as religious groups, funeral groups, and savings and credit groups. Understanding these structures, their linkages, and processes at the community level can be helpful to improve a specific health care area. Conceived of as a *community health system*—that is, the existing organizations and social structures within a community that support the health and wellbeing of their members—such as a network can be mobilized to improve the health and wellbeing of community members.

The community health system is comprised of CHWs, community group members from existing groups (savings and credit, etc), a community management committee (may also be known as a village health committee or community development committee), health care providers, local government officials, and representatives from other sectors such as education and agriculture. Representatives from each of these organizations can come together to serve as the community management committee for the purposes of identifying local health priorities and developing strategies to address local needs.

Most communities will have these structures in place, however they may be poorly organized, dysfunctional, or not connected to appropriate resources to be able to address health concerns of its members. Integrating local, existing structures into a community health system will also provide an opportunity to strengthen these organizations and also increase the ability of the system to reach all households in the community with health education and services. Working through these local structures will also contribute to the sustainability of the community health system since they are already ingrained in the community.

By engaging this community health system, families and community members can be empowered to share their needs and concerns with their community groups who in turn can share those concerns with higher levels, thereby increasing the responsiveness of services provided for the community.

The community health system can also create a stronger link between the community and higher levels of the government and the Ministry of Health. Since health facilities and local government representatives already have established relationships with district and regional officials, their involvement in the community management committee will allow them to gain insight into the health needs and challenges of the community and share this information with higher levels of the government.

When all elements of the community health system are functioning well, health services become more accessible to members of the community and information will travel more rapidly from the health facility down to the household level and back up again. Some type of management committee needs to be established in order to bring the groups together and provide oversight, either by converting one of the well-functioning traditional community groups or by creating a new committee that includes representatives from all of the existing community groups.

B. Adapting Facility-based Quality Improvement at the Community Level

The model for improvement¹ has been successfully applied in health care facilities in developing countries to improve maternal, newborn and child health (MNCH), malaria and tuberculosis diagnosis and treatment, and HIV care. Most health care improvement initiatives have focused on facility-based

¹ <https://www.usaidassist.org/topics/improvement-science>.

improvement teams consisting of different cadres of health care providers, administrators, volunteers, community outreach workers, and even patients. The community representatives and the management teams have been involved in facility-based improvement as a means of holding facilities accountable to their clients and community and improving linkages between the community and facility. However, these days there are more health and social services at the community level to address HIV, MNCH and needs of vulnerable children. Community-level health services include health education, basic care for MNCH, family planning, malaria, tuberculosis, behavior change messages, referrals, follow-up, and links to the formal health sector. Facility-based teams are unable to improve community-based care, presenting the need for quality improvement activities based at the community level.

In most health facilities there are CHWs who are selected by the community who serve as the link between the formal health facility and the patients in the community. But the CHW program in many countries has shown that the CHW has not been able to provide health services to every household. CHWs or outreach workers cannot handle the entire burden of care alone.

HCI has developed and tested a conceptual framework of the community health system and engages this system to improve the coverage and responsiveness of community-level health services, using the model for improvement. The community health system conceptual framework considers that every rural community has a system which they use to work together, support each other, and make decisions for community welfare which is not always visible from outside the community.

Quality improvement programs are designed to work within, not parallel to, government health care services to enable improvement to continue beyond the end of the project. The same holds true for communities but the structure may be a combination of a formal government structure for managing the committee and health care and informal structures in the community.

In a facility, the administration can make the decision to bring improvement activities into a facility, then provide leadership to move the activity forward, including recommending specific team members. A community, in contrast, has many different groups that are not under the influence of formal leaders.

At the community level, improvement teams should include representatives of all the groups or networks in the community who not only provide care but also have influence over the process of care. Improvement teams need to reflect the community system and all of its component groups. If a community level health management committee or similar group exists, this can function as the improvement team, with additions to ensure that there is representation from across the community.

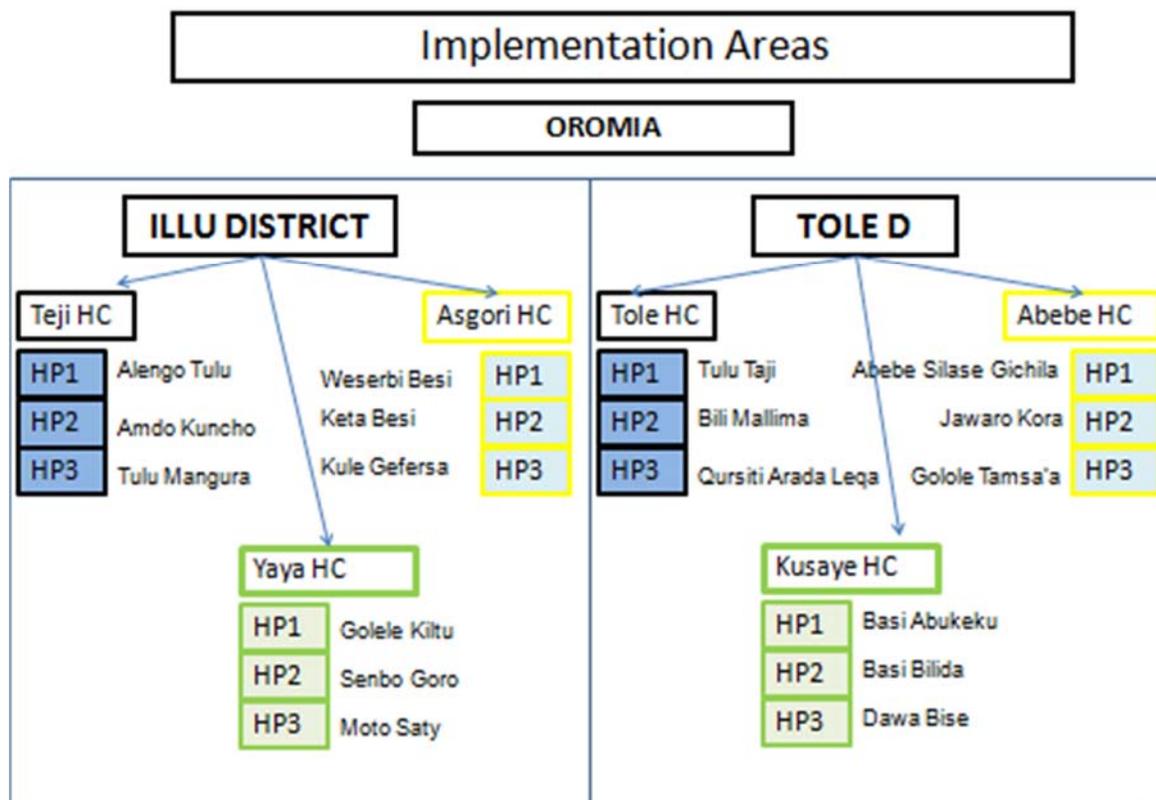
Each quality improvement team requires a coach who can provide support during implementation including guidance on improvement approaches, support for data management and use, and content training and supervision. In community-based improvement, the coaches come from the health center or from the respective district. Selecting CHW supervisors as coaches from within the existing referral health center results in improved linkages and communications between communities and the formal health center.

C. CHW Improvement Collaborative

1. Structure of the improvement collaborative

In 2012 HCI implemented a demonstration CHW collaborative project in eighteen health posts within the catchment area of six health centers in two districts (*woredas*) of the Oromia Region. Figure 1 shows the facilities involved in Illu and Tole districts.

Figure 1: Implementation structure of the Ethiopia community improvement collaborative



The demonstration project began with an orientation for regional, district, and health center staff about the application of the model for improvement to improve the quality of health services. The HCI Improvement Advisor then worked with regional, district, and health center staff to select supervisors from each level to act as a pool of coaches for improvement teams at the community level. Twenty coaches from the two districts and the six health centers received three days of training in quality improvement and data management.

After the training, coaches of each health center and the *kebele* manager conducted a situational analysis of the existing community groups and their networks, other sector groups, volunteers, village chief, schools, and other health agents. In each *kebele* or health post catchment area, the HCI Improvement Advisor, coaches and *kebele* manager called a meeting with a representative of each community group identified and briefed them about the objective of the community health improvement work and the roles and responsibilities of these community groups to support the performance of HEWs. Toward the end of the meeting, a village committee is converted into an improvement team including a representative from each of the community groups (e.g., leaders of *Gare*, which is a local government group of 30-40 households; savings and credit groups; etc.), *kebele* managers, health extension workers, health center staff (who served as the coaches), religious leaders, and government Development Agents.

In this way, 18 community improvement teams were formed, one in each of the 18 *kebeles* selected for the intervention.

Each of the community groups was formed to share information in their area of focus (e.g., agriculture), and to support each other to improve their quality of life. The community groups' meetings were designed to include time for members to discuss personal and family health issues and to learn more

about seeking care. The representative from that committee would then carry results of this discussion on health concerns/requests/needs to the main committee, and in turn, return to his/her committee with new health information/requests.

2. Implementation

The CHW collaborative improvement project in Illu and Tole districts focused on improving HEWs' performance in the following areas: antenatal care (ANC) services, testing pregnant women for HIV, post-natal care, and hygiene and sanitation. In order to achieve this objective, the HCI Improvement Advisor worked with the health facilities staff to agree on the following indicators to measure the improvement in the performance of the health extension workers:

- % of pregnant women visited health post for ANC services;
- % of pregnant women referred by health extension workers and tested for HIV at the health center;
- % of postpartum women followed-up for postpartum services;
- % of households having a latrine.

The community improvement teams met every two weeks to determine the improvement being made in closing the gap between the number of pregnant women identified by community improvement team members and the number of pregnant women who received ANC services from the health post. The community improvement team members tested change ideas like mobilizing *Idir* (funeral group), women's development armies, religious groups, *Gare* group etc., and share this information with the community improvement team.

At the district level, a one-day monthly review meeting was held where the coaches presented improvement ideas in the above four indicators by the community improvement teams that were under their supervision.

In February 2012, the CHW collaborative demonstration project conducted its first two-day Learning Session with 49 improvement team members from the two districts, Illu and Tole. Two to three improvement team members came to the learning session from each of the 18 improvement teams. The purpose of this session was to share among the improvement teams the effective change ideas (e.g., use of *Gare* leader, *Idir*, religious groups, and *kebele* managers) used for improvement of ANC services in their health posts. The learning session was facilitated by district and zonal health office staff. The improvement teams shared their change ideas and the improvements made in the following three indicators: percentage of pregnant women identified and referred to the health post; percentage of pregnant women referred to and tested for HIV at the health center; and the percentage of households with standard latrines.

The CHW collaborative demonstration project's direct support ended on October 31, 2012. The project held a transition meeting with regional, district health office, health center and improvement team members to develop a strategy to continue strengthening the community system to support HEWs to improve their performance.

III. RESULTS

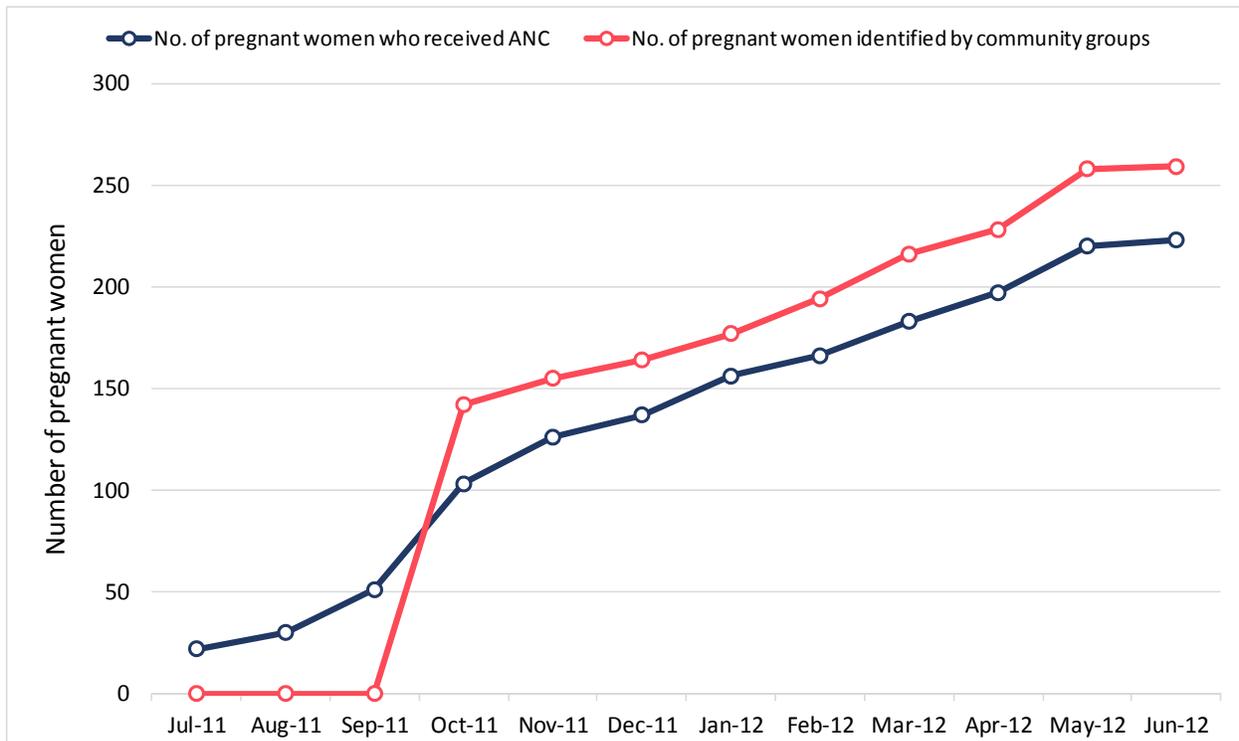
A. Extending Coverage of HEW Services

Before the community improvement teams were established, HEWs were going house to house to identify pregnant women and provide basic ANC information and services. Since they were not able to go to every household, the number of pregnant women identified by individual HEWs was always low. But after the community improvement teams and community groups started sensitizing their members'

families, the number of pregnant women identified by the community groups and number of pregnant women visiting the health post for ANC increased.

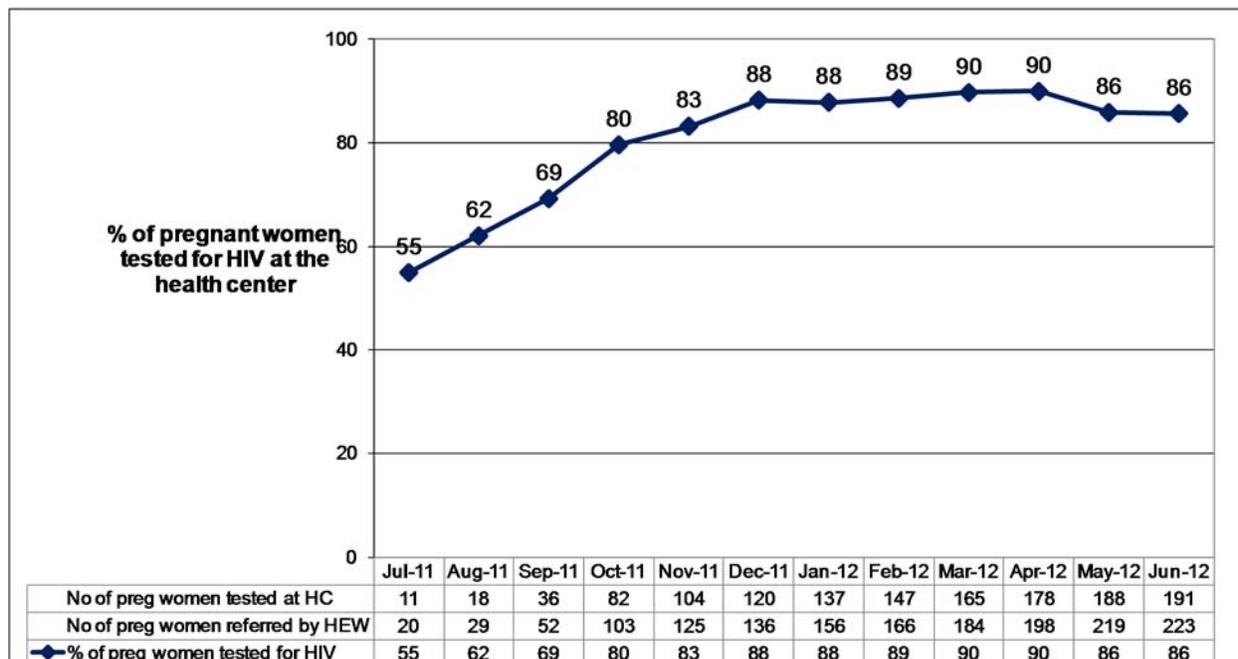
For example, as shown in Figure 2, before the community health intervention, HEWs in the catchment area of nine health posts in Illu were able to identify and refer only a small number of pregnant women for antenatal care. Immediately after the mobilization of community groups in October 2011, 143 pregnant women were identified, and of these, 103 (72%) registered for antenatal care at the health post. Over time this number increased to 259 pregnant women identified by community groups, of whom 86% registered for antenatal care at a health post.

Figure 2: Number of pregnant women identified by community groups and number receiving antenatal care at a health post, Illu District, July 2011–June 2012



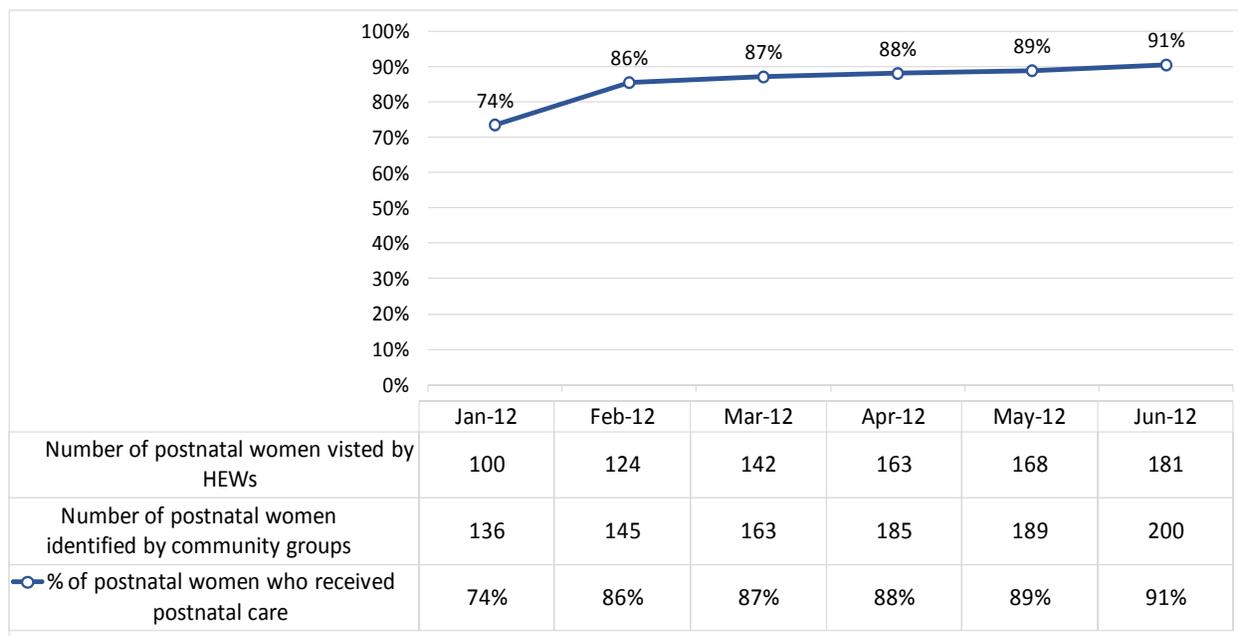
Community improvement teams developed their own methods to measure and improve services. Through this process, the Alengo improvement team increased the percentage of pregnant women attending health posts for ANC services from 33% to 88 % in three months. The changes that led to improvement were members of the community groups encouraging family members and mobilization of *Idir* (community funeral cooperative), *Gare* groups, and teachers. Similarly, the Golole health post community improvement team increased the number of households with latrines from 30% to 60%, and the Tulu Mangura health post improvement team in Illu District increased the proper use of latrines from 36% to 76% of households. The change ideas that led to this increase were utilizing community leaders, *Idir*, savings and credit groups, and religious group to reach out to the community. As shown in Figure 3, the number of pregnant women tested for HIV increased from 11 in July 2011 to 191 in June 2012 in the Tole District health center. This represented an increase in coverage of pregnant women for HIV testing from 55% in July 2011 to 86% in June 2012.

Figure 3: Percentage of pregnant women referred by health extension workers and tested for HIV, Tole Health Center, Tole District, July 2011–June 2012



The community improvement teams introduced improving postnatal visit as an improvement aim after January 2012. Within six months of the intervention, the number of postnatal women who were visited by the HEW for postnatal care increased from a few to 100 and reached 181 in number by June 2012, as shown in Figure 4. This represented a coverage of 91% of postnatal women by June 2012.

Figure 4: Percentage of post-natal women visited by health extension workers, Nine health posts, Illu District, January–June 2012



B. Qualitative Study of the CHW Collaborative

A retrospective cross-sectional qualitative study was conducted in September 2012 in three out of the 18 participating *kebeles* to document the impact of the collaborative approach on the community health system and its management, linkages between the community and the health system, and support offered to HEWs. Seventeen informants were interviewed, including HEWs, improvement team members, HEW supervisors, health facility managers, and service recipients.

Support and supervision of HEWs was perceived as improving during the improvement intervention, as members of the improvement teams and other community group leaders took greater responsibility for providing HEWs with feedback and linking community members with their services. Furthermore, members of the improvement teams felt more accountable to the community.

One team member, an agricultural development agent, expressed that prior to his membership he did not know how to respond to community members' requests for advice on health issues. Being part of the team made him aware of and confident in referring individuals to HEWs. Strengthening these links made HEWs feel more connected and, in their view, more effective. One HEW noted *"Previously the community was not convinced that I could indeed help them with their health problems. Now they are convinced that not only me, but improvement team members could also contribute to their own health."*

Respondents indicated that prior to the establishment of the improvement teams, there was no mechanism for identifying challenges in service delivery, such as lack of medicines and supplies. Improvement team meetings offered a venue for challenges to be raised and solutions identified. Supportive supervision also became a means through which challenges in service delivery could be addressed. However, limited support to HEWs, specifically through in-service training despite HEWs' expressed need and desire for additional training, was a barrier to developing their practical skills. According to one HEW supervisor, *"training is organized based on decisions at a higher level"*, and neither HEWs nor their supervisors were involved in identifying those needs.

Upon reflection, HEWs and improvement team members expressed satisfaction with services they provided, contending that over the course of the intervention year the community had taken greater ownership over its own health. HEWs also felt their reach had increased: *"There is not member of a household who cannot be reached now. Each improvement team knows who is pregnant, who is lactating, who has a latrine, who sleeps under an [insecticide treated bednet]."* Interviewed clients shared that they were more comfortable with community-level health services, commenting that *"The HEW is like our friend. I do not find it difficult to share every problem I have with her as she either helps me or takes me to the health center."*

All respondents perceived that the intervention was simple, dynamic, and cost-effective. Zone Health Department (ZHD) staff noted a positive impact on coverage, stating *"We realized that this is a cost-effective and innovative initiative. Performance of ZHD as concerns maternal health [ANC] is 60% but in operational kebeles [where the collaborative took place], our performance shows nearly 100%."*

IV. CONCLUSION

In Ethiopia, access to health services has been a critical challenge due to limited infrastructure and availability of trained health professionals. However, improvements have been seen since the implementation of the Health Extension Program. Yet existing evidence shows that the quality of service provision at the community level continues to be a challenge due to weak support of HEWs and their heavy workload.

The community health system piloted in this improvement collaborative demonstrated that it is possible to extend the reach of HEWs by engaging the broad range of community groups with interests in the health of their members. As a result of the strengthened community health system, participants

observed that HEW workload decreased, while coverage of services increased. Additionally, communities had better understanding of and confidence in HEWs and increasingly sought their services.

While this intervention was limited in size, it provides evidence that a community health system can be strengthened to improve health services utilization and quality. The utilization of the community system model also contributes toward the achievement of Universal Health Coverage and greater equity in health service delivery. The findings are consistent with studies elsewhere which have documented that supporting community health workers can strengthen the health system and improve efficacy.

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