Empowering the community – Build the competence of Health Development Army

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Background

Ethiopia has been using voluntary community health workers since around 1974. Various names and scopes of practice were given to these volunteers: community health agents, Community Reproductive Health Agents, etc. Then, after the initiation of the Health Extension Program, a new name and organization/structure introduced. The program recommended having 10 Volunteer Community Health Promoters (VCHP) for each Health Extension Worker (HEW). Due to the epidemiologic, demographic and socioeconomic transitions in the country, relaying on HEWs and very few volunteers was not adequate to reach every household and every target individuals and bring about dramatic changes in the health status of the community. In response, based on the commendable experience and role development armies played in other sectors, the government has introduced Health Development Army (HDA) in the system around 2002/2003 EFY. HDA refers to an organized, inclusive and collaborative movement of the community through participatory learning and action. The Networking and organization of families/households in the Health Development army is based on physical proximity (being neighborhood), and their social and cultural relation and proximity. Once the households are networked/organized, they select the leader of each network and then the leaders participate in a training organized by the Health Extension Workers and Health Centre staff.

After the introduction of this initiative, remarkable changes have been observed in improving maternal, newborn, child and nutrition services, prevention and control of major communicable diseases and hygiene and sanitation services. To further advance this commendable achievement, it is imperative to build the capacity of WDA leaders. the Federal Ministry of Health have thus prepared a strategy to train and qualify WDA through an organized and tailored theoretical and practical training approach which finally leads them to become competent and get certified with level 1 and 2.

Background of HDA members

A rapid assessment aimed at understanding the sociodemographic characteristics of the current 1 to 5 network leaders was carried out by FMOH and its partner in nine selected kebeles from the four agrarian regions (n=1077). The result showed that nearly all of the HDA members were married, and majority, as per the HEWs assessment, were actively working at the time of assessment. Some of the HDA members (11%) had previous experience of working as a volunteer in their kebele. In addition, the age of HDA members was between 18 and 60 years, while the median age was 32 years. Moreover, the data were further analyzed to determine their literacy level. It showed that very few completed selected grades - 4th, 8th and 10th grade (22%, 8% and 4%, respectively).

Rationale for HDA level 1 and 2 qualification

Since the introduction of the Health Development Army, there have been significant improvements in the health system and household level practices. However, as a matter of fact, behaviors unless be maintained at the desired level, they don't bring continual improvements in healthy practices at the household level. Among other factors, individuals need assurance of the started practices at the household level is important and right. The competence based training and the qualification reaffirms the knowledge and skills are important. In addition, apart from the continuous discussion between the HDA leaders and followers, building confidence and then self efficacy would be a key attribute to enhance further behavior changes at the household and community levels. Taking a competence examination and receiving a qualification will also enhance the confidence of the leaders to provide services more intensively.

Process of Implementation

National Qualification Framework (NQF) and training

In collaboration with technical, vocational and educational training agency (TVET), ministry of health has drafted national qualification framework (NQF) for level 1 and level 2 Health Development Army trainings. Following the draft NQF, curriculum, assessment tools, training facilitation guide and manual were drafted and tested at the field level. For the initial pilot program two regions – Tigray and Oromia Regional States were selected and RHBs are now rolling the trainings in the selected pilot woredas. The trainings are given at the kebele level by health extension workers in close supervision from Health Centers and TVETs.

Competence assessment

The competence assessment guide and questions are prepared by the Federal TVET agency in collaboration with Federal Ministry of Health and Partners. While preparing the assessment tools, necessary materials were also identified. As Health extension workers will do the assessment, training on basic skills on assessment would be given to them and the Agency of Competence (AOC)/ Regional Center of Competence (COC) will certify them as an assessor.

After completion of all the competencies for each level, the trainees would be assessed by certified HEWs from other woredas/kebeles through strong supervision from the AOC/ COC.

Certification

When the trainee completes each unit of competence, the training institution/woreda health office will provide certificate for completion. But when the trainee completes the chart of competences for each level, they are expected to take the qualification examination provided by Agency of Competence (AOC)/ Regional Center of Competence (COC). Should they pass the qualification exam, they receive a competence certificate from the AOC/COC.

Anticipated challenges

The nature of competence based training which requires extended period of time to complete each competence may not attract the trainees to join or compete the training. The venue for the training might not be also an attractive place to come and stay for long hours in a day. Moreover, low literacy level at the community level might affect the confidence of trainees and may hold them to take exams. Lastly but not least, multi-sectoral involvement of the HDA members might affect their commitment for the training and service provision.

Conclusion

The health system has invested a huge amount of resources and time transferring knowledge and basic skills to the households and made them produce their own health. This intervention has been effective and contributed to the improvement of health in Ethiopia. It now requires recognition of the graduated model households by AOC/COC which demands qualifying for the set of competencies. Taking the examination and having a qualification would boost the confidence of households/women to further improve the health and wellbeing of the residents in their neighborhood. In addition, the program provides an opportunity for the health extension workers to delegate some of their responsibilities to the qualified health development army.

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