

# Community Mobilization to Enhance Community Production and Ownership of Health

The case of USAID Transform: Primary Health Care

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## Summary

To support the Ethiopian government in reducing preventable maternal and child deaths, Pathfinder International implemented the United States Agency for International Development (USAID) Transform: Primary Health Care Activity (2017-2022) in partnership with JSI Training and Research Institute, Abt Associates, Encompass LLC, and the Ethiopian Midwives Association. The Activity was implemented in Ethiopia's five agrarian regions—Amhara, Oromia, Sidama, Southern Nations, Nationalities and Peoples (SNNP), and Tigray—at the primary health care level to provide broader access to quality essential health services while bridging the gap in service utilization by promoting timely health-seeking behaviors. Its social and behavior change (SBC) strategy used multipronged community-level approaches to improve health-seeking behavior (through demand generation interventions); enable the community to improve their own health (through community engagement and mobilization, community capacity strengthening, and creating women leaders in the community); and supporting the community to make informed decisions for social accountability (through community town hall meetings and health post open houses). This brief presents one of the major SBC interventions implemented by the Activity's community mobilization efforts.

## Community Mobilization

The USAID Transform: Primary Health Care Activity defines **community mobilization** as a capacity-strengthening process through which communities explore problems; develop a plan of action; and carry out, monitor, and evaluate activities on a participatory and sustained basis to improve their health and lives.

In this collaborative work, people who share a common place or interest plan and act together to create an environment that promotes and supports widespread behavior change. Unlike traditional interventions, community mobilization focuses on uniting a community around a single issue to create social and structural change as envisioned by the community. The overarching goal is to enable communities to become producers and stewards of their health.

## Context

Ethiopia has made significant progress in improving the health status of its population over the last two decades.<sup>1</sup> Modern contraceptive use among married Ethiopian women increased from 27% in 2011 to 41% in 2019. Antenatal care coverage (at least one visit) improved from 62% in 2016 to 74% in 2019. Skilled attendance of deliveries increased from 18% in 2016 to 50% in 2019. Early postnatal care also increased to 34% in 2019 compared to 17% in 2016.<sup>2</sup> Accordingly, the maternal mortality ratio has decreased from 676 deaths per 100,000 in 2011 to 401 in 2017. Under-five mortality and infant mortality also declined from 123 and 77 respectively in 2005 to 59 and 47 respectively in 2019.<sup>3</sup>

Yet despite diligent efforts and remarkable progress in improving health service coverage, Ethiopia still carries high burdens of preventable disease, such as malaria and tuberculosis, and mortality.<sup>4</sup> Health service utilization remains unacceptably low due to sociocultural, behavioral, and service-related factors that deter the adoption of appropriate health practices.<sup>5</sup>

These factors include the following:

- Religious and traditional beliefs and practices;
- Limited risk perception, recognition of illness, and prompt care-seeking;
- Misconceptions related to causes and

treatments of illness, including belief in predetermined outcomes of pregnancy or sickness by God/Allah;

- Perceived and actual poor quality of care;
- Geographic barriers;
- Low health and health-system literacy, and lack of awareness of available services at health posts;
- Reluctance to disclose pregnancy early due to shame and fear of the evil eye and of miscarriage; and
- Women's lack of decision-making autonomy.

Ethiopia's health services are delivered in a three-tier system. Primary health care units (PHCUs) provide comprehensive primary care for up to 100,000 people. PHCUs are supported by a primary hospital and composed of one health center and five satellite health posts. Rural health centers serve populations of about 25,000, while urban health centers tend to serve around 40,000. Health posts serve approximately 3,000 (in pastoralist settings) to 5,000 (in agrarian settings). The secondary level includes general hospitals, which serve as referral centers for PHCUs, and serve 1 to 1.5 million people. The tertiary level consists of specialized hospitals, which serve as referral centers for general hospitals and serve 3.5 to 5 million people.<sup>6</sup>

Ethiopia's Health Extension Program (HEP) has contributed significantly to the country's improved health outcomes by working toward equitable access to health services across Ethiopia. The HEP is a community-based strategy to deliver health promotion, disease prevention, and selected curative health services free of charge at the community level. The HEP health packages fall into four major categories: hygiene and environmental

sanitation; prevention and control of major communicable diseases; family health

<sup>6</sup> "Health Sector Transformation Plan I, 2015-2020." Addis Ababa, Ethiopia: Federal Ministry of Health of Ethiopia, 2015.

<sup>1</sup> "Health Sector Transformation Plan II (HSTP II), 2020/1 to 2024/5." Addis Ababa, Ethiopia: Federal Ministry of Health of Ethiopia, n.d.

<sup>2</sup> "Ethiopia Mini Demographic and Health Survey 2019: Final Report." Rockville, MD, USA: Ethiopian Public Health Institute (EPHI) and ICF, 2021. "Ethiopia Demographic and Health Survey 2011." Addis Ababa, Ethiopia: Central Statistical Agency/Ethiopia and ICF International, 2012. "Ethiopia Demographic and Health Survey 2016." Addis Ababa, Ethiopia: Central Statistical Agency/CSA/Ethiopia and ICF, 2016.

<sup>3</sup> HSTP II

<sup>4</sup> "A Roadmap for Optimizing the Ethiopian Health Extension Program 2020-2035." Addis Ababa, Ethiopia: Federal Ministry of Health of Ethiopia, 2020.

<sup>5</sup> Ethiopia Mini-DHS 2019. "Barriers to Uptake of Integrated Community Case Management of Childhood Illness (ICCM) and Community-Based Newborn Care (CBNC) Services in Selected Woredas of Amhara, Oromia, SNNP, and Tigray Regions, Ethiopia: Summary Report." Seattle, WA, USA: PATH, 2016.

services; and health education and communication. A team of two health extension workers (HEWs), deployed in a community health post serve a catchment population of 3,000 to 5,000 in a village, or kebele. In addition to providing basic health services, HEWs represent the health sector in the local administration.<sup>7</sup>

In 2011, to enhance the efforts of the HEP, the Ethiopian Government introduced the Women's Development Army (WDA)—a group organized by settlement or social proximity to participate, teach, learn, and take practical actions to improve individual, family, and community health. WDA members are commonly called “one-to-five” networks, denoting one leader and five member households. Five or six “one-to-five” networks are grouped into a women's development team comprising 25 to 30 households, called “one-to-30”, denoting one team leader to about 30 member households. HEWs, with the support of the kebele administration; Children, Youth, and Women's Affairs; and the woreda health office (WorHO), organize WDAs. Early adopters and volunteers who have the credibility from the community are selected by team members as leaders. The HEWs train these leaders on key health issues using the Family Health Guide. The WDA team leaders then support the HEWs in promoting uptake of key health services, disseminating essential health messages, practicing key health actions, generating demand for the community health insurance scheme, and collecting health information. WDAs also play key role in facilitating the creation of model kebeles.

A **model kebele** (village) is a kebele with high (at least 85%) coverage of model households, skilled birth attendance, improved latrine coverage, and model schools. A model household is a family that adopted most, if not all, of the government's 16 priority interventions – from vaccinating their children and sleeping under mosquito bed nets to building separate latrines and using family planning. Model families are celebrated at village ceremonies with certificates.

Though the WDA approach initially helped to improve community engagement and health-seeking behavior, its acceptance and functionality has shown significant decline in recent years. Challenges include selection of WDA leaders, poor community acceptance, the prevailing view of WDAs as political tools rather than volunteer change agents, poor quality of training, limited support by husbands for their wives' involvement, lack of incentive schemes, inadequate support from the local leadership and health system, poor multi-sectorial engagement, and weak coordination. Men, youth, religious institutions, community elders, and other community structures, such as Idir, have also been underutilized in the improvement of community health because of over dependence on WDA structures.<sup>8</sup>

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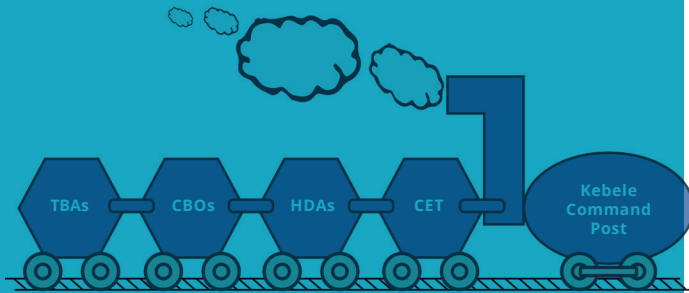
7 “A Roadmap”

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8 Ibid

# The USAID: Transform Primary Health Care Activity Approach to Community Mobilization

Ethiopian culture is built on a strong community network, administratively centered around Ethiopia's lowest and smallest administrative unit, the kebele. The Activity, therefore, defines communities as neighborhoods, towns, or kebeles where people live and are served by a common health post. Kebele administration plays a key role in community mobilization. In fact, they are the drivers of the "community mobilization train."



To improve health behaviors and bridge the gap in service utilization, the USAID Transform: Primary Health Care Activity implemented a mix of mutually reinforcing SBC interventions, including community mobilization (CM). The objectives of the Activity's CM efforts were to:

1. Improve household and community health practices;
2. Increase reproductive, maternal, newborn, and child health and nutrition (RMNCH-N) service uptake; and
3. Support the creation of model kebeles.

Central to CM is the community action cycle, a community empowerment model that outlines a process through which communities collectively organize, explore, set priorities, plan, and act for improved health (Figure 1). Strengthening community capacity fosters ownership,

sustained collective action to improve health, social legitimization of healthy behaviors, and strategies that respond to local needs. It equips communities to demand quality health services, driving a cycle of responsive health service delivery, which will result in improved outcomes. The community action cycle entails four stages with associated steps: (1) Organize, (2) Explore and plan, (3) Act together and monitor, and (4) Evaluate, learn, and replan. This process enables the community to better organize to identify and address pressing health issues.



**Figure 1. Community Action Cycle**

## STAGE ONE: ORGANIZE



The Activity team or the subgrantee woreda holds a two-day workshop to orient local authorities, sector office leads, and other community representatives on CM and priority health issues. Afterward, the participants establish a multisectoral CM team, or core group, of 15 to 25 members, including kebele leaders, school directors, agriculture extension workers, HEWs, women and youth representatives, religious and community leaders, former traditional birth attendants, selected women and men who are development team leaders, and other interested and affected individuals. At least 30% of the CM team members should be women. The team should have a chairperson, vice chairperson, secretary, and treasurer. It should have a written vision statement and code of conduct. The team should also document selected service uptake indicators to serve as a baseline.

## STAGE 2: EXPLORE AND PLAN



The CM team explores and prioritizes barriers to adoption of appropriate health behaviors in the kebele. The team then develops a plan of action to address the prioritized problems, holds a meeting to introduce the initiative to the broader community, and solicits feedback and support.

## STAGE 3: ACT TOGETHER AND MONITOR



The CM team represents sector offices, villages, community-based organizations, and faith-based organizations and regularly monitors the planned activities in their respective institutions and catchment areas. The team also supports HEWs and women development team leaders in realizing their demand-creation objectives. The catchment health center provides ongoing technical support to the CM efforts aimed at creating model kebeles to capture their experiences to share with the remaining PHCUs and kebeles for potential scale-up.



## STAGE 4: EVALUATE, LEARN, SHARE, & RE-PLAN

The CM team evaluates the outcomes of the initiative with the support of the catchment health center using the baseline data collected just after the CM kickoff workshops in each kebele. The team also shares its experiences with neighboring PHCUs and kebeles with the support of the WorHO and catchment health center. The experience-sharing forum is organized at woreda level so that health centers and kebeles will learn from each other's experiences.

## Implementation activities

The Activity trained 266 health experts to enable them to facilitate CM kickoff workshops and support the intervention rollout in each woreda (Table 1). While the Activity facilitated some CM kickoff workshops, woredas planned and facilitated others themselves with subgrants made available through the Activity.

**Table 1. Community Mobilization Training**

Regions	# Trainees	# Kickoff workshops	# Kickoff workshop participants	# Review meetings	# Woredas that participated in CM	# Kebeles that participated in kickoff workshop
Amhara Direct	55	6	434	5	12	30
Amhara Grant	65	40	2,171	22	40	176
Oromia Direct	47	9	451	6	9	37
Oromia Grant	-	24	1,697	1	24	96
SNNP Direct	80	7	369	22	12	37
SNNP Grant	-	88	5,638	67	88	436
Tigray Direct	19	4	52	0	5	16
Tigray Grant	-	-	-	0	-	-
<b>Total</b>	<b>266</b>	<b>178</b>	<b>10,812</b>	<b>123</b>	<b>190</b>	<b>828</b>

## Implementation challenges and responses

**The Activity team responded to the following challenges during the implementation process:**

**Challenge:** COVID-19 and political instability affected the effective implementation of the CM intervention as both situations restricted travel and the ability to meet in person.

**Response:** The team adopted COVID-19 prevention protocols and other safety measures that allowed them to implement the approach safely.

**Challenge:** Political instability led to high turnover of trained kebele leadership and catchment health center and WorHO staff.

**Response:** The Activity team tried to mitigate this challenge with regular supportive supervision visits and review meetings.

**Challenge:** Catchment health centers and WorHOs were not monitoring the implementation of the intervention with the frequency of supportive supervision visits needed and expected due to lack of commitment and recurrent emergency situations.

**Response:** The Activity team has advocated for increased supportive supervision and monitoring at the review meetings.

**Challenge:** Dwindling functionality of the WDA—Ethiopia’s national community engagement structure—has affected community health status across all health indicators. Several factors have led to this decline, including the negative political connotation attached to WDAs, poor quality of training, lack of incentive schemes, and inadequate support from the local leadership and health system.

**Response:** The Activity team has advocated for and contributed to the scheme’s revision, which is currently being piloted by the Federal Ministry of Health (FMOH).

**Challenge:** Health care providers favor quick-fix approaches like information dissemination over process, and their community-empowerment skills are limited. Moreover, many health care providers did not consider SBC and community empowerment, including community mobilization, as their responsibility.

**Response:** The Activity team conducted capacity strengthening and advocacy workshops to enhance providers' community empowerment skills.

An additional constraint was that, though the Activity team introduced indicators and data collection tools to the sub-grant woredas, they were unable to regularly follow up with sub-grantees due to competing priorities and the emergence of COVID-19 pandemic. Therefore, measurement of progress and outcomes has been a major challenge.



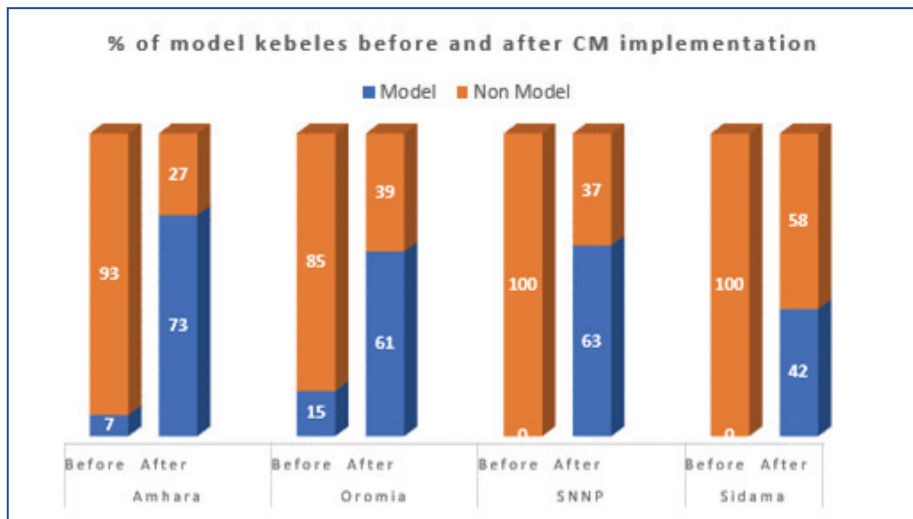
## Performance

Data on model kebele status was collected from 94 direct-support kebeles that participated in two-day kickoff workshops and day-long review meetings in Amhara, Oromia, SNNP, and Sidama regions to measure change following the CM intervention (Table 2). To become a model kebele—the FMOH's vision for all kebeles—a kebele must meet criteria including coverage of skilled birth attendance, latrine access, and presence of model households and schools that have adopted the government's priority interventions (see box, page 3). The findings indicate a 55% increase in model kebeles.

**Table 2. Model Kebele Status of Direct-Support Kebeles**

Region	# Kebeles directly supported	# Model kebeles before CM	# Model kebeles after CM	Difference
Amhara	30	2 (7%)	22 (73%)	+20 (67%)
Oromia	33	5 (15%)	20 (61%)	+15 (44%)
SNNP	19	0 (0%)	12 (63%)	+12 (63%)
Sidama	12	0 (0%)	5 (42%)	+5 (42%)
<b>Overall</b>	<b>94</b>	<b>7 (7%)</b>	<b>59 (63%)</b>	<b>+52 (55%)</b>





## Acceptability of the community mobilization intervention

Data collected from 49 key informants comprising HEWs, catchment health center and WorHO staff, kebele leaders, and kebele education and agriculture representatives showed that almost all participants agree or strongly agree that CM is effective in improving uptake of RMNCH-N services; model kebele Indicators; enrollment in and renewal of community-based health insurance, a scheme that pools members' premium payments into a collective fund that covers basic health care costs to remove financial barriers to health service access; multisectoral collaboration; and community ownership. They expressed a strong belief that the CM team is a local support structure for HEWs and is easy and cost effective to implement (Figure 2).

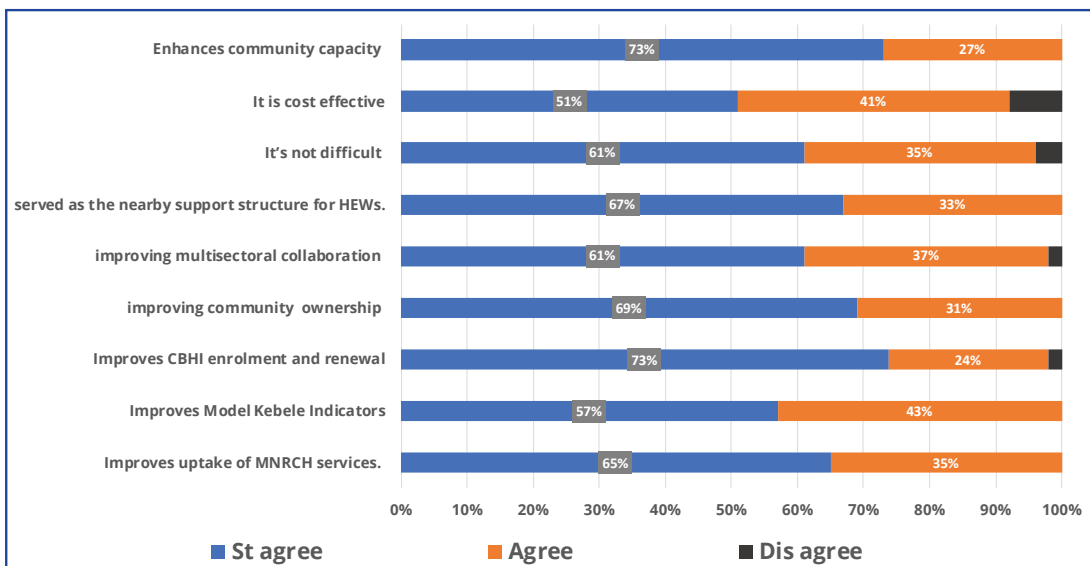


Figure 2. Implementers' Views on the Effectiveness of the Community Mobilization Approach



*Photo credit: Jimmy Teshome, Pathfinder International. Problem analysis using a problem tree during a CM kickoff workshop in Amhara region, Ethiopia*

## Facilitators of sustainability

Several factors contributed to the sustainability of the CM approach:

- The Activity's focus on working within existing community structures such as the kebele command post, and on community capacity enhancement, facilitated program ownership and sustainability. The commitment of WorHOs, catchment health centers, and kebele leadership was essential to the success and sustainability of the intervention.
- With subgrant funds made available by the Activity, 152 WorHOs planned and implemented CM on their own.
- Five woredas scaled up the CM intervention in 18 additional kebeles using their own resources.
- The Activity created a pool of 266 CM trainers and organized advocacy and experience-sharing events through various platforms, often integrated with other activities.
- CM is included in the draft national advocacy and social mobilization guide of the FMOH.
- Community mobilization is a resource-intensive endeavor. Therefore, when replicating or scaling this intervention, prioritize communities with the highest burden of disease and that could benefit most and/or communities that are most interested and that have some previous positive history of collective action.
- Promote shared concern, vision, and responsibility among community members to ensure ownership and sustainability of outcomes.
- Sustain momentum by beginning implementation activities immediately after the CM kickoff workshop, while community representatives are motivated to act.
- The kebele command post—which brings together sector offices such as health, education, and agriculture—played key role in the success of CM efforts. Development partners, and even other sectors, can plug into this platform to advance their community development agendas.
- Be flexible to adapt elements, including the health area of focus, the CM agenda, and the frequency and location of meetings, to the needs of a specific context.

## Lessons and Recommendations

It is worth advocating for the integration of the CM approach into the broader national or regional health plan. CM enables communities to identify and address their most pressing health problems. This sense of ownership leads to improved health behavior and uptake of services. It also facilitates the creation of model kebeles by enhancing sectoral collaboration. The CM team also serves as a nearby support structure for HEWs.

The following lessons and recommendations can help guide the replication and scale-up of this approach in additional settings.

- To strengthen CM efforts in the future, catchment health centers must conduct regular supportive supervision and mentoring visits. The frequency of support should be higher in the first three months to keep momentum.
- Plan for a minimum of two years. Community empowerment approaches such as community mobilization require time to mature and show results—for example, the transformation of kebeles into model kebeles.

## Project overview

Benefiting nearly 53 million people, the USAID Transform: Primary Health Care Activity (2017-2022) strengthens the management and performance of Ethiopia's national health system by improving quality of service delivery across the continuum of primary health care, improving household and community health practices and health-seeking behaviors, and strengthening program learning to impact policy and activities related to the prevention of child and maternal deaths.

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