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**Maternal and Child
Survival Program**

MCSP Community Health Contributions Series: Ethiopia

August 2019

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Background

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP) operated globally and in 32 countries with the ultimate goal of preventing maternal and child deaths. To support community health structures in these countries, MCSP advocated for institutionalizing community health as part of national health systems, strengthening the capacity of community health workers, and supporting community infrastructure in partnership with country governments and civil society organizations. This brief is one of an eight-part series developed by MCSP to review and understand the processes of community engagement in MCSP-supported countries and identify how the community health approaches implemented by the project have contributed to changes in health service uptake and behavioral outcomes.



Opportunities to actively engage fathers were a key MCSP-NEGA demand creation principle. At the health post, local men talk about why they are involved in promoting safe delivery for women. Photo Credit: Karen Kasmauski/MCSP

In Ethiopia, MCSP's community-based newborn care (CBNC) project, Newborns in Ethiopia Gaining Attention (NEGA), supported the Ethiopian Federal Ministry of Health in strengthening the country-led health system. MCSP-NEGA's goal was to improve the capacity of primary health care staff to provide high-impact, quality newborn care services at the community level and empower communities to actively participate in demand creation strategies that support the effective use of maternal, newborn, and child health (MNCH) services. In line with the government's approach, MCSP-NEGA's endorsed meaningful community participation and ownership in planning, implementing, monitoring and evaluating community-based interventions. Between 2014 and 2018, MCSP-NEGA worked in 135 woredas (equivalent to a district) across four regions: Tigray (two zones), Amhara (four zones), Oromia (two zones), and Southern Nations Nationalities and Peoples' Region (four zones). The project covered total of 3,762 kebeles (communities), 3,605 health posts, and 730 health centers.

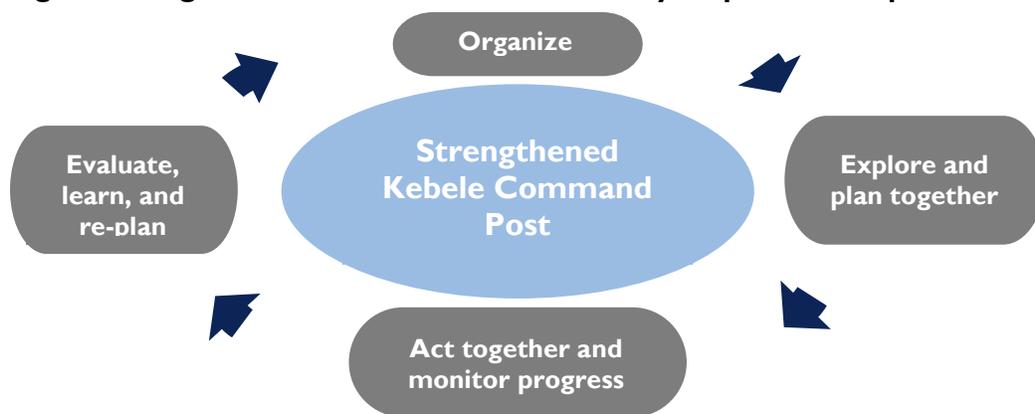
Community Health Focused on Maternal, Newborn and Child Health

Using the Government of Ethiopia's community health platform, MCSP-NEGA implemented community service delivery, community capacity-strengthening, and social and behavior change strategies with an aim of strengthening existing community health platforms to cater to newborns. Through the implementation of

interventions at multiple levels (national, primary health care unit [PHCU], kebele, household, and individual), the project contributed to an enabling environment by improving service delivery, promoting active community engagement, and increasing social support for women and their families. For instance, at the national level, MCSP-NEGA developed an MNCH-CBNC demand creation orientation guide and a half-day training for health extension workers (HEWs), which have been integrated into the existing Federal Ministry of Health (FMOH) CBNC training. The training provides an opportunity for HEWs to analyze the interconnectedness between provision of services and the barriers and enablers for families and communities to demand these services. Additionally, at the PHCU level, the project developed a series of six supportive supervision guides and associated tools to assist PHCU performance review teams in building community capacity to organize, explore, plan, and act together for improved MNCH.

At the community level, MCSP-NEGA focused on capacity-strengthening and linking existing community groups and networks (e.g., health development army leaders, traditional birth attendants in a non-delivery role, respected elders, interested and affected individuals, and representatives from faith-based organizations and other community groups) for improved MNCH-CBNC. Specifically, the project worked with kebele command posts (KCPs) to apply the community action cycle (CAC). The CAC model of community empowerment enabled communities to identify barriers, prioritize MNCH-CBNC issues, develop an action plan, act collectively, and celebrate successes. The process entailed four stages, with associated steps (Figure 1).

Figure 1. Stages of the CAC model of community empowerment process for MNCH-CBNC



MCSP’s decision to work with KCPs was based on: their existing role as a government multi-sectoral development platform; the decision-making role they play in their catchment areas; and their potential to mobilize human, financial, and material resources. MCSP-NEGA developed guidance on how to select new members, develop norms for a functioning group, and create participatory tools, such as the “problem tree” to explore issues affecting mothers and newborns in the community. Additionally, MCSP-NEGA created a guide on how to prioritize community issues; how to make a community action plan; and ways to mobilize human, material, and financial resources to implement action plan activities.

MCSP-NEGA also piloted a partnership-defined quality (PDQ)¹ approach with six of the project-supported health centers’ quality improvement teams to foster community engagement in the quality-of-care improvement process. PDQ reinforces the social accountability role communities play through ongoing dialogue, planning, collective action, and monitoring of outcomes, leading to increased demand for and access to health services. The PDQ approach brought together health service providers and users/clients to define, explore, and improve the quality of health service delivery.

In addition to developing guidance documents and various trainings, and implementing the CAC and PDQ approaches, MCSP-NEGA carried out numerous other activities to strengthen the capacity of primary health

¹ Save the Children. 1996. *Partnership Defined Quality: A Tool Book for Community Health Provider Collaboration for Quality Improvement*. Fairfield, CT: Save the Children.

care staff to provide high-impact, quality newborn care services in the community and empower communities to actively participate in demand creation strategies that support the effective use of MNCH services. For instance, in 2014, the FMOH and MCSP-NEGA, including country partners supporting MNCH-CBNC, developed a *Demand Creation Strategy for MNCH-CBNC (draft, 2015)* that focused on approaches, which, when implemented, would be feasible, effective, and scalable to address the persistent low demand for CBNC. The design process included a review of global and local demand creation experiences for MNCH-CBNC, consultation workshops, and community-to-community learning visits aimed at transferring MNCH-CBNC demand creation-related lessons to neighboring kebeles and health centers, as well as a design workshop attended by the FMOH and its partners. The resulting strategy supported a systems-strengthening approach that built the capacity of zonal, woreda, PHCU and kebele levels to improve MNCH-CBNC. **Table 1** outlines activities implemented by MCSP based on three pillars—community service delivery, community capacity-strengthening, and community social and behavior change.²

Table 1: Three pillars of MCSP’s community health approaches in Ethiopia

Service Delivery	Capacity-Strengthening	Social and Behavior Change
<ul style="list-style-type: none"> • Piloted the PDQ process in six health centers. • Developed a series of six supportive supervision guides and associated tools, which aligned with the CAC, as on-the-job training guides to assist PHCU performance review teams in the step-by-step implementation of MNCH-CBNC demand creation strategies with their community partners. 	<ul style="list-style-type: none"> • Facilitated the CAC at scale. • Facilitated community-to-community learning exchange visits. • Created portable community health bulletin boards to aid in decision-making for improved community planning. • Revised the national <i>Health Extension Workers-Health Development Army Meeting Guide</i>, which is used during regular fortnightly meetings by HEWs to strengthen their capacity in their key health promotion tasks. • Revised the national <i>Pregnant Women’s Conference Facilitation Guidelines</i> to create a more participatory environment during community meetings and broaden the topics covered, and provided training to midwives and health workers who facilitated the women’s groups at the kebele level so that newborn-related issues were properly integrated into discussions. 	<ul style="list-style-type: none"> • Strengthened the capacity of HEWs who oriented the school community (teachers and students) on key MNCH-CBNC information. • Adapted the national <i>Family Health Guide (FHG)</i> for use by agricultural development agents who integrated this information into their regular engagement with men. • Strengthened faith-based leaders’ membership and function within KCPs through the CAC process, and trained faith-based leaders on key MNCH-CBNC actions who went on to train other faith-based leaders. • Started radio listening groups and culturally appropriate local radio programs with a focus on newborn health, disseminated pre-recorded key MNCH-CBNC messages at large gatherings, and developed CBNC educational DVDs in the Amharic and Affan Oromo languages³ that were played in patient waiting areas of health centers.

Achievements

The findings of the MCSP-NEGA final evaluation⁴ and feedback from key informants from regional, zonal, and district health offices indicate that the project’s community health approaches contributed to the government’s effort to improve MNCH outcomes in the four regions where the project was implemented. The results indicate statistically significant improvements in several key indicators at the end of the project compared with the baseline study

² For a more in-depth review of the demand creation activities implemented by MCSP-NEGA see the brief entitled, *Maternal and Child Survival Program (MCSP) Community-Based Newborn Care (CBNC)/Newborns in Ethiopia Gaining Attention (NEGA) Project: Implementing a Demand Creation Strategy for Improved Maternal, Newborn, and Child Health Outcomes*.

³ The DVDs were developed by Save the Children’s Saving Newborn Lives Project with technical contribution from MCSP. MCSP received 1,100 DVDs and distributed them to all 730 health centers and 135 woreda health offices.

⁴ Maternal and Child Survival Program (MCSP) Community-Based Newborn Care (CBNC)/Newborns in Ethiopia Gaining Attention (NEGA) Project, End-line Survey Report. 2018.

Improvements in Maternal Health

Over the project period, MCSP consistently promoted and supported the use of the FHG as the main MNCH-CBNC communication tool at the community level. MCSP distributed over 65,000 FHGs in Amharic, Oromifa, and Tigrigna to communities in all of the 135 project woredas. During home visits, HEWs and members of the Ethiopian Women's Development Army used the guide and actively sought out and engaged fathers, mothers-in-law, and other influential family members. **Home visits during early pregnancy (first 12 weeks) more than doubled by the end of the project.**

Improvements in Newborn Health

Improving the health of mothers and newborns through well-organized institutional delivery services is central to achieving reduced maternal and newborn morbidity and mortality. Through various channels, MCSP-NEGA promoted facility delivery, as well as antenatal care, birth preparedness, postnatal care for the mother and baby, and awareness of newborn danger signs. **Facility delivery increased by approximately 8% between the baseline and endline research, and at endline, there was a statistically significant increase (almost a doubling) in the proportion of mothers with babies who received postnatal care home visits within 48 hours in MCSP-NEGA areas.** These findings demonstrate increased capacity and responsiveness among HEWs to provide critical follow-up to mothers and newborns for general care and to identify danger signs in the postnatal period.

Improvements in Women's Capacity

The guidance provided by the *Demand Creation Strategy for MNCH-CBNC* encouraged the use of existing community platforms and approaches to engage community members around MNCH-CBNC (e.g., actively engaging men and other decision-makers in families, using community-based data for decision-making, building and linking community social networks). At endline, women were asked about their perceptions of their own capacity and that of their community around MNCH-related issues. **There was statistically significant improvement in perceived self-efficacy (70% at baseline vs 77% at end-line; $p < 0.001$), collective action (72% at baseline vs 75% at end-line; $p < 0.05$), effective leadership (55% at baseline vs 67% at end-line; $p < 0.001$), and participation (63% at baseline vs 71% at end-line; $p < 0.001$) at the end of the project by women aged 15–49 years.**

Conclusion

MCSP's collaboration with the government of Ethiopia showed that large-scale and sustainable implementation of community empowerment and demand creation activities is possible. Maternal and newborn health is a top priority for the government of Ethiopia and communities are generally expected to have the capacity to promote and support facility delivery; nevertheless, the project's community empowerment/demand creation strategy systematically engaged communities to identify and act on priority MNCH issues within their localities. Using community platforms, such as strengthened KCs, MCSP facilitated institutionalization of community empowerment approaches and collective ownership. Moreover, integrating empowerment approaches into existing community platforms enabled large-scale implementation within a short period of time.

This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.