Building Community Competence for Public Health

Prepared for a panel discussion at the 139th APHA Conference in Washington DC, 29 October-2 November 2011

Prepared By
Workneh Kassie
22 October 2011

EXECUTIVE SUMMARY

World leaders met at the UN Headquarter in New York in 2000 and adopted eight Millennium Development Goals (MDGs). They also made strong commitment to the achievement of the Goals by 2015. Ethiopia as a member of the UN body adopted to implement all the eight goals. Accepting the MDGs and aspiring to achieve the goals have been a daunting task for the country since the country is one of the least developed country with poor resource and having the highest poverty incidence, highest child and maternal mortality, high HIV and sexually transmitted disease infections and the lowest health service and water and sanitation coverage in the world. In order to achieve the health and health related MDGs, a health reform programme was introduced by adopting a health policy in September 1993 and a 20-year health strategy in April 1995. The strategic plan was designed to be implemented in phases of five-year Health Sector Development Programmes (HSDP). Democratization, decentralization, intersectoral collaboration and community participation were among others the main features of the health policy. Providing comprehensive and integrated primary health care at the community level.

Emphasizing preventive and promotive aspects of health care, focusing on communicable disease, common nutritional disorders and on environmental health and hygiene, giving special attention to maternal and child care, immunization, reproductive health, treatment and control of basic infectious disease, strengthening IEC about health and nutrition and developing and adopting a cost sharing mechanism were the main thrusts of the health sector strategic plan. Based on the policy and strategic plan, a health extension programme (HEP) was introduced at the village (kebele) level and staffed two female salaried health extension workers (HEWs). These cadres of health workers are trained for one year at technical and vocational and education training centers (TVET) to provide sixteen community-based health packages. They spend 75% of their time conducting outreach activities by going from house to house. They spend the remaining 25% of their time in health posts which are equipped with basic essential materials. They provide antenatal care, delivery, immunization, growth monitoring, nutritional advise, family planning and referral services. The HEW get supportive supervision from the next level of health facility i.e. health centers.

HEP has also brought in what are known as model families. These are lower level of health cadres trained by the HEWs to serve as role models. They help the HEWs in diffusing health messages that lead to the adoption of the desired practices and behaviors by their communities. In order to strengthen the HEP, a Health Development Army (HDA), has been introduced in 2011. This is to capacitate families which are lagging behind in terms of adopting health practices. These health cadres are parts of the communities which their competence needs to be built continuously in a formal and informal way through a

participatory approach. Their cognitive capacity, creativity, visioning, organizational management, intercommunity relation development, self confidence, adjustment of behaviors, and other competences have to be built to make them effective and reliable partners with government and donors.

Building Community Competence for Public Health

1. Background

It was in September 2000 that the world leaders met at UN Headquarter in New York, adopted the Millennium Declaration and made strong commitments to achieve the Millennium Development Goals on eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and women's empowerment, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and others major diseases, ensuring environmental sustainability and developing global partnership for development. Eighteen measurable targets were laid down under the patronage of the eight goals.

Ethiopia having adopted all the MDGs has been challenged due to its status of being the least developed country with the highest poverty incidence, highest child and maternal mortality, high HIV and sexually transmitted infections and the lowest health service, water and sanitation coverage in the world.

The baseline targets for the MDGs are as follows lows[1]:

Baseline for Health and Health Related MDGs

S.No.	Indicator	Status 1990
1	Children under 5 who are underweight	47.6%
2	Prevalence of undernourished (% population)	71%
3	Infant mortality rate	124/1000
6	Under 5 mortality rate	210/1000
7	Maternal mortality ratio	990/100,000
8	Adult HIV prevalence	0.7
9	Access to safe water coverage	17%
10	Latrine coverage	4%
11	Measles immunization coverage	38%
12	ANC coverage at least four visits	10.4
13	Deliveries attended by skill attendant	10%
14	Contraceptive use among married women, 15-49 years	2.9%

Accepting the MDGs and aspiring to achieve the goals have been a daunting task for the country in general and the government of Ethiopia in particular. Since the country is one of the resource poor countries in the world.

[1] Federal Democratic Republic of Ethiopia, Ministry of Health, Health and Health Related Indicators , 2009/10

To achieve these, the government developed and implemented two national medium term development plans. The first was Sustainable Development and Poverty Reduction Programme, 2002/03-2003/04) and the second one was the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) for the period 2005/06-2009/10.

Prior to this, a health reform programme was introduced by adopting a health policy in September 1993 and a 20-year health strategy in April 1995. The strategic plan was designed to be implemented in phases of five-year Health Sector Development Programmes (HSDP) with the following main features.

- Democratization of the health system establishing health councils with strong community representation at all levels and health committees at grassroots levels to participate in identifying major health problems, budgeting, planning, implementing, monitoring and evaluating health activities.

- Decentralization of decision-making power to regions with clear definition of roles and increased capacity for planning, implementation and monitoring
- Emphasizing inter-sectoral collaboration
- Strengthening health education
- Undertaking promotive and preventive activities
- Human resource development with focus on focus on team approach, training of community-based task oriented frontline and middle level health workers to serve at the grassroots level
- Promoting family health services assuring adequate maternal health care intensifying family planning for the optimal health of the mother, child and family.

The major features of the health strategy include:-

- Providing comprehensive and integrated primary health care at the community level.
- Emphasis on preventive and promotive aspects of health care
- Focusing on communicable disease, common nutritional disorders and on environmental health and hygiene.
- Special attention to maternal and child care, immunization, reproductive health, treatment and control of infectious disease such as upper respiratory tract infection and tuberculosis, control of endemic disease like malaria and sexually transmitted disease particularly AIDS
- Strengthening IEC on health and nutrition
- Developing and implementing cost sharing mechanism

Both the policy and strategy documents emphasized democratization and decentralization of the health delivery system. The health care delivery at the grassroots level and community participation emerged within those policy and strategy stances. Democratization calls peoples' participation at all levels while decentralization calls task shifting to the regional, district and

community levels. It also calls fiscal decentralization and decentralization of resource mobilization through revenue collection and cost sharing mechanisms. These implied the participation of individuals and communities in all aspects of health service delivery and also in sharing the benefits.

2. Objective of the paper

Member countries of the UN body are now heavily engaged in planning and implementing policies, strategies and programme to meet the commitments they made at the UN General Assembly in 2000 regarding the MDGs. With only four years away from the target year of 2015, innovative development strategies to achieve these goals have focused on community participation and competence building. Therefore building the competence of communities for genuine and effective participation has become crucial. This paper therefore takes stocks of the issues related to community participation at theory and practical levels. The paper includes definitions of community participation, gap analysis of community competence and country level experiences related to Ethiopia. The paper focuses on planning and implementation of primary health care for the achievement of the health MDGs. In this context, the paper will briefly share some theoretical and practical lessons on what kind of competence can be built and on how community competence can be built or strengthened to make communities effective partners in the planning, implementation and evaluation of national and local development initiatives to achieve the MDGs.

3. Developing Community Competence for Public Health to Achieve the MDGs

3.1 Introduction

Developing Community Competence is a subject that has many components. Therefore there is a need to define community and participation. It is also important to define community competence since it is necessary for the achievement of the MDGs. It is also equally important to make gap assessment on community competence to address these gaps. Let us briefly look at the definitions of community, participation and community participation.

3.1.1 Community

According to Neek Wates (community planning handbook), community is defined as a group of people sharing common interests and living within a geographically defined area. This definition shows that the term community has both social and spatial dimensions and that generally the people within a community come together to achieve a common objective even though they have certain differences.

In Charles Abram's book, "The Language of Cities", community is defined as a mythical state of social wholeness in which each member has his/her place and in which each life is regulated by cooperation rather than by competition and conflict. There are other definitions. For instance, in the Encarta Dictionaries community is defined as a group of people who live in the same area, or

the area in which they live, a group of nations with a common history or common economic or political interests. Let us stop here on defining community and look how participation is defined.

3.1.2 Participation

Participation is a rich concept that varies with application. The way it is defined also depends on the context in which it occurs. Nevertheless, the Oxford Dictionary defines participation as "to have a share in" or "to take part in". The Encarta Dictionaries also dscribes participation as contribution, input, sharing, partaking, involvement, membership

Brazer, Specht, and Torczyner (1987) defined participation as a means to educate citizens and to increase their competence. Participation is a vehicle for influencing decisions that affect the lives of citizens and is an enabling environment for transferring political power.

Weslergaard (1988) also defined participation as "collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from control". The World Bank Learning Group on Participatory Development (1995) defined participation as "a process through which stakeholders influence and share control over development initiatives, and the decisions and resources which affect them".

All of the above and other definitions given by different social scientists imply the involvement of a significant number of persons in situations or actions that enhance their well-being which could include their income, security or self-esteem. But there must be ideal conditions that contribute to genuine and meaningful participation.

3.1.3 Community Participation

Community participation is defined as some form of involvement of people with similar needs and goals, in decision making affecting their lives (Habraken, "Towards" 139).

Charles Abrams (Abrams, Language 63) defines community participation as a process where a community gets an active role in programmes and improves conditions that directly affecting it. The proponents of community participation believe that that community participation brings many lasting benefits to people instead of only a means of getting things done. The definition given by Oaklay and Marsdon (1987) is as follows:

Community participation is the process by which individuals families or communities assume responsibility for their own welfare and develop a capacity to contribute to their own and their community's development.

This definition implies that community participation is an active process whereby the beneficiaries influence the direction and execution of development projects rather than merely receive a share of project benefits.

3.2 Objectives of community participation

Community participation has objective to achieve. The following are the main objectives for community participation in development projects.

- To ensure ownership and partnership
- To ensure relevance/need-based/ sustainability
- To share project costs
- To increase project efficiency
- To increase project effectiveness
- To build beneficiary capacity
- To increase empowerment/competence/capacity i.e. to increase the control over resources and dictions that affects the lives and participation of the underprivileged in the benefits produced by societies.

Many argue that participation without redistribution of power is an empty and frustrating process for the powerless and marginalized people. Therefore community participation is not in any way an end in development. But it is rather the realization of people's empowerment.

3.3 Approaches to community participation

Two approaches are known to community participation. They are the top-down and bottom up/partnership approach. The top down approach implies that the government decides and provides for the communities. This approach is not ideal as it develops a sense of dependency and lethargy among peoples in communities.

The bottom up/partnership approach is a partnership approach in which governments, donor agencies and communities work hand in hand through clearly defined functions among the partners. Both parties work and benefit together. This gives communities some degree of control over their affairs and support sustainability of projects.

3.4 Community Participation in Ethiopia

Community participation in Ethiopia has a long history. Although the definite time could not be known, it existed over many centuries. It is reflected in the form of Edir where neighborhoods come together to support and comfort each other during times of grief. Members of the Edir organize themselves, mobilize and give in kind assistance to grieved members of the Edir and also visit and comfort the grieved family.

The other form of traditional community participation is what is known as Maheber where it brings together members beyond neighborhoods. The aim is to meet regularly on fixed days in their constituency church compounds to discuss matters of local interest and to organize themselves for active labor work during land preparation i.e. cutting down of trees and clearing of land, plowing, weeding and harvesting. They also come together and help each other for the construction of residential houses. They are called on fixed days by any member of the Mehaber for joint

activities. The attendants of such collaborative activities are mostly men. They work together all day. Lunch, drinks (local beer) and snacks are provided by the family that invited members for the work. This is by and large practiced among rural and sedentary populations.

The third traditional form of community participation is the Ekub. It is largely practiced in the urban and semi-urban areas. People organize themselves in the work environments and residential areas for the purpose of mobilizing financial resource for a member who needed money at a particular moment. This could be for buying a private or business car, house, and furniture for the home and for opening a business establishment. All these traditional social organizations have their own leaders (chairpersons, secretaries, accountants, social affairs communication officers and others) elected by them.

The formal and modern social organizations have been established under government proclamations during the early years of the previous military government (Derg) regime in 1975. The decree allowed the organization of urban and rural communities to form village (kebele) associations with clear objectives and terms of reference. They were often called "Urban Dwellers Associations (UDA) and Farmers Associations (PAs). The associations were initially created to promote development, manage the land reform and ensure local and national security. There were also Women's and Youth Association within each kebele that looks after the political and economic rights and interests of their constituencies.

The kebeles are the smallest administrative units of Ethiopia synonymous to the wards of western countries. They constitute neighborhoods or localized groups of male and female combined.

In April 1981, the Derg issued another proclamation No. 25 that provided kebeles with extended power and a more elaborate administrative structure. According to the new structure, the general assembly, composed of all kebele residents was empowered to elect their executive committee which will have a chair, vice chair, secretary and members that have different responsibilities.

The kebeles have continued to be the pillars or backbones of the current socioeconomic development of the country especially for the implementation of the Agricultural Extension Programme (AEP)and the Health Extension Programme (HEP) which the Ministries of Agriculture and Health are implementing. Their role and functions have been strengthened/deepened by the decentralization and democratization policies of the current government. There are now over 15,000 rural and 1,260 urban kebeles all over the country.

Community participation has also played a major role in specific areas like the expansion and strengthening of primary schools, in malaria control, alcohol, drug and substance abuse control (EPHA/CDC), control of non-communicable diseases like cancer (EPHA/Ethiopian Cancer Society), injury prevention (EPHA/CPHA), conducting community-based disease surveillance (EPHA/African Network), health management training at district/woreda level and in moving towards the achievement of the MDGs in all sectors. Community participation is also considered

as a development initiative to significantly strengthen disaster management, food security and sustainable livelihoods in the country.

3.5 Abuses in community participation

Although community participation is a policy driven development initiative, its implementation has not been up to expectation. There were communities that have been neglected and abused in real sense of participation. A study done in 2005 in Sida district (woreda), East Gojjam zone showed that community participation was increasing in implementation in terms of contribution of labor and material. The communities in the district (woreda) were supposed to cover 25% of the cost of the project in the first and second phases of the programme and 75% of the cost in the third phase. However, their involvement in planning was reduced. They were virtually excluded from monitoring and evaluation activities. Their involvement in managing and administering the project was very low. According to the assessment report (2005), the low participation of the community at different stages of the project was mainly due to the poor design of programmes[2].

4. Primary Health Care (PHC) in Ethiopia

4.1 Evolution

The idea of extending a network of basic health services throughout the country was conceptualized and the need and interest to train teams of mid-level health workers to serve both in clinical settings and public health interventions was expressed in the 1950s. The opening of the Public Health College in Gondar on the basis of the agreement reached between the Ethiopian Government, WHO and USAID (which was then known as Point-Four), led to the training of a team of public health professionals (health officers, community nurses and sanitarians). The training of laboratory technicians and health assistants was added later on. Health centers were constructed for the team to function and health stations/clinics which were closer to the communities were staffed by health assistants to function under the supervision of the health centers.

The first initiative for training and deployment of community health workers (CHW) was made by this College in the early 1960s. These workers were serving with some monthly payment, and supervised by intern trainees from the College. Unfortunately this arrangement of health care delivery was phased out due to lack of budgetary support from the government[3].

Cognizant of the fact that Ethiopia continued to be a country with an appalling record of child and maternal morbidity and mortality, primary health care (PHC) was adopted in 1978 as a paradigm

[2] Addis, Gedefaw: Assessment of Community participation in Sida's Woreda Support Programme Activities, 2005
[3] Habtamu Argaw, The Health extension Programme (HEP) of Ethiopia, Summary of Concepts, Progress, Achievements and Challenges, WHO Ethiopia Country Office, Sept.2007

for the delivery of basic health service at the grass root level characterized by lack of access and utilization of adequate child and maternal care was upholding.

The Derge regime gave emphasis to primary health care, rural health services, prevention and control of common diseases, self-reliance and community participation as a policy direction until 1976. Later on, the government endorsed the 1978 Health for All (HFA) by the year 2000 target with PHC strategy. The Chinese "Barefoot Doctor" and the "Mass Line" approach in controlling communicable diseases were taken as models and best practices and gave impetus to PHC adoption and implementation in Ethiopia. Cuba, Vietnam, the Indian State of Kerela and Costa Rica were also taken as models for PHC success stories.

Plans, objectives and targets were set at the central level and passed down as mandatory directives to be implemented by lower levels. The central planning was issuing pre-plan guidelines to the sector ministries and government agencies. The regions developed and implemented plan of action after getting approval from the central sector ministries. These plans of actions were followed-up by the Ministry of Health and the Regional Health Departments and implemented by health care institutions and operational departments of the Ministry.

The Ten Year Perspective Plan of 1984-94 also reverberated PHC as its policy and indicated community participation, inter-sectoral collaboration, gradual integration of vertical programs and specialized health facilities and delivery of essential health care at affordable cost as policy directions. It was at this time that the community health services at the health posts (HP) level was added at the bottom of the five tier health care delivery system that was installed during that time. HPs were staffed by trained Community Health Agents (CHA) and Trained Traditional Birth Attendants (TTBA). The CHAs and TBAs were trained for three months and one month period respectively. In addition to these categories of health cadres, there were nutrition, hygiene, sanitation and family planning promoters who were selected and trained for 2-3 weeks. These lower levels of health workers were entirely selected and supported by their respective communities.

PHC policies, planning and training have been sustained over time with some progress. Increase in life expectancy, and decrease in infant and under five child mortality were observed. Fewer epidemic outbreaks and a better control of HIV/AIDS, Tuberculosis and Malaria have been also registered. Similarly, the health care delivery system and its management was restructured on six tiers basis, with a central referral hospitals, regional hospitals, and rural hospitals for every 500,000 population, one health center for every 100,000 population, one health station for every 10,000 population, one community health service for every 1,000 population.

But the PHC approach slowed overtime due to lack of consistent and sufficient support from the next higher level of health system and partly from the respective communities. Supportive supervision and in service training were lacking. PHC also suffered from lack of managerial

capabilities, mostly at the intermediate district (woreda) level. Budgetary limitations, shortage of staff, low level of community participation and weak inter-sector coordination exacerbated the situation. Because of these reasons, the PHC approach which was adopted and implemented by the Derge regime was neglected for some time and later in the years gave way to the evolution of the health extension programme.

4.2 The Health extension programme

4.2.1 Evolution

The present government introduced the health extension programme (HEP) as a discussion point since it provides a comprehensive lesson related to community competence building for achieving the MDGs. Series of health reforms began to be implemented after the adoption of the 1993 health policy. Following the decentralization policy, more tasks were shifted to regional health bureaus. The decentralization policy covered the district and community levels. Communities were resonated by policy as starting points for socioeconomic development. Following this policy, the government introduced the health extension programme (HEP) to accelerate the expansion of primary health care services and to facilitate the achievement of universal coverage of PHC services in rural and urban areas. The overall goal of the HEP is to create a healthy society and reduce rates of maternal and child morbidity and mortality. The specific objectives are the following[4]:

1. To improve access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas
2. To ensure ownership and participation by increasing health awareness, knowledge and skills among community members
3. To promote gender equality in accessing health services
4. To improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through the HEWs
5. To reduce maternal and child mortality
6. To promote healthy life style.

HEP is an extension of the PHC approach which was adopted in 1978 and implemented by the previous government. It is a community-based programme introduced during the second five-year Health Sector Development Programme (HSDP II) in 2003. It is designed to provide services at kebele level. The services comprises of 16 health extension packages under three major areas and one crosscutting approach. HEP involves the deployment at each village (kebele) level of two salaried female health extension workers (HEW) who are trained for a year at Technical and Vocational Training and Education Centers (TVET).There are now over 34,000 HEWs (110% of required) spread all over the country.

HEWs spend 75% of their time conducting outreach activities by going from house to house. They implement the community-based health package that comprises of communicating health messages by HEWs that involve communities from the planning to the evaluation stages. Women and youth

[4] *Health Extension and Education Center, Ministry of Health: Health Extension Programme in Ethiopia, June 2007*

associations, schools and traditional associations such as Iders, Mahebers, Ekubs organize and coordinate events where the community participate to raise money, material and labor.

HEP has also brought in what are known as model families in the system. Model families are identified and trained by HEWs to serve as role models. They help the HEWs in diffusing health messages that lead to the adoption of the desired practices and behaviors by the communities.

In order to strengthen and improve the HEP, the organization and mobilization of Health Development Army (HDA) is also introduced in 2010/11 to capacitate families which are lagging behind in terms of adopting safe health practices. HDA is said to be a key strategy to scale up best practices by organizing and mobilizing families. The HDA will be a network created between five households and one model family to influence one another in practicing healthy life style. This network of families will be provided training and technical support to implement the packages of HEP. HDA will also help to expand the successful HEP experiences deeper into communities and families. They will be engaged in the promotion and prevention activities at household and community level, including the regular coordination of structured community dialogue/conversation sessions, with the guidance of the HEWs. Thus, HDA will help improve community ownership and scale up best practices.

The HEP structure comprises of the village council which is an elected member of the kebele, the agricultural development agent (DA) and teachers serving in kebeles. The kebele council brings together the kebele administration and sector specialists. This ensured the HEP's close linkage with related sectors and promoted inter-sectoral collaboration.

Health posts in rural, pastoral and urban areas are standard structures equipped with basic essential materials. Antenatal care, delivery, immunization, growth monitoring, nutritional advice, family planning and referral services are provided in the health posts.

4.2.2 Functions of the HEW

As mentioned above, the HEW is expected to pass 75% of her time outside the HP dealing with model families; community groups and households. Her specific tasks are the following:

1. Collect and document basic data of the kebele. This is the starting point.
2. Select model households and working with them
3. Provide training on the package for up to 60 members and graduate them when they are convinced and well informed of the interventions
4. Undertake house visits and deal with individuals they give trainings, make demonstrations and educate families particularly mothers
5. Organize their communities for joint plans and joint outreach interventions related to health

6. Mobilize, train and use volunteers including TTBAs and CHAs to deliver messages and to implement interventions
7. Provide limited services at the HP services include-immunization, health education, antenatal care, family planning, delivery, postnatal care growth monitoring , diagnosis and treatment of malaria, diarrhea, with oral rehydration fluids, eye infections with eye ointment and skin problems, vitamin A supplementation, first aid, referral of difficult eases, documenting and reporting.

4.2.3 Achievements in PHC

The following are some of the major achievements of HEP as of 2010/11[5]

S.N	Selected Indicator	Performance 2010/11
1	Trained and deployed HEWs	34,000
2	Model families/households graduated	12,178,603 (70% of 17,427,888 planned)
3	HPs constructed	15,095 (91% equipped)
4	Health Development Army trained	
5	Health coverage by the HEP	
6	Antenatal coverage (at least one visit)	86%
7	Delivery attended by skilled health worker	15%
8	Contraceptive prevalence rate	62%
9	Child immunization (Pentavalent 3 vaccine	85%
10	Bed net distributed	39,516,866
11	TB detection rate	39%

4.2.4 Strengths and Challenges of HEP

The following are some of the strengths and main challenges identified by a review done in 2006.

Strengths

- HEW are females, hence good role models for female rural children
- They try their best to promotive health at household level
- They have good communication skills. Advantage for health promotion activities

[5] *Federal Ministry of Health, Annual Review of HSDP III, October 2011*

- HEWs are female and hence facilitated effective communication with mothers
- They have good relationship with CHAs and TTBAS

Main Challenges

- There exists no integrated monitoring and evaluation on HEP
- Low coverage of skilled delivery and newborn care (demand is low due to economic and cultural factors)
- Weak referral system
- Recruitment of HEWs from urban and pre-urban areas. Hence no permanent availability in the kebeles
- Lack of effective supportive supervision and guidance from HCs and woreda management teams

1. Building community competence

5.1 Definitions

Community competence is defined as the ability of a community to collectively solve problems **to** achieve community goals and meet its basic needs. Community capacity is also defined as the interaction of human capital organization, resource and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well being of that community. Community competence building takes into account the experiences and circumstances that shape a community. The experiences and circumstances include history, culture, context and geography[6].

In order to build the competence of communities, a community competence assessment has to be undertaken first to identify the competence gaps.

A community competence assessment is also needed to find ways of building competences which are tested and found to be core, culturally appropriate and more effective. The following are the instruments for testing them.

- Relevance: The competence must give something that strongly influences the work of the community. If it does not, then it has no effect and is not a core competence.

- Difficulty of imitation: The core competence should not be difficult to imitate unless it is in a business venture which requires a higher level of competence to make the business viable and profitable.

[6] Robert G. Robinson, Chronic Disease Notes and Reports, 2002 Issue

- Breadth of application: The competence should be something that opens up a good result in community initiatives.

Community assessment can be done through focus group discussions, key informal interviews, surveys, community resource mapping, observations and opinion polls.

Community competence assessment can also be undertaken through community participatory research. This is a research and data collection methodology for greater level of community participation and ownership at all levels. This method highly values the process of community inclusion and strives to foster greater community empowerment in the process.

5.2 Methods of community competence building

There are a number of methods for community competence building. The major ones are the following:

1. Public investments that involve communities are highly regarded to spur community competence and growth since the process for growth and development contribute to community competence.

2. Community conversations which are designed to focus on finding a better way of living. Community conversation seeks improved outcomes for individuals and families and as well as neighborhood conditions by working comprehensively across social and economic sectors. The four building blocks which include conversing, engaging, collaborating and developing of visions contribute to community competence building since they work on institutional buildings at community level and enhance social, capital and personal networks and development of leadership.

3. Competence building activities include leadership development, technical assistance, network building, fund raising and training of community members. Competence building lays foundation for communities. It can assist to achieve programme objectives, infrastructure, and programme and policy initiatives building competence at individual and community levels.

4. Community-based participatory research (CBPR) is a "collaborative approach to research that involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community, has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities and to build community competences. In this process, communities are actively engaged in research process through partnerships with academic institutions. CBPR also known as Participatory Action Research (PAR), is an interdisciplinary research methodology in which scientific professionals and members of a specific community work together as equal partners in the development, implementation,

and dissemination of research that is relevant to the community. Community competence is built during this participatory research process.

5. Community competence building can also be achieved through informal trainings, social processes and or organized efforts by individuals, organizations and social networks that exist among community members and the larger systems of which the community is a part.

5.3 Competences that need to be built

More skills and strengths should be built on the following strategic areas to better prepare communities to achieve their goals.

5.3.1 Cognitive capacity: This refers to assess, plan, design and implement and inform.

5.3.2 Creativity: This entails building the competence communities to be creative enough to identify their basic needs, and generate approaches to meet their needs

5.3.3 Visioning: Communities should have the competence to develop a vision for what they are striving to achieve in the long term.

5.3.4 Management competence: This comprises of understanding the community and the role it plays, the challenges faced by elected members of the community, knowing who the key players are

5.3.5 Organizational management: This is an area of competence which is basic and crucial to community participation.

- Team work (team orientation, contributing to team, maintaining respectfulness, sharing expertise, consulting openly, achieving consensus
- Partnering (partnering with others at different levels, maintaining formal and informal networking outside community, working collaboratively with partners, sharing responsibilities and resources, reducing inefficiencies and redundancies

5.3.6 Intercommunity relations: Interacting with other communities and organizations, , developing and maintaining positive working relationship, possessing a genuine respect and concern for others and their situations, recognizing and diffusing potential conflicts using open and honest interactions, working collaboratively and openly

5.3.7 Communication: Communicating clearly, transparently and concisely, using sound judgment when communicating sensitive issues,

5.3.8 Stamina and challenge resistance: Ability to manage challenges, remaining committed to policies, community objective and priorities, being realistic about community limits,

5.3.9 Ethics and values: Holding high ethical standards, being objective, fair and balanced when evaluating programmes, policies and initiatives

5.3.10 Behavioral flexibility: Adjusting behavior to the demands of a changing environment to remain good service organizer and provider, remaining focused and productive during periods of transition and uncertainty, being receptive to new ideas and alternative approaches

5.3.11 Self confidence: Being independent, self reliant, seeking the assistance of others when necessary, learning from successes and failures, interacting confidently and with credibility when dealing with a wide range of people and organizational entities.

6. Conclusions and recommendations

Annual and mid-term reviews of HSDP have consistently shown increased number of health infrastructure and human resource development and service coverage at all levels of the health system. This has been due to increased funding of the health sector by the government and development partners. For example the share of health budget as total of the government budget was 10.4% in 2010/11 and the total amount fund committed by the international development partners was USD 485.44 million for same year. As indicated above over 34,000 HEWs have been deployed to work in 15,095 health posts. The number of model families that graduated has reached to 12.7 million out of 17.4 million planned. The health development army initiative has been introduced. Although there are many challenges ahead, it is expected that those and other interventions will help to change the health demographic profile of the country and to the achievement of, if not all, but many of the health and health-related MDGs.

The other issue that has to be looked is how to sustain the achievements gained so far and that will be achieved in the future. There are some examples that would force us to think on this issue. For example, according to the HSDP IV Annual Performance Report of 2010/2011, clean and safe delivery service coverage by HEWs declined from 17% in 2009/2010 to 14.7% in 2010/2011. Similarly, Pentavalent vaccine coverage decreased from 86% to 84.7% and measles vaccine coverage from 82.4% to 81.5% and TB treatment success rate showed a down turn during the same period. These are wake up calls for the government to do something. It is therefore recommended that Federal Ministry of Health take such challenges into consideration and be proactive to overcome them by developing special mechanisms.

References

1. Ministry of Finance and Economic Development, Ethiopia: Development and Poverty Reduction programme (SDPRP), 2002/03-204/05, July 2002
2. Ministry of Finance and Economic Development, Ethiopia Interim Poverty Reduction Strategic Paper (I-PRSP)
3. UNDP Human development , April 2003
4. World Health Organization, Commission on Social Determinants of Health, Closing the gap Generation; Health and Equity through action on the Social Determinants of Health
5. Ministry of Finance and Economic Development, A Plan for Accelerated snf Sustained Development to End Poverty (PASDEP 2005/06- 2009/10
6. Federal Ministry of Health, Health Sector Development Programme (HSDP) 1997/98-2005/06
7. Ministry f Health , Health Sector development Programme (HSDP)III, 2005/06-2010/2011
8. Habtamu Argaw, The Health Extension Program (HEP) of Ethiopia, Summary of Concepts, Progress, Achievements and Challenges, September 2007