**Title: Community health volunteers as mediators of accessible, responsive and resilient community health systems: lessons from the Health Development Army in Ethiopia**

**Theme:** **Human Resources for Health (HRH)**

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**Background**

Faced with chronic health worker shortage, many LMICs have invested in community health workers to extend and enhance health care in rural areas. In Ethiopia, the PHC health strategy is implemented by two distinct cadres: the Health Extension Workers provide basic health care in rural areas supported by the Health Development Army (HDA), a large multi-purpose cadre comprising locally-recruited and trained community volunteers. Predominantly women, the HDA act as intermediaries between the community and formal health system, mobilising communities and responding to their concerns. HDAs are perceived as champions critical to government’s vision of building resilient and responsive PHC, with communities being ‘producers of health’.

**Methods**

The study explores the role of the HDA in Ethiopia, and identifies the conditions, under which they can maximise their potential to improve access to care and attain health sector goals. Data are obtained from: 18 focus group discussions with HDA volunteers, leaders and community members in 3 Oromia districts with differential system performance; 39 key informant interviews with stakeholders at district, zonal, regional and federal level; analysis of policy and regulatory documents comparing planned policy with reality on the ground.

**Results**

Preliminary findings suggest that the HDA approach has successfully engaged the community, identifying local bottlenecks that hinder uptake of services, and scaling up best practices. The HDA shows potential in improving access to essential health services provided at the village and household levels, contributing to the improvement of the health status, building on local technologies and coping strategies. The initiative has contributed to a sharp reduction of home delivery from 74% (EDHS, 2014) to zero at places. It has also fostered community engagement and responsibility for improving health and preventing disease. Challenges include training and linking the HDA leaders into networks, low level of skills and experience of those managing the HDA implementation process, as well as the failure of districts and kebele level management staff to perform regular supportive supervision.

**Conclusions**

The study suggests that community volunteers can support participatory and responsive models of grassroots PHC to improve access to and resilience of essential services. Given the nature of health systems as social contracts, HDA volunteers are well placed to promote trust and bridge the gap between communities and service delivery. However, efforts should be targeted to train, support, and motivate HDA, with realistic expectations of their role, and integrate them within a unified PHC institutional framework.

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