Case Study One:
Health Facility Based Experience Share Programs & Peer Learning Opportunities

Hintalo Wajerate Woreda
Tigray, Ethiopia

"The experience share program is a relatively new and innovative approach to trainings, organized by the WoHO beginning in 2004 EC, as a practical approach in furthering the knowledge base of other WoHO experts."

"Hintalo Wajerate woreda has used it successfully in order to reach and educate its vast set of rural communities."

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Acknowledgments

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<th>Description</th>
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<tbody>
<tr>
<td>CLTS</td>
<td>Community Lead Total Sanitation</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FIM</td>
<td>Field Immunization Manager (UI-FHS staff)</td>
</tr>
<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HC</td>
<td>Health Center</td>
</tr>
<tr>
<td>HEP</td>
<td>Health Extension Package</td>
</tr>
<tr>
<td>HEWs</td>
<td>Health Extension Workers</td>
</tr>
<tr>
<td>HF</td>
<td>Health Facility</td>
</tr>
<tr>
<td>HH</td>
<td>Households</td>
</tr>
<tr>
<td>HP</td>
<td>Health Post</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>PHCU</td>
<td>Primary Health Care Unit</td>
</tr>
<tr>
<td>RA</td>
<td>Rapid Assessment conducted by UI-FHS team</td>
</tr>
<tr>
<td>REST</td>
<td>Relief Society of Tigray</td>
</tr>
<tr>
<td>RHB</td>
<td>Regional Health Bureau</td>
</tr>
<tr>
<td>SNNP</td>
<td>Southern Nations Nationalities and People’s Region</td>
</tr>
<tr>
<td>UI-FHS</td>
<td>Universal Immunization through Improving Family Health Services Project</td>
</tr>
<tr>
<td>WHDA</td>
<td>Women’s Health Development Army</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WoHO</td>
<td>Woreda Health Office</td>
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Executive Summary

Universal Immunization through Improving Family Health Services (UI-FHS) is a three and a half year learning project implemented by JSI Research & Training Institute, Inc. in collaboration with the Federal Ministry of Health (FMOH) of Ethiopia. The project aims to inform a FMOH evidence-based decision on whether and how to purse nationwide universal immunization, integrated with family health approaches, and what it will take to do so effectively, affordably and sustainably. UI-FHS is active in three woredas, Arbegona, Assaieta, and Hintalo Wajerate located in SNNPR, Afar, and Tigray respectively. Hintalo Wajerate woreda in Tigray is the focus of this case study.

The case study is a collaboration between the Woreda Health Office (WoHO) and Peace Corps Volunteer Shamara Wheldon, along with the assistance of UI-FHS, in order to support the “Best Practices” initiative implemented by the FMOH. The case study is designed to better understand the implementation of peer learning methods throughout Hintalo Wajerate woreda and the impact of the peer learning process on the woreda health staff and its communities. A mixed method collections approach was used for this case study consisting of; qualitative interviews, focus group discussions (FGDs), and a quantitative review of the Health Centers (HCs) data, in order to triangulate comparisons in the data collected. The study uses a facility-based approach with collection of data from the WoHO, HCs, Health Posts (HPs), and the local NGO working in the woreda, Relief Society of Tigray (REST). The data was then analyzed using WEFT QDA (qualitative data analysis) software.

Hintalo Wajerate woreda is one of the best performing woredas in Ethiopia, with committed health workers from all levels, including WoHO administration and expert staff, Primary Health Care Unit (PHCU) directors, Health Extension Worker (HEW) supervisors, HEWs, etc. One reason for this commitment is the strong partnership established between the WoHO, the woreda administration and other sectors in the woreda which has led to productive committees wanting to see healthier communities.

However, there are other reasons behind the success in Hintalo Wajerate. For instance, the woreda regularly encourages the concept of peer learning. This is done at all levels of the health system to expand the knowledge base of trained professionals working in the woreda. One of the most effective ways to learn new skills is to see them implemented in action. As such, this woreda organizes cross visits and conducts review meetings to share experiences, spread ideas and educate other communities. In addition, during the cross visits, the WoHO administrative staff takes the opportunity to recognize individuals who performed well through utilizing new and innovative ideas.
I. Case Study Goals and Objectives

In cooperation with UI-FHS and the WoHO, the goal of this case study is to better understand the implementation of peer learning methods throughout the Hintalo Wajerate woreda and the impacts of the peer learning process on woreda health staff.

Objectives

- To determine how health related peer learning programs are organized and implemented in Hintalo Wajerate woreda
- To explore peer learning as an effective tool for implementing “best practices” in the health sector
- To determine the benefits of health related peer learning programs

II. Purpose of the Case Study

Hintalo Wajerate is recognized as one of the best performing woredas for health in Ethiopia. This lead the UI-FHS project to explore the reasons behind the woreda’s success, particularly in implementing quality health practices within its communities. The results of the case study will be used to scale up practices currently being implemented within Hintalo Wajerate and adapt these practices for implementation in other woredas.

III. Woreda Demographics

Hintalo Wajerate woreda is located in the south eastern zone of Tigray which covers an area of 193,309 hectares and includes 22 kebeles\(^1\) with an estimated population of 181,274.\(^2\). There is only one rainy season in Tigray, falling between the months of June and August. By definition, 95% of the residents within Hintalo Wajerate are classified as rural, while the remaining five percent are urban.\(^3\) The woreda has a total of

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\(^1\) kebele is a subcomponent of a woreda
\(^2\) Source: Woreda Health office
\(^3\) Source: Rapid Assessment done by UI-FHS
seven HCs and eighteen HPs. The town of Adigudom is the center for all woreda offices, which is about 36 kilometers from Mekele, the regional capital. Due to Adigudom’s proximity to Mekele and the rural demographics, the woreda is visited by the Regional Health Bureau (RHB) quite frequently, as well as by many other interested organizations.

IV. Study population and Demographics

UI-FHS and WoHO administration staff took an investigative look at the demographics of Hintalo Wajerate to select two HCs for the study. The two HCs chosen for this case study were Dabub HC and Adikayh HC. Both HCs have similar demographics, with one major distinction; Dabub HC is recognized as “high” performing by the WoHO while Adikayh HC is considered to be “under” performing. Previously, both HCs provided services of a health clinic before elevating their standards to provide services of a HC.

Dabub HC is located 30 kilometers from the WoHO and also 30 kilometers from the closest asphalt road, in a town called Barhitsaba with an estimated population of 9,947 and an estimated cluster population of 19,416.\(^4\) In addition to the HC, there are two HPs located in Seberbera and Gonka which make up the Dabab HC cluster. Currently, there are two HEWs working in Gonka and only one HEW located in Seberbera. Both of the HPs are considered hard to reach as they are not accessible by car during the rainy season.\(^5\)

Adikayh HC is located 55 kilometers from the WoHO on an all asphalt road in the town of Adikayh with an estimated population of 7,938 and an estimated cluster population of 23,096. There are two HPs within the Adikayh cluster; Adimesno HP and Tsehafi HP. Respectively, there are two HEWs in the Tsehafi HP and one HEW in the Adimesno HP. For many years, Adikayh HC has been located on a gravel road. However, in November 2012 a new asphalt road originally built from Alamata the southernmost town in Tigray to Mekele, travels now through the town of Adikayh. Due to the construction of this new asphalt road, both of these HPs are easily accessible by car.

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\(^4\) Source: Woreda Health Office  
\(^5\) Source: Rapid Assessment conducted by UI-FHS
V. Methodology

1. Design

This case study uses a method mix of qualitative interviews, FGDs, and a quantitative review of the HC’s data in order to triangulate the commonalities across the three types of data collections used. Semi-structured data collection questionnaires were developed and the tools were shared with the WoHO for review.

Table 1: Target Groups

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Topics covered in Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCU Director</td>
<td>General attitudes of experience share</td>
</tr>
<tr>
<td>HEW Supervisor</td>
<td>Organizational logistics</td>
</tr>
<tr>
<td>Head Nurse</td>
<td>Topics</td>
</tr>
<tr>
<td>EPI focal person</td>
<td>Accountability</td>
</tr>
<tr>
<td>HEWs</td>
<td>Financials</td>
</tr>
<tr>
<td></td>
<td>Other facility based peer learning opportunities</td>
</tr>
<tr>
<td>Women’s Health Development Army (WHDA)</td>
<td>General attitudes</td>
</tr>
<tr>
<td></td>
<td>Topics</td>
</tr>
<tr>
<td>Community Priest</td>
<td>Facilitators</td>
</tr>
<tr>
<td>Elderly Association</td>
<td>Benefits</td>
</tr>
</tbody>
</table>

2. Selection of health facilities, communities, and members of FGDs

A small series of informal interviews and documents were collected from the WoHO and the woreda Planning and Financial Offices in Hintalo Wajerate by Ms. Wheldon and the data collection team. This information was then reviewed and discussed with the WoHO Health Supervisor and the UI-FHS Field Immunization Manager (FIM) in Tigray to determine a set of cluster facilities for the case study.

3. Data collection

Initially, the first introduction to each HC was done using a hired translation consultant as well as an expert from the WoHO staff. After each initial introduction, the case study team was able to conduct interviews and FGDs as needed. Interviews were conducted in a confidential setting, usually in the office.

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6 WHDA: is a group of approximately 30 women living in the same area, who gather to discuss and implement the 16 HEP components.
7 Elderly Association: is a committee formed by some of the most respected town elders. This association helps in implementing community awareness.
of the interviewee. Furthermore, women who are part of the WHDAs, priests and men from the elderly association within each catchment area were also interviewed as cross-references. In each community, cross-reference interviews were conducted away from the supervisor in a confidential setting. Before beginning each interview, informed consent was obtained, which included consent of having the interview tape recorded. Data collection was performed through reviewing HC and WoHO documents.

4. Data Analysis

Interviews and FGDs were audio recorded and transcribed directly following each interview. All interviews, FGDs, and data collected were translated and then transcribed into English with the help of the hired translation consultant. Transcripts were entered into the qualitative data analysis software “WEFTQDA” which aids in qualitative analysis. The transcripts were then reviewed and edited for the purpose of this case study.

VI. Findings

A. Experience Share Programs

1. Introduction

The experience share program is a relatively new approach to trainings, organized by the WoHO beginning in 2004 EC\(^8\) as a practical approach in furthering the knowledge base of other WoHO experts. In addition, the experience share program is an innovative approach Hintalo Wajerate has adopted in order to reach and educate its vast set of rural communities.

The WoHO staff organizes two different types of experience share programs; expert based and community based. Expert based experience share programs include individuals coming from outside the woreda, including regional health office experts from all areas in Ethiopia and the FMOH. According to the

\(^8\) EC is Ethiopian Calendar, which follows the Julian year; 2004 falls in with 2011/2012
WoHO staff, the main focus of this type of experience share program is to explain how a WoHO can effectively perform data collection, conduct supportive supervisions and facilitate review meetings, in order to provide quality health services to rural communities. The expert-based experience share involves a practical component, which a hard to reach kebele is visited to show attendees how the HEP is being implemented at the grass roots level.

Furthermore, the community based experience share is restricted to individuals living or working within Hintalo Wajerate; including woreda staff, communities, and all health facility (HF) staff. This type of experience share helps create an opportunity for peer learning, furthering the knowledge base of its staff and communities. The HF staff reported one of the greatest challenges they face is gaining acceptance of the communities they work in. The following quotes better illustrate the HF staffs opinions on the matter:

“Convincing the community is difficult and if an outsider comes in to try (and talk about health) it does not happen. The community does not believe an outsider about anything.” (Cluster staff, Dabub)

“We sometimes provide trainings for the WHDA leaders, some of the women understand and some of them do not understand. They still do not believe us.” (Cluster staff, Adikayh)

As a result of this challenge, the community-based experience share approach was created, thus establishing a forum for neighboring kebeles to share with one another. The REST Sanitation expert stated: “The more the communities take ownership over their health, the more sustainable and likely the people are going to implement better lifestyle techniques.”
Table 2: Experience share programs held in the woreda and recognized by the WoHO Supervisor

<table>
<thead>
<tr>
<th>Name of Group Targeted by the Experience Share</th>
<th>Number of Attendees</th>
<th>Date (EC)</th>
<th>Financial Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 HEWs &amp; Technical WoHO staff</td>
<td>272</td>
<td>Aug – 2004</td>
<td>Public and Gov. Relations office</td>
</tr>
<tr>
<td>2 String Committee Members&lt;sup&gt;9&lt;/sup&gt;</td>
<td>326</td>
<td>July – 2004</td>
<td>Zonal Administrative offices</td>
</tr>
<tr>
<td>3 WHDA Team Leaders</td>
<td>2185</td>
<td>Aug – 2004</td>
<td>UNFPA NGO</td>
</tr>
<tr>
<td>4 Midwives</td>
<td>40</td>
<td>Sept – 2004</td>
<td>WoHO Budget</td>
</tr>
<tr>
<td>5 Amhara WoHO Supervisors &amp; Zonal office Supervisors</td>
<td>22</td>
<td>Dec – 2004</td>
<td>N/A</td>
</tr>
<tr>
<td>6 Federal Representatives &amp; House of Federation Representatives</td>
<td>8</td>
<td>Jan – 2005</td>
<td>N/A</td>
</tr>
<tr>
<td>7 Oromia Regional Health Experts</td>
<td>12</td>
<td>Jan – 2005</td>
<td>N/A</td>
</tr>
<tr>
<td>8 European Leaders</td>
<td>21</td>
<td>Sept – 2004</td>
<td>N/A</td>
</tr>
<tr>
<td>9 FMOH</td>
<td>21</td>
<td>Oct – 2004</td>
<td>N/A</td>
</tr>
<tr>
<td>10 Tigray Regional Health Beauro</td>
<td>54</td>
<td>Dec – 2004</td>
<td>N/A</td>
</tr>
<tr>
<td>11 Amhara &amp; Oromia</td>
<td>17</td>
<td>Feb – 2005</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<sup>9</sup>N/A: funding for these experience share programs came from outside the woreda and are unknown

Table 3: Experience share programs organized in collaboration with the WoHO HEW expert but were not accounted for by the WoHO supervisor. (Information provided by the REST office)

<table>
<thead>
<tr>
<th>Name of Group Targeted by the Experience Share</th>
<th>Number of Attendees</th>
<th>Date (EC)</th>
<th>Financial Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Dejen Leaders</td>
<td>14</td>
<td>Oct – 2004</td>
<td>REST</td>
</tr>
<tr>
<td>2 Firewayni Festival</td>
<td>452</td>
<td>Dec – 2004</td>
<td>REST</td>
</tr>
<tr>
<td>3 Dejen Festival</td>
<td>117</td>
<td>Dec – 2004</td>
<td>REST</td>
</tr>
<tr>
<td>4 Dungolat Festival</td>
<td>135</td>
<td>Dec – 2004</td>
<td>REST</td>
</tr>
<tr>
<td>5 Senale leaders</td>
<td>27</td>
<td>Jan – 2005</td>
<td>REST</td>
</tr>
</tbody>
</table>

<sup>9</sup>String committee: A committee in every HC with representatives from every governmental sector office
2. **Topics**

All community based and expert based experience share programs are centralized around the 16 components of the HEP. The HEP was created in 2003 EC\(^{10}\) as a response to the Millennium Development Goals (MDGs) set forth by the World Health Organization (WHO) and deployed in Ethiopia in 2001EC. “With such a large rural population and an extremely low number of skilled health practitioners, the health system needed a way into the communities to provide care as well as encourage the utilization of health services by the community.”\(^ {11}\) There are four defined parts to the HEP; Hygiene and Environmental Sanitation, Family Health Services, Disease Prevention and Control, and Health Education and Communication.

**Table 4: The HEP Components**

<table>
<thead>
<tr>
<th>Health Extension Program Components</th>
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</thead>
<tbody>
<tr>
<td><strong>Hygiene and Environmental Sanitation</strong></td>
</tr>
<tr>
<td>1. Building and maintaining healthful housing</td>
</tr>
<tr>
<td>2. Construction, usage and maintenance of sanitary latrine</td>
</tr>
<tr>
<td>3. Control of insects, rodents and other biting species</td>
</tr>
<tr>
<td>4. Food hygiene and safety measures</td>
</tr>
<tr>
<td>5. Personal hygiene</td>
</tr>
<tr>
<td>6. Solid liquid waste management</td>
</tr>
<tr>
<td>7. Water supply safety measures</td>
</tr>
<tr>
<td><strong>Family Health Service</strong></td>
</tr>
<tr>
<td>8. Maternal and child health</td>
</tr>
<tr>
<td>9. Adolescent and reproductive health</td>
</tr>
<tr>
<td>10. Family planning</td>
</tr>
<tr>
<td>11. Vaccination services</td>
</tr>
<tr>
<td>12. Nutrition</td>
</tr>
<tr>
<td><strong>Disease Prevention and Control</strong></td>
</tr>
<tr>
<td>13. HIV/AIDS and tuberculosis prevention and control</td>
</tr>
<tr>
<td>14. Malaria prevention and control</td>
</tr>
<tr>
<td>15. First Aid</td>
</tr>
<tr>
<td><strong>Health Education and Communication</strong></td>
</tr>
<tr>
<td>16. Health education and communication methods</td>
</tr>
</tbody>
</table>

\(^{10}\) EC is Ethiopian Calendar  
\(^{11}\) (Oot, 2006)
As a result of the HEP, all topics listed in Figure 4. above are covered in all experience share programs. This was recognized by the WoHO HEW expert and also confirmed by the PHCU directors, HEW supervisors and HEWs in the following statements:

“Experience share topics include all of the 16 HEP components.” (Cluster staff Adikayh)

“Our main focus of experience share programs is the 16 components but we mainly focus on sanitation programs.” (Cluster staff Dabub)

“The reason for this is because the HEP was developed off a base of the (MDGs) and the 16 components was a strategy created by the FMOH to successfully complete the requirements of these goals.” (WoHO HEW expert)

Through observation, additional topics were discussed during an expert-based experience share including: transparency of all information collected by the WoHO staff, quarterly supportive supervision visits, accuracy of data collected, feedback documents and problem solving techniques. Furthermore, when attending an expert-based experience share in a practical setting, HEWs discuss the many successes of the kebeles which include: high immunization coverage rates, low child mortality, increased institutional delivery rate, and other successfully implemented sanitation techniques. Aside from the HEW discussions, no other main topics are covered during the experience shares; discussions are general and encompass all components of the HEP.

3. Organization & communication

All experience share programs are organized and facilitated with the help of the WoHO HEW expert. This is due to the fact that all programs revolve around the HEP implemented through the HEWs.

**Expert-based Experience Share chain of communication**

- WoHO Supervisor is notified that a group of attendees will be coming to view the woreda (dates are discussed at this time).
- WoHO HEW Supervisor is notified by the WoHO Supervisor to begin the planning phase for an experience share. A cluster area is selected for the participants to go out and visit. He begins the initial communication with the cluster in which the experience share will be performed.
- PHCU Director and HEW Supervisor of cluster area are informed of an experience share date.
- HEW is informed by his/her supervisor of the experience share date and begins the preparation of the koshet\(^\text{12}\) the experience share will take place in. HEW will organize in the koshet around six to twelve households for viewing of the participants.
  - Requirements for viewing are model households who have successfully passed all sanitation requirements designed by REST. Usually these households include women who are knowledgeable about immunization, Family Planning (FP), and delivery services.
  - The HEW also informs the head of his/her string committee and the kebele leader of the program

The most commonly viewed koshets are those in high performing areas. The “under” performing HC staff report that they have attended experience share programs but have never hosted one.

The WoHO staff keeps detailed records of data collected on each of the kebeles in the woreda. This is updated yearly; however, data is collected monthly by the WoHO HEW expert. Below is the general rating system used to determine the areas to visit during an expert-based experience share program. The areas with the highest rankings are selected to host the experience share program.

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**WoHO General Rating System**

![List of four areas the WoHO evaluates all kebeles](image1)

![The ranking of HP and HC in the woreda](image2)

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**Daily Events of an Expert Based Experience Share**

Most expert-based experience share programs are a day long. Observations reveal that following the participants’ arrival at the WoHO, an overview is given by the WoHO supervisor on how the WoHO accomplishes its daily task and networking strategies of the WoHO experts. Next, they are given a tour of all major components of the WoHO office, including the experts’ office, HMIS office, and the financial

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\(^{12}\) Koshet: is a term describing an area of people smaller than a kebele but larger than a gott
office. Afterwards, the participants are escorted out to a cluster area by the WoHO HEW supervisor where the PHCU director, cluster HEW supervisor, HEWs, and kebele leaders of the koshet are waiting to greet the guests. After introductions are made and health statistics for the kebele are shared, the HEWs take the participants to view approximately six to twelve households in the area. According to the HEWs, the items the guests should be looking for are as follows:

- Separate living areas in the compound for the cattle away from humans
- Chicken coups
- Modern kitchen
- Pit latrine inside the compound
- Hand washing station outside the pit latrine
- Lid over the pit latrine
- Liquid waste disposal pit
- Solid waste disposal pit

After visiting the koshet, the HEW Supervisor and the PHCU director take the participants to the HC where they discuss about the services offered and the general layout of the HC. The discussion also includes the process of information reported from the HC to the WoHO experts, as well as supportive supervision visits and feedback. Participants return to Mekele the same day.
According to the WoHO Supervisor, per diem is calculated and administered by the woreda administration annually. But according to the WoHO HEW expert, the total per diem allocated by the woreda is not enough to conduct regular experience shares among HC clusters. Unfortunately, the WoHO did not allocate per diem for any type of experience share programs.

However, in 2005 EC\textsuperscript{13}, the per diem allocation increased significantly, as the woreda administration provided funding to cover the per diem for a six day bi-annual review meeting, including PHCU directors, all HC supervisors and WoHO staff and experts for the first time. At the administration annual meeting the woreda administrative staff discussed financial allocations for the upcoming fiscal year. This year, the supervisor of the WoHO identified annual health plans for the upcoming year, indicating that this bi-

\textsuperscript{13}EC is Ethiopian Calendar
annual review meeting is necessary to monitor and evaluate the health goals set forth by the FMOH. Furthermore, the HEW expert indicated that this review meeting would also include all priests and Imams (Muslim leaders) in the woreda. The experts are aware that all women have contact with their priests and Imams daily and these individuals are very influential in the communities. As a result of the communities’ religious beliefs, the WoHO has reached out to these religious leaders to create awareness and provide support within their communities.

4. **Accountability**

The WoHO does not follow up with outside woreda expert staff to determine if activities discussed during an expert based experience share, which they hosted, are actually implemented in other areas around Ethiopia. However, observations indicate that all expert based experience share programs could be an indirect way of holding HEWs, PHCU Directors and HEW Supervisors within Hintalo Wajerate accountable for the HEP. The experience share programs happen randomly and frequently throughout the woreda and it is expected that the HEWs and HEW supervisor maintain the quality of implementation of the HEP in their respective kebeles. When an expert based experience share occurs these individuals scrutinize how well the HEP was implemented. In addition, it holds communities accountable for maintaining the quality of the 16 components in their compounds, as experience share programs include household visits regularly. On the other hand, WoHO experts become accountable for all data collected in the woreda because outside experts could be from the FMOH or the Regional Health Bureau (RHB). Similarly, regular visits by individuals from outside the woreda help keep staff at all levels more candid about the quality of activities they are implementing.

**B. Relief Society of Tigray (REST) Office and Community Based Experience Share Programs**

1. **Introduction**

The REST NGO, also known within Ethiopia as Maret, is located in Mekele, with several smaller branches located throughout Tigray. “The mission of REST is to contribute to the eradication of poverty in Ethiopia by promoting the livelihoods on a sustainable basis, within the context of stimulating wider economic dynamism and growth within the regional state of Tigray.”

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14 Source: REST Adigudom branch
Adigudom has a REST branch office that works closely with the WoHO experts with the objective of identifying and implementing different programs within the communities of Hintalo Wajerate. In addition, to the communities of Hintalo Wajerate, REST also oversees projects in the bordering woreda of Enderta. The Adigudom branch has several experts working in agriculture, irrigation construction, well construction and income generating activities. REST has two health experts in their Adigudom branch; one is specifically assigned to sanitation projects while the other one focuses on general health projects in the area.

One of REST’s main priorities is to do all work in collaboration with the WoHO. The staff believes that nothing can be established or completed without the help of the WoHO and the staff working at the HCs and HPs. It is apparent through discussions with REST staff and WoHO experts that they equally agree that their partnership is important to the success of projects.

In regards to sanitation, the sanitation expert at REST, while working in collaboration with the WoHO HEW expert, is beginning to implement peer learning and community-based experience share programs at the kebele and koshet levels. These programs are centered around a general topic of sanitation. However, the WoHO HEW expert stated “that while sanitation is the main priority, it is a link to other health related activities.” It was found that collaboratively, REST and the WoHO HEW expert are the key individuals facilitating these community based peer learning approaches.

2. **Community Led Total Sanitation Program (CLTS)**

The CLTS program has a four-step implementation process including: community mobilization, implementation of peer learning between community leaders, and experience share festivals.

*Step 1: Pre-Triggering*

The pre-triggering phase includes baseline sanitation data collection of the community, recruitment of community committees and essential kebele leaders. All work is completed within the HC cluster and reported back to the REST expert and WoHO HEW expert.

*Step 2: Triggering*

The triggering phase is about mobilizing the community and creating community awareness in relation to sanitation. There are three elements to this phase: shaming the community, creating a sense of disgust among the community and establishing fear within the community. This phase is facilitated and
implemented by the HEW, with the support of HC cluster supervisors and kebele leader. During the implementation, natural leaders are identified and leaders are elected. If this phase of the four-step process is implemented correctly, the facilitators should see a shift of ownership of the program.

**Step 3: Post-Triggering**

Post-triggering is the training of identified natural leaders and elected leaders of the community. A two-part training is organized for these leaders on proper sanitation practices. The lecture part of the training includes experts from the agriculture and health offices, whereas the second part which is the practical approach involves community leaders of one kebele visiting a neighboring successful kebele, to share experiences on proper implementation of sanitation techniques. There is no significant data yet to support the success or failure of this part of the program as it is still relatively new.

Once all trainings are complete, an action plan for the community is created. According to the WoHO HEW expert, “this is where we try to link in other health related activities like immunization, mother health care etc. These leaders become very aware of the areas within the communities they are managing and can help with registering pregnant mothers, and registering age appropriate children for immunization.”

**Step 4: Festivals**

Festivals are programs designed to congratulate a community on the success of completing a sanitation program. While the WoHO has labeled these as “experience share programs” observations suggest that festivals are opportunities for communities, “to show off” their accomplishments to other important health related individuals and neighboring kebeles; peer learning is not actually the main focus of these festivals. Though this is not expressed verbally, anyone who attends these events can see that the celebrated community takes great pride in its accomplishments and this sense of pride only heightens as more visitors come to witness its success. In conclusion, a festival is an indirect benefit of the experience share program, not only for the community but also for the HEWs and HC staff. At the festival the case
study team attended, the HEWs and kebele leader were recognized for their hard work in successfully completing all sanitation techniques in every HH; other accomplishments recognized were immunization, HIV/AIDS and agriculture success rates.

### 3. Finances

All financial assistance for the four-step CLTS program within this woreda comes from the REST office. This was verified by the case study team who reviewed financial documentation, confirming that REST provides per diem, transportation and supplies needed to do all community-based experience share programs for the woreda on sanitation.

#### 4. Review of REST’s partnership in community-based experience share programs and CLTS approach

The community-based experience share program exists as a result of a bigger program being facilitated by the REST office. REST has been assisting the WoHO with the organization of community-based experience share programs in the last 10-12 months; this is a relatively new approach to teaching at the community level. According to the records at REST, there have only been four areas of Hintalo Wajerate that have either done this type of experience share program or been through the four step process. The new CLTS program is beginning to replace the old model households (HH) approach for the following reasons that were identified by the experts:

“"The CLTS approach is much more effective than the model HH technique. Before, we had a hard time convincing communities that sanitation would help increase health and this approach
to training has communities teach each other with a sense of ownership component.” (REST expert)

“The model HH approach was an old and inefficient program that we only use during experience share programs. The model HH approach is time consuming with the HEW going house to house advising families. The communities took no ownership over the model HH approach leading to lack of sustainability.” (WoHO expert)

Clearly the experts and HEWs are finding it is hard to reach these rural communities and are coming up with innovative ways to raise awareness in order to successfully and sustainably implement the MDGs. The model HH approach has been implemented since 2003EC and Hintalo Wajerate has found it to be ineffective. The new CLTS approach allows the HEW to reach a larger section of the community at a time due to its setup within the community.

c. Other peer learning opportunities: in the Health Center with health staff

From the interviews conducted in both Adikayh and Dabub HCs, it can be concluded that case studies are the only other means by which the HC staff implement peer learning. Case study presentations are executed by the nurses on topics such as malaria, stroke, hypertension, acute blood loss etc. These presentations are encouraged by both PHCU directors and head nurses as they help the staff gain additional knowledge and recover lost information from previous presentations. In both HCs, it was observed that the case presentations were done at the weekly staff meetings. The frequency with which these presentations occurred seemed to vary depending on the HC according to the following account:

“Every week we do a case study presentation and it is part of my job to help motivate the nurses to do their case study. Also if there are any questions I am there to help.” (Cluster staff Dabub)

“We sometimes do case presentation however not very often due to not having a classroom to do the presentation in.” (Cluster staff Adikayh)
Case study presentations serve as the forum for spreading peer learning; they are performed by the HEWS and HC staff.

d. Peer Learning opportunities between PHCU clusters

Quarterly, the WoHO expert staff meticulously reviews the documentation and assesses the performance of each PHCU cluster using questionnaires and checklists. This process is formally known as Supportive Supervision. Each questionnaire and checklist is broken down into several categories and lays the foundation for regular evaluation and feedback of each PHCU from the WoHO. These quarterly documents are analyzed by the WoHO experts and feedback is provided to each PHCU cluster. This information and feedback is discussed at quarterly review meetings, which includes all PHCU directors and the WoHO expert staff. While this information is specific to each PHCU cluster, it is shared and discussed among the group, creating an open forum for sharing experiences indirectly.
### Table 6: Questionnaires and Surveys Conducted

<table>
<thead>
<tr>
<th>Name of Questionnaires conducted in Every PHCU cluster</th>
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<tbody>
<tr>
<td>1. Mother to child statistics</td>
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<tr>
<td>2. HIV/AIDS</td>
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<tr>
<td>3. Customer service for overnight patients</td>
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<td>4. Customer service for daily patients</td>
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<td>5. Checklist for Malaria, TB, and Leprosy</td>
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<tr>
<td>6. Customer service performed by HEWs</td>
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<td>7. Customer Service performed by the HEWs but answered by their communities</td>
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<tr>
<td>8. Pharmacy</td>
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<tr>
<td>9. Checklist for overall PHCU logistical activities</td>
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<td>10. Checklist for accurate documentation in PHCU sectors</td>
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<tr>
<td>11. Disease prevention &amp; immunization checklist</td>
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<tr>
<td>12. HEW logistics and data collection checklist</td>
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In addition to the supportive supervision documents, the WoHO experts are continually looking for “best practices” in the PHCU clusters that can be utilized or adapted in other areas. A template was created to document best practices from the PHCUs; this document was shared with the PHCU Directors in paper form. During information gathering for this case study, the case study team observed the template being used in both Adikayh and Dabub clusters, and was found to be up to date in the records of each PHCU. While the case study team was encouraged to see that each PHCU was documenting their best practices, the template does not capture “how” the best practices were being implemented and this is an area which could be further improved. This open and forward thinking by the WoHO expert staff has allowed for another way to share information between PHCUs. Below are examples of best practices that were implemented by the Religious Leaders of Firewayni Kebele, during the first quarter of 2005 EC, and shared by the WoHO experts with all PHCUs:

1. They built a pit latrine at the church for males and females
2. A separate administrative pit latrine was also constructed at the church
3. The priest provided health education for students who came to church on maternal issues, immunization, nutrition and the use of pit latrines
4. The names of pregnant mothers in the kebele were given to the priests for follow-up
5. At a baptism the priest registered the child and asked the mother where she gave birth.
6. In addition to registering where mothers give birth the priest also registers pregnant mothers at the baptism
7. The priests built a traditional ambulance and mobilized the students to carry pregnant mothers to the HC
8. The priests held discussions with the string committee of the kebele and gaps were identified in the HEP and assistance with educational services was provided
9. In October, the priests tried to ask every member of the kebele to build permanent pit latrines. 428 families were asked. Now the HEW is organizing community experience share programs to help implement latrine construction in other areas of her kebele
10. Some community members were recognized for their motivation in providing support to the HEWs of working in their kebele
11. Based upon the information given to the HEWs all mothers were either delivered at Hiwane HC or Adigudom HC

Also of note, deliveries at HFs have increased in the woreda due in part to the active mobilization and work of the WHDA and the string committee.

VII. Discussion

Findings indicate that while the WoHO does facilitate all experience share programs, there are some external sources motivating the staff. An in-depth analysis of the organization of community-based and expert-based programs shows that the main focus of these programs is not to share information between the health facilities but rather to share information with external experts and allow for community-based peer learning opportunities. While the WoHO does have open and transparent relations with its HCs, information shared among HCs is conducted through feedback documents and review meeting discussions.

The community-based experience share programs are a unique approach to teaching the HEP, to very rural and hard to convince communities and have only supported the HEWs quest to achieve the MDGs. These experience share programs, however, are only a part of a much larger national sanitation program assisted in the Tigray region by the REST office.
The expert-based experience share programs are vague and do not allow for the participants to fully understand the bulk of the work being executed by the WoHO experts. The woreda takes a very meticulous approach in finding gaps, implementing programs, and evaluating cluster areas. For this reason, it would be difficult for an outside expert to successfully implemented Hintalo Wajerate’s procedures and strategies in other woredas, unless more information is provided.

While these findings provided a more in depth review of peer learning, there seems to be a significant lack of documentation from the WoHO regarding these experience share programs. When the WoHO staff was asked for documentation of the experience share programs, the only information that could be provided was the target groups, the number of people in attendance and the approximate date. This information is located in the personal journal of the WoHO supervisor and is also incomplete. There is no official documentation on community-based experience share programs by the WoHO. Findings from the HCs also indicate they do not keep documentation of any experience share program conducted in their HC Cluster.

Due to the apparent lack of documentation from the WoHO, it would be interesting to conduct a study to evaluate the participants’ retention of information and to track the type of information spread to other woredas. The results of this additional study would determine the effectiveness of these experience share programs as a means to share information.

VIII. Recommendations

While peer learning can be an extremely effective teaching tool, the approach with which a facilitator implements this tool determines peer retention, sustainability and implementation of strategies. If UI-FHS decides to set up a peer learning program in the woreda, a recommendation would be to create a system to document the peer exchange process and the activities discussed during the exchange. The document should capture how the activities discussed during a peer learning session are being used by the HFs and health staff that attended the peer exchange. Creating this system in the beginning will allow for expectations to be set up prior to the exchanges, and will help facilitators effectively monitor and evaluate the experience share programs.

Furthermore, the few experience share programs observed by the case study team revealed that the information presented was vague, standard and repetitive. It is recommended that UI-FHS request some specific topics to be discussed more in depth, as this would allow for a more focused experience share program. More specifically, the techniques used to provide supportive supervision by WoHO experts,
how review meetings and feedback are conducted and how challenges were overcome by the HC staff and HEWs are a few recommended topics.

Finally, for Hintalo Wajerate, it is recommended that the WoHO experts expand its peer learning programs to include HEWs. A peer learning activity is very different from the already implemented experience share programs. Peer learning can take a more in-depth and focused approach to implementing strategies in the HC and at the community level. Many times HPs face similar challenges and taking the time to openly share the ways one HP has accomplished a task could benefit other HPs. The recommendation is this type of experience share take place at least bi-annually. To work within the budget of the WoHO, a supplementary two hour session when HEWs come in for training could be added. This would minimize travel and cost expenses as the HEWs would already be in the area together. It would be the responsibility of WoHO experts to recognize challenges that reoccur in HPs, identify the “best practices” that are being implemented and to act as facilitators in the peer learning program.

In addition, to a bi-annual verbal peer learning session when a “Best Practice” document is received by a HC from the WoHO the HEW supervisor take the time to share the document with the HEWs in that cluster. Ideally a basic discussion would include ways to implement and identify gaps on the received “Best Practices” document.

IX. Conclusion

The Hintalo Wajerate woreda has a solid foundation for expert-based experience share programs and continues to expand its community-based experience share programs. Our recommendation is to build upon this foundation, creating a more robust set of peer learning opportunities for staff members at the HC/HP levels. Individuals at the HP/HC level currently implement innovative practices to educate and create awareness within their communities and these ideas should be documented and shared.