Delivering Services through Health Extension Workers in Ethiopia.
December, 2011

Dakar, Senegal
Background Information, 2011
Ethiopia

- Second most populous nation in Africa
- It covers 1,104,300 square kilometers
- Geographic location- Horn of Africa
- Estimated total population in 2011- 79.8 million (Projections from the 2007 population and housing census)
- Predominately young with 44% < 15 years, and over half (52%) between 15 and 65 years.
Women in the reproductive age group constitute 24% of the population.

Fertility rate – 4.8 births per woman (EDHS 2011)

Annual Expected Pregnancies > 2.8 million

Teen age pregnancy = 17% (EDHS 2005)
Background Information, 2011
Ethiopia

- Maternal Mortality Ratio = 470 per 100,000 live births (WHO 2008)
- Neonatal Mortality = 37 per 1,000 live births (EDHS 2011)
- CPR = 40% (L10k 2011) 29% (EDHS 2011)
- Unmet need for FP = 25% (EDHS 2011)
Health Extension Program

• The Health Extension Program (HEP) is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households;

• HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facility-based services;

• The philosophy of HEP is that if the right knowledge and skill is transferred to households, they can take responsibility for producing and maintaining their own health;

• The HEP is the main vehicle for bringing key maternal, neonatal and child health interventions to the community
The HEP Packages

16 Health Extension Packages

- Disease Prevention & control (3)
- Hygiene & Environmental Sanitation (7)
- Health Education and communication
- Family Health (5)
Health Extension Program

• The program is based on expanding physical health infrastructure (health posts) and developing a cadre of Health Extension Workers (HEWs) who will provide basic curative and preventive health services in every rural community.

• There is a clear referral linkage between the health posts and to the health centers,

• The health extension supervisors regularly supervise the HEWs.
Health Extension Program

• Health extension workers are engaged in distributing condoms, pills, providing injectables and inserting Implanon (a single rod implant) at community and health post level.

• This has complemented the delivery of the wider range of FP services that is provided at HCs and Hospitals.
Results Achieved So far

• The trend in health post visits has increased from 51% to 59%

• The percentage of service delivery points offering at least three methods of modern contraception has increased from 60 percent in 2006 to 90 percent at health posts in 2010;

• The contraceptive prevalence rate (CPR) has increased from 15% to 29%; Health posts had also become the major source for current users of contraceptives,

• The trend in source of FP for current users in health posts has increased from 56% to 63%, and in health centers from 23% to 28%;

• Trends in ANC use has increased from 56% to 66%;

• Trends in household utilization of latrine has increased from 61% to 72%;
Results Achieved So far ...... cont’d

• The proportion of households with access to sanitation, improved disproportionately in HEP villages compared to non–HEP villages between 2005 and 2007;

• Awareness of HIV/AIDS also improved, with the level of knowledge of condoms as a means of preventing HIV increasing by 78 percent in HEP villages and 46 to control villages;

• Vaccination coverage improved significantly. Significantly larger proportion of children in villages where health extension workers were deployed were vaccinated against diphtheria, polio, and tetanus (DPT); measles; polio; tuberculosis; and main antigens;

• The most important success factor has been the increase in expenditure allocated to implement the HEP
Challenges

• Incentive packages for health human resources are lacking, and there is a weak link between compensation and performance;
• In some area, health posts are not fully well equipped with needed equipment and supplies;
• Weak Institutional arrangements for management of health service extension program in some regions;
• The capacity of the Woreda/District Health Offices to provide supervision, monitoring, and evaluation is low;
Lessons Learned

• Political leadership and champions at higher levels are a critical success factor in improving health outcomes;

• Delivery of services and management of programs should be integrated into existing systems. What HEP has demonstrated is that vertically mobilized resources can be utilized for system wide interventions;

• The HEP is transferring the right knowledge and skills to communities and households so that they will be able to adopt behaviors that improve their own health.

• Major shift in the amount and modality of financing of the sector/HEP has resulted to smooth implementation of programs interventions;
Lessons Learned ....... Cont’d

• The HEP has created a unique model for partnership and collaboration between the government and various actors in the health system, thus the trust has resulted in harmonization of financing, program implementation, monitoring, and evaluation, leading to further strengthening of health systems;

• The HEP has been implemented in settings with significant diversity in socioeconomic, cultural, and geographic conditions. This flexible nature is unique to the different environments, facilitating replication in other countries;

• Implementation of HEP has shown encouraging results in a short time in terms of increasing coverage of essential interventions and reducing morbidity and mortality related to communicable health problem.
Ameseginalehu
Thank you
Community Health Worker improved FP & MH services among rural women of Bangladesh
Program Intervention:

Domiciliary services were crucial to break the barriers

- Socio-Demographic situation in mid 1970s -
  - moderately conservative Muslim country, restricted women’s mobility
  - high fertility, low CPR, high population growth rate
  - low literacy rate, poor economic conditions
  - poor public health infrastructure, insufficient clinic-based FP service
  - conservative attitude & low demand for contraceptives

- Model initiated through Family Welfare Assistants (FWAs) -
  - female FWA recruited from the respective community
  - assigned for 500 – 600 ELCOs of her working area
  - minimum high school (SSC) education
Evolution of CHW’s Role & Responsibilities:

Bridge HH to facility, increased demand & access to FP/MH

1976 - Recruitment of 23,500 FWA for couple registration, motivation, counseling, distribution of OCP & condom, referral to facility for LAPM

1980 - Community awareness on MCH integrated Family Planning program

1985-1990 - Introduced FWA register - record HH data on FP/demographic
Introduced satellite clinic - MCH-FP/EPI services in remote & rural areas.
FWA supports in organizing satellite & assisting service provider

1994 - Pilot of doorstep services of injectable from 2nd dose onward
1995 - National Scale-up of doorstep injectable from 2nd dose onward

2003 – Pilot 18 months CSBA training for FWAs
2004 – Started scaling-up, currently 6560 trained, 7000 more will be trained

2011 – Provide FP & MH service through Community Clinic (3 days/week)
Key provider of temporary FP methods:

Steady increase in performance

Ref: DGFP MIS
CHW are now skilled for MH services:

Steady increase in MH services by CSBA

Ref: DGFP MIS
Impressive progress in FP situation:

CHW Contributing to closing in on fertility transition

Ref: BDHS
Bangladesh is on track of MDG 5:

CHW Contributing to steady increase in SBA

Proportion of births delivered by SBA

3.5% delivery conducted by CSBA
Challenges:

Accelerated progress in FP/MH can be achieved

- No carrier path – *develop reluctance to drive for performance*
- No recruitment for long time - *many vacant positions especially in the hard-to-reach areas*
- Increase workload, almost double ELCOs – *reduced efficiency*
- Interrupted supply of long acting methods – *hesitant to referee*
- Lack of technical supervision – *challenged to provide MH services*
Lessons learned:

CHW is a feasible option to increase FP/MH demand & supply

- Without conventional training, CWH can contribute to FP/MH
- Starting with basic training, additional training on FP/MH in phases to CHW is a realistic & feasible option
- Female CHW from own community -
  - Uphold cultural & social values
  - Increase trust & accessibility to all community members
  - Sustainability of information & services in the community
- Quality comprehensive training, continuing supervision & functional links with health facility is key to success
CHW offers Beautiful World For Them
KEY ELEMENTS OF SUCCESSFUL PROGRAMMES WHICH DELIVER FP SERVICES THROUGH COMMUNITY HEALTH PROGRAMMES

Cathy MUGENI
Daphrose NYIRASAFALI
November 29- December 2, 2011
Dakar, Senegal
Rwanda National Health Policy
(based on WHO’s seven building blocks health systems strengthening)


2. To consolidate, expand and improve services for the prevention of disease and promotion of health

3. To consolidate, expand and improve services for the treatment and control of disease

Levels of Intervention
- Family-oriented community based services
- Population oriented schedulable services
- Individual oriented clinical services

To increase the availability and quality of human resources for Health

To ensure financial accessibility to health services for all & sustainable & equitable financing of the health sector

To ensure geographical accessibility to health services for all

To ensure (universal) availability & rational use at all levels of quality drugs, vaccines & consumables

To ensure the highest attainable quality of health services at all levels

To strengthen Specialised Services, National Referral Hospitals and research capacity

To strengthen the sector’s institutional capacity

To ensure financial accessibility to health services for all & sustainable & equitable financing of the health sector
Community Health Structure

**NATIONAL LEVEL**
- Minisante
  - Community Health Desk

**DISTRICT ADMINISTRATION**
- District Health Supervisor

**DISTRICT HOSPITAL**
- District Hygiene and Sanitation Officer
- Community Health Officer

**HEALTH CENTER/COOPERATIVE**
- Hygienist or Sociologue in charge of Community Health Activities

**CELL LEVEL**
- Binome Supervisor
  - (1 per cell, elected from among the binomes)

**UMUDUGUDU (VILLAGE) LEVEL**
- Community Health Workers
  - Binomes (male & female worker in each umudugudu)
  - CAS (1 per umudugudu)
  - ASM (1 per umudugudu)
  - Palliative Care (2 per umudugudu, not yet elected)
Strengthening health systems through community health

Evolution of CHWs

BEGINNING OF CHW

- Initiated: 1995 (after Genocide)
  Objective: first level of entry to the health system
- Operates at smallest administrative unit of the country (villages)
- Includes a minimum package of activities focusing on primary health care

Evolution

- Selection and training of CHWs countrywide
- Linkage to a diversification of strategies
  - to reduce child and maternal mortality
  - community case management
Community Health Workers

1 Binome: female & male

1 CHSA (in charge of social affairs)

1 Female in charge of maternal Health

4 CHWs/village
CHW PROGRAMMES

Preventive Services
- Community sensitization on prevention of common diseases: malaria, diarrhoea, ARI, for prevention of sexual transmitted infections, health campaign on hygiene and sanitation, immunization etc.
- Educate communities on use of water treatment solutions and distribute them
- Vaccination campaign
- Provision of family planning services including FP products
- Community Maternal Newborn Health (Rapid SMS)

Curative Services
- Community Case Management of malaria, ARI, diarrhoea, vaccination, malnutrition (e.g. Community Integrated Management of Childhood Illnesses/Community IMCI)
- MISO
- Engage in community DOTs for tuberculosis, HIV

Promotion Services
- Nutrition education to communities
- Growth monitoring particularly among children under five years old
- Nutrition surveillance
- Routine home visits for active case finding
- Hygiene Clubs

C-HMIS & C-PBF
- C-HMIS:
  - mUbuzima: all CHW received the mobile phone
  - Monthly report: 40 indicators
  - Rapid SMS
- C-PBF:
  - 5 Maternal and Child Health Indicators
  - 2 TB indicators
  - Report

COOPERATIVES
- 499 CHWs cooperatives
- They help CHWs to use the PBF money to collectively invest it in profitable ventures
- They generate income to allow CHW’s.
1995-2005: General training

2003: CBNP
2004 – 2008 : Training on HBM 3 Days

2008-2010: Training on IMCI 5 days

2009 – 2012 : Training on MNH & MISO Pilot Phase

2010-2012 : Training on CBP 10 Days

2010 -2012 : Rapid SMS & mUbuzima : 3 days

2010-2011 : Training on cooperative management

2011- 2012 : Training on CBNP, IYCF, CMAM 5 days
CHALLENGES

- Huge number of CHWs who need training and supportive supervision;
- Low education level of CHWs call for demanding and frequent training
- Weak financial management skills and systems hampering initial stages of business growth
- Logistical support to meet CHW need Strengthening the functionality of CHW Cooperatives (need for technical support)
LESSONS LEARNED

• Good Governance: leadership, ownership, clarity of vision
• IMIHIGO:
  Territorial administration performance contracts with HE the President of the Republic of Rwanda including Health Indicators;
• Integration/Decentralization
  Task shifting and home based management
  Administrative, fiscal and financial management
  Community participation in governance
LESSONS LEARNED….

- Community Health Approach
  - For accessibility, health services are provided first at family level up to national level;
  - CHWs - 60,000 (4/village) are organized in cooperatives
- Introduction of SWAP mechanism at local level through the Joint Action Forum (JAF).
- Performance based financing
  - Promotion of local innovation and competition and accountability for performance;
  - Priority to composite indicators and avoid selective performance;
THANKS
HE KAGAME PAUL WITH ALL CHWs
Distribution à base communautaire des produits contraceptifs au Burkina Faso

Conférence internationale sur la planification familiale du 29 novembre au 3 Décembre 2011 à Dakar, Sénégal

Présentée par Dr SANON Djénéba
CONTEXTE (1/2)

- Burkina Faso: **16 248 558** habitants avec un taux de croissance de 3,1%
- **Extrême jeunesse** (46,7% ont moins de 15 ans)
- Extrême pauvreté (43,9% en dessous du seuil absolu)
- Indice synthétique de fécondité: **6,0**
- PC méthodes moderne: 15%
- Besoins non satisfaits: 31,1%
- **RMM**: 560/100 000 NV
CONTEXTE (2/2)

• Approche de contractualisation des activités de santé avec les ONG et associations: optimiser la contribution de la société civile à l’accélération de l’atteinte des OMD liés à la santé,

• Définition d’un dispositif de contractualisation: documents, paquets d’activités dévolu (prise en charge, sensibilisation, distribution),

• Mécanisme financier: panier commun,

• En plus, fonds dits ciblés pour certaines interventions dont la distribution à base communautaire de contraceptifs: appui de l’UNFPA
MISE EN ŒUVRE DE LA DBC (1/3)

• Distribution à base communautaire des produits contraceptifs: stratégies d’amélioration de la PC

• Opportunité pour booster la PF dans un contexte d’intégration des activités

• **Échelle nationale** en 2010: financement de l’UNFPA de $ US 1 739 648 (exécuté à 94%)

• Extension thématique et géographique

• Élaboration des outils de suivi évaluation de l’approche de contractualisation
MISE EN ŒUVRE DE LA DBC (2/3)

- Recrutement et formation de
  - 14 ONG de renforcement des capacités
  - 150 Organisations à base communautaire d’exécution (OBC-E)
  - agents DBC, des animateurs et des superviseurs

- Dotation des OBC-E en produits contraceptifs (stock initial),

- Tenues de rencontres d’information et de sensibilisation des acteurs et des leaders communautaires,

- Activités de distribution,

- Réalisation de deux sorties de suivi de la mise en œuvre des activités des ONG-Rencap et des OBC-E sur le terrain,
MISE EN ŒUVRE DE LA DBC (3/3)

• Rencontre de concertation,

• Distribution des produits contraceptifs: depuis Juillet 2011,

• **Couverture**: toutes les régions – 76% des districts sanitaires - 1454 villages situés à plus de 10 km d’une formation sanitaire (36,4% des villages couverts par ONG/OBCE),

• **Produits contraceptifs distribués (**bilan provisoire**):**
  - condoms masculins (24 024),
  - condoms féminins (762),
  - pilule (3 846),
  - collier (186).

• **8 449 personnes** dont 6 402 hommes et 2 047 femmes.
DÉFIS

• Mobilisation des ressources additionnelles pour soutenir l’extension de la DBC,

• Synergie des financements,

• Suivi et documentation de la stratégie,

• Concertation entre les acteurs districts et ONG /OBCE,

• Supervision des acteurs de distribution.
MERCI POUR VOTRE ATTENTION
FAMILY PLANNING AT THE COMMUNITY LEVEL IN BENIN

Ms. Diene KEITA
UNFPA Benin CO Representative
Donors Health Group Chairperson

Maternal Mortality Ratio: 397 per 100,000 live births (DHS 2006).

Modern Contraceptive Prevalence: 7.2% in 2001 and 6.1 in 2006. FP unmeet needs increased from 27% to 30% (same period).

Community Health Workers (CHW) Needs: 25,000 for the whole country.

CHW available: 12,000
PF utilization per administrative divisions
STUDY SETTING AND OBJECTIVES

In 2010, an Analysis of the perception of FP by the community stakeholders was carried out in the country.

Objective:
To identify the successes and challenges of the community interventions implementation regarding FP in order to address the bottlenecks.
METHODOLOGY

Target population

- Community workers,
- Community and religious leaders,
- Members of women, men and young people groups,
- Members of Civil Society organizations

Data Collection Methods

- Key documents review,
- Key Informal Interviews,
- Focus group discussions,
- Observations
**KEY FINDINGS**

**Awareness**
- The community is more aware about the importance of a sensible balance between economic and population growth and the imperative of having a <<parenté responsable>>.

**Availability**
- CHW Community are available to provide FP services in remote villages with few health infrastructures.

**Involvement in FP promotion**
- Community workers (health and social),
- Community and religious leaders,
- Members of women, men and young people groups,
- Members of Civil Society members organizations.

**Strategies**
- IEC/BCC sessions for students,
- Periodic campaigns on FP services,
- Mobile Strategy to provide FP services.
Women socio-economic status strengthening.

(i) CHW motivation,
(ii) Management of preconceived ideas on FP,
(iii) Integration of FP/HIV/RH services.

Improving men’s commitment and support to FP promotion. Involving community medias.
Extension of free access to FP services including sustainability mechanisms

Strengthening of community-based services by reinforcing:
(i) community distribution of the RH commodities
(ii) mobile strategies to provide FP services
(iii) Training of assistant nurses on FP

Advocacy targeting men and community leaders’ organizations for a wider involvement of men in promoting FP.
THANK YOU !!!