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# Pro-Equity RMNCH Programming: Experiences from Bangladesh & Honduras

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# Agenda

- Introduction
- Bangladesh MaMoni HSS: Tanvi
- ChildFund Honduras: David

# Bangaldesh MaMoni HSS

# Project Background

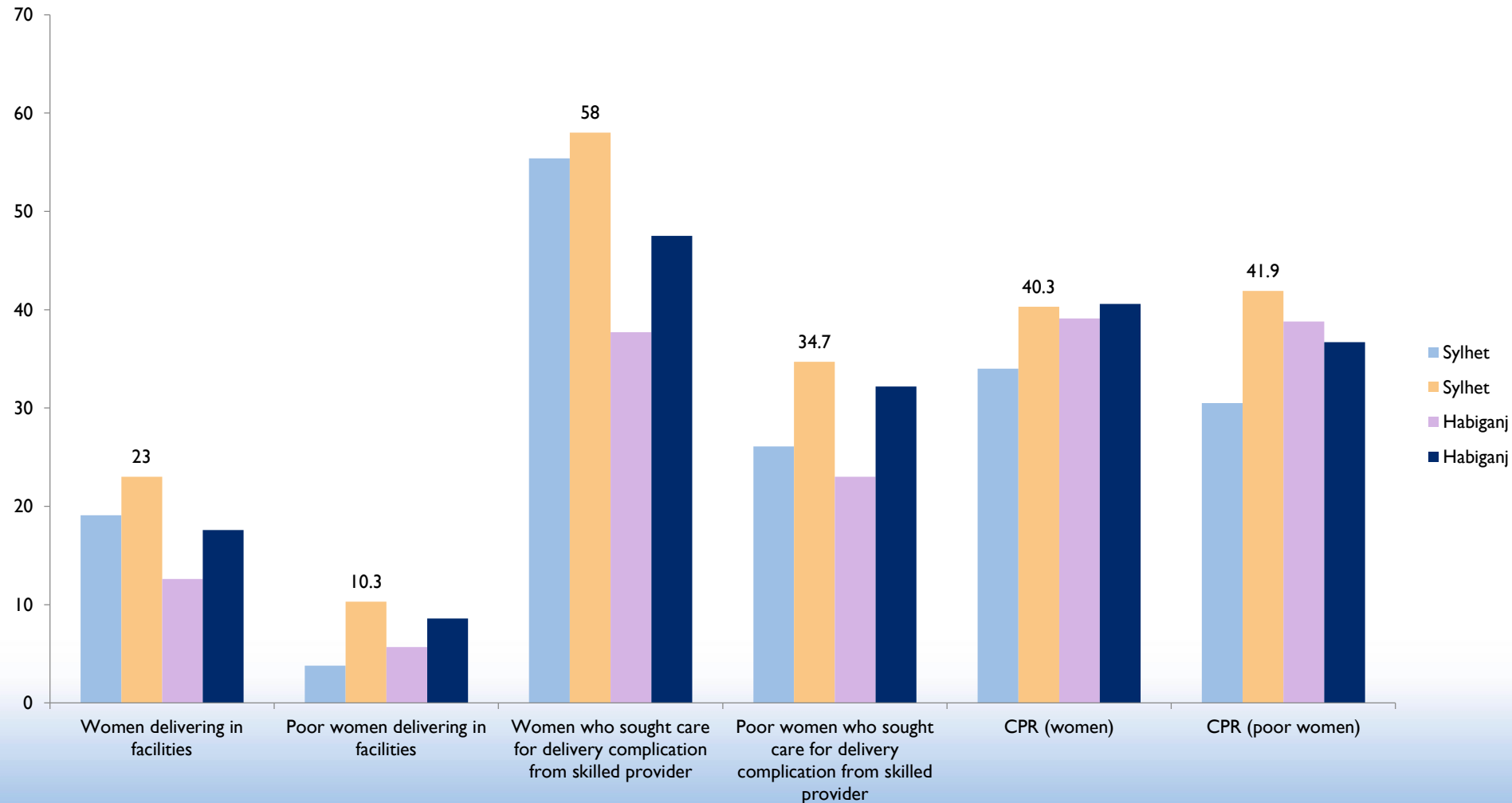
- MaMoni Health Systems Strengthening
- 4 year MCHIP Associate Award (2013-2017)
- Main objectives:
  - Improve service readiness through critical gap management
  - Strengthen health systems at the district level and below
  - Promote an enabling environment to strengthen district-level health systems
  - **Identify and reduce barriers to accessing health services**

# Socioeconomic Inequity

- Facilitating referrals and emergency transports
- Allocating project and leveraged resources to hard-to-reach and poor communities
- Habiganj tea garden strategy
- Negotiating rates for private providers



# Key RMNCH Indicators



# Geographic Inequity

- Using Bangladesh Maternal Mortality and Health Survey 2010 to identify and prioritize districts with the greatest need:
  - Women delivering in facilities
  - Women who sought care for delivery complication from skilled provider
  - Contraceptive prevalence rate

# Geographic Inequity

- Community mapping to upgrade strategically located government health facilities
  - Focused on underserved sub-districts
- Training 24,000 CHVs
- Water ambulances





# Gender Inequity

- Male participation
- Union Education, Health and FP standing committees are chaired by elected women
- Income generation activities for women
- Maternal death audits

# Conclusions

- Forefront of innovative pro-equity program approaches
- Utilized various types of data to identify most vulnerable populations
- Worked with community members and local government structures to make services accessible

Questions?



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# Using Community Health Workers to promote equity and reach the most vulnerable: *Unidades Comunitarios* in rural Honduras

## Authors:

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and Alex Ergo

# A four year project funded by USAID's Child Survival and Health Grant Program, 2009-13

- The project was located in 12 southern municipalities of the Department of Francisco Morazán, which includes 293 communities.
- Intended to address health inequity, specifically: improve physical access to health services by the poorest and most remote populations, lower their out-of-pocket (OOP) costs, and increase the use of health services.

# Project Partners

- ChildFund International served as lead organization.
- Honduras MOH participated locally and regionally.
- ADAL and ADACAR are implementation CSOs in Lepaterique and in Curaren, Alubaren, and Reitoca.
- Centro Nacional de Educación para el Trabajo (CENET) contributed to the development of the descriptive case study, and related Operations Research (OR).
- The University Research Corporation (URC) conducted the initial implementation of the CQI process at Health Facilities (HF) and UCOS.
- The Spanish Red Cross and World Vision provide implementation support for select AIN-C groups and UCOS.

# Problems faced by local project population

Health facilities over 2 hour walk for 69% of the target population (total = 41,000 WRA and U5 children)

High OOP costs to access existing public services among client families

Common complaints of existing public services included:

- limited and/or unavailable staff
- limited hours of operation
- frequent stock outs
- poor client treatment
- limited staff training and supervisory support
- poor quality care

# Development Hypothesis

*A community-based model of integrated basic MNCHN services (community volunteers working from a local physical structure applying quality improvement practices) linked to the Honduras national health system's decentralization strategy will improve health equity among rural, low income beneficiaries by lowering barriers to access, cost and use.*



# Three Community-based Innovations

1. Define and standardize the role of communities in order to increase institutional deliveries and strengthen CB obstetric and neonatal care within a national decentralization strategy;
2. Create self-sustaining CB health units (UCOS) which integrate vertical MOH MNCHN programs and various cadres of community volunteers; and
3. Adapt and implement CB continuous quality improvement (CQI) systems for UCOS.

# What is UCOS?

*UCOS are small freestanding structures located in selected communities, equipped with essential drugs, basic equipment and health education materials. Community volunteers offer care, attention, and education to persons in need, with an emphasis on women, infants and children. They are self-sustaining financially, managed by the community, supervised by the MOH, and given technical and logistical support by ChildFund Honduras. UCOS sustainability depends upon a functioning revolving drug fund.*

# Services offered at UCOS

- Pregnancy registries;
- Promotion of facility based pre-natal visits and key messages;
- Promotion of hygienic practices for home deliveries;
- Promotion of attended, facility based delivery
- Facilitated transportation for emergency obstetric care;
- Post-natal and neonatal home visits within the first three days of life;
- Counseling on breastfeeding and infant care;
- Routine monthly growth promotion and monitoring activities for children under two years of age and their mothers;
- Community case management of diarrhea and pneumonia (including first-line treatment and referral to local health facilities) among children under five; and
- Surveillance of maternal and young child mortality.

# Four cadres of community volunteers

1. Trained traditional birth attendants
2. Nutrition monitors
3. Community health volunteers (CHVs)
4. Emergency evacuation committee members.

Additionally, community health committees also were trained to manage the UCOS.

A total of 790 volunteers were trained to provide the aforementioned services over the life of the project.

# GPS Mapping Process

## Partners:

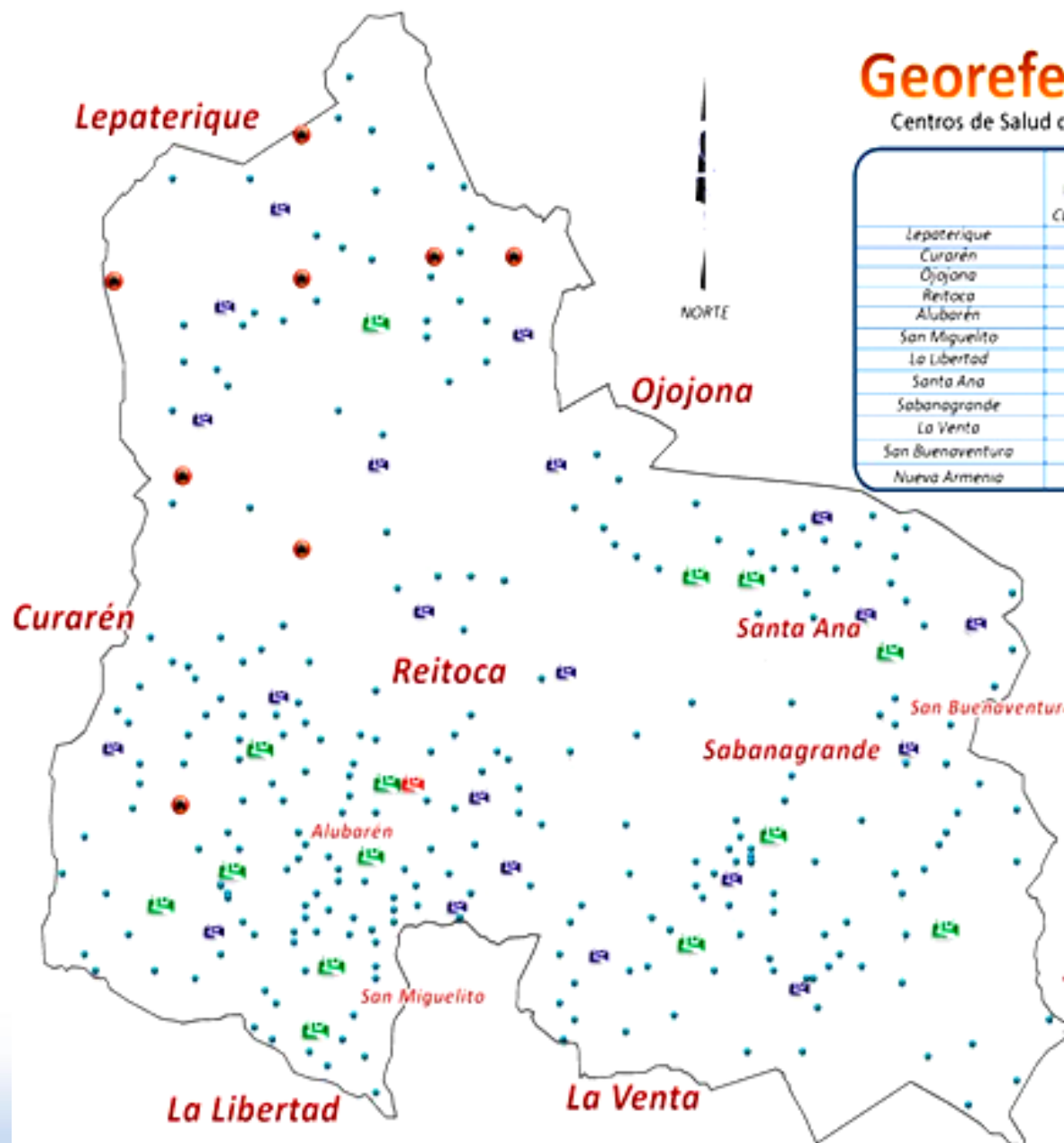
- MOH, representatives of local government, local CSOs and local beneficiaries

## Criteria for UCOS location selection:

- Existing health service locations, population density, transportation routes and access, community interest and resources, and political support

# Georeferenciación

Centros de Salud del Sur de Francisco Morazán



					
	CESAMO	CESAR	CLÍNICA	UCOS	AGI
Lepaterique	1	5	-	7	47
Curarén	3	3	-	1	55
Ojojona	1	2	-	-	16
Reitoca	1	3	1	-	31
Alubarén	1	1	-	-	19
San Miguelito	1	-	-	-	16
La Libertad	1	-	-	-	11
Santa Ana	1	1	-	-	14
Sabanagrande	1	2	-	-	37
La Venta	1	1	-	-	18
San Buenaventura	1	3	-	-	17
Nueva Armenia	1	-	-	-	17
	<b>14</b>	<b>21</b>	<b>1</b>	<b>8</b>	<b>298</b>

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# Detailed descriptive case study of the pre-existing pilot UCOS sites

- Direct observation, and focus group discussions (FGDs) of community volunteers in the 8 established UCOS
- Information collected on: flow of activities in the integrated model, minimal number of resources for optimal operation, identification of basic preventive and curative services, hours of service, and definition of supervisory activities and reporting models, among others.

## Case study outputs

- Case study activities led to the development of definitions, standards and practices for community management of UCOS, and formal linkages with local MOH public health services.
- Training guides and implementation manuals and tools were developed to ensure standardized training and supervision for all 28 UCOS sites.



## Four study methods

1. LQAS-based Knowledge, Practice, and Coverage (KPC) surveys pre- and post-implementation (N=209; 2011, and N=209; 2013, respectively) on an independent, random samples of mothers with children under the age of five and pregnant women, representative of the entire project area.
2. Cost study of services offered through UCOS, health posts, health clinics, and private hospitals in the project area (personal interviews with staff; 2012).

## Four study methods (cont'd)

3. Client exit interviews conducted that included client satisfaction and out-of-pocket cost measures (N=464; 2013). OOP expenses considered: time requirements of the patients and caregivers; transport expenses; direct service fees; costs of medicines and supplies, and food and drink expenses.

Asset information from two groups of service users (users of UCOS services and users of MOH and private hospital services).

## Four study methods (cont'd)

4. Final project evaluation included sites visits, FGDs, and UCOS and health facility records reviews (2013). Among other analyses conducted, the author estimated trends in mortality in the project area.

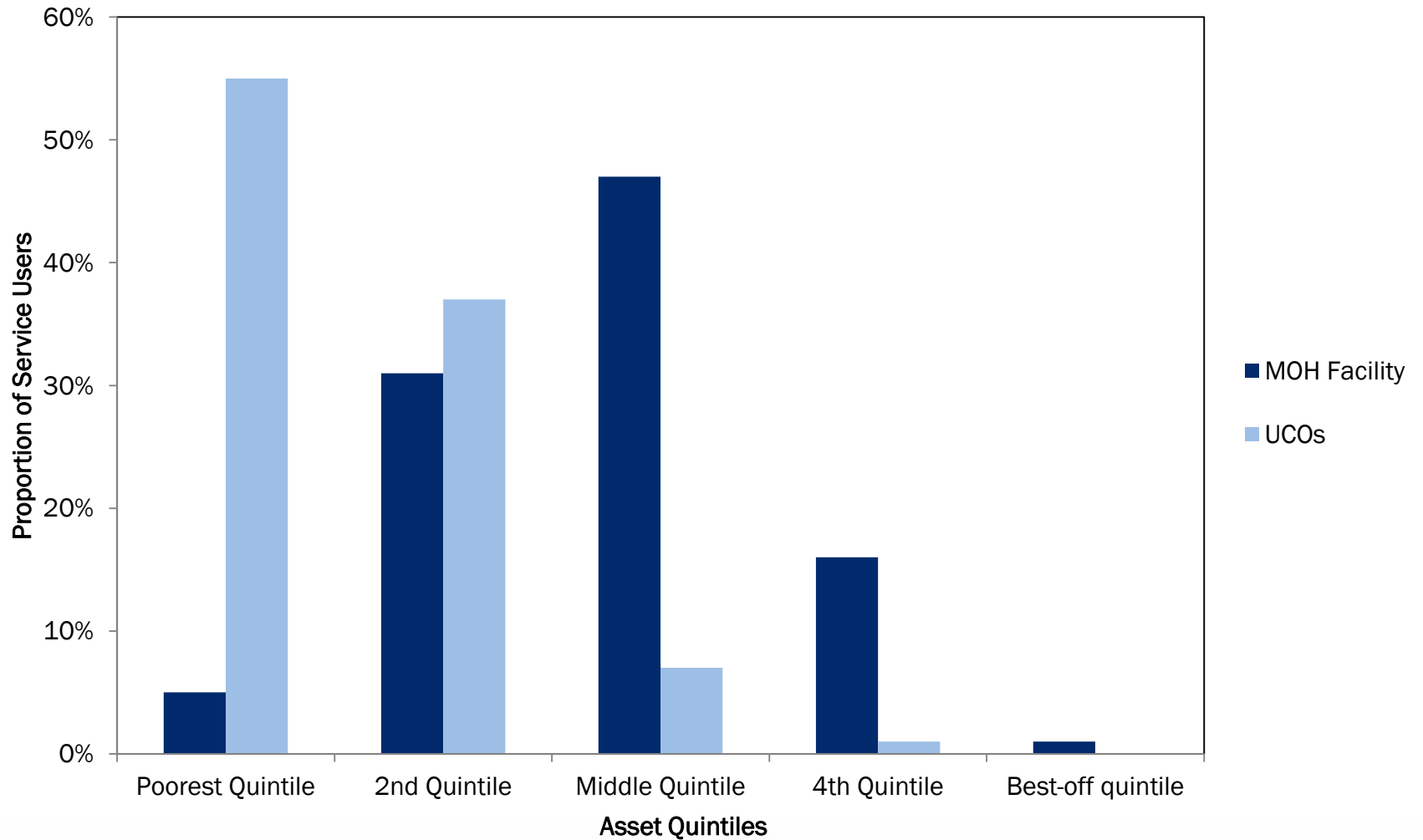
# Results: Physical access to health services among poorest and most remote population

- Before the introduction of the UCOS, over two-thirds of pregnant women walked two hours or more to access a health facility.
- By the end of the project, 21 percent of the entire project service area population was served by the UCOS sites.
- While 69 percent of women still reported walking to a facility for health care, 14 percent more of these women (as compared to before the project activities) were walking less than one hour to get there.
- All 28 UCOS sites also had functioning transportation committees run by volunteers who responded to emergencies when no transport was otherwise available.

# Results: Physical access to health services among poorest and most remote population

- Overall, 92 percent of all UCOS users fell into the two lowest wealth quintiles.
- Fifty-five percent of UCOS clients were from the lowest socioeconomic quintile, whereas only 5 percent of the clients who used an MOH facility in the same region were from the lowest quintile.
- The results confirmed that UCOS services reached a higher percentage of the poorest population than was reached by MOH services.
- UCOS also increased utilization of local health care services among people in general and women in particular in the target population. The overall number of children less than five years of age treated through the UCOS increased by 254 percent between 2012 and 2013.

# Figure 2. Client wealth quintiles



## Results: Out of pocket costs to clients

- With the introduction of the UCOS, services were brought closer to the community, which reduced family expenditures on health care by as much as 32 times.
- UCOS services reduced family out-of-pocket spending on health by four times, six times, and 23 times, respectively, compared to health posts, health centers, and hospitals.
- The out-of-pocket cost of care given to an under-five sick child at the UCOS was \$3.50 USD, which was between 75 percent and 95 percent lower than the out-of-pocket costs incurred at public health facilities.

## Results: Utilization of services and changes in selected health behaviors

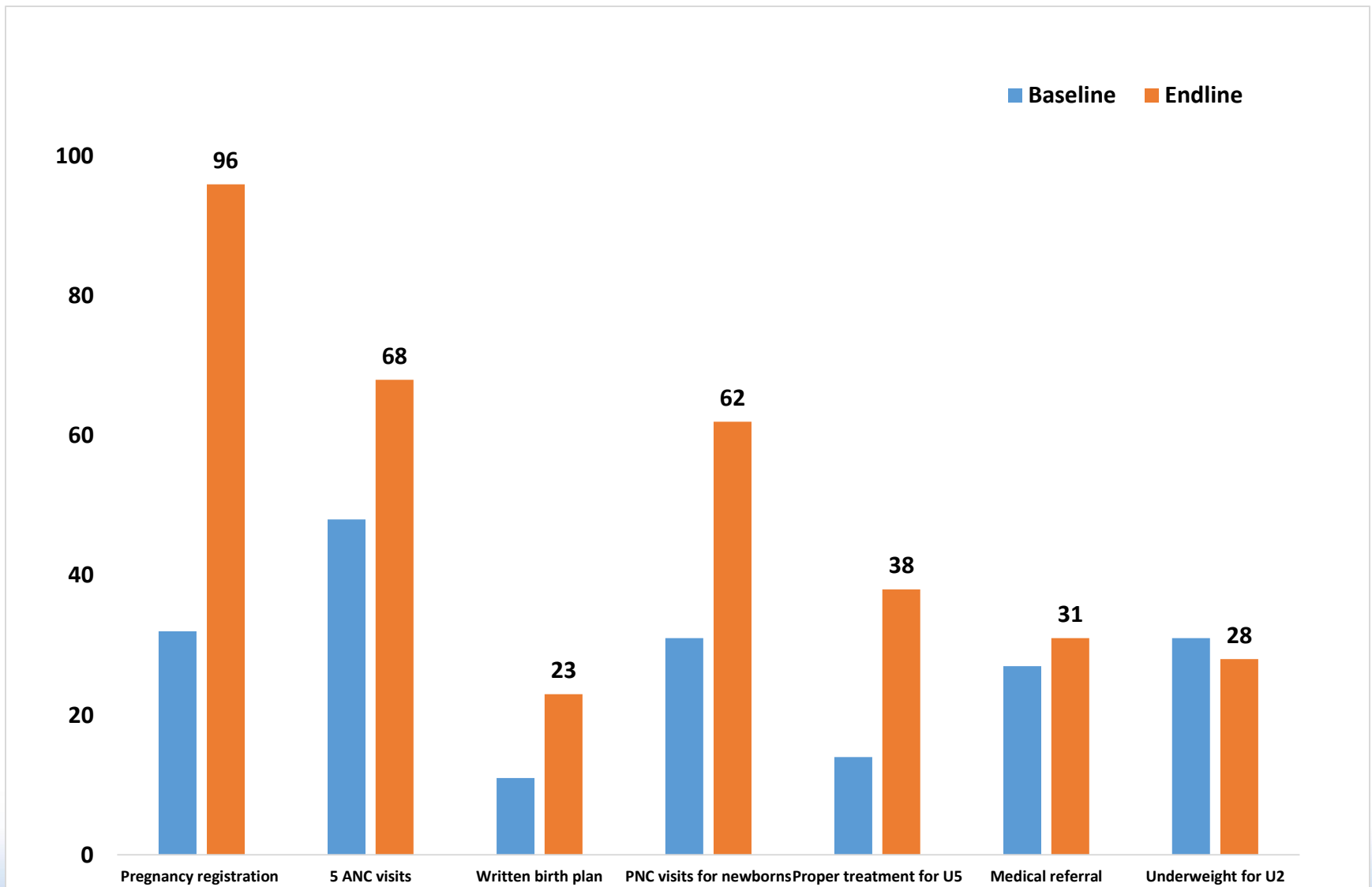
- Women reported improved knowledge and practices regarding key maternal and child health behaviors that save lives. For example, survey results indicate that the number of women who knew newborn danger signs increased from 7 percent at baseline to 44 percent at endline.
- At endline, 70 percent of women breastfed their babies immediately after birth, compared to 44 percent at baseline.



# Results: Utilization of services and changes in selected health behaviors

- Between the pre- and post-intervention surveys, there were statistically significant differences in the number of pregnant women registered by the UCOS (an increase of 200 percent between surveys), the number of women who received at least five prenatal care visits (a 46 percent increase), and the number of women who had a birth plan (a 109 percent increase).
- As a result, the proportion of attended births increased from 71.4 percent to 93.7 percent.
- There was also a significant increase from baseline to endline in postnatal care for newborns by a health volunteer within three days after birth (a 100 percent increase) and proper treatment by a health volunteer for sick children less than age five (a 171 percent increase).

# Key Indicators at Baseline and Endline



# Concluding remarks

This project demonstrated:

- 1) the UCOS model improves equity through its pro-poor approach;
- 2) community-based services delivered by community health workers improves coverage of essential health interventions cost-effectively; and
- 3) a monitoring and evaluation component built into the program from the outset is feasible and effective.

# Concluding Remarks

To meet the mandate of universal health care, it will be necessary to locate low-cost, community-supported health services where impoverished populations actually live.

Access to facility-based public health services is an essential element of this model, but it is not the sole means of reaching those without coverage.

National health system strengthening will necessarily require prioritizing low-income populations, in the most affordable manner possible, with meaningful local community engagement, as soon as possible.

Questions?

For more information, please visit  
**[www.mcsprogram.org](http://www.mcsprogram.org)**

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