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Community Based Health Care Programme in Eritrea

Bridging the Gap between Communities and Health Services in Eritrea

Von Tseggai Gherezghiher

Five years ago Vision Eritrea and the Swiss Red Cross launched a community based health care programme in Eritrea, which was integrated in the national primary health care policy: Experiences of a comprehensive initiative.

Eritrea became a sovereign nation in 1993, inheriting a destroyed infrastructure and a very poor country. The economy was in shambles, with high illiteracy rate, poor access to health services and lack of participation of the community in any development activity due to the war. Currently the country is made up of six zones. Each zone is divided into sub-zones. Each sub-zone in turn is administered through kebabis (administrative area made of an average of five villages) and village administrations.

The Ministry of Health (MoH) adopted a primary health care policy with a five year strategic plan in 2004 emphasizing community based health services. This policy has enlarged access to essential package of care leading to positive impact in reducing morbidity and mortality. The health system is structured into five levels of care: the community level (with malaria agents and health promoters); health stations, health centre or community hospitals at sub-zonal level, and regional referral hospital at zonal and national referral hospital at the central level. Continuing health status improvement is observed in child and infant mortality trends in the last 12 years. According to the Demographic and Health Survey of 2002 mortality rate of children under the age of five decreased from 136 in 1995 to 94 per 1000 live births and infant mortality rate reduced from 72 in 1995 to 48 per 1000 live births in 2002. Access to clean water has increased from 22% (in 1995) to 37% in 2002. In urban and semi urban areas according to the same DHS document, however it is still a big need and priority within the communities.

Background

The Swiss Red Cross (SRC) and Vision Eritrea (VE) a National NGO in Eritrea launched a five year Community Based Health Care (CBHC) project in 2003 responding to a request from the MoH to improve access to health care at community level through a change in health seeking behaviour and establishment of essential care package at the community level. The project has successfully been completed and hence, a second three years continuation phase is under progress at the moment. Elements of the strategy of the project were:

• Establishing health posts that serve clusters of remote villages and are constructed by communities with the support of the project
• Training of comprehensive community health workers and traditional birth attendants for these health posts
• Establishing Village Health Committees that coordinate the necessary community support for the health posts and in general act as a bridge between the health care system and communities
• Increase quality of care of the health facilities through training
• Involve and empower communities in order that they take initiatives and interventions in health development on their own (bottom up planning and action)
• Improving access both to basic health care, preventive services and health information
• Capacity building of MoH, communities and other partners
• Integrate the project into the health system and annual action plans
• Involve local government authorities from the bottom to the top at all stages in planning, implementation and evaluation.
• Set the stage for policy review and update by the MoH

The goal of the project was to contribute to the improvement of the health status of the Eritrean population through support and implementation of community based health care activities in 4 sub-zones. The purpose was to improve the health seeking behaviour of individuals and families in target communities. The main objective was to establish a community based health care model for the Eritrean Health care system that would be efficient, effective and affordable in meeting health need for all and could be adopted on the district and the national level to be systematically integrated and institutionalised in the national primary health care policy.

Approaches and Processes of the Community Based Health Care Project

The project ensured complete integration into the MoH and local government structures, systems and activities by involving all the key stakeholders in all stages: conceptualization, development, implementation, monitoring and evaluation.

The implementation strategy was built on existing structures and initiatives: the health system through linkage with health facilities and management teams; training of community health worker, traditional health attendants and Village Health Committees. Health Information

System for project monitoring was built on the MoH health management information system; local government structures (Village, Kebabi). The only new element was the health post which was to be established, in villages more than 10km away from the nearest health facility, through community investment and hence ownership.

In addition to the construction of the health post and the training of comprehensive community health workers and traditional birth attendants, the VE/SRC established a revolving grant fund to establish the initial stock of essential drugs which would continue to generate income through cost sharing to support the health post and the community health workers. The rate of payment for services was decided upon solely by the local community through their Village Health Committees. Once the clients pay for the consultation fees, they receive the needed drugs without additional payment. The money is kept by their own treasurer, used to purchase drugs and to pay the community health workers. Because the cost sharing income is still low, averaging 500 Nakfa per month, communities work out other mechanisms of to complement revenue such as annual contribution of grain, eggs, or cultivation of a portion of land for the community health workers.

The responsibility of supervising the activities of health post and the community health workers rests with the MoH, which is not a new activity as they have been responsible for supervising health workers of vertical initiatives. Community health workers are able to treat diarrhea, acute respiratory infections, malaria, skin diseases and eye infection, to conduct health promotion talks and home visiting, as well as to identify and to refer cases with danger signs or serious illnesses.

In addition the project supported the strengthening and training of the zonal and sub-zonal health management teams to enable them to supervise the health post, community health workers and trained traditional birth attendants. All the practicing health workers, birth attendants and Village Health Committees were also trained in health promotion and disease prevention. While the sub-zonal health management teams were given training on quality assurance/quality improvement, the zonal medical officers and administrators in the MoH received training in health district management and design.

Achievements

The project planned and accomplished the following: Thirty two health posts were established and are providing basic care at village level. The project trained 400 Village Health Committees, 65 comprehensive community health workers and 76 traditional birth attendants. This has increased the utilization of services, increased referral by both health workers and birth attendants, and the provision of basic care to the most common health problems.

1. The model has been fully supported by communities. It has demonstrated that it is ideal for remote villages and that it is doable under the normal MoH functions.

2. From surveys the percentage of under one years fully immunized improved from 84% to 89%; health facility deliveries from 10% to 19%; re-impregnation of bed nets from 78.7% to 87.2%; Absolute neutrophil count (ANC) attendance of three visits from 45% to 63%; completed Tetanus Toxoid vaccination (TT2+) among pregnant women from 50% to 77%; and a decrease in the proportion of children undergoing female genital mutilation in last 3 years from 46% to 38% at baseline and end-line surveys respectively.

3. Health posts and comprehensive community health workers service have contributed to the reduction of deaths due to pneumonia, malaria, malnutrition and diarrheal diseases and early referral of very sick children and pregnant mothers to higher levels.

4. Communities continue to remunerate the working comprehensive community health workers in cash and kind.

5. The revolving grant fund has helped to sustain the supply of essential drugs.

Factors in favour of Sustainability of the Project:

• The project was consistent with policy trends in the country, such as the MoH's reforms focusing on promotion of self-reliance in health care through community participation. The project intended to fill gaps especially in the delivery of basic health services in remote areas.
• Involvement of the MoH, the local governments and the communities in all stages of the project conceptualization, development, implementation.
• Building on ongoing initiatives and activities rather than creating new ones and introducing minimum improvements, such as the health post in distant hard to reach villages, to address community identified gaps. Avoiding the introduction of new elements unfamiliar to the MoH and local government personnel ensured rapid adoption and sustainability beyond the project period.
• Local governments support the community ownership of health posts and communities willingly participated in the establishment of health posts. Their contribution reached up to 33%.
• Communities make decisions on the modality of health posts operation.
• Remuneration strategies were designed by communities and are being implemented.
• Village Health Communities and local governments are running the health posts including coordination of their activities.
• The MoH has approved and put in action the modality of operation for the health posts and the free supply of certain essential drugs to all functioning health posts.
• MoH has established drug supply system, supervision and data collection to and from the functioning health posts.
• As part of the strategic development of the MoH, health posts and community health workers service have contributed to the reduction of deaths due to pneumonia, malaria, anemia/malnutrition and diarrheal diseases.

Experienced Limitations and Challenges

1. Absence of policy guidelines for key activities such as training of comprehensive community health workers, health post design, remuneration, role of Village Health Committees, structures linking the health system with the community based system, supportive supervision and logistics. Lack of policy also means that community based health care activities cannot be included in annual operational plans and budget and may affect sustainability.
2. Recently the MoH has been shifting the strategy on the role of trained traditional birth attendants. The uncertainty of managing this transition has made the activities relating to them difficult to implement.
3. Inadequate emphasis on disease prevention and health promotion.
4. Inadequate income at the health posts to certain activities due to the low population served.

Recommendations for the future

1. In the second phase the community based health care module should focus on policy advocacy to ensure that the model is embedded into the MoH primary health care policy framework.
2. Facilitate the strengthening of linkages between the community based health care and the health system.
3. Strengthen preventive, promotive aspects of community based health care by regular household visits and problem based dialogue to accelerate behavior change.
4. Making health posts and community health workers more financially viable with revenue beyond the fee for service payments with the local government taking more direct financial responsibility.
5. Regularize monthly integrated outreach services at all the health posts to ensure effective contact, supervision, and referral back up.
6. The role of SRC/VE in the next phase to focus on policy advocacy and training of trainers.

Tseggai Gherezghiher is pharmacologist. 1995 he founded Vision Eritrea in Asmara and works a Director of this registered local NGO. Vision Eritrea is active in the areas of: Health Care (community based health care; health service institutions hospitals, health centers & health stations; blindness; prevention including establishment of a regional referral eye hospital), child care (establishment of six small group home orphanage houses, educational facilities and software components), emergency & rehabilitation (programs during and after wartime) and poverty reduction (micro credit & saving for women's economic empowerment, food security).
Contact: drtseggai@gmail.com

Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Medicus Mundi Suisse
Rue de Varembé 1
CH-1202 Genève
Tél. +41 22 920 08 08
contact@medicusmundi.ch

Bankverbindung
Basler Kantonalbank, Aeschen, 4002 Basel
Medicus Mundi Schweiz, 4056 Basel
IBAN: CH40 0077 0016 0516 9903 5
BIC: BKBBCHBBXXX