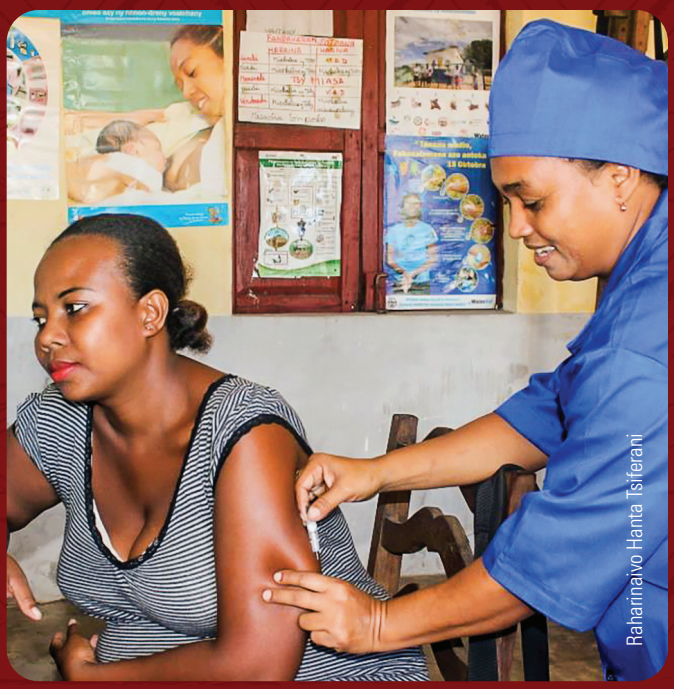
USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM

Strengthening Last-Mile Interventions for Maternal Health: Community Health Promoters Step Up to Provide Needed Services and Referral Linkages in Madagascar's Rural and Remote Communities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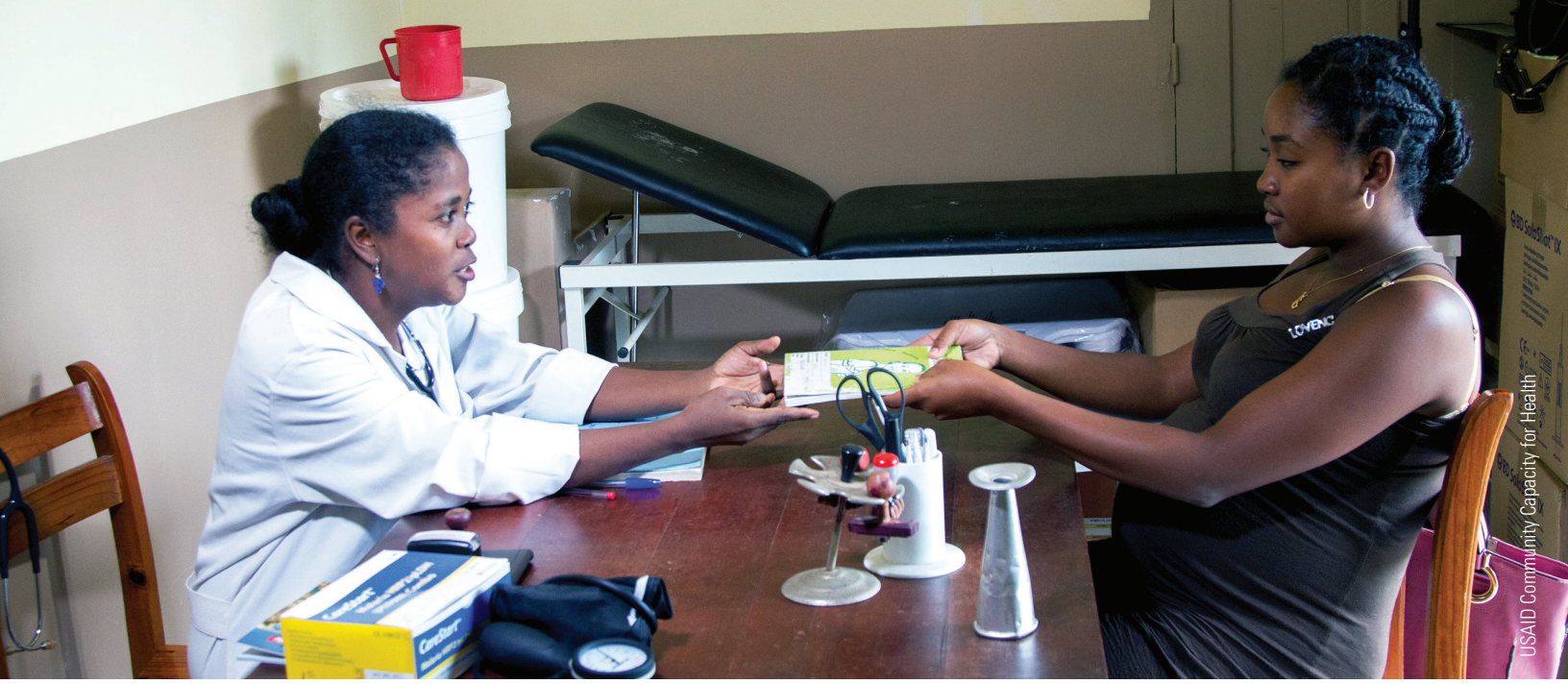
PROGRAM SUMMARY

The USAID Community Capacity for Health Program—known in Madagascar as Mahefa Miaraka—is a five-year (2016–2021) community-based integrated health program funded by the United States Agency for International Development (USAID). The Program is a collaborative effort among the Ministry of Public Health (MOPH), USAID, and JSI Research & Training Institute, Inc. (JSI). Mahefa Miaraka provides tools and capacity-building training to approximately 10,000 community health volunteers (CHVs) who provide basic maternal health, child health, and family planning services to their local communities. The Program also works with national and local government stakeholders to strengthen the health sector and health policies.

MAHEFA MIARAKA

- OPERATES IN **7** REGIONS OF MADAGASCAR
- COVERING A TOTAL OF **4,708** VILLAGES
- WITH A TOTAL POPULATION OF **6.6** MILLION PEOPLE
- OR **28** PERCENT OF THE COUNTRY'S TOTAL POPULATION

JSI



OVERVIEW

Although important global progress has been made to improve maternal health in the last two decades, an unacceptably high number of women continue to die during and following pregnancy and childbirth, including in Madagascar. The most common causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labor.[1] The majority of these deaths are preventable with antenatal care (ANC), the presence of a skilled attendant at birth, and access to emergency obstetric care.

Despite the Government of Madagascar's commitment to improve maternal health, progress toward reducing maternal mortality has been slow over the last two decades. The country's maternal mortality rate stands at 426 maternal deaths per 100,000 live births, compared to the global average of 211 deaths per 100,000 live births.[2,3] Although ANC visits help pregnant women prepare for safe delivery while linking them to the formal health system, in 2018, only half of pregnant women in Madagascar completed four visits.[4] This rate is low, especially considering both the World Health Organization (WHO)[5] and Madagascar's national guidance[6] recommend that pregnant women have eight ANC visits. Furthermore, six of ten deliveries take place at home, and only half of deliveries are assisted by skilled personnel.[7] Through its complementary and mutually reinforcing community health interventions, Mahefa Miaraka aimed to contribute to the objectives of the MOPH, which include improving the supply of and demand for health services by the population and reducing maternal and newborn mortality rates.

APPROACH

The Program supported CHVs to effectively provide the following counseling and services related to maternal health:

- family planning (FP) counseling and short-term contraceptive methods, with referral for long-acting reversible contraception (LARC);
- nutritional counseling;
- referral for ANC, including vaccination and malaria prevention (promotion of intermittent preventative treatment in pregnancy, distribution of insecticide-treated nets);
- counseling on and distribution of misoprostol for prevention of postpartum hemorrhage and chlorhexidine (CHX) for prevention of newborn cord infection; and
- referral for delivery and postnatal care.

A key part of the Program's approach to building demand for quality maternal health services at the community level was its social behavior change (SBC) approach. Knowing that the likelihood of clients adopting healthy behaviors increases when they receive the same message on multiple occasions, Mahefa Miaraka designed and undertook a multi-pronged SBC approach to promote consistent messages on maternal health through various communication channels. These channels included:

- counseling during home visits and organized community-based education sessions by CHVs, including radio listening groups, whereby CHVs led groups to tune in and listen at certain times of the week;

1 WHO Maternal Mortality Fact Sheet, 2019.
2 Ibid.
3 Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2019.
4 INSTAT and UNICEF. "Multiple Cluster Indicator Survey (MICS)," 2018.
5 WHO recommendations on antenatal care for a positive pregnancy experience, 2016.
6 Madagascar Ministry of Public Health, Normes et Procédures en Santé de la Reproduction, 2017.
7 INSTAT and UNICEF. "Multiple Cluster Indicator Survey (MICS)," 2018.

- catalyzing families to adopt health behaviors and engage agents of change in the community beyond CHVs through the Model and Mentor Families approach;
- using women's health cards to reinforce key messages from counseling, mass media, and other sources; and
- leveraging mass media, such as Program-sponsored radio spots and dramas on key maternal health and birth preparedness messages.

In addition, the Program supported communities to develop and execute health evacuation and emergency transport plans for community members who are ill or pregnant. Nearly half of Program-supported villages are inaccessible by vehicle during four months of the year, with 20 percent of them inaccessible for half the year. Therefore, CHVs and village leaders developed emergency transport plans and strengthened emergency networks in villages, linking villages to basic health centers using locally available transport. These networks ensured that community members had timely access to skilled care, particularly women experiencing complications during pregnancy, delivery, and the postnatal period.

KEY ACTIVITIES

CHV training on FP and safe motherhood. The Program supported health center staff to provide initial and refresher trainings of CHVs as well as to strengthen CHVs' clinical skills during monthly meetings at the health center. The Program trained and equipped nearly 10,000 CHVs on maternal health and provided them with technical supervision via monthly meetings and onsite supervision visits from health center staff, MOPH staff at district and regional levels, and Program staff.

Referral for higher-level services and community follow-up. CHVs were trained to provide referral to health centers for danger signs, ANC, vaccination, delivery, and LARC. CHVs also worked with health centers and clients to ensure that counter-referral forms were completed by the health center and returned to the CHV by the client. Counter-referrals from health centers helped CHVs keep track of which clients followed through on care and signaled the need for them to make home visits to follow up with clients after treatment at the health center.

Support to monthly review meetings at the health center. Monthly meetings provided an opportunity for CHVs to submit their monthly activity reports and to resupply their stock of health commodities. The meetings were also an opportunity to receive refresher training, discuss work-related challenges, and identify potential solutions to address barriers with the support of the health center staff and other CHVs.

Promotion of the woman's health card and FP invitation cards. The Program promoted essential family practices in communities through the distribution by CHVs of the MOPH woman's health card. The health card provides basic information on sexual and reproductive health, FP, nutrition, danger signs during pregnancy, and birth preparedness, and they also serve as a vaccination and ANC record for pregnant women. In addition, CHVs distributed FP invitation cards to new and regular users for them to share with their networks, with the aim of increasing the number of community members learning about and accessing FP services through their social networks.

Engaging communities through Model and Mentor Families. The Program's Model and Mentor Families approach served to promote optimal maternal health behaviors and multiply the number of health actors sustaining positive behaviors within families across Program regions. Participating households worked toward becoming a Model Family by completing essential health actions that corresponded to four life stages for families with a pregnant woman or a young child. Once the household completed the health actions for their specific life stage, the household was publicly recognized as a Model Family, that could then become a Mentor Family by providing encouragement and guidance to their neighbors to become Model Families. The essential health actions for pregnant women include:

1. Complete at least four antenatal visits before delivery.
2. Sleep under a long-lasting, insecticide-treated net.
3. Receive two doses of the tetanus vaccine, and be aware of pregnancy danger signs.
4. Eat a diet diverse in nutrients.
5. Go immediately to the health center if there are any concerns or symptoms of poor health.
6. Take the daily dose of iron folic acid as indicated by the health worker.
7. Give birth under the supervision of health care workers at a health facility.

Radio broadcasts and high visibility events. The Program contracted with local regional radio stations to broadcast radio spots and dramas on key health messages, including those addressing FP and safe motherhood. In addition, CHVs and community leaders helped to organize and participated in large-scale national and international events promoting maternal health, including Mother and Child Health Week, World Contraception Day, and International Women's Day.

RESULTS

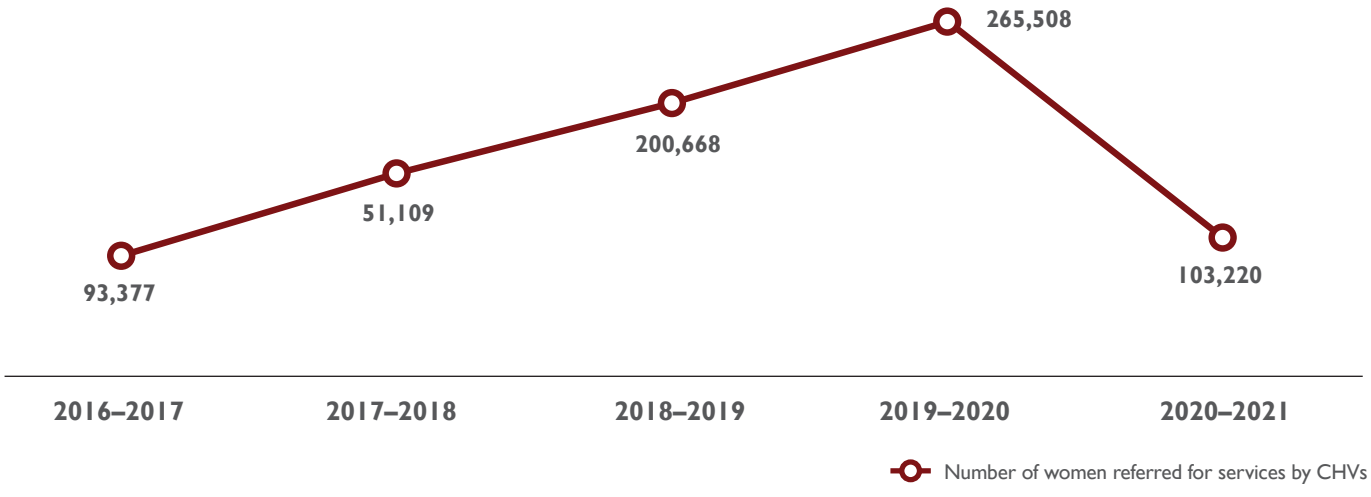
- Over the course of the Program, 9,465 CHVs were trained in safe motherhood and FP counseling and services, 6,545 CHVs were trained in the use of pregnancy tests, and 8,761 were trained in the use and distribution of misoprostol and CHX.
- CHVs provided FP services to 468,251 regular users and referred 35,660 women for LARCs at the health center or mobile clinics.
- CHVs made 413,425 referrals for women of reproductive age (WRA) for antenatal services, 228,976 for tetanus vaccination, and 134,821 for facility delivery.
- Because of CHVs' efforts to counsel and distribute CHX and misoprostol to pregnant women, 34,321 newborns had CHX applied at birth and 19,496 pregnant women used misoprostol after delivery.
- CHVs distributed 878,636 FP invitation cards and 216,333 woman's health cards.
- 1,805,000 people were reached with messages on maternal health through CHVs via home visits, counseling, and group health education; 1,146,000 people were reached through the Program-supported local radio broadcasts; and 1,427,000 people were reached through high visibility events, including Mother and Child Health Week, World Contraception Day, and International Women's Day.
- Through the Model Family and Mentor Families approach, 352,359 Model Families committed to undertake key health actions, and 181,209 Mentor Families provided encouragement, guidance, and support to their neighbors based on their experience as Model Families. Nearly one-third of these were households, including pregnant women.
- The vast majority of Program-supported villages (97 percent) developed health and emergency evacuation plans. Over the course of the Program, Program-supported communities conducted emergency evacuations for 82,948 community members, including 16,845 pregnant women, using locally available transport.

CHALLENGES

Low rates of completion of at least four ANC visits and delivery by a skilled attendant. Although the national Multiple Indicator Cluster Survey (MICS) done in 2018 found that more than 80 percent of pregnant women in most Program regions attended at least one ANC visit, these rates could be improved, and one region (Menabe) had a rate of 65 percent. Moreover, in all Program regions, less than 60 percent of women completed the recommended minimum of four ANC visits during their pregnancy. Similarly, the survey found that rates of delivery by a skilled attendant were below 50 percent in five of the Program's seven regions. Major barriers to ANC visits and delivery with a skilled attendant include the limited availability of transport, the cost of emergency transport, and areas of difficult terrain and seasonal rainfall.

Commodity stock-outs. The Program experienced extended periods of stock-outs of maternal health and FP commodities. Mahefa Miaraka attempted to address bottlenecks at the national level while also working closely with regional and district health offices to ensure that CHV needs are taken into account when health centers resupply at district pharmacies and to assist providers to reallocate surpluses of stock to areas that have reported stock-outs. Both misoprostol and CHX were stocked out due to a lack of product in the country and shortages in the global supply chain. Once made available again, the uptake of both products was slow due to their long absence from the community. Re-establishing the supply processes took time and required re-orienting CHVs on the use and distribution of these products, re-introducing these commodities to communities, and communicating their availability in order to increase awareness and demand. For FP, oral contraceptives and injectables had relatively lower levels of stock-outs throughout the life of the Program (averaging 18 and 12 percent, respectively). However, DMPA-SC (Sayana Press), which was in high demand after its initial introduction, was then unavailable for a period of about one year after its introduction.

FIGURE 1. NUMBER OF WOMEN REFERRED BY CHVS FOR HEALTH CENTER SERVICES



Delays in implementing routine use of pregnancy test kits by CHVs. Ensuring routine use of pregnancy test kits by CHVs during the Program's pregnancy test pilot in five regions posed a challenge. Unavailability of kits delayed the scale-up of training in the Program's seven regions. Initially, many CHVs used the pregnancy test kits on a limited basis, for example, to verify if women who suspected they were pregnant were in fact so, but not as a routine component of determining eligibility to use contraceptives with new users or regular users who had a gap in the use of contraception.

Low rates of counter-referrals. Increasing the percentage of counter-referrals received by CHVs remained a challenge. Counter-referrals made CHVs aware that clients followed through on care and, in certain cases, signaled the need for them to make home visits to follow up with clients after treatment at the health center. At times, women did not bring the referral slip with them for FP, ANC, or delivery services at the health centers, or health center staff did not remember to fill out the counter-referral information. Even if health workers correctly filled out the counter-referral information, women at times did not return the completed referral slip to the CHV.

Lack of human resources at health centers. The Program supported health center staff to conduct practical training courses and refresher sessions for CHVs as well as to conduct monthly meetings and onsite supervision to ensure that CHVs have strong technical knowledge and skills. Certain health centers have only one health staff available. CHVs in these areas were less likely to receive routine onsite since health center staff would need to leave their post with no one there to receive clients while they visit the CHVs. To address staffing gaps at these centers, the MOPH recruited volunteers to ensure continued services, typically recent graduates from accredited nursing schools. Ensuring monthly CHV review meetings at the health center takes on greater importance in light of the current human resource limitations.

RECOMMENDATIONS

Continue to support monthly CHV meetings at the health center in order to maintain competencies on maternal health counseling, services, and referral at the community level. Maintaining CHVs' skills is an essential component to expand and sustain access to essential services in rural communities.

Employ a comprehensive SBC strategy to saturate communities with key messages on maternal health and birth preparedness through multiple, mutually reinforcing approaches in order to accelerate the adoption of healthy behaviors and increase demand for maternal health services at the community level. A multi-pronged approach contributes to the adoption of healthy behaviors through various points of contact, leading to increases in the number of clients using these services.

Identify and address barriers to use of ANC and skilled delivery attendance. Low uptake of ANC and related vaccination, counseling, and malaria prevention activities is a significant missed opportunity for improved birth outcomes. In most Program regions, less than half of all pregnant women attend four ANC visits, reducing the chances for additional counseling on skilled birth attendance, danger signs, post-partum FP, and neonatal care.

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