Innovations to Improve Maternal Health in Remote Areas of Madagascar

INTRODUCTION

In Madagascar, the maternal mortality ratio remains very high at 498 per 100,000 live births and 64% of deliveries occur at home[i]. Two USAID-funded programs, MAHEFA and MCHIP, are implementing interventions to improve access to and utilization of quality MNCH care. USAID is committed to an integrated approach to evidenced-based programming in Madagascar. The MAHEFA and MCHIP programs are addressing a number of key delays to accessing care through complementary interventions, which have been positioned for rapid scaleup, if proven successful. The MAHEFA and MCHIP community- based programmes have the potential to serve a combined population of almost 5 million people living in the targeted regions.

This poster highlights:

1.1 Barriers to accessing maternal health care and strategies to address them

1.2. Innovative approaches to address emergency transport challenges

1.3 Community-financing approaches to improve access to maternal health care

2. Increased utilization of uterotonics to prevent postpartum hemorrhage.

1-MAHEFA

MAHEFA (MAlagasy HEalthy FAmilies) is an integrated community-based health program with the goals of reducing maternal, under-five and new born mortality as well as fertility in rural and difficult to reach areas in the north and west of Madagascar. Three international organizations partner for the implementation of MAHEFA: JSI Research and Training Institute, Inc., The Manoff Group and Transaid. MAHEFA supports training, provision of commodities, supervision and followup for over 7500 Community Health Workers (CHWs) who provide basic services and counseling. Interventions for behavior change, emergency transport and community funds are part of the program's strategy to achieve its objectives and reduce maternal mortality.

1.1 Barriers to accessing maternal health care and strategies to address them

MAHEFA conducted formative research to determine key barriers and motivators, including major cultural influences on behavior change in maternal health from December 2011 - August 2012 in three rural program regions. These studies included a Barrier Analysis, Ethnographic research and Trials of Improved Practices (TIPs) in selected regions. Based on the results from these studies, MAHEFA's regional teams developed locally appropriate Behavior Change (BC) strategies to directly address the barriers and cultural influences while accentuating the motivators to behavior change. BC strategies are being developed for all MAHEFA regions.

One example of results of these studies and planned interventions are summarized below.

Major Motivators to ANC Visits	Key Determinant	Intervention planned
Mothers' perceptions that ANC visits are important for baby's and mother's health	Perceived positive consequences	Community Health Workers (CHWs) and birth attendants lead fortnightly group discussions with pregnant women and husbands; women who have received free medicines during their ANC visits describe their experiences and discuss the impact on baby and mother's health.
Mothers' perceptions that husbands & village birth attendants support their ANC visits	Perceived social norms	
Mothers' perceptions that they will receive free medicines (malaria prophylaxis , Tetanus Toxoid, etc.) when they go for their ANC visits	Perceived positive consequences	

Major Barriers to ANC Visits:	Key Determinant	Intervention planned
Health centers are too distant and difficult to access.	Perceived self-efficacy/access	Male support groups (composed of CHWs & husbands of pregnant women) meet to discuss ways to remedy the "distance barrier" –village saving loan associations, birth preparedness plans and local transport solutions.

Household Level Interview for Trials of Improved Practices (TIPS) – Boeny Region

1.2 Innovative approaches to address emergency transport challenges

In Madagascar, distance to the nearest health facility and the need to use a means of transport to get there are amongst the 5 main barriers to accessing health care identified by women of reproductive age (respectively 41.8% and 31.4%)[i]. In May/June 2012 MAHEFA conducted a Transport and Logistics needs assessment which provided additional information about access to health facilities in MAHEFA's regions. The table below shows distances from primary and secondary-level health facilities to higher- level referral facilities.

Distance to higher- level referral facility	From primary-level to referral health facility (37 health facilities interviewed)	From secondary-level to referral health facility (91 health facilities interviewed)
< 10 Km	5.4%	16.5%
10 Km-49 Km	40.5%	41.8%
50 Km - 119 Km	40.5%	37.4%
>120 Km	13.5%	4.4%
Total (%)	**100.0%**	**100.0%**

The study also showed that the majority of the population in MAHEFA regions has to use two modes of transport to reach a health facility where an adequate level of care can be provided. This is often a complex process. As such, MAHEFA is implementing two emergency transport pilot interventions in 2013. One will provide low cost transport from the community to the first level health facility. The second pilot will address the whole referral chain from community to health facility and onwards to hospitals. With timely access to health care so critical in an obstetric complication, these transport innovations can help prevent maternal deaths. As with all MAHEFA interventions the project is designed to enable rapid scale up to other regions.

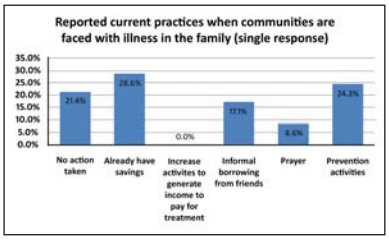
Example of a low cost, community managed means of transport that is being used successfuly for maternal referral in Zambia – the bicycle ambulance.

1.3 Community-financing approaches to improve access to maternal health services

In the context of Madagascar's high mortality rates, high poverty rates (72.5 % in rural areas; 34.5% [ii] in urban) and a serious problem of isolation in many communities due to a lack of appropriate transport facilities, MAHEFA identified a need for accessible funds at community level to aid the response to maternal health emergencies.

MAHEFA is in the process of assessing community-based structures for health financing schemes linked with Microfinance Institutions, to increase the ability of the community to access funds to respond to health emergencies. By ensuring that cash is available to members of the group in times of medical emergency one of the main delays in seeking health care will be addressed. MAHEFA is exploring rural and urban models as poverty rates vary significantly between the two levels.

This histogram shows the results of a MAHEFA feasibility study on the reported current practices of the population when faced with an illness in the family.



MAHEFA technical team with the targeted population for community funds for access to health care

The study showed that 45.7% of the community members surveyed either had savings (28.6%) or were prepared to borrow money(17.1%) to pay for health care. This shows a willingness and acceptance towards savings and a desire to access funds for a health emergency which can be built upon. Currently the majority of people do not have access to funds or are not using them for medical emergencies and MAHEFA intends to address this need, in order to avert maternal deaths. A work plan has been developed by committees composed of community members, leaders at district and municipality level and local associations. By April 2013 the two pilot models will be operational and will be monitored closely and if successful will be scaled-up rapidly.

2-MCHIP

The goal of USAID's Maternal and Child Health Integrated Program (MCHIP) is to assist in scaling up evidence-based, high-impact maternal, newborn and under five health interventions and thereby to contribute to significant reductions in maternal and child mortality and progress toward Millennium Development Goals 4 and 5.

Increased utilization of uterotonics to prevent postpartum hemorrhage (PPH)

All women who give birth are at risk for PPH regardless of where they deliver. In order to be effective in a challenging context like Madagascar, use of evidence-based interventions to prevent PPH should be targeted at women giving birth at health facilities as well as at home. In Fenerive-Est, the percentage of women that give birth at health facilities is only 19%, and the majority of women have no access to quality services where Active Management of the Third Stage of Labor (AMSTL) is practiced.

The program will test the programmatic effectiveness of:

1) association members distributing misoprostol to pregnant women during ANC visits and
2) CHWs distributing misoprostol during home visits for use by women when they are not able to give birth at a facility. The use of oxytocin for AMTSL will be promoted as the gold standard uterotonic in contexts where its use is feasible.

After successful implementation in Fenerive-Est, MCHIP will work with partners to finalize recommendations for the scale-up of the project. This will help ensure a sustainable national program for increasing uterotonic coverage throughout Madagascar.

Woman being provided misoprostol tablets immediately after delivery of her baby

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i- National Demographic Health Survey 2008/2009

ii- Instat/DSM/EPM/2010

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