
Maternal Health Alliance Project
Global collaboration to improve the science of implementation
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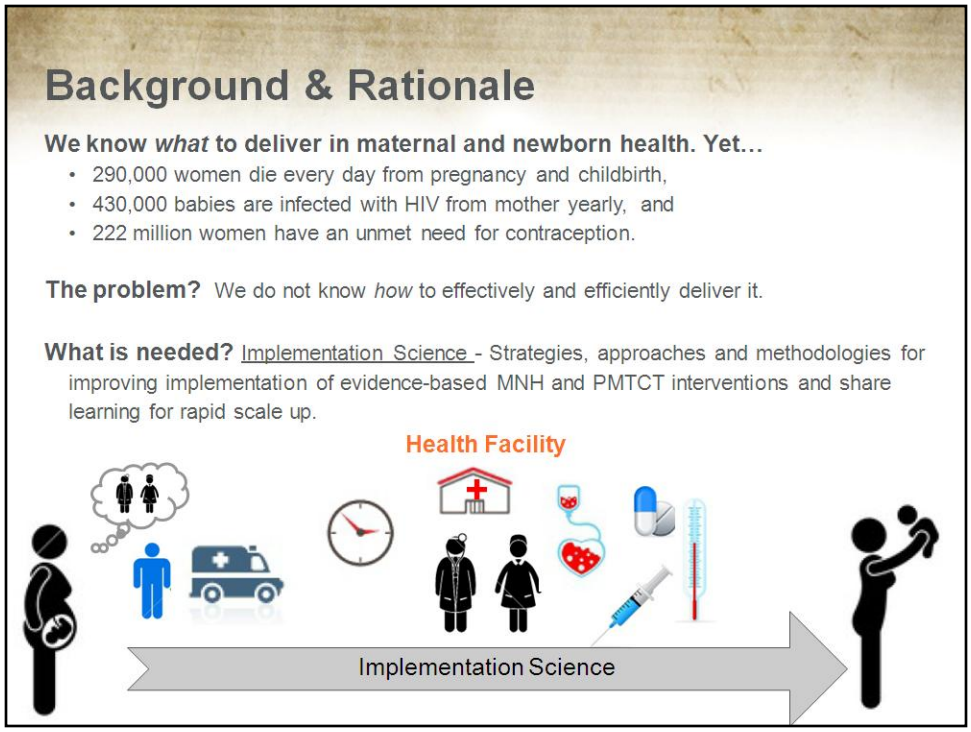


The practice and science around *what* to deliver in maternal and newborn health is well established, but despite this evidence:

1) Approximately 800 women die everyday from preventable causes related to pregnancy and childbirth amounting to 290,000 maternal deaths a year.
2) Yearly, 430,000 babies are infected with HIV from an HIV-positive mother.
3) Worldwide 222M women have an unmet need for contraceptives, leading to 79,000 maternal deaths and 1.1 million infant deaths.

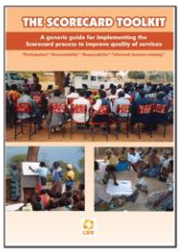
The global community has recognized that program strategies – even if they are based on the best available science – will not reduce maternal and infants deaths unless they are appropriately adapted and effectively implemented in specific country contexts. Essentially, we do not know *how* to effectively and efficiently implement the MNCH and HIV prevention interventions for the greatest impact.

Therefore, the aim of MHAP is to inform the development of sound strategies for addressing the social, economic, and political obstacles that hinder the effective implementation of proven technical interventions in the field.

Project Overview

Goal: Develop & test broadly applicable approaches to improve MNH implementation and outcomes

Imp. science approach: Community Score Card- an approach that involves citizen representatives and health service providers in a mutual process of identifying problems, generating solutions, and working in partnership to improve coverage, quality and equity of services.



Timeline: 5 years (Jan 2011 – Dec 2015)

Donor Support: Sall Family Foundation

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Location: Ntcheu, Malawi

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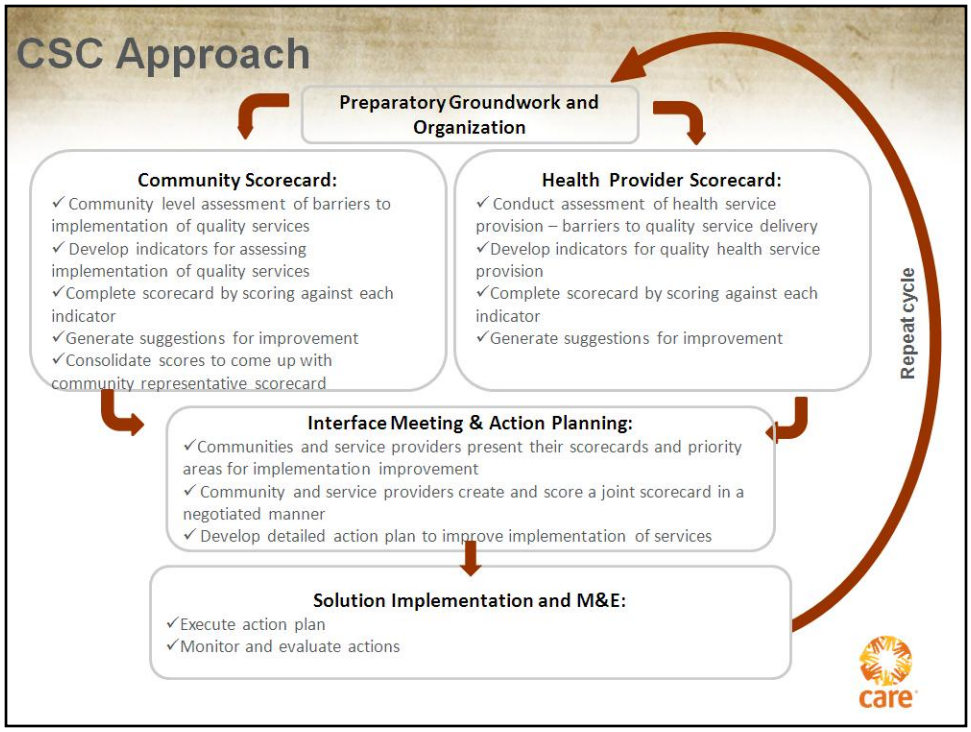
Goal: Develop, implement, and test broadly applicable strategies, approaches and methodologies for systematically improving the implementation of evidence-based maternal and newborn health interventions and to share learning for rapid scale up in order to maximize impact. In other words, CARE is working to improve the science of implementation.

CARE's approach for achieving this is participatory governance. CARE's experience has shown that participatory governance is a key strategy to addressing important barriers to health, including socio-cultural barriers as well as coverage, quality, and equity in service delivery. We use a tool called the Community Score Card (CSC), an internationally recognized participatory governance tool that was actually developed by CARE Malawi. The CSC is a tool that engages the community and local health providers and officials in an ongoing dialogue to jointly identify problems, propose solutions, and implement action plans to improve the availability, accessibility, and quality of the health system in order to meet community needs. With support from the Sall Family Foundation, we have now adapted the CSC for use in this ground-breaking implementation science initiative.

CARE's hypothesis is that the CSC process will cultivate participatory governance, including:

- Empowered citizens: citizens who are aware of their healthcare rights, have a stronger voice and contribute to change;
- Health service providers and local government who are effective, accountable, and responsive; and
- Spaces for negotiation between power-holders and citizens that are expanded, inclusive, and effective.

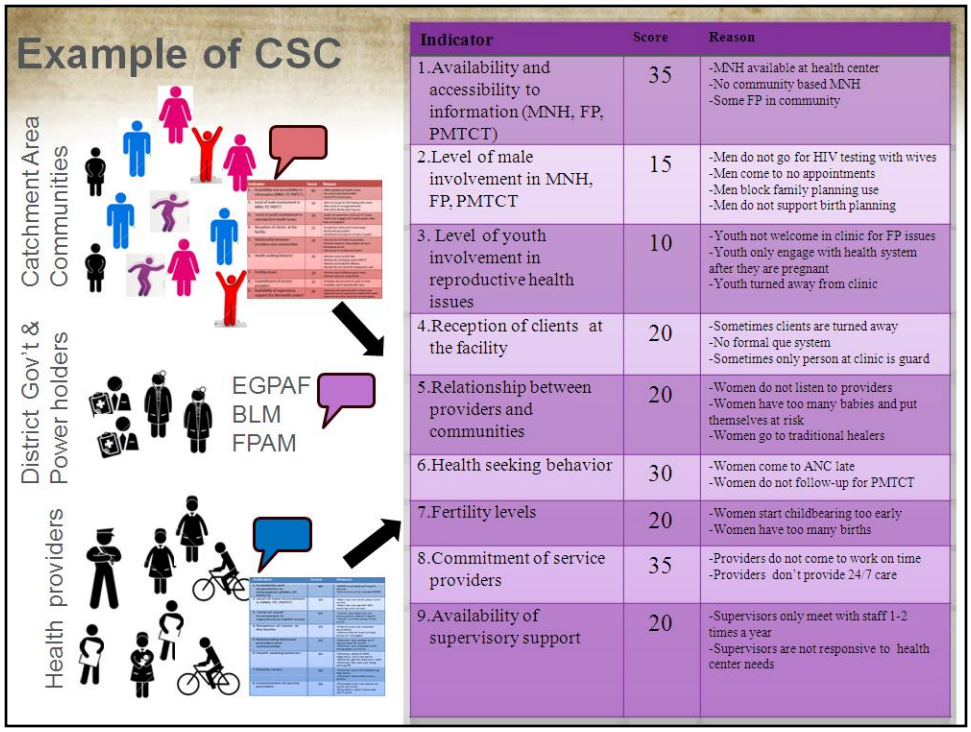
With these elements in place, there will be a sustainable and equitable system for communities, service providers and local government to identify priority maternal and newborn health areas for improvement and generate locally applicable innovative solutions—in other words, community- and facility-level changes to improve maternal and newborn health service implementation, which in turn leads to improvements in maternal health coverage, quality and equity.



The CSC is conducted between a service user unit and service provider unit – in this case between the health care centers and the community members in its catchment area. Important to note, is that the CSC process is not a one off process but done repeatedly every 6 months.

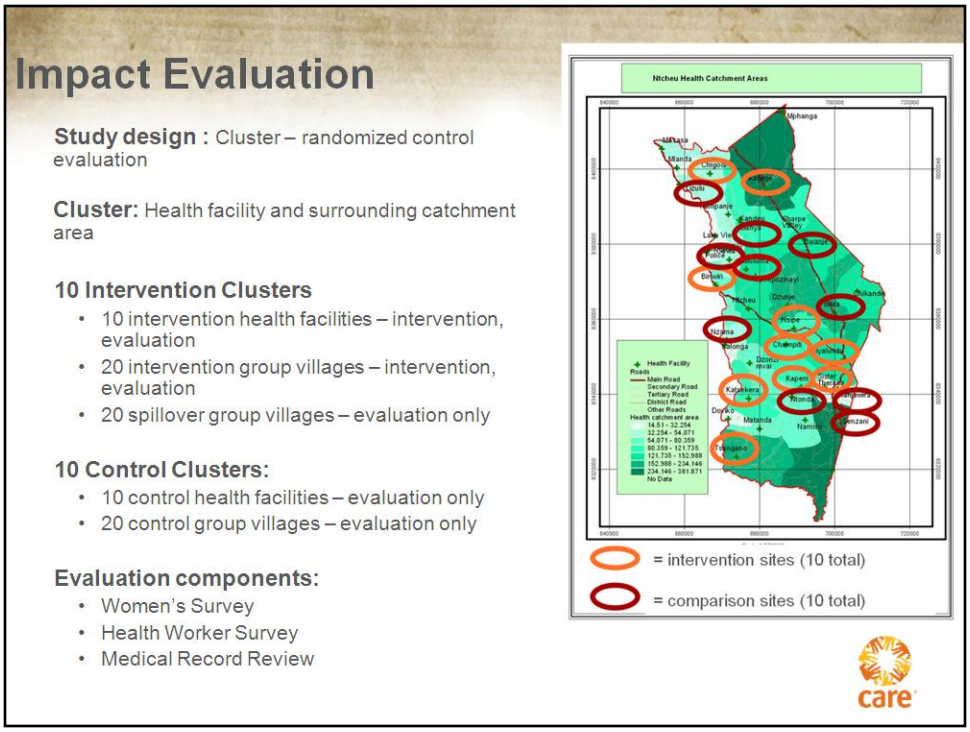
The CSC process had 5 main phases:

1. Preparation and planning, including mapping and selecting the districts in which to operate, building project support with the local government, and training facilitators.
2. Once set up, we held the CSC with community members to identify barriers to accessing quality health services and identify the maternal and newborn health, family planning, and PMCT issues they face;
3. Next, a similar process of generating issues was also conducted with health providers with a focus on barriers they face in delivering maternal and newborn health, family planning, and PMTCT services.
4. Once both groups had developed Score Cards an interface meeting was held to create a joint score card for prioritizing issues and developing action plans to correct barriers; Action plans include: steps to address issue; realistic deadlines; roles and responsibilities; and resources required.
5. The final step is then implementing the action plans and tracking for improvement.



Indicator	Score	Reason
1.Availability and accessibility to information (MNH, FP, PMTCT)	35	-MNH available at health center -No community based MNH -Some FP in community
2.Level of male involvement in MNH, FP, PMTCT	15	-Men do not go for HIV testing with wives -Men come to no appointments -Men block family planning use -Men do not support birth planning
3. Level of youth involvement in reproductive health issues	10	-Youth not welcome in clinic for FP issues -Youth only engage with health system after they are pregnant -Youth turned away from clinic
4.Reception of clients at the facility	20	-Sometimes clients are turned away -No formal que system -Sometimes only person at clinic is guard
5.Relationship between providers and communities	20	-Women do not listen to providers -Women have too many babies and put themselves at risk -Women go to traditional healers
6.Health seeking behavior	30	-Women come to ANC late -Women do not follow-up for PMTCT
7.Fertility levels	20	-Women start childbearing too early -Women have too many births
8.Commitment of service providers	35	-Providers do not come to work on time -Providers don't provide 24/7 care
9.Availability of supervisory support	20	-Supervisors only meet with staff 1-2 times a year -Supervisors are not responsive to health center needs

This is another way of looking at the CSC process and shows the Score Cards that are generated as a result of the process.



In order to demonstrate the impact of the CSC and participatory governance as an effective Implementation Science approach, CARE is using a cluster-randomized control design to test it.

Within the Ntcheu District, 20 health center/catchment areas were identified as eligible for the study. These were then matched into 10 pairs (matching characteristics included: services provided, health center administration, proximity to the Mozambique border, and catchment population size). After pairing, we randomly allocated one cluster in each pair to either intervention or comparison.

Across the 10 intervention health center/catchment areas, 20 group villages in total were selected to participate in the CSC process with their respective health facilities. (Used probability proportional to size (PPS) to select the village groups). Across the 10 comparison health center/catchment areas, 20 group villages in total were also selected for comparison evaluation. Further, to examine spillover effects of the CSC intervention on those communities within the intervention catchment area but not participating in the CSC, an additional 20 group villages were selected for evaluation.

The evaluation of the intervention versus control areas will be done through two cross-sectional surveys (the women's survey and the Health worker survey) and a medical chart review at baseline (2012) and endline (2015).

We believe, that only solid compelling evidence will garner the support of the global community and give us the opportunity to translate our experience with the CSC in Malawi into action that will dramatically reduce MNH deaths in the other high burden countries.

Expected Outcomes

1. Demonstrate the value of the collaboration to advance implementation science.
2. Demonstrate in a compelling way the impact of the CSC on maternal and newborn health implementation and outcomes.
3. Develop a menu of high impact implementation improvement ideas.
4. Improve maternal and newborn health implementation and outcomes in Malawi.
5. Cement CARE's leadership role in maternal and newborn health, governance, and implementation science.

Contact person/team members

CARE Malwai

Thumbiko Msiska

Project Manager, MHAP

thumbiko.msiska@co.care.org

CARE USA

Sara Gullo

Technical Advisor, Sexual, Reproductive and Maternal Health

sgullo2@care.org