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Maternal and Child Health  
Integrated Program

## **Collaborating with Communities and Aligning with National Systems to Achieve High Impact and Coverage for Mothers and Newborns: USAID's partnerships with International Non-Governmental Organizations through the Child Survival and Health Grants Program**

During pregnancy and around the time of birth, women in resource-poor settings often face barriers to accessing services or adopting behaviors that can improve their own health and that of their newborn. In order to address these challenges, International Non-Governmental Organizations (INGOs) supported through the United States Agency for International Development (USAID) Child Survival and Health Grants Program (CSHGP) work closely with their local partners to empower and engage pregnant women, their families, and their communities to improve their health and the health of their babies, while also improving quality of and access to maternal and newborn care (MNC) services. CSHGP projects also support and help inform national systems for coordinated and sustainable efforts among multiple stakeholders. Essential to the success of these projects is the grantees' ability to create effective links between households and health facilities by making information and services more accessible and culturally responsive to the community and empowering communities with problem-solving skills.

INGOs supported through the CSHGP have a strong tradition of working within communities to raise awareness, increase knowledge, improve skills, and change behavior by implementing interventions based on available scientific evidence and internationally recognized best practices. Their projects are designed to be responsive to the local context and aim to achieve widespread public health impact. Across the life of the program, grantees have achieved significant increases in coverage of high impact interventions around the time of birth, helping to improve the lives of mothers and newborns.

### **CSHGP Projects have high impact and contribute to global evidence by:**

- Improving coverage of high impact interventions around the time of birth, often achieving gains in multiple indicators in their project areas;
- Generating learning through operations research on challenges during pregnancy and around the time of birth; and
- Engaging policy makers to implement supportive national policies and strategies.

Among the thirty-seven active CSHGP projects<sup>1</sup>, twenty-seven implement MNC interventions, eleven devote at least half of their project effort to MNC, and ten address challenges in MNC service delivery

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<sup>1</sup> Active projects as of May 1, 2011

through operations research (OR). CSHGP projects are integrated across the continuum of care for maternal, newborn, and child health (MNCH), and integrated packages are tailored to the local context.

This brief highlights CSHGP's contributions to advancing MNC by:

- 1) summarizing the achievements of CSHGP projects in improving MNC indicators, with results presented for selected indicators across CSHGP projects to demonstrate achievements across contexts as well as within selected projects to showcase achievements through integration;
- 2) highlighting selected operations research being led by CSHGP grantees in partnership with research institutions and/or relevant national and local partners (e.g., Ministry of Health [MOH]); and
- 3) providing examples of CSHGP grantee contributions to national strategies and policies.

## Improvements in coverage of high impact interventions

CSHGP projects consistently demonstrate impressive, statistically significant increases in high impact interventions<sup>2</sup> along a continuum of care that includes recognition of danger signs, antenatal care (ANC) visits, skilled birth attendance (SBA), exclusive breastfeeding (EBF), breastfeeding within one hour of delivery, and post-natal visits. They collect baseline and endline information through population-based surveys, which include a set of standard indicators collected through the Rapid Core Assessment Tool for Child Health (Rapid CATCH)<sup>3</sup>. The same indicators are reported regardless of a project's intervention mix in order to understand the overall MNCH situation in a project area before and after implementation. The data presented below illustrate the success of CSHGP projects that started between 2000 and 2006—the most recent of which ended in 2010, dedicated at least 30 percent level of effort (LOE) to MNC, and had relevant baseline and endline data to allow for the calculation of confidence intervals around the coverage estimates (n=20).

### Danger Signs and ANC Visits

To reduce the delay in time before women seek help for potentially life-threatening complications, many grantees have worked to increase knowledge of danger signs during pregnancy, birth, the postpartum period, and in newborns. Among projects reporting indicators in these areas, nearly all grantees have been successful in significantly increasing the recognition of danger signs in all periods at and surrounding birth, which increases the likelihood that mothers will seek care when necessary.

ANC coverage has also increased widely in project areas since 2000, although it has only been in recent years that reporting four or more ANC visits became an international standard. As grantees strengthen linkages between communities and existing health systems, making services more accessible (e.g., through outreach clinics) and raising awareness about healthy pregnancy practices, the demand for ANC services has grown in many project areas.

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<sup>2</sup> p < 0.05, 95% confidence interval

<sup>3</sup> Two important MNC indicators – SBA and EBF – have been collected by projects as part of the Rapid CATCH since 2000. Other indicators listed here have not been reported by all grantees but are key MNC indicators that did show large gains across several projects. Of note: 4+ ANC visits (*the percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child*) was added to the CATCH indicators in 2008.

## Skilled Birth Attendance

Since 2000, the proportion of pregnant women delivering with skilled attendants, including doctors, nurses, midwives and auxiliary midwives, has increased across the areas where CSHGP grantees have implemented programs. Many CSHGP projects have worked to promote the importance of having a health provider with midwifery skills present at delivery and create/strengthen links between communities and health facilities. Community health workers (CHWs) in several projects have been trained to help women to develop a birth plan and also devise contingency plans in case an emergency arises.

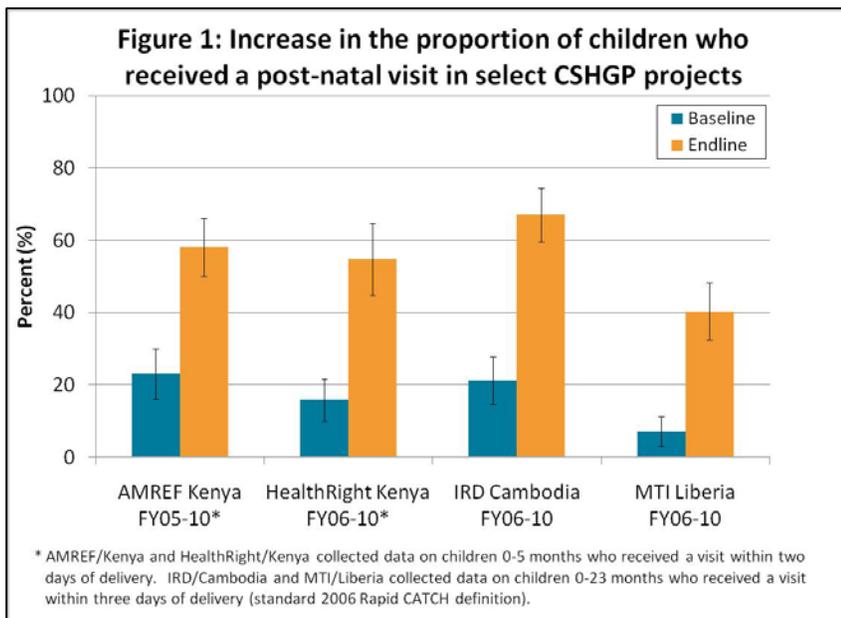
Across the 20 projects starting between 2000 and 2006, there was an average increase of 43 percent in SBA coverage in the project areas. Five projects saw SBA coverage more than double over the life of the project, including CARE in Sierra Leone, Health Alliance International (HAI) in East Timor; the Haitian Health Foundation (HHF) and The African Methodist Episcopal Church Service and Development Agency (AME-SADA) in Haiti; and African Medical and Relief Foundation (AMREF) in Kenya.

## Breastfeeding

Several projects have implemented breastfeeding support groups or mother-to-mother support groups in which EBF was one of the key topics. Other grantees have worked with CHWs to change mothers' breastfeeding practices and reached women and their families through timed and targeted counseling (e.g., antenatal and postnatal care visits) and health education sessions. Deliveries attended by an SBA and/or trained traditional birth attendant are additional opportunities to encourage early and exclusive breastfeeding first-hand.

The increases seen in the initiation of breastfeeding within one hour of delivery and EBF among children 0-5 months speak to the effectiveness of community education and counseling in CSHGP project areas. In Save the Children's Tajikistan project, for example, EBF increased by more than

seven-fold over the life of the project, from 12.5% at baseline to 93.5% at endline. In Nepal, PLAN saw a more than six-fold increase, from 9% to 66%.



## Post-Natal Visits

As illustrated in Figure 1, CSHGP grantees successfully increased the proportion of children who received a postnatal visit within three days of delivery through their community-based projects. Reporting of post-natal visits<sup>4</sup> was introduced as a Rapid CATCH indicator for projects starting during or after 2006; grantees

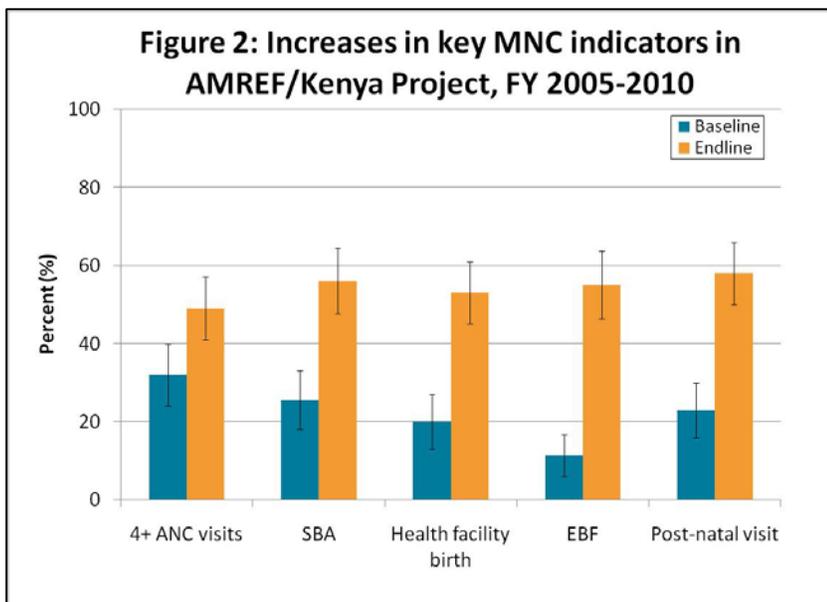
<sup>4</sup> Defined as the percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker (e.g., skilled birth attendant [SBA], CHW, or trained traditional birth attendant) within three days of his/her delivery. For projects that started in/after 2008, the indicator was modified so that the data are collected within two days of delivery – rather than three days.

submitting their final evaluation reports in 2010 were the first to report the indicator at baseline and endline.

The four projects highlighted took diverse approaches to increase the proportion of children receiving post-natal visits within three day of birth. In Kenya, both AMREF and HealthRight saw particularly large increases in post-natal visits, while International Relief and Development (IRD) and Medical Teams International (MTI) also saw increases in Cambodia and Liberia. In the two projects in Kenya, increases can be attributed, in part, to CHWs promoting the use of health services during health talks and home visits. In Cambodia, IRD promoted post-natal care (PNC) through village health volunteers and saw increases despite not having MNC as a primary focus of the project. MTI promoted PNC through Care Groups and health facility staff training in Liberia.

### Projects with Improvements in Multiple Indicators

Select CSHGP projects have been particularly successful in generating improvements across multiple MNC indicators, including those facilitated by AMREF and HealthRight in Kenya; Concern Worldwide International (Concern) in Bangladesh; and Mercy Corps in Tajikistan. Highlights from each project and graphs of key indicators at baseline and endline follow.



#### AMREF/Kenya (2005-2010)

AMREF increased health facility utilization and SBA in Busia District, Kenya by improving the quality of facility-level care, and then initiating a community strategy to increase referrals and utilization of health facilities. According to AMREF’s final evaluation, improvement of quality of care at existing health facilities and the creation of four Maternal and Newborn Health Centers of Excellence increased client and family satisfaction with facility deliveries. Compared to most maternity wards in developing

countries, the renovated hospitals provided more privacy and comfort, along with treatment by a responsive and respectful staff. Nurses in the AMREF facilities felt they could provide better care as a result of the upgrading, resulting in higher job satisfaction.

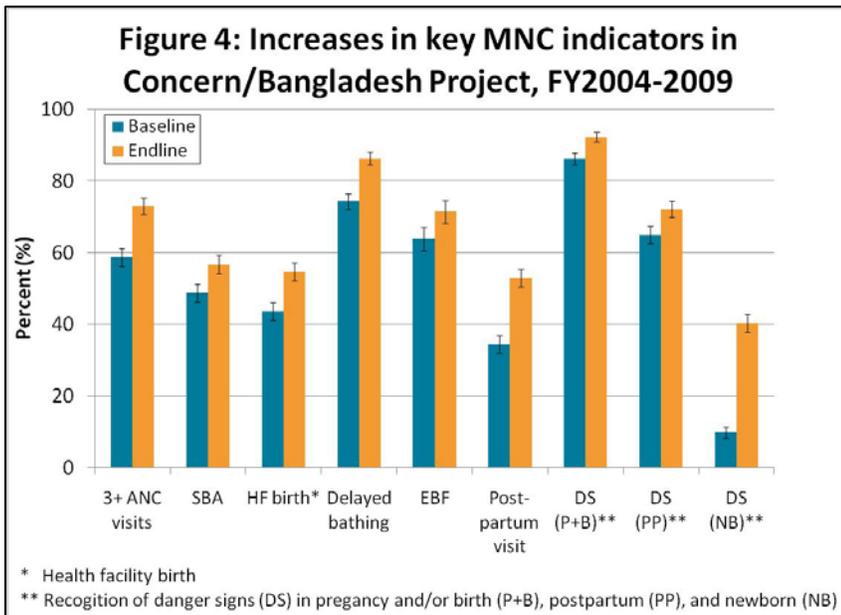
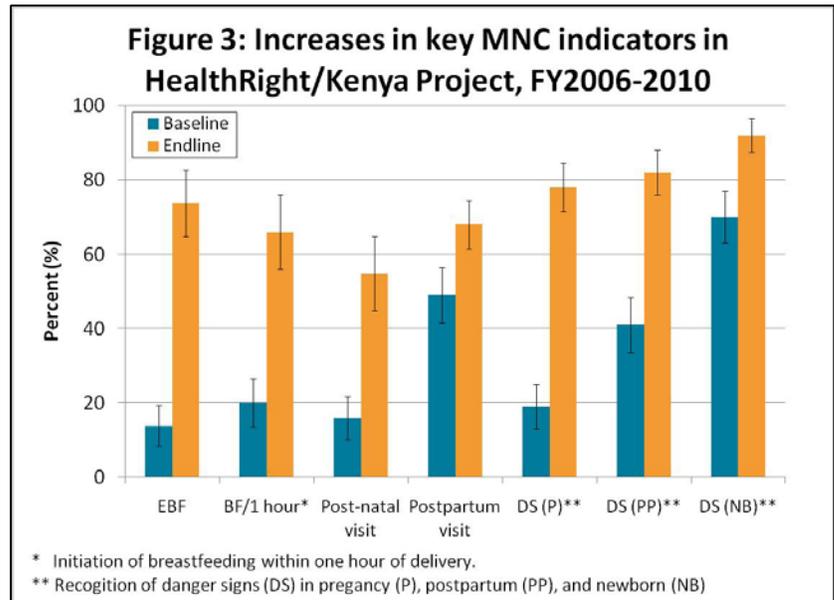
After care at the facilities had improved, AMREF invested heavily in training CHWs in health education, outreach and referral. The CHWs were directly linked to health facilities and community health committees (CHCs). In addition, mother-to-mother support groups were created by identifying pregnant women who were attending antenatal clinics in a specific area. Acting as positive deviants—attending ANC visits in areas where many pregnant women were not—these groups of women met on a regular basis and served as role models for women who were not attending antenatal clinics. Women

not receiving ANC were also invited to support group meetings, which provided information on all matters pertaining to maternal and child health, including postpartum care and EBF.

### HealthRight/Kenya (2006-2010)

HealthRight worked in the Greater West Pokot District, Kenya, and also saw increases coverage of their MNC indicators over the life of their project. HealthRight’s overall strategy was to establish a continuum of knowledge, access, skills and care from households to hospitals that promoted maternal and neonatal health, while also integrating essential HIV/AIDS and malaria interventions. The first year of implementation was focused on improving the quality of services available at the nine target health

facilities. Beginning in the second year, HealthRight promoted healthy social behavior change by supporting the National Community Strategy of CHWs, CHEWs (extension workers), and CHCs in one sub-location in each division and by using mass media, drama, video, radio, and health discussions in the entire project area. Efforts to improve access to MNC services included support for monthly mobile outreach clinics in fourteen rural locations, construction of maternity waiting homes in three facilities, and emergency transport planning with CHCs.



### Concern/Bangladesh (2004-2009)

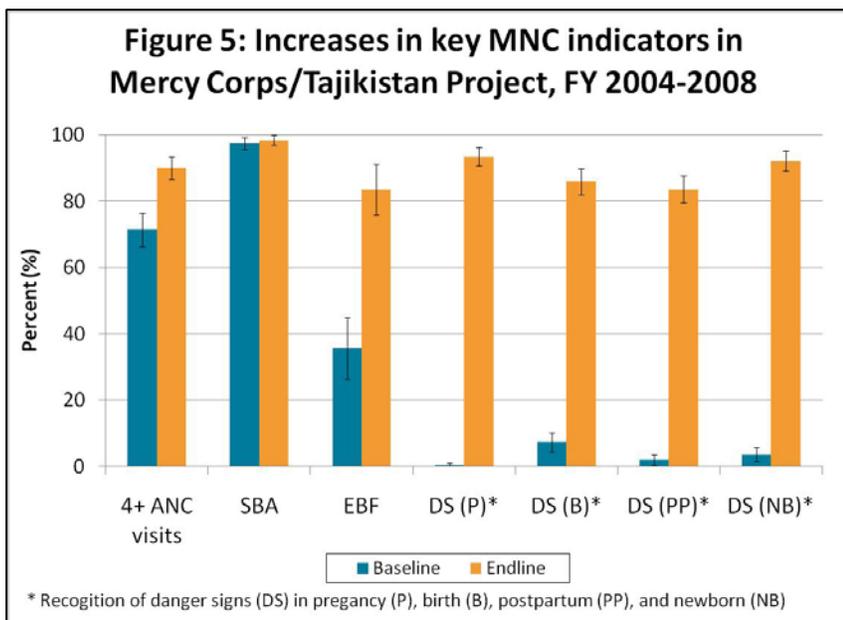
In Concern’s Bangladesh project, community birth attendants (CBAs), and to a lesser extent the community health volunteers (CHVs), were the primary intervention implemented to increase use of MNC services. Nine key MNC indicators increased over the life of the project. CBAs were trained to encourage women to seek ANC, help women plan for births, conduct normal/clean deliveries, identify danger signs and refer women with complications.

A total of 258 CBAs trained through the program indicated that they had

adopted several new ideas/practices as a result of the training including: the importance of encouraging mothers to ensure a clean place for delivery, resting and eating more food during pregnancy, feeding colostrum (first breastmilk) to a newborn, and wrapping the baby immediately after birth. CBAs also

said that having an identity card helped to raise their status in the community, and more women were willing seek information and care from them. CBAs were willing to refer women because they knew the staff at the Maternal and Child Welfare Centers (MCWCs), saying “they are like our family.” Staff at the MCWCs said that there was an increase in ANC referrals and CBAs were referring complications with pregnancy and delivery earlier than in the years before the project was implemented.

One of Concern’s objectives was to ensure poor women could access delivery services, and the project achieved an overall increase in deliveries with SBAs from 48.8% to 56.7%. Of particular note was the doubling of SBA coverage in the poorest quintile (from 17% to 34%), and the increase in the third quintile (from 39% to 54%). As a result, the equity gap in SBA coverage among the poor and the wealthy decreased significantly, as services were able to reach some of the poorest with greatest need.



**Mercy Corps/Tajikistan (2004-2008)**

For Mercy Corps in Tajikistan, SBA was nearly universal at the start of the project, and the majority of women attended four or more ANC visits. However, there was still space for improvement in ANC attendance, as well as awareness of danger signs and breastfeeding practices. The key to household behavior change in Sughd Oblast was focusing on mothers-in-law and men. When these decision-makers realized that poor nutrition was the main cause of illness and death for mothers and newborns, they advocated for dramatic changes. At

the conclusion of the project, 85% of pregnant women were increasing their food consumption during pregnancy, compared with only 9% at baseline. EBF also became the norm in many communities.

As was typical in the region, when the project started, newborns were routinely taken from their mothers at birth and returned two or more hours later. Colostrum was considered bad for the newborn, and by the time infants were one month old, they were fed cake, bread and tea. However, when the project finished, the evaluation team found a sense of relief in the community in the knowledge breast milk was all that the infant needed for his/her first six months, and staff at maternity houses witnessed how the babies were much healthier if they had immediate skin-to-skin contact and breast milk.

Although the CSHGP grant concluded in FY2008, funding from the Swedish International Development Agency (SIDA) allowed modified project activities to continue in the four project districts through 2010. Due to their success, the activities were also adapted and replicated in three new districts in Sughd Oblast and one district near Dushanbe through a five year Maternal Child Health (MCH) project funded by the Regional USAID office in Almaty, integrating lessons learned from CSHGP into the new project.

## Projects conducting innovative MNC operations research

CSHGP innovation grantees develop pioneering operations research (OR) designs as a part of their projects in order to generate evidence and lessons for innovative or expanded approaches. These programs act as learning laboratories in the communities they serve, with OR designs that range from simple descriptive evaluations to rigorous randomized cluster designs with intervention and control groups.

Currently, there are 17 active projects with OR components across 16 countries; those projects with OR questions related to MNC and the research questions they are investigating are included in Figure 6. For more information on the CSHGP innovation portfolio, please see the brief entitled “Testing innovations to improve and scale up service delivery in vulnerable communities: USAID’s partnerships with 14 International Non-Governmental Organizations (INGOs) in 16 countries.”

**Figure 6: Examples of CSHGP Projects generating learning through operations research in order to improve maternal and newborn outcomes, particularly during pregnancy and around the time of birth**

Country/Grantee	Illustrative Research Questions
<b>Afghanistan</b> World Vision 2008-2012	Does a mobile technology innovation strengthen routine care for pregnant women and newborns and improve access to obstetrical and newborn emergency care by increasing referrals as well as prompting essential life-saving actions at the time of delivery?
<b>Cambodia</b> International Relief and Development 2010-2014	Does a maternal nutrition strategy that combines accurate detection and treatment of anemia using HemoCue, food supplementation, and household follow-up visits during pregnancy improve maternal nutritional status and pregnancy outcomes (i.e., ?reduced incidences of low birth weight in low-resource settings)?
<b>Ecuador</b> Center for Human Services 2009-2013	Does the implementation of early postpartum home-based care by trained traditional birth attendants (TBAs) and skilled providers increase coverage and quality of MCH services through coordinated continuum of care from home to facility and improve maternal and newborn outcomes?
<b>Liberia</b> Africare 2010-2014	Does establishing maternity waiting homes (MWHs) near a health facility improve maternal and newborn outcomes (i.e., institutional births and postnatal care)?
<b>Nepal</b> HealthRight 2009-2013	Does integrating a community-based newborn care package (CB-NCP) model with MCH approaches and building community-facility linkages yield greater impacts on MNCH?
<b>Nicaragua</b> Catholic Relief Services 2008-2012	Does constructive male involvement improve care seeking behavior and maternal and neonatal health outcomes?
<b>Pakistan</b> Aga Khan Foundation 2008-2013	Does a new package of training and deploying a cadre of community midwives (CMW) improve the skills and retention of CMWs for improved maternal and newborn outcomes?
<b>Zambia</b> Save the Children 2009-2014	Does TBA-CHW teaming in delivering integrated, community-based newborn care and community case management (CCM), continuum of care for under 5 years, linked to health facilities and neighborhood health committees (NHCS) improve MNCH outcomes?

## Grantees Influence National Level Policy

CSHGP grantees go beyond implementing highly effective, community-based programs to improve maternal and neonatal health outcomes around birth and conducting research to help determine best practices for providing MNC. Grantees also influence local and national policies by providing input on documents, piloting specific interventions of interest to the government, and communicating with high-level officials. In addition to the anticipated policy influences operations research programs described above, other important CSHGP grantee contributions have included:

- AMREF and HealthRight each pilot-tested the rollout of the Kenya Ministry of Public Health and Sanitation's (MOPHS) Community Strategy, which is now being adopted in all regions of Kenya. AMREF helped to develop many of the training materials for the government, including the national curriculum for community-based maternal and newborn care. HealthRight also contributed to the development, testing and final ratification of community-based health information system (CBHIS) tools, which have become part of the MOH's standard Health Management Information System, and also to the CHW training curriculum. A CHC curriculum based on the community strategy policy documents and adapted CBHIS tools for non-literate CHWs have also been developed and shared at the national level.
- Save the Children's Malawi program is a vocal advocate for improved access to MNC. Funding from both USAID/Washington and Saving Newborn Lives (Bill & Melinda Gates Foundation), as well as complementary funding from USAID/Malawi to the ACCESS project, places Save the Children at the center of policy dialogue and development, advocacy and communication; the design and management of innovative service delivery models; and, ultimately, taking to scale a comprehensive community-based newborn care (CBMNC) package. This package was officially adopted in February 2010 as a national program. Furthermore, to ensure that use of kangaroo mother care (KMC) is consistent along the household-to-hospital continuum of care, the Malawi Newborn Health Program (MNBHP) revised the draft national KMC service guidelines to incorporate guidance for providing KMC services at the health center and community levels in collaboration with the MOH Reproductive Health Unit and the ACCESS program.

Through operations research, these projects inform national policy and identify strategies to inform the development of future programs and interventions.

## Conclusion

In this time of renewed focus on the key interventions occurring around the time around birth, the CSHGP experience presented here suggests the INGO community offers rich experiences from which others can draw. The CSHGP has been supporting these types of interventions for more than a decade. Over time, the expertise and lessons learned from these projects have been leveraged by national governments to inform and improve health policies, broadening the reach of the program beyond the target recipients and to a greater audience. As CSHGP projects move forward and focus on specific research questions in the present portfolio of grants, the program will continue to serve as a major player in MNC service provision and an innovator in the use of community-based strategies to reach vulnerable populations, particularly women and newborns beyond the reach of traditional health services.

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