Recommendations for Future Programming

In almost all cases, work begun under ACCESS continues to be supported and expanded by host country governments, other in-country partners, USAID and/or other donors. This section presents a number of important lessons learned in targeted areas that should be considered as work initiated by ACCESS is expanded upon by other partners and programs.

ANTENATAL CARE AND MALARIA IN PREGNANCY

To adequately address MIP, policy dissemination and program implementation need to move forward at the same time, complementing one another for wide-scale impact. A platform of ANC, coupled with community mobilization efforts, leads to improvements in MIP intervention coverage. However, to achieve national coverage, programs should consider additional proven approaches—such as quality improvement, pre-service education and engagement with the faith-based sector—to augment existing strategies.

Specific suggestions for moving forward with FANC/MIP include:

- The ANC platform should promote all three prongs for preventing and treating malaria in pregnancy: IPTp, use of ITNs and case management.
- Advocacy for stronger relationships within MOHs—especially between RH and malaria control programs, as well as HIV, tuberculosis (TB), diagnostics and lab—can increase program effectiveness.
- Advocacy for continuation of SP supplies for prevention at the ANC facility, especially as countries transition to artemisinin combination therapies for treatment, is essential to avoid stock-outs at ANC clinics.
- Incorporating MIP into pre-service education for medical, nursing and midwifery schools will ultimately support sustainability and cost-effectiveness.
- Integrating monitoring and recordkeeping into programs as a routine component will explain program trends and inform the direction of the program.
- Involving communities early on and engaging women and their families to mobilize demand for services can increase timely attendance at ANC clinics.

PREVENTING POSTPARTUM HEMORRHAGE IN HOME BIRTHS

Every woman, regardless of location, should have the basic right to a healthy and safe delivery. However, many women die from largely preventable causes because they do not have access to simple, life-saving interventions. The ACCESS experience showed that community-based education and distribution of misoprostol is a safe, acceptable, feasible and programmatically effective tool for preventing PPH in low-resource settings where access to skilled attendance is limited. Other innovative technologies have also become available, including oxytocin in Uniject for prevention of PPH and the uterine tamponade and the anti-shock garment for treatment of PPH. As complementary components of a comprehensive strategy to address PPH, these innovative interventions show promise for the many women in the world who live in remote settings, without access to facility-based skilled care, to prevent unnecessary maternal deaths that occur from PPH.

Specific suggestions for moving forward to prevent PPH at home births include:

- Distribution of misoprostol is not a stand-alone, single approach to address the burden of PPH. Education and distribution of misoprostol are appropriate in settings where there are a large proportion of home births and an existing cadre of CHWs who can reach pregnant women in the community. The intervention should be a component of a comprehensive PPH prevention package, including efforts to

increase the availability and accessibility of skilled attendance at birth and facility-based emergency obstetric services.

- The intervention can be integrated within the existing government health service delivery framework. In Afghanistan and Nepal, existing CHWs were widespread, accepted in the communities, and supervision and logistics systems were in place to oversee performance and provide supplies. Both projects delivered interventions as part of a basic package of care. Moreover, skilled attendants were present in facilities to manage referred cases of PPH and other complications.
- The community should be an active partner in any strategy to improve maternal health. The community used innovative and non-monetary methods for motivating and supporting CHWs. In Afghanistan, many CHWs stated that community recognition was a primary impetus that motivated them to fulfill their responsibilities related to the project. Community support is important and leads to increased knowledge about MNH, danger signs, the need for skilled attendance at birth and transport to emergency care.
- Delivering a PPH prevention measure directly into the hands of women makes good sense. Sadly, there are many women in the world that give birth alone. This intervention provides a protective method to the one person who will unequivocally be present at the moment of birth: the woman. Trained and supervised CHWs were successful sources of education to women on the risks of PPH and the safe and correct use of misoprostol.

INCREASING THE SUPPLY AND ACCESS TO SKILLED BIRTH ATTENDANTS

ACCESS worked in 14 countries to increase the availability and competence of SBAs. Efforts included support to roll out government SBA policies, development of training materials and training packages tailored to the needs of the country, support for in-service training, strengthening of pre-service institutions and mobilizing communities to increase demand for delivery with a skilled provider. Ultimately, a strong, standardized, competency-based, pre-service education system will have the most far-reaching impact on expanding the cadre of SBAs.

Below are specific suggestions for future investments in pre-service education as an upstream method for increasing the supply and competence of skilled providers:

- BEmONC skills are basic skills that need to be in the repertoire of midwives at the time they enter the workforce and need to be incorporated into midwifery pre-service curriculum of studies.
- MOHs and the respective regulatory authorities for both medicine and nursing/midwifery must be engaged in the planning of programs that will enhance or expand the scope of practice of midwives, so that these skills can be acknowledged, valued, supported and facilitated at both policy and practice levels.
- Recruitment and admissions policies for midwifery students should encourage enrollment of the more qualified and better educated candidates, preferably at post-secondary level, and with the option of a direct-entry pathway to midwifery.
- Regional training can be effective for content that can be transported across country borders without the need for "translation" (e.g., adult learning principles, teaching skills); however, country-based training is preferable for teaching of clinical skills that must be tailored to the country context.
- Teaching and learning BEmONC skills require the investment of substantial time for acquisition of the fundamental anatomic and physiological principles and the "hands-on" skills of the various maneuvers. A standardized, competency-based, teaching/learning package cannot be "short-cut" without compromise to quality.
- Investments in the clinical training environment must be made if BEmONC training is to have any impact. The enabling environment includes basic equipment and supplies, and, as importantly, requires

that peer practitioners, supervisor and other medical practitioners are also updated in these evidence-based practices.

USING KANGAROO MOTHER CARE TO SAVE NEWBORN LIVES

In Nigeria, Rwanda and Nepal, ACCESS established the foundation for future expansion of KMC services by establishing KMC learning centers and supporting the provision of KMC services in a number of hospitals. In Malawi and Ethiopia, ACCESS built on the foundation of an already-established program to expand KMC services to additional hospitals. The Program experience introducing and expanding KMC services highlights the importance of engaging appropriate stakeholders—the MOH in particular—and professional bodies to ensure local acceptance and ownership of KMC for preterm babies. Engagement of these stakeholders facilitated the development and acceptance of national KMC guidelines and associated training materials. The establishment of learning centers served as an advocacy "tool" in facilitating the adoption of the method by other in-country development programs, thus assisting in the expansion of KMC services. To further expand KMC services, programs need to assist nursing and medical institutions to incorporate this method into their pre-service curricula.

Specific suggestions for moving forward with KMC include:

- Scale-up of KMC services requires the technical and financial collaboration of multiple partners—including the MOHs and national professional associations—and cannot be supported by one organization alone.
- Introduction and expansion of KMC services requires local ownership from program start-up.
- Having national KMC policies, guidelines and a training manual with associated job aids facilitates introduction and expansion.
- Following up with mothers after discharge from the KMC unit is the single biggest challenge and will require extending KMC training/services beyond the facility level.
- KMC training should be integrated into ongoing MNH training. A two- to three-day training in KMC is sufficient when integrated into other MNH in-service training. However, a stand-alone KMC training program for persons not competent in identification of danger signs and newborn feeding techniques (including breastfeeding and cup feeding) requires four to five days of training to ensure appropriate skills are acquired.
- KMC training should include a hands-on practicum to ensure trainees acquire the necessary competencies.
- A general orientation of all facility staff on KMC, not just the immediate care providers of LBW babies, has proven beneficial.
- A system for ensuring training or mentoring for new staff posted to KMC units is essential to guarantee the continuation of service whenever trained staff is reassigned out of the unit.

INTEGRATING HIV AND MATERNAL AND NEWBORN HEALTH SERVICES TO INCREASE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION COVERAGE

Although there are ample opportunities to integrate PMTCT into routine MNH services, different funding streams, divisions within ministries, and the involvement of multiple implementing partners all present challenges. However, with persistence and a commitment to consider all possible opportunities, ACCESS strengthened integrated PMTCT-MNH service delivery in Ethiopia, Kenya, Malawi and South Africa, thereby increasing the numbers of women and children receiving critical, life-saving services.

Specific suggestions for moving forward with MNH-HIV integration for expanding PMTCT coverage include:

- Experience from Ethiopia demonstrated that community-based Health Extension Workers (HEWs) represent a viable opportunity to expand the availability of—and thus increase the uptake of—PMTCT services. In order to sustain their effectiveness, they need training, follow-up supervision and the necessary supplies and materials.
- Experience from Kenya showed that use of an integrated (RH and HIV) supervision tool, along with introduction of a facility-based quality improvement process, helps supervisors and motivates providers to improve the quality of care.
- Integration activities must be flexible to accommodate all contingencies. An example from Malawi showed that community-based collection of specimens was more effective than sending community members for HIV antigen testing.
- It is critical to have appropriate tools for monitoring services and progress—ensuring these are in place can take time. Integrated services include integrated registers, which need to be tackled from the outset if results are to be accurately captured. Ideally, instead of developing project-specific registers, MOH registers will be enhanced.
- Linking Mother Infant Pair follow-up to household counseling and or community MNH mobilization efforts is an excellent way to ensure that HIV exposed infants return for follow-up care until a definitive diagnosis is reached.

MOBILIZING COMMUNITIES TO IMPROVE MATERNAL AND NEWBORN HEALTH

ACCESS's work in community mobilization identified several challenges and lessons learned. The Program found that CHWs are often overworked and community mobilization work competes with many other priorities. Although ensuring stakeholder ownership is critical, it takes time—as does the community mobilization process. Ensuring supportive supervision and mentoring for community groups can be challenging.

Specific suggestions to overcome these challenges and move forward with community mobilization for MNH include:

- Advocate with donors and program managers to include a community mobilization component in all comprehensive MNH programs. Community mobilization is an essential component of the HHCC approach, and is effective in increasing demand for and use of services.
- Analyze the programming context carefully to identify existing systems, resources, policies, community structures and cultural factors. A community mobilization initiative that fits with and builds on local resources is more likely to be sustained and scaled up.
- Continue to simplify community mobilization processes and tools—without losing the empowering, capacity building foundation.
- Disseminate guidance on community mobilization indicators and monitoring systems so that program managers will be confident in tracking and reporting community mobilization outputs.
- Budget sufficient resources to document and share community mobilization results—especially in peer review journals, because these are powerful advocacy tools.
- Conduct cost-effectiveness studies to quantify the added-value of community mobilization.
- Test variations of the community mobilization model for peri-urban and urban contexts.

INTRODUCING STANDARDS AND RECOGNIZING ACHIEVEMENTS

The ACCESS Program used a quality improvement approach in 11 countries to improve maternal, newborn and reproductive health services. Jhpiego's SBM-R approach was used in a fairly consistent manner across all countries. The approach, which focuses on standardization around clearly defined service delivery processes or a specific content area, is an internal quality improvement process that involves providers, health workers and managers, and emphasizes internal learning and continuous improvement.

Specific suggestions for moving forward with quality improvement approaches include:

- Linking facility improvements to community mobilization will likely increase the impact. In some ACCESS countries—such as Nigeria, Malawi and Rwanda—the quality improvement process was loosely linked to community mobilization work. Given that communities have a stake in facility performance and have the power to mobilize resources, closer ties between these approaches should be promoted as they are expanded within MCHIP and elsewhere.
- Selected outcome indicators should be tracked alongside of improvement in standards. Although most standards promoted through SBM-R are evidence based, it is important to demonstrate that achievement of standards is directly linked to improved practices and health outcomes. The work started by Malawi to track health outcomes should be expanded and replicated in other countries.
- Build on what is in place: promote quality improvement principles, not a branded approach. ACCESS did not insist on calling the quality improvement process "SBM-R" if a country already had a quality strategy in place. The term "SBM-R" is not used at all in Tanzania or Malawi, for instance. And, in Afghanistan, the ACCESS Associate Award and the HCI project are collaborating on improving quality of health services with the MoPH, and the term used for the process is "quality assurance."
- Ensure involvement of district level stakeholders to avoid "plateau-ing". A typical pattern for achieving standards is quick initial gains followed by a slowing down and possible stalling when some of the barriers are out of the control of hospital management (e.g., supply chain issues). The SBM-R process is designed to tackle the "quickw wins" first and then engage a broader group of stakeholders to tackle the more systemic problems. Broad and representative stakeholder involvement from the beginning can help facilities resolve the more difficult problems.
- Recognition is a critical component of the process, and linking incentives with quality improvements should be vigorously pursued. Recognition increases motivation; it can promote healthy competition and help increase utilization of services. While formal accreditation based on provision of quality services is the ultimate goal of this process, incremental and informal recognition can motivate providers and "advertise" high-quality services to surrounding communities. Linking quality improvements to tangible incentives should be expanded where governments are seeking to base financing on performance.

USING SMALL GRANTS TO SCALE UP EVIDENCE-BASED MNH INTERVENTIONS

With less than USD$200,000, ACCESS helped to build the capacity of 14 FBO, community-based organization (CBO) and professional organizations throughout sub-Saharan Africa. Due to their presence in the community and intent to stay—regardless of the funding or political atmosphere—investment in these types of grassroots organizations has an enormous ability to make sustainable changes to MNH. These organizations are familiar with the local culture and therefore adept at transmitting messages and influencing behavior change, and have a significant outreach capacity as well as the trust of the communities in which they work. Moreover, professional associations have the capacity to set the standards for their respective professions.

However, in program planning, the need to build in adequate time and resources cannot be overemphasized. Recipients of small grants often lack either the financial, technical or managerial skills to implement larger programs. It is therefore imperative to concentrate on improving these skills of small grantees, especially since these grants are small investments for often large returns.

Specific suggestions for future MNH investments through small grants include:

- Build in adequate monitoring and evaluation and financial management technical assistance for small grant funding. Link the monitoring and evaluation plan to the results required for the sponsor.
- Issue fewer grants and set aside more resources for technical assistance for the entire process from proposal writing, baseline data collection, implementation, endline assessment, report-writing and supervision activities.
- The time frame to use the funds must be realistic. The capacity to use money efficiently and in a short period of time can be overwhelming for small organization.