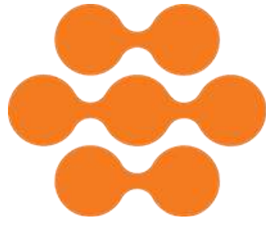

seed **madagascar**

sustainable environment, education & development

Interim Report

Project Votsira (Phase 3): Improving women's health practices by increasing access to sexual, reproductive, maternal and child health information

Activities conducted from July 2016 to December 2016

March 2017

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1. Project Summary

Madagascar's position of 154th out of 187 countries on the 2015 Human Development Index (UNDP, 2015) is testament to the country's immense and long-standing development challenges. In a context characterised by extreme poverty, a lack of political commitment and insufficient service provision, it is unsurprising that the country's health outcomes are amongst the lowest in the world (World Bank, 2017). The outlook for mothers is particularly bleak, with little progress made over the last two decades in reducing the alarmingly high maternal mortality rate [MMR] (USAID, 2014). With the MMR standing at 353 per 100,000 live births in 2015 (WHO, 2015) and women facing a lifetime risk of maternal death of 1/47 (Save the Children, 2015), figures only serve to highlight the importance of addressing the barriers to improving maternal health in Madagascar. Current global priorities aligning to Sustainable Development Goal 3 of ensuring healthy lives and promoting wellbeing (United Nations, 2017) call for a renewed focus on the dire yet preventable health outcomes frequently associated with pregnancy and birth in Madagascar.

In the remote southeast Anosy Region, the situation is no more promising. A lack of education and cultural preferences for traditional health providers compound already insufficient access to health services and dismal government spending on health – equivalent to US$22 per capita (WHO, 2014). In the regional urban centre of Fort Dauphin, these factors perpetuate detrimental maternal health behaviours and practices during pregnancy and childbirth. Indeed, during previous SEED Madagascar (2014) research, one in two women reported consulting a traditional midwife or healer during her last pregnancy; advisors who commonly prescribe dangerous practices and treatments. A dearth of reliable and accurate health information inspired Project Votsira, which utilises a community-based approach to improve knowledge of a range of issues pertinent to safeguarding the health of both mothers and children.

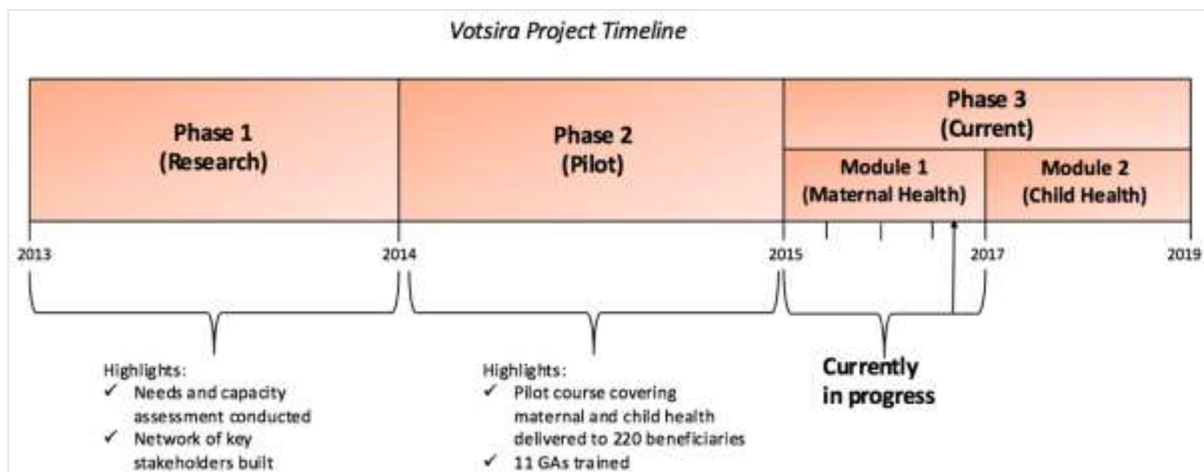
Now in the second year (PY2) of its third phase (2015-2017), Votsira continues to work with local government health agents [GAs] to disseminate maternal health information to women and community elders throughout Fort Dauphin. Building on the successful capacity-building and training sessions during project year 1 (PY1), SEED is supporting GAs to deliver a specially-developed Health Pregnancy and Birth Preparedness Course [HPBPC] through a series of focus groups, one-to-one home visits and information sessions. This report reviews the activities and baseline-endline surveys for the penultimate round of the HPBPC, running from July to December 2016. Results indicate that momentum has been maintained from PY1, with the latest group of course participants also showing significant improvements in knowledge, attitudes and practices across a range of global benchmark indicators related to sexual, reproductive, maternal and child health.

2. Project Activities

2.1 *Project Review and Development*

Informed by research and a pilot during earlier Votsira phases (see *Project Timeline* below), Votsira Phase 3 is comprised of two complementary modules designed to improve maternal (Module I) and child (Module II) health. Ongoing evaluation, including needs assessments and stakeholder feedback sessions, have been crucial for revising both course content and delivery. For example, the latest round of the HPBPC has seen the continued involvement of community elders in focus group sessions following their successful inclusion at the start of Module I. By facilitating the integration of wider community members, Project Votsira works to build a supportive local context by ensuring that mothers and other key caregivers are equipped with accurate and reliable health information.

As previously reported, Module I focuses on the dissemination of maternal, family planning and sexual health information delivered through the HPBPC. The course covers eight key topics tailored to both the local context and the health challenges facing new and expectant mothers in Fort Dauphin. These include antenatal visits, breastfeeding, HIV and sexually transmitted diseases, contraception, birth complications, sanitation, birth preparedness and vaccinations. In keeping with the participatory approach of the project, beneficiaries continue to be assigned responsibility of choosing the order in which topics are covered, helping to ensure participants are supported in addressing their imminent concerns and priorities.



2.2 *Government Health Agent support and training*

- Top-up training provided to GAs prior to delivery of the new HPBPC round
- Monthly review meetings held with GAs as part of project monitoring

SEED continues to work closely with the Ministry of Health to support GAs in delivering accurate and comprehensive health information. As reputable members of the communities

which they serve, GAs are best-placed to identify the vulnerable families that are most likely to benefit from Project Votsira. As GAs have insight into the pertinent maternal and child health challenges within their *fokontany*, Votsira has also been able to directly address the most pressing problems at the community level*,* whilst working towards the individual needs of women via focus groups and household visits.

In July 2016, prior to the start of the new HPBPC round, GAs received top-up training to refresh their knowledge of course content as well as skills in facilitation and participatory approaches. Monthly review sessions subsequently afforded space to raise emerging concerns or problems, with the Votsira Project Coordinator providing additional training or support where required.

Government Agents assist to identify the most vulnerable beneficiaries to attend focus groups

2.3 *Activity Summary and Participant Numbers*

- An additional round of the HPBPC involving 88 focus group sessions; two a month per group for each of Fort Dauphin's 11 *fokontany*
- Focus groups had an average of 18 participants; over 50% of participants were pregnant women, with the rest of participants comprising new mothers, community elders and other key caregivers
- A total of 352 household visits conducted (eight in each of the 11 *fokontany* per month) providing one-to-one and tailored support to 88 pregnant women and their families
- GAs attended 68 antenatal sessions at two public clinics in Fort Dauphin (from August-November 2016) broadening project reach, and providing additional information and support to pregnant mothers

3. Case study: Votsira's Project Coordinator

As Votsira Module I enters its final 6 months, a review of project learning will be crucial for assessing the impacts on maternal health as well as for informing the delivery of Module II (child health) from July 2017. SEED's Project Development team sat down with Gerard, the Project Votsira Coordinator, to review the achievements and challenges so far.

Project Year 1 saw the successful delivery of 176 focus groups and 704 household visits. Was this success replicated during the next round of the HPBPC (July-December 16) and if so, how?

Success has certainly been replicated in this most recent round as reflected in the high number of focus group sessions and household visits conducted by GAs. However, I am also pleased that the new group of participants have been just as receptive to the course content and keen to gain new knowledge so that they can care for themselves and their babies.

Participants have taken a particularly strong interest in topics such as STIs and postnatal visits. This is important as it indicates that participants are not only becoming more aware of the high rates of STIs in their communities, but are motivated to safeguard their children's health. Interest in postnatal visits shows the willingness of beneficiaries to continue healthy practices into the future. Despite the first six weeks after birth being a critical time for both the health of the child and mother, postnatal care is still relatively new to Fort Dauphin. To see such significant improvements from baseline to endline in the uptake of postnatal visits (*see Graph 9,* p.10) is extremely promising and shows the beneficiaries' improved understanding of the importance of the postnatal period.

What challenges have you identified? How would you address these in the future?

For me, the biggest challenge is the discord between knowledge and behavioural change. We need to make sure that the information we provide is transferred into positive behavioural changes by supporting women. This is where Votsira benefits from GAs whose close relationships with their communities ensure they work closely with beneficiaries, tailoring the course content and their approach. Individual household visits are also crucial for GAs to work one-to-one with women and their families to address specific risks and concerns.

It is difficult to measure behavioural change. We have tried to choose indicators which capture both knowledge uptake and behaviours (e.g. antenatal and postnatal visit attendance), looking to the future it will be important to continue revising these indicators and considering how we measure success. I'd also like to see Votsira continue to support past beneficiaries in utilising and retaining their newly acquired knowledge.

Could you provide one example that you feel highlights the positive impacts of Project Votsira on target beneficiaries?

Last year, myself and a GA worked closely with a 20-year old woman in Tanambao (a *fokontany*) who was both a regular attendee at focus group sessions and received one-to-one household visits. She gave birth to a healthy set of twins in October 2016. She was grateful for the support and information that had been provided to her during pregnancy, and she continued to be motivated to learn about healthy practices following birth to ensure that her twins stayed healthy. For me, it's witnessing this motivation and the healthy child and mother that really reflect the success of Project Votsira.

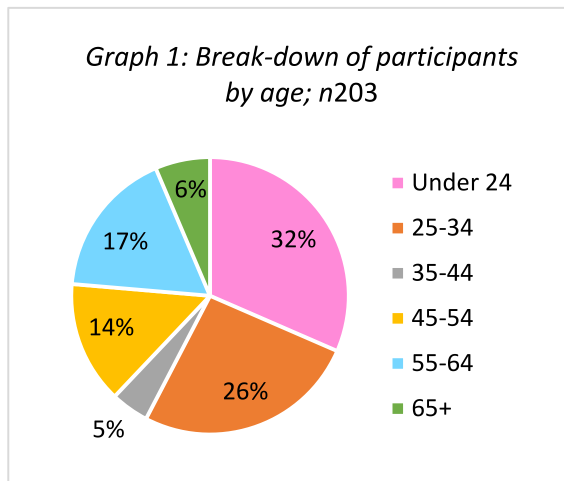
Top: Women attending a focus group on HIV and sexually transmitted diseases in Amparihy fokontany; Bottom: Participants of a focus group on breastfeeding in Bazarbe fokontany

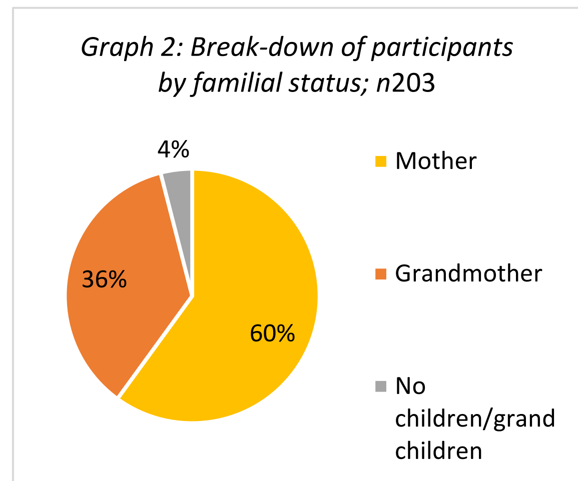
4. Monitoring and Evaluation

4.1 *Baseline and Endline survey results*

The first half of PY2 ran 88 focus groups from July to December 2016, with an average of 18 people participating in each session, half whom were pregnant women. No men participated in the focus groups. Over half of participants were under 34, while women aged over 45 – generally elders supporting mothers during pregnancy and birth – comprised over a third of the group. Inclusion of these older women is imperative in the broader dissemination of health information, as they fulfil their community roles in providing support to their familial networks.

The results discussed below were collected through individual baseline and endline surveys with focus group participants. The number of respondents to each question is represented by *n.* Aside from the demographic information, each graph is representative of a specific survey question, depicted in the graph's title. With the exception of Graphs 9, 10 and 11, bars represent the percentage of positive responses. When answering each knowledge question, survey respondents were presented with all answers, and selected those which they believed correct. Questions around behaviours and practices were open-ended.

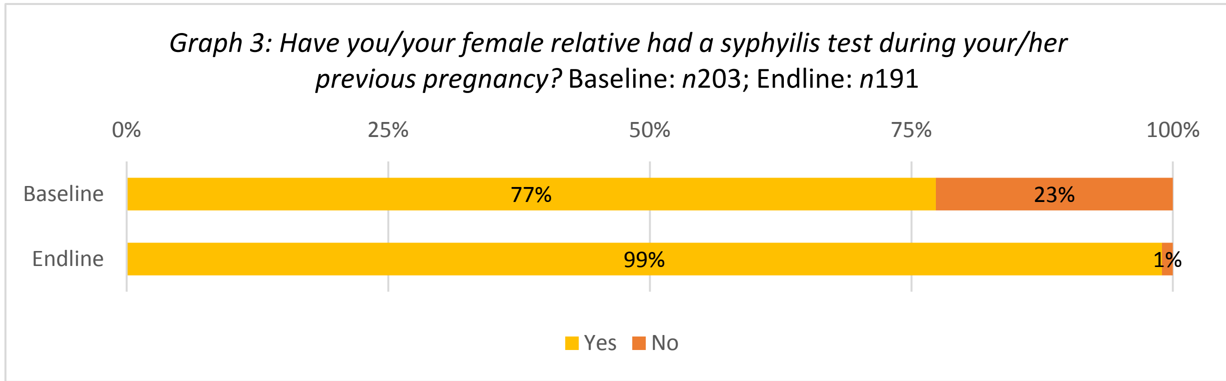


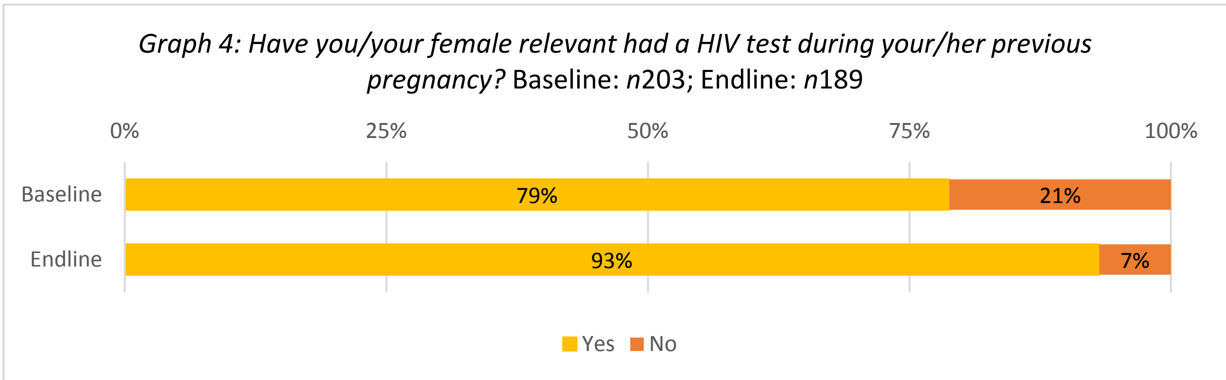


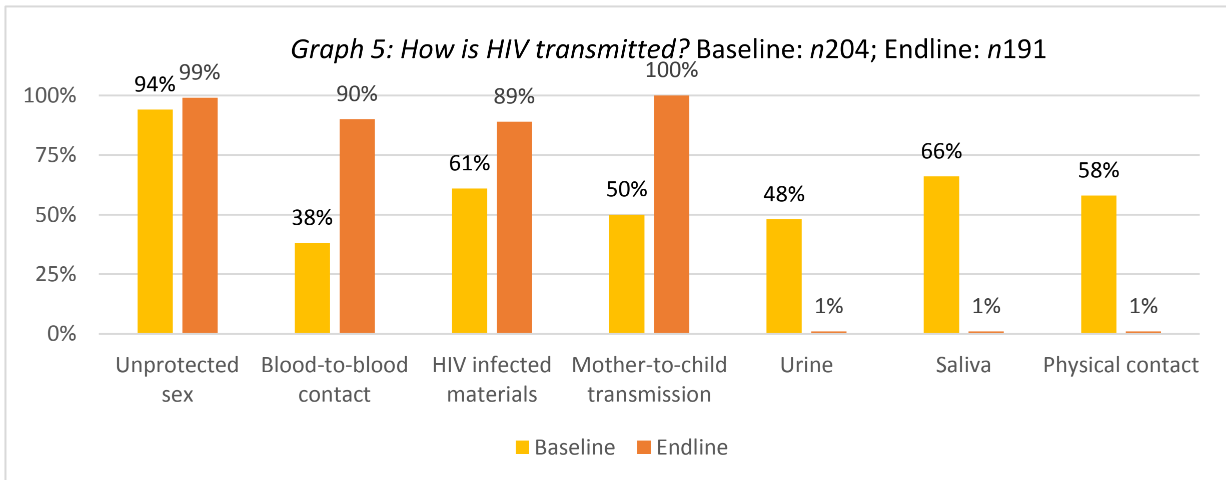
4.1.1 *HIV and Syphilis*

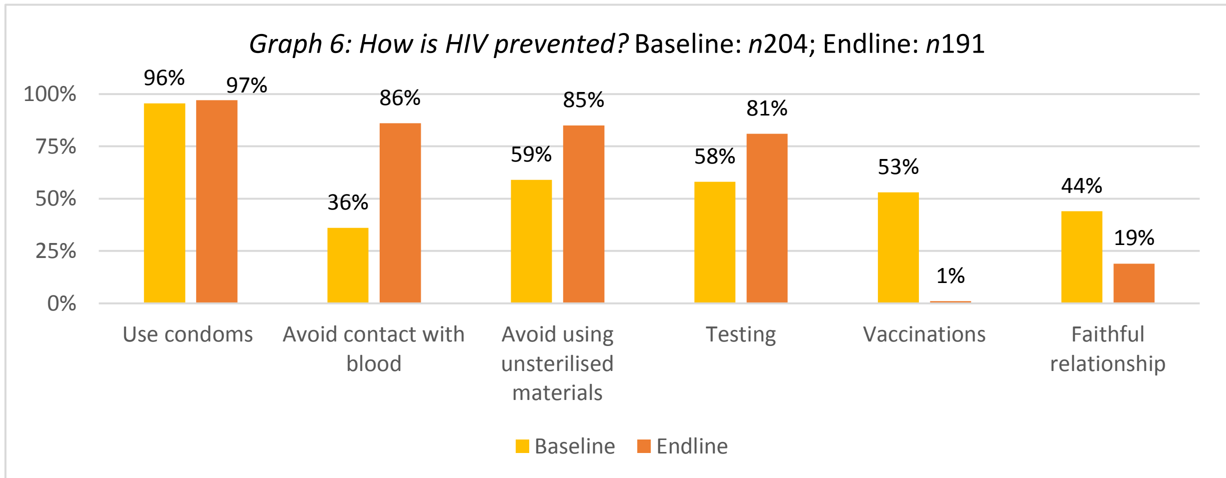
Baseline knowledge of HIV and syphilis was relatively high, with 85% of respondents reporting knowledge of HIV. While baseline respondents reported a relatively strong uptake of HIV and syphilis testing during her last pregnancy – 79% and 77%, respectively – these were lower than the baseline figures of the previous round of the HPBPC, conducted in January 2016. Encouragingly, significant progress was still evidenced during this course, with at endline reported testing rising to 93% and 99% for each test respectively.

By endline, all 191 participants knew what HIV was and understood it exists in Fort Dauphin. More significant changes were noted in terms of knowledge of HIV transmission and prevention (*Graphs 6 and 7*, below).


Graph 3: Have you/your female relative had a syphyilis test during your/her previous pregnancy? Baseline: n203; Endline: n191
0%
25%
50%
75%
100%
Baseline
Endline
77%
23%
99%
1%
Yes
No

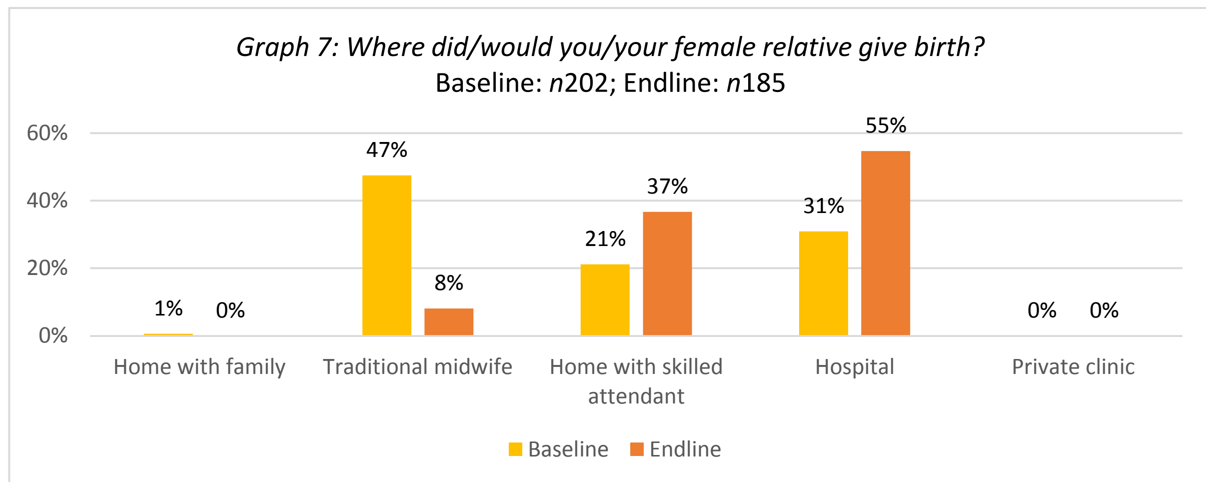

Graph 4: Have you/your female relevant had a HIV test during your/her previous pregnancy? Baseline: n203; Endline: n189
0%
25%
50%
75%
100%
Baseline
Endline
79%
21%
93%
7%
Yes
No


Graph 5: How is HIV transmitted? Baseline: n204; Endline: n191
100%
75%
50%
25%
0%
94%
99%
38%
90%
61%
89%
50%
100%
48%
1%
66%
1%
58%
1%
Unprotected sex
Blood-to-blood contact
HIV infected materials
Mother-to-child transmission
Urine
Saliva
Physical contact
Baseline
Endline


Graph 6: How is HIV prevented? Baseline: n204; Endline: n191
100%
75%
50%
25%
0%
96%
97%
36%
86%
59%
85%
58%
81%
53%
1%
44%
19%
Use condoms
Avoid contact with blood
Avoid using unsterilised materials
Testing
Vaccinations
Faithful relationship
Baseline
Endline

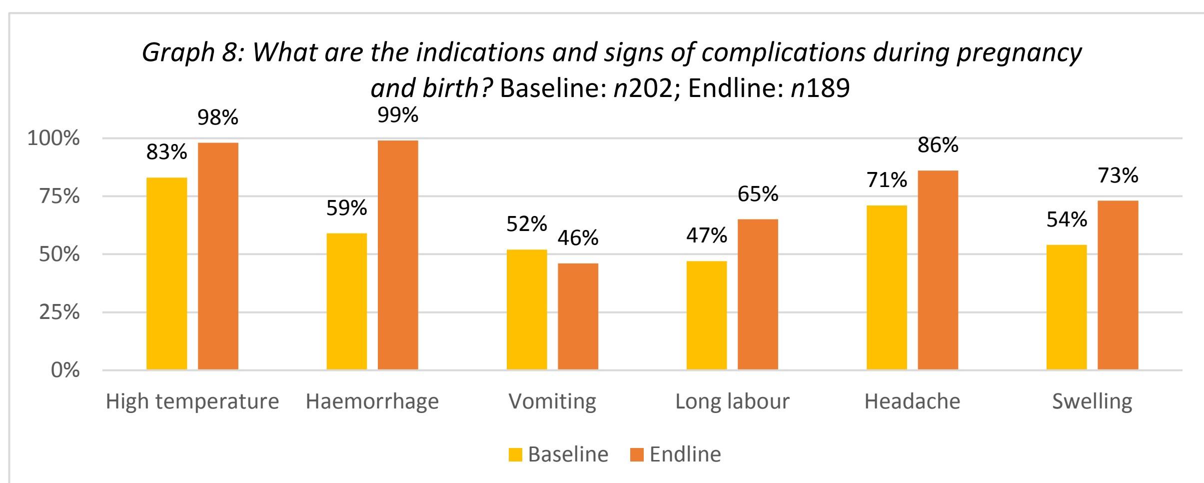
4.1.2 *Birth Location*

When asked where they or their female relatives last gave birth, the baseline survey revealed that nearly half of women opted to give birth at home with only a traditional midwife for support. By endline this preference had fallen dramatically to below 10%, with over 90% saying they would now opt for a hospital or home-birth with a skilled attendant present.



4.1.3 *Birth Complications*

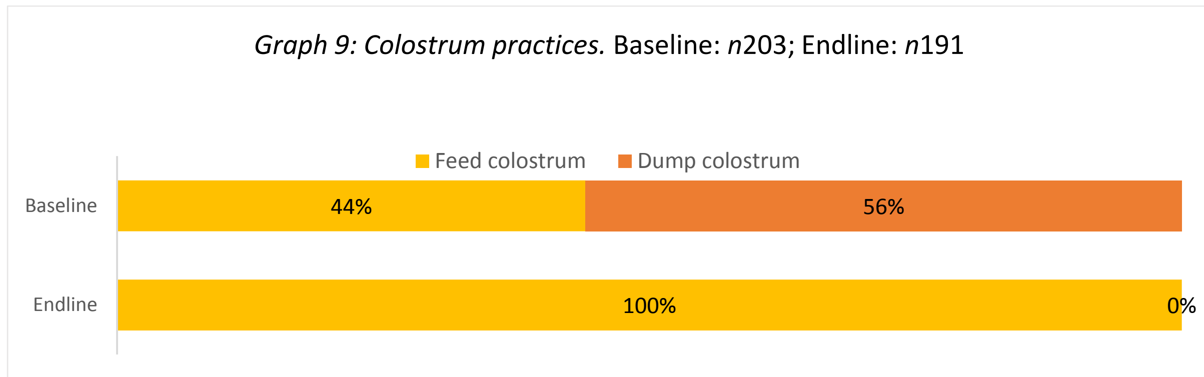
During baseline and endline surveys participants were asked to identify signs of complication during birth. By endline, five (of the six) common signs of birth complication showed higher rates of recognition amongst participants, with almost all participants recognising high temperatures and haemorrhaging as signs of complication.



4.1.4 *Breastfeeding*

Comparisons between baseline and endline data reporting on the practice of colostrum dumping showed extremely positive improvements to breastfeeding practices. Whereas at baseline less than half of all participants said they would (or would recommend their

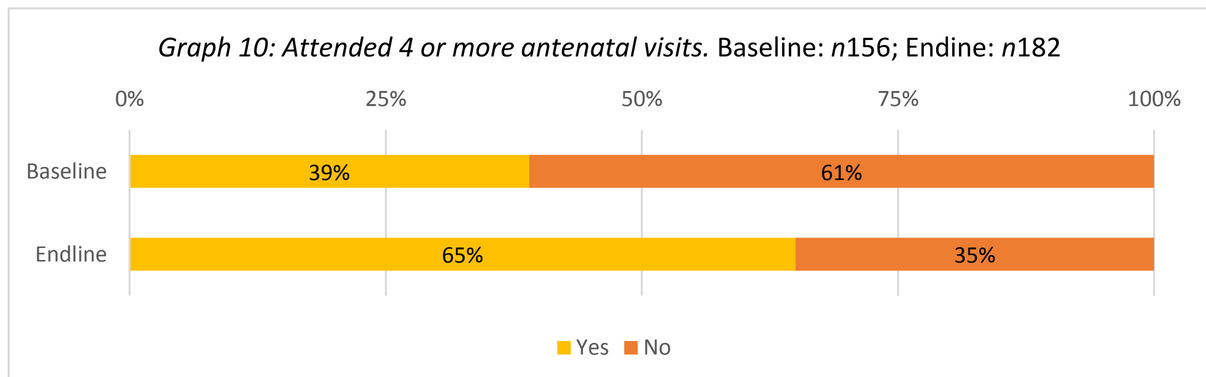
relative to) feed highly nutritious colostrum, this increased to 100% when participants were asked again after focus groups.



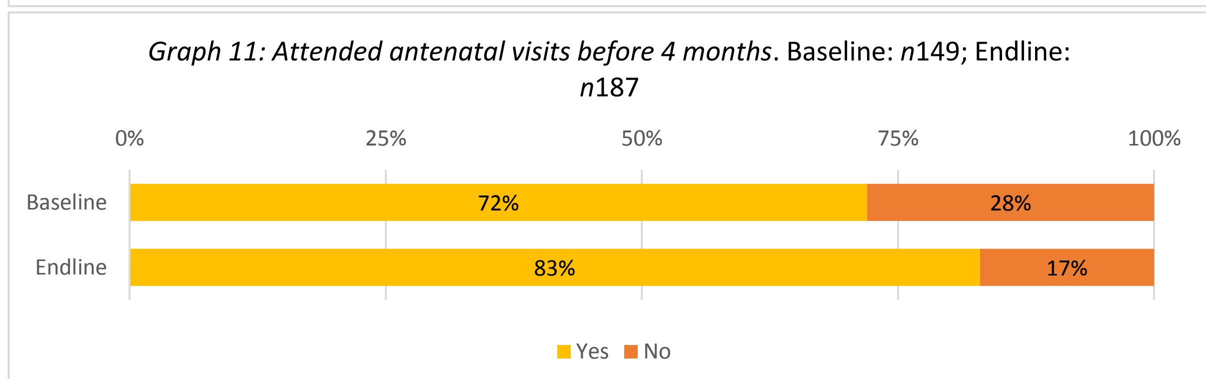
Graph 9: Colostrum practices. Baseline: *n*203; Endline: *n*191

4.1.5 *Antenatal Visits*

At baseline, while 95% of respondents said they had or would attend antenatal visits during pregnancy, only 39% would have attended the recommended four visits. More than a quarter of women would wait until after the fourth month of pregnancy before her first visit. By endline these rates had improved, with the percentage of respondents attending the recommended four visits increasing to 65%, and 83% saying they had or would attend the first antenatal visit during the first four months of pregnancy.



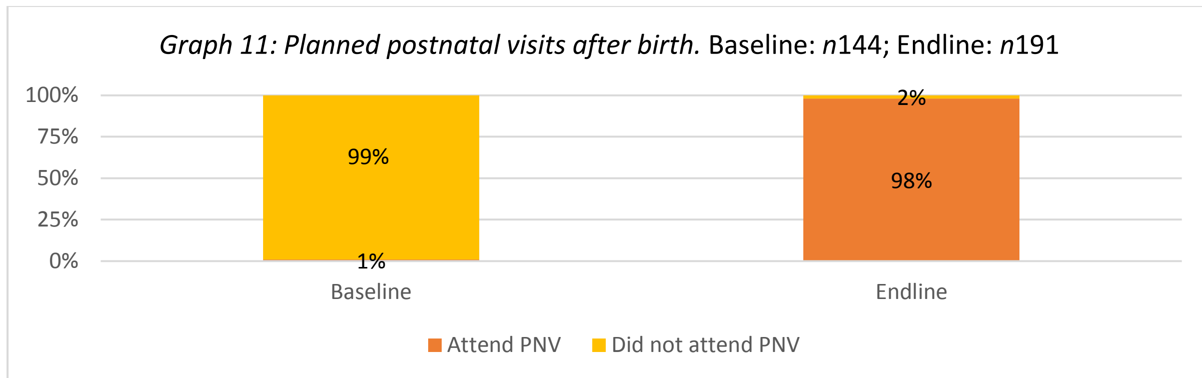
Graph 10: Attended 4 or more antenatal visits. Baseline: *n*156; Endine: *n*182



Graph 11: Attended antenatal visits before 4 months. Baseline: *n*149; Endline: *n*187

4.1.6 *Postnatal Visits*

Enormous improvements were reported for the proportion of postnatal visits attended by participants. At baseline just 1% of participants had gone or would go to postnatal visits after birth. These figures had reversed by the endline survey with 98% of respondents preferring to attend postnatal visits an average of 3.8 times.



4.2 *Project Delivery Monitoring*

Alongside baseline-endline surveys , monthly monitoring and feedback sessions held with the GAs continual opportunity for the Project Team to answer questions, resolve issues and provide additional training. The presence of either Gerard, the Project Coordinator, or Jeanella, the Senior Community Liaison Officer, at all focus group sessions also ensured consistent monitoring of GA's performance. In light of this, refresher training in the facilitation approach was provided to a number of GAs to ensure focus group sessions were run in an open and participatory manner.

Votsira seeks to preserve the wellbeing of both mother and baby

5. Conclusion

Progress made during the first year has continued in the latest (and penultimate) round of the HPBPC. A new group of beneficiaries were identified by GAs, with over 400 participants receiving essential health information via focus group sessions and/or household visits. By equipping women and other primary caregivers with the knowledge to safeguard the health of both the mother and her child, Votsira supports beneficiaries to make informed choices and enact positive behavioural changes during pregnancy, birth and the post-natal period.

Baseline-endline surveys showed significant and promising improvements in participants' understanding of course topics and corresponding health behaviours. Notable improvements were displayed in birth location choices, breastfeeding and postnatal visits providing evidence that beneficiaries are successfully implementing newly-acquired knowledge into practice.

As Module I enters its final round, SEED is seeking funding for Module II, which forms the next part of the organisation's maternal and child health strategy. Launching in July 2017, Module II will focus on the implementation of a Child Health Course [CHC], following a similar structure to VP3MI via focus groups and household visits. Despite child mortality rates having significantly reduced in recent decades, 100 Malagasy children still die every day from common and preventable diseases (USAID, 2014). The tragedy of these diseases, however, lies not only in the preventable deaths they cause, but also in their capacity to weaken children, reducing their quality of life and their ability to attend school. Covering the causes, symptoms and treatment of common childhood illnesses [CCIs] – including acute respiratory infections, malaria and diarrhoea – alongside issues of hygiene and nutrition, Module II will directly target 4,800 under-fives significantly reducing the incidence and impacts of CCIs in Fort Dauphin.

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