

seed **madagascar**

sustainable environment, education & development

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



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**SEED Madagascar**

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## 1. Introduction

The Millennium Development Goals made significant progress in improving maternal health worldwide, with the global maternal mortality ratio (MMR) almost halving between 1990 – 2015. However, huge disparities still remain; in 2015, the MMR was almost 14 times higher in developing versus developed regions (United Nations, 2015), whilst in Madagascar, the MMR stood at 353 deaths per 100,000 live births. With nearly 80% of the population living below the international poverty line of \$1.95 a day (World Bank, 2012), poor health outcomes in Madagascar are attributable to a combination of factors, including low government investment, insufficient access to quality health services as well as a reliance on traditional and informal healthcare (Barmania, 2015). Crucially, most of these deaths are largely preventable, representing a significant, yet often missed, opportunity to support proven and cost-effective health interventions, including skilled delivery, antenatal and postnatal care. While Sustainable Development Goal 3 has set an ambitious target of reducing the global MMR to less than 70 deaths per 100,000 live births by 2030, a long road lies ahead if Madagascar is to play any part in contributing to the projected reduction.

In the remote southeast Anosy region, a lack of birth spacing, poor nutrition and untreated STIs significantly increase the risk of maternal death (Morris *et al.*, 2014). Nearly half (44%) of girls have a child or are pregnant by the age of 19 and 28% of births occur within less than 24 months of each other (Robson *et al.*, 2015). In the urban centre of Fort Dauphin, a lack of quality health services compounds an already widespread reliance on traditional health practices and providers. Previous Votsira research (2014) found that over 90% of respondents had engaged in the risky practice of post-partum confinement, whilst nearly one in three mothers reported delivering at home without a skilled birth attendant. With insufficient formal healthcare services and infrastructure, community-level education and behavioural change interventions are particularly well suited to improving the town's poor maternal health outcomes.

Launched in July 2015, Votsira Phase 3 Module I (VP3MI) was a two-year health education project, designed to foster positive behaviour changes among mothers during the pregnancy, birth and postpartum periods. In Project Year 1 (PY1), SEED Madagascar trained local government health agents (GAs) to deliver a specially-developed Healthy Pregnancy and Birth Preparedness Course (HPBPC). Disseminating information across 11 communities in Fort Dauphin, PY1 ran two rounds of the HPBPC through a series of focus groups, individual household visits and antenatal sessions. Year 2 has successfully delivered an additional two course rounds alongside on-going capacity building of GAs through top-up training and monthly review sessions. This report reviews the results of the final round (January – June 2017) and reflects on the overall achievements, challenges and learnings from VP3MI. Ultimately, having equipped over 700 mothers and their families with the information necessary to safeguard both maternal and newborn health, VP3MI has supported significant and consistent improvements in knowledge, attitudes and practices across all four course rounds.

## 2. Project Activities

### 2.1 Project design and rationale

Since 2013, Votsira has run three complementary phases, designed to understand and tackle the barriers to improving maternal and child health in Fort Dauphin. Phase I, a year-long research project, explored common practices, beliefs and traditions during pregnancy, delivery and postpartum periods. Having identified low levels of health knowledge among local women of reproductive age, Phase II piloted an education course delivering information covering reproductive, sexual and child health to 220 beneficiaries. The current phase (i.e. Phase 3) refined the course content into two separate modules: Module I (2015 - 2017) for new and expectant mothers, and Module II (2017 -2019) for families with children under-five.

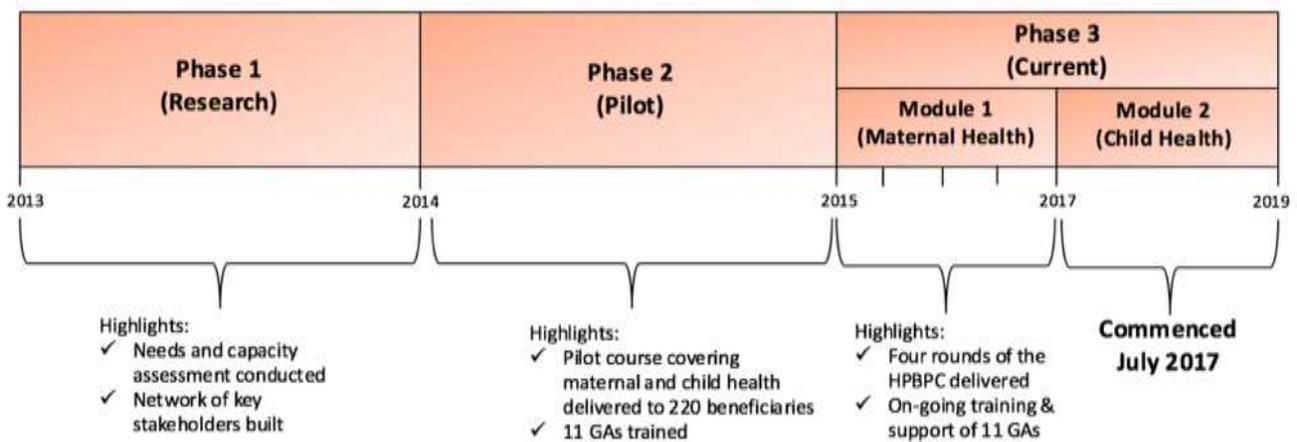


Figure 1: Project Votsira Timeline (2013 – ongoing)

Through four rounds of the HPBC, Module I focused on the dissemination of family planning, and maternal and sexual health information. Informed by previous Votsira phases and international best practice, the course covered eight topics crucial for improving the health of both mothers and their newborns. These included: antenatal visits, breastfeeding, HIV and sexually transmitted diseases, contraception, birth complications, sanitation, birth preparedness and vaccinations. Critical to both the approach and delivery of Module I has been an understanding that interventions should be designed with a strong awareness of the local context. *Table 1* highlights how SEED’s research as well as ongoing evaluation throughout the three phases have informed the content, structure and approach of VP3MI.

**Table 1: Votsira project rationale**

<b>Previous Votsira Research and Evaluation Findings</b>	<b>Response of VP3MI (Structure, content &amp; approach)</b>
Almost 50% of adults in the Anosy region demonstrated a lack of knowledge about STIs (Robson <i>et al.</i> , 2015)	The HPBPC covered information on the symptoms and prevention methods of various STIs, including syphilis, gonorrhoea and HIV/AIDs
Women have limited access to formal health services in Fort Dauphin (Morris <i>et al.</i> , 2014)	VP3MI partnered with 11 government health agents who were trained to deliver the HPBPC through focus groups and household visits within the community
Little counselling is provided during antenatal visits at public health clinics in Fort Dauphin (Morris <i>et al.</i> , 2014)	GAs received training to improve the quality of counselling and recommendations provided to women during antenatal visits
Community elders, particularly women, have a strong influence in family's healthcare decisions (Morris <i>et al.</i> , 2014)	Female elders were included in focus group sessions
Votsira Phase 2 highlighted the strengths of participatory approaches for maximizing beneficiary engagement	Across all rounds, participants in each <i>fokontany</i> chose the order in which course topics were delivered
Almost 50% of adults in the Anosy region demonstrated a lack of knowledge about STIs (Robson <i>et al.</i> , 2015)	The HPBPC covered information on the symptoms and prevention methods of various STIs, including syphilis, gonorrhoea and HIV/AIDs

## 2.2 Government Health Agent support and training

Recognising the value of community-led interventions, the latest phase of Votsira has continued to work alongside 11 GAs, building their capacity to deliver comprehensive and accurate health information. Well-established and respected within the communities which they serve, GAs were best placed to identify families most in need of assistance, whilst also providing the targeted support required to address the most pressing health challenges in their *fokontany* (suburbs).

At the start of VP3MI, SEED's Health team delivered a six-day intensive training course equipping GAs with both the knowledge and skills to independently deliver the HPBPC. Top-up training in PY2 alongside monthly review sessions provided ongoing opportunities to refresh GAs' knowledge of course content as well as continue developing their skills in facilitation and participatory approaches. Attendance of Votsira's Project Coordinator or Community Liaison Officer at focus groups and household visits further supported GAs in their information-giving responsibilities, whilst allowing the quality of the HPBPC delivery to

be monitored across all four rounds. Consequently, emerging issues were promptly addressed, which included replacing two GAs in PY1 as well as providing one-to-one support to GAs at monthly review meetings.



*Left: Votsira’s Project Coordinator (second from right) & CLO (first left) alongside nine GAs at a monthly review meeting; Right: All GAs met individually with Votsira’s Project Coordinator to discuss course outcomes, progress and challenges in their respective fokontany*

### 2.3 Activity Summary

From January – June 2017, VP3MI delivered the fourth (and final) round of the HPBPC across each of Fort Dauphin’s 11 *fokontany*. This included:

- 88 focus group sessions; two held per month in each *fokontany*
- A total of 352 household visits delivering information and one-to-one support to 88 pregnant women (eight women per *fokontany*)
- GA attendance at 66 antenatal sessions at two public clinics aimed at improving the quality of antenatal counselling provided to expectant mothers in Fort Dauphin

A training course developed & delivered to 11 GAs (PY1)	Four rounds of the HPBPC delivered (PY1 + PY2)			2-day antenatal protocol development workshop delivered to local health professionals (PY1)
GA top-up training (PY2)	<b>352</b> focus groups	<b>1408</b> household visits	<b>265</b> antenatal sessions	2 blood pressure monitors, 2 weighing scales & 2 thermometers distributed to 2 public clinics in Fort Dauphin (PY2)
16 GA review sessions (PY1 + PY2)				

*Figure 2: VP3MI outputs (2015 – 2017)*

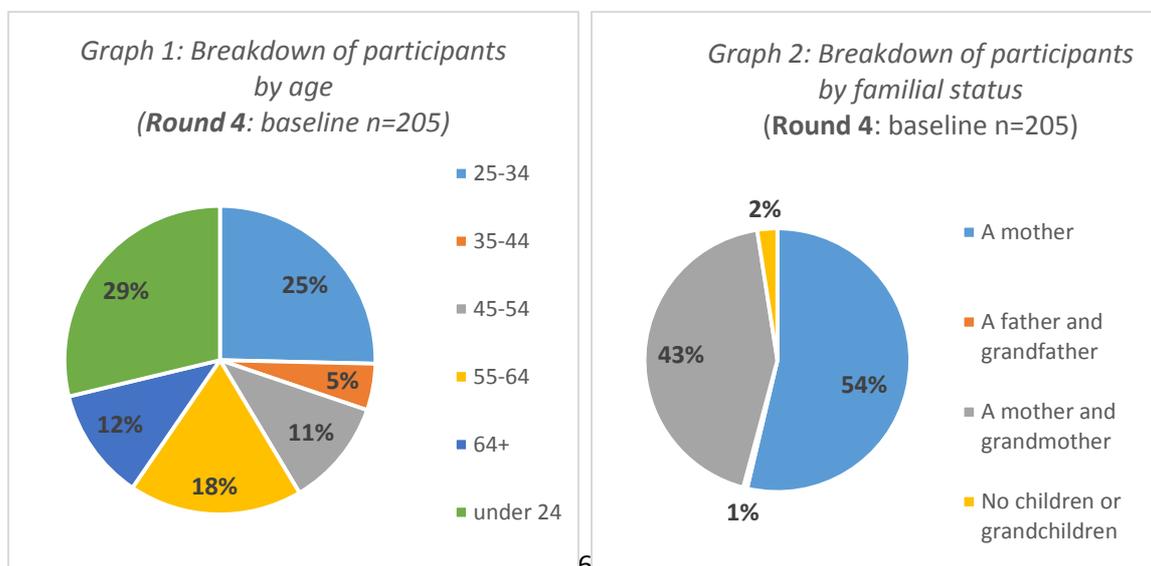
### 3. Monitoring & Evaluation

Over two years, VP3MI has run four rounds of the HPBPC; this section will analyse the results of the **final round** (i.e. **Round 4: January – June 2017**), as well as identify key achievements and challenges across **all course rounds**. All results were collected through individual baseline and endline surveys. These were conducted with focus group participants one month prior to, and following, delivery of each HPBPC. Most survey items tested participants' knowledge of course topics. However, where possible, some questions also attempted to gauge potential changes in behaviour including breastfeeding practices as well as self-reported attendance at antenatal and postnatal visits. 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. Please note that the survey was adapted following the **Round 1** baseline to account for a larger selection of indicators related to maternal and child health. This explains why *Graphs 4, 7, 8 and 11* only present results from **Rounds 2–4**, given that no baseline-endline data comparison can be made for **Round 1**.

#### 4.1 Participant demographics

The **final round** ran 88 focus groups (22 every month), with an average attendance of 18 participants per session. Over half of these participants were pregnant women, of which 88 also received individual household visits. The remainder of participants were accounted for by mothers or elders, with the latter playing a key role in disseminating health information within communities as well as influencing decisions around sexual and reproductive health practices at the household level.

*Graph 1* and *2* shows the breakdown of **Round 4** participants by age and familial status at baseline. Over half of the participants were under 34. Almost all (99%) were female, mostly either mothers and/or grandmothers. Only one male (an elder) participated in focus group sessions. The majority of participants had low levels of education; one-third had not completed primary school and less than 10% had achieved a middle or high school qualification.

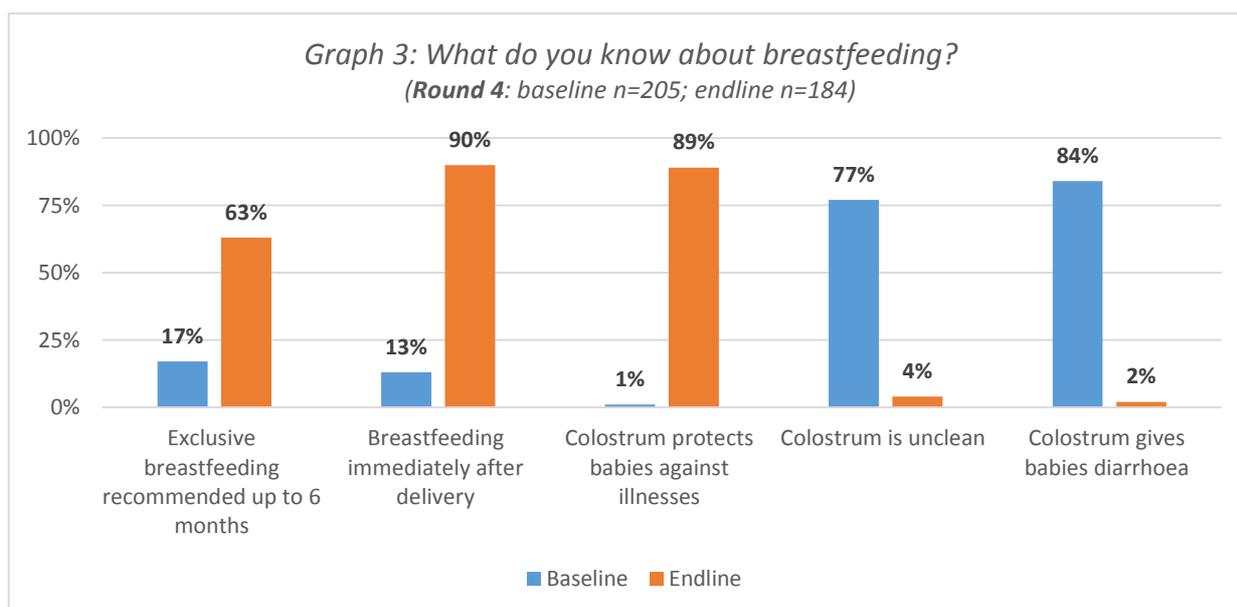


## 4.2 Baseline and Endline survey results: Reflection on final round & across the project

### 4.2.1 Breastfeeding

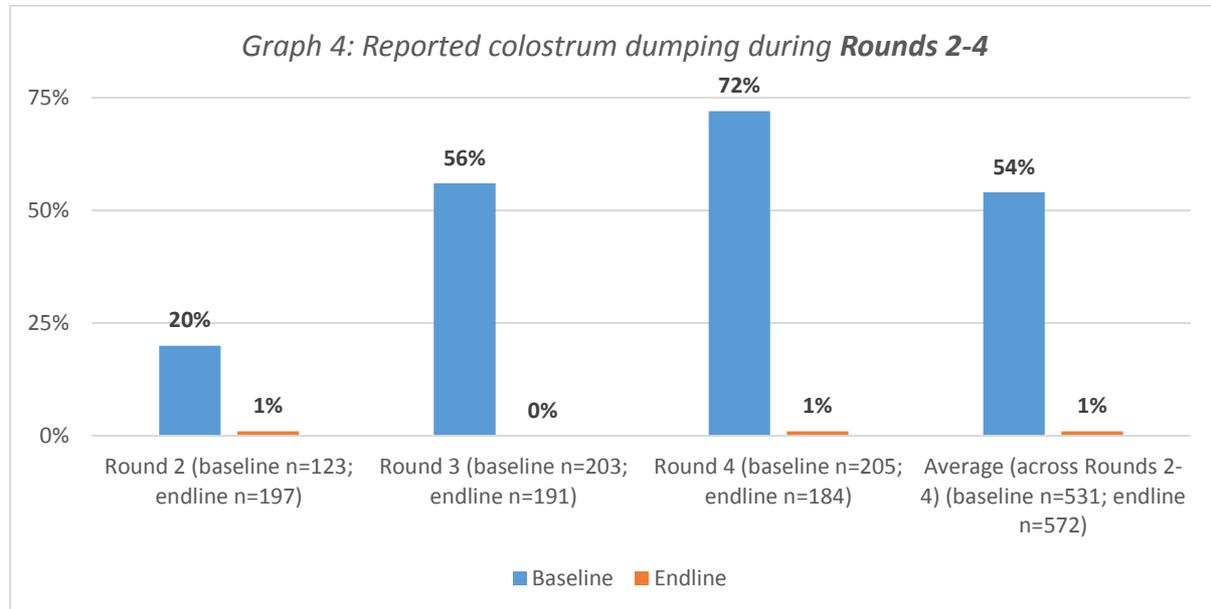
*An exclusively breastfed infant is 14 times less likely to die in the first six months of life than a non-breastfed child*

The World Health Organisation (2017) recommends breastfeeding as an essential practice for the healthy growth and development of infants – particularly in low-income countries where people may not have access to high-quality formula. WHO guidelines include the timely initiation of breastfeeding (i.e. within the first hour of life) and exclusive breastfeeding (i.e. breast milk without any additional food or drink) up to six months of age. Participants in the **final round** of the HPBPC showed significant improvements in their understanding of the importance and duration of optimal breastfeeding practices, as shown in *Graph 3*. Promising improvements were also exhibited in participants' understanding of breastfeeding as a form of birth control. At endline, 62% of participants recognised breastfeeding as a natural contraceptive, compared to only 1% of participants at baseline. This is particularly important for contributing to the overall health and wellbeing of mothers through improved spacing of children.



Colostrum is the highly nutritious milk produced during pregnancy and into the early days of breastfeeding. Colostrum dumping is a common practice in Fort Dauphin, with the potential to impact negatively on the health of the newborn as well as delay uterine contraction in the mother. There were significant achievements during **Rounds 2–4** in reducing this harmful practice. At baseline, over half of all participants reported that they would (or would recommend their relative) to dump colostrum. This decreased to 1% (n=8) at endline, corresponding to an outstanding 99% (n=569) of participants who, after the delivery of the HPBPC, reported that they would give colostrum to their baby when first breastfeeding. A

breakdown of the reduction in reported colostrum dumping for each round is shown in *Graph 4*. Consistent with results across the previous rounds, the **final round** has also successfully challenged and changed common misconceptions around colostrum including beliefs that colostrum is unclean, causes diarrhoea and does not protect the baby from illnesses, as shown in *Graph 3*.



*At endline, colostrum dumping had been **nearly eliminated**, with **99%** of women reporting that they would give colostrum to their baby (Rounds 2-4)*

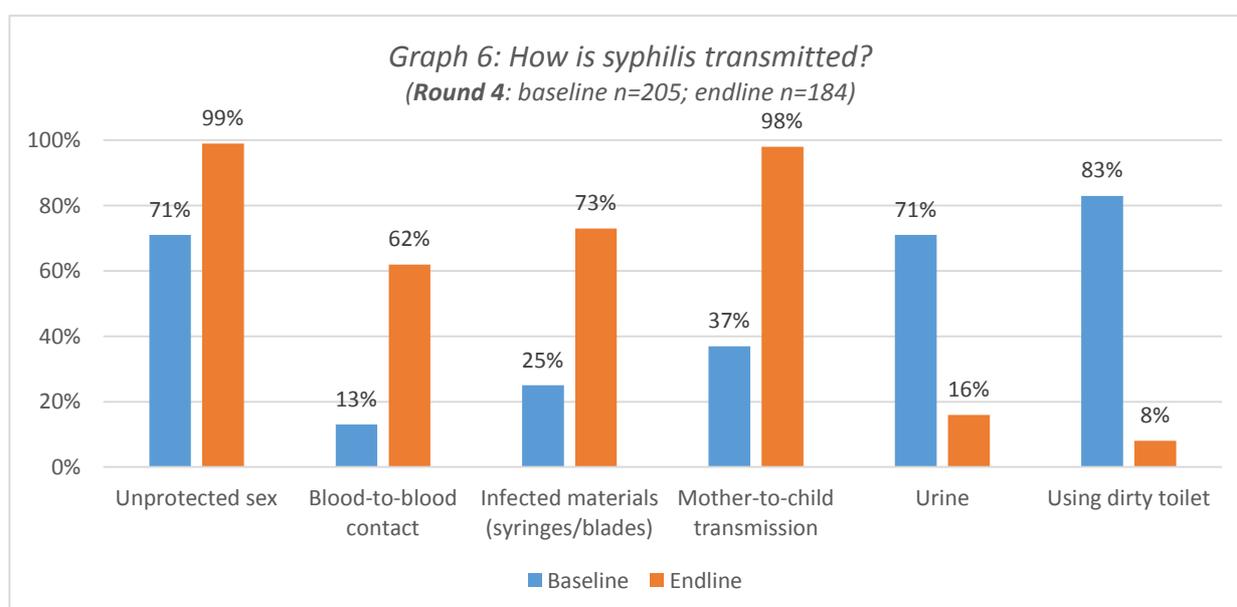
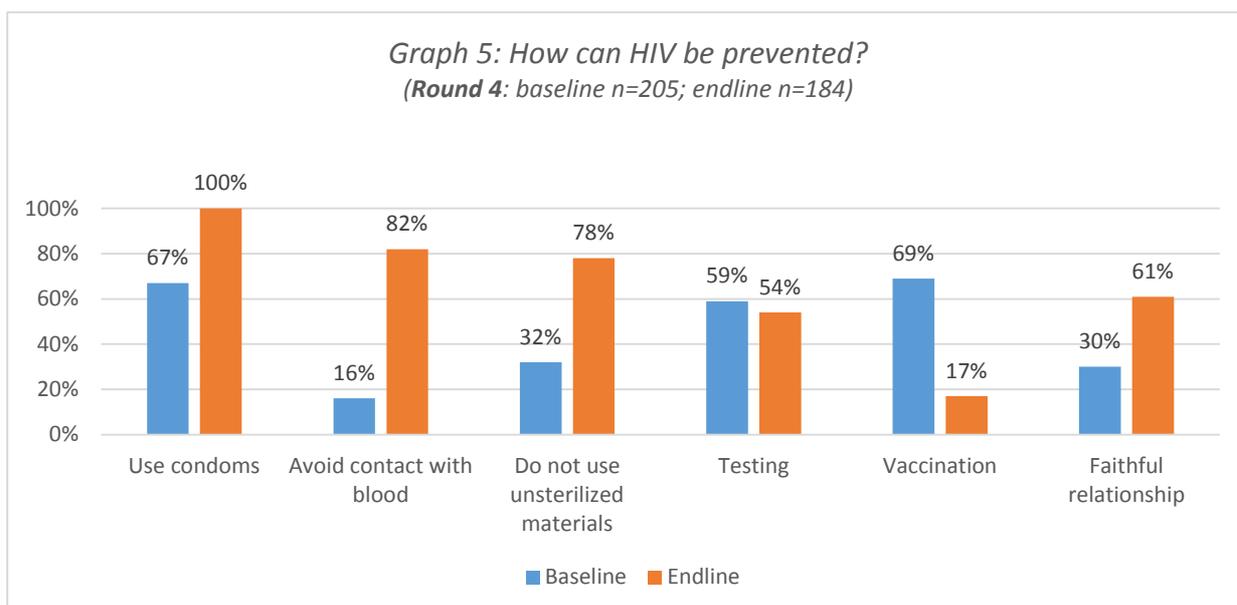


*Participants at a focus group session on breastfeeding in fokontany Bazaribe*

#### 4.2.2 Sexually Transmitted Infections (STIs), HIV & Syphilis

*STIs are a **significant** public health burden in developing countries and have an **adverse impact** on reproductive & child health outcomes*

Compared to **Round 3** (July – December 2016), participants in the **final round** had a lower understanding of HIV and syphilis at baseline, including knowledge of disease transmission and prevention. Only 18% of baseline participants identified blood-to-blood contact as a method of HIV transmission, whilst 74% of participants believed syphilis could be prevented through vaccination. **Round 4** participants showed significant improvements in their understanding of STI transmission and prevention by endline, as shown in *Graph 5* and *6*.



The Year 1 report discussed the discord between knowledge and practice, particularly for STIs. As such, baseline-endline surveys during **Round 1 and 2** found that despite significant improvements in participants' *understanding* of how to prevent HIV and syphilis, this did not always transfer into risk mitigation behaviours such as increased contraceptive use. For example, at endline, 100% of Year 1 participants identified condom use as a method of HIV prevention, yet only 47% reported that they had ever used (or were currently using) contraception. Following a review of the HIV and contraception topics at the start of Year 2, encouraging improvements can be identified, with 65% of participants across **Rounds 3 and 4** reporting contraceptive use by endline, compared to 14% at baseline.

The most significant indication of participants successfully converting their knowledge into positive behaviour change was reflected in the uptake of STI testing. In **Round 4**, 96% of endline participants reported that they had taken an HIV and syphilis test during their current (or previous) pregnancy, compared to a respective 56% and 54% at baseline. These results were generally consistent with the previous rounds, with a respective 83% (and 94%) of participants across **Rounds 1–3** reporting that they had taken an HIV (and syphilis) test by endline.

*At endline, nearly **double** the number of women had been tested for HIV and syphilis (Round 4)*

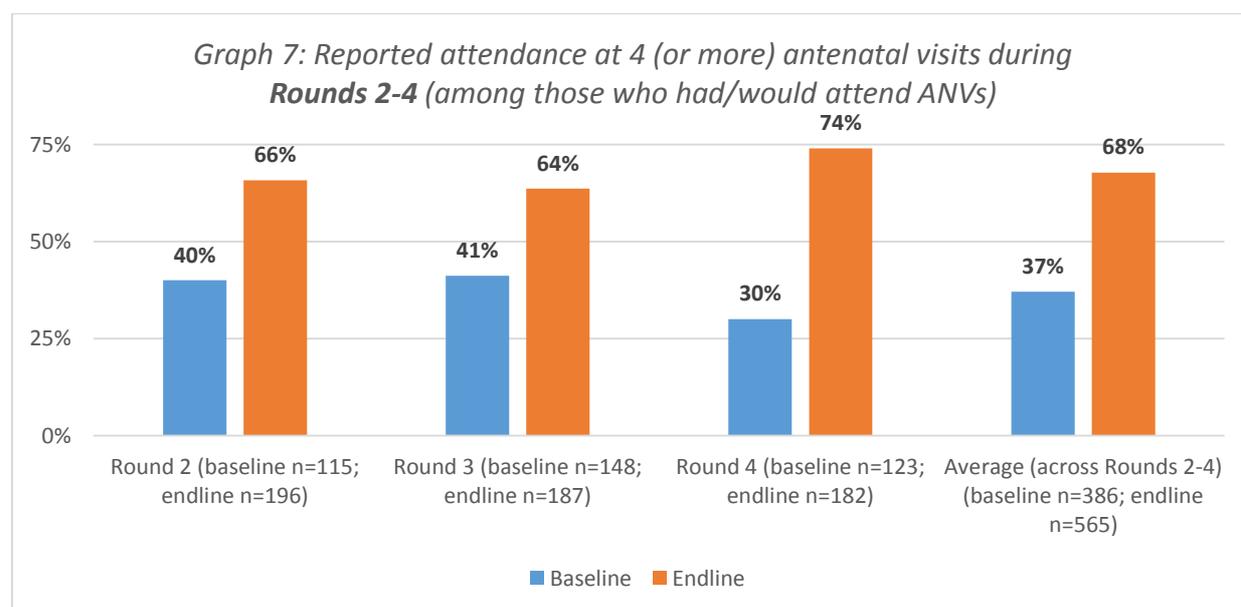


*GA Ellah (fokontany Ampamakiambato) following the successful delivery of an antenatal session covering the importance of STI testing during pregnancy*

### 4.2.3 Antenatal visits

#### *Antenatal care is a **critical opportunity** to deliver care, support and information to pregnant women*

Antenatal care promotes a healthy pregnancy for both a mother and her child by providing support and information around nutrition, labour, delivery and newborn care. While 61% of baseline participants in the **final round** reported that they had or would attend antenatal visits, only 30% of these respondents would have attended the recommended four or more visits. More than half of women would also wait until after the fourth month of pregnancy before her first visit. Significant improvements were seen in both the number and frequency of antenatal visits following delivery of the **final HPBPC**. At endline, 74% of participants reported that they had attended four or more visits, whilst 86% of participants reported that they had attended an antenatal visit before four months of pregnancy. These results were generally consistent across **Rounds 2–4**, as shown in *Graph 7*. Crucially, among all course participants at endline who reported that they had *not* (or would *not*) attend antenatal visits, no participants reported that that this was due to a lack of knowledge. The most common reasons for non-attendance included “no hospital” and “distance from hospital”.



Nearly **twice** as many women opted to attend **at least four** antenatal visits by the end of the module (Rounds 2-4)



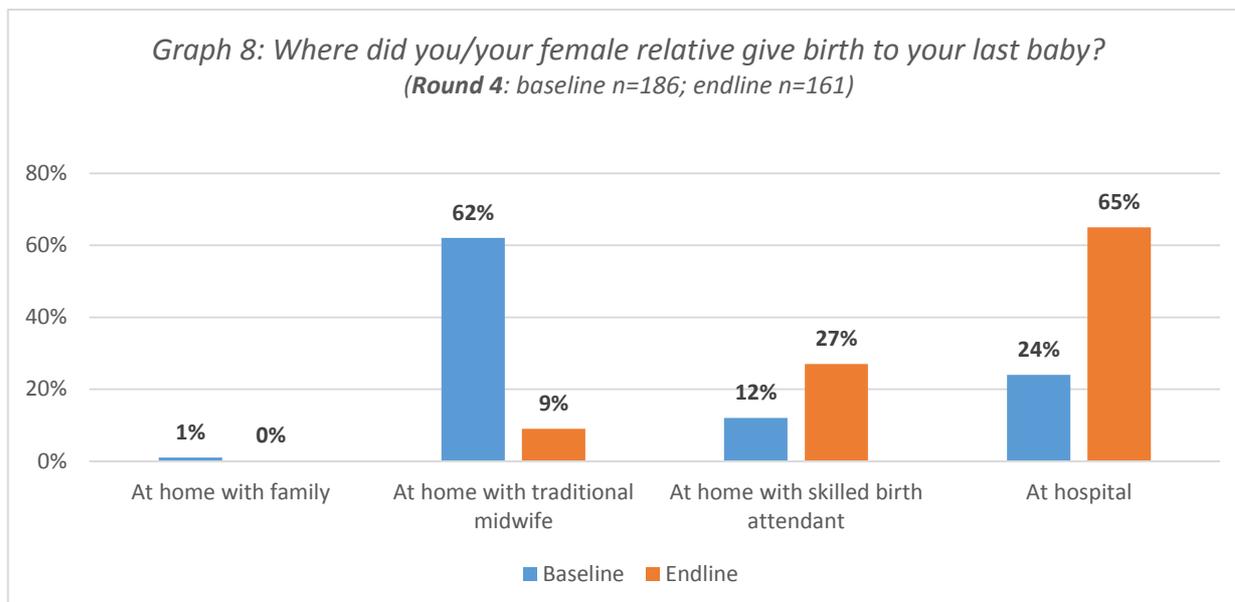
Left: expectant mothers attend an antenatal session at one of the two public clinics in Fort Dauphin; Right: A beneficiary receives her fourth household visit discussing her concerns in choosing a facility delivery for her next birth.

#### 4.2.4 Birth location choices

##### Skilled care at birth reduces the risk of maternal and neonatal mortality

Previous Votsira research (Morris *et al.*, 2014) highlighted the prevalence of traditional care practices during the pregnancy, delivery and postpartum periods, including the use of traditional midwives for home delivery. These findings were mirrored in the **fourth round**, with 62% of baseline participants reporting that they gave birth at home with a traditional midwife during their previous pregnancy. This figure was much higher than the previous two rounds, with a respective 41% and 22% of baseline participants in **Rounds 2 and 3** reporting use of a traditional midwife when they last gave birth.

Multiple studies (Lucey *et al.*, 2011; Marchie, 2012; Morris *et al.*, 2014) have discussed the ways in which traditional care practices can negatively impact both maternal and newborn health, including through unsafe/unclean delivery, pushing on the abdomen to speed labour, and negative implications of postpartum confinement practices such as not bathing. The **fourth round** showed an encouraging change in participants' birth location choices, with only 9% of participants reporting that they would opt to use a traditional midwife by endline. The remaining 91% preferred to give birth either at hospital or at home with a skilled birth attendant (SBA), as shown in *Graph 8*. Similar results were found in the previous rounds, with only 15%, 4%, and 8% of participants in **Rounds 1, 2, and 3**, respectively, reporting a preference for traditional midwives by endline.

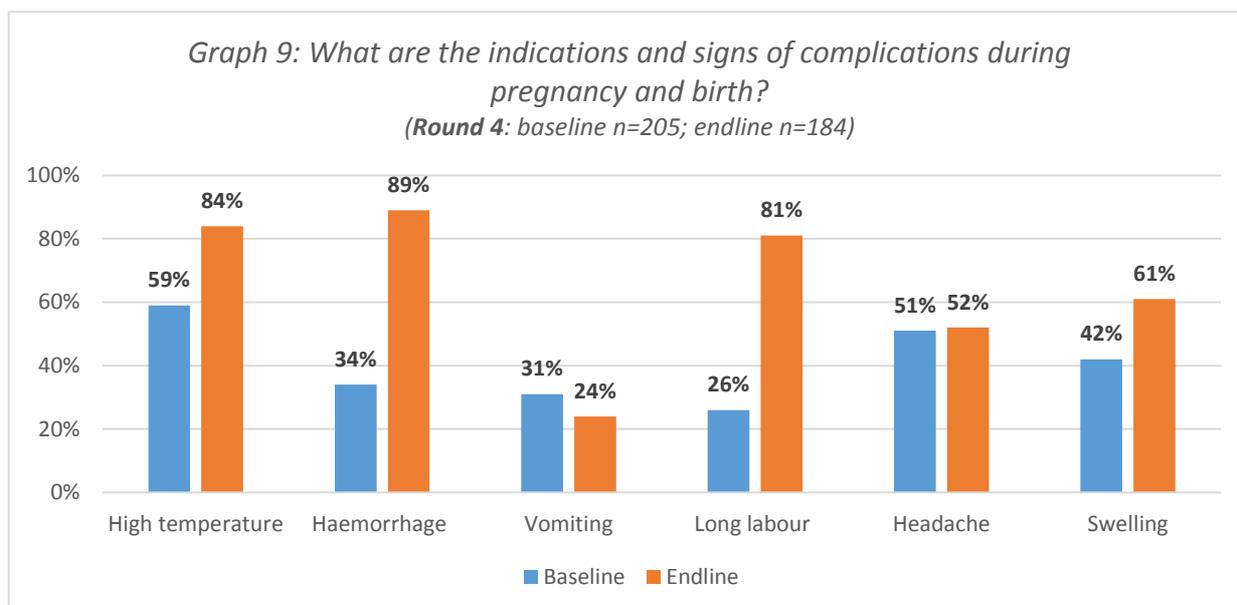


By endline, the **vast majority** of participants had changed their birth preference from traditional midwife to SBA or hospital delivery (Round 4)

#### 4.2.5 Birth complications

In 2015, approximately 303,000 women worldwide died from pregnancy or childbirth-related complications, most which were **preventable or treatable**

An ability to recognise complications during pregnancy and birth has been associated with reduced delays in seeking care as well as an increased likelihood of facility deliveries; factors both linked to improved maternal health worldwide (Hailu *et al.*, 2011; Nikiema *et al.*, 2009). Compared to the previous round (**Round 3**: July – December 2016), participants were less able to identify key signs of birth complications at baseline, with only one third of participants recognising haemorrhaging and long labour as indications of complications. By endline, however, **Round 4** participants showed a much better understanding of complications during pregnancy and childbirth, with five (of the six) common signs showing higher rates of recognition, as indicated in *Graph 9*. Interestingly, there were variations **across the four rounds** in the rates of recognition of some signs. In the **final round**, 52% of endline participants identified headache as a warning sign, compared to 48%, 69% and 86% in **Round 1, 2 and 3**, respectively. Despite this, all rounds showed improvements from baseline in participants' understanding of most birth complications, particularly haemorrhaging, with 99% of participants (n=600) in **Rounds 1, 2 and 3** being able to identify this critical warning sign by endline.



As discussed in *Section 4.2.4*, the latest round showed encouraging improvements in the number of participants opting to use skilled care (i.e. skilled birth attendant or health facility) at birth. Similar baseline-endline improvements were also found in participants' preference for the type of care (skilled vs. traditional) that they would consult to manage complications during pregnancy and birth. At baseline, a concerning 60% of **Round 4** participants reported that they would opt to visit a traditional midwife if they experienced complications during pregnancy. This decreased to 8% at endline; a result consistent across the **previous 3 rounds** (n=604) with only eight participants opting for a traditional midwife after delivery of each HPBPC.

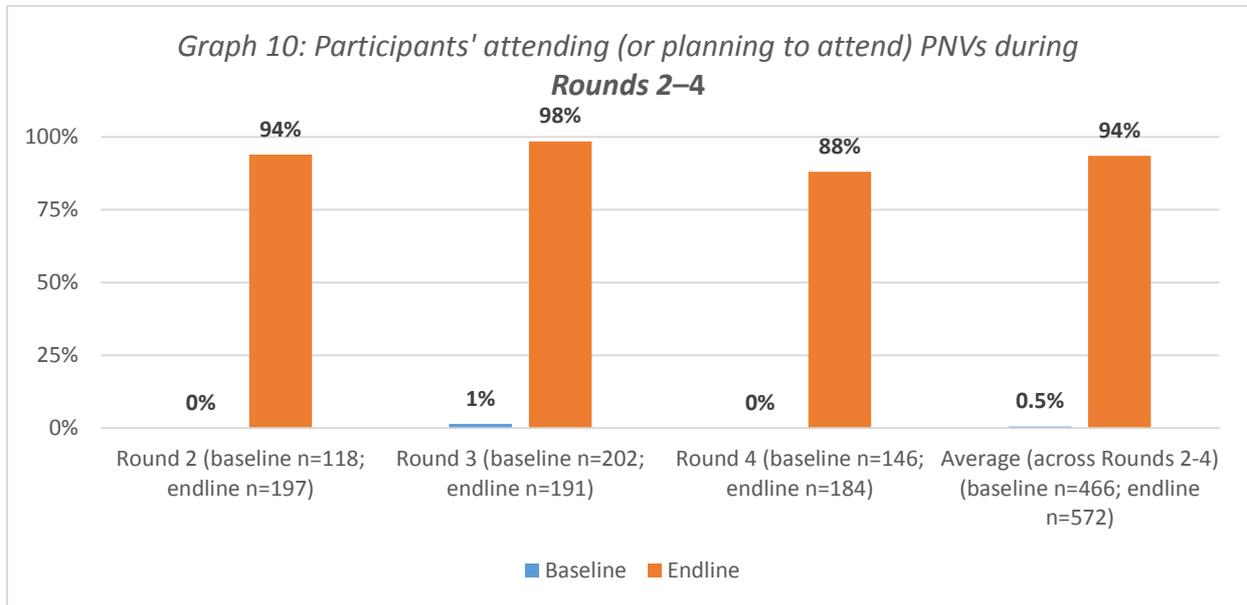
By the end of the project, **764** participants identified haemorrhaging as a sign of pregnancy-related complications (Rounds 1-4)

#### 4.2.6 Postnatal visits

##### Most maternal and child deaths occur during the postnatal period

Postnatal care provides a critical opportunity for health workers to examine both mothers and newborns for potential complications following birth, while affording time to provide guidance on basic newborn care in the first six weeks of life (WHO, 2017). In the **final round**, no baseline participants reported either attending (or planning to attend) postnatal visits [PNVs] after birth. There were huge improvements in the proportion of participants reporting a preference for PNVs by endline, with 88% attending (or planning to attend) PNVs. Crucially, these participants also showed an understanding of optimal timing and frequency of PNVs, with 98% having attended (or planning to attend) their first PNV within six hours of birth, and 83% having attended (or planning to attend) a total of three or more PNVs. *Graph 10* highlights the consistent improvements across **Rounds 2–4** in participants' understanding of the importance of PNVs, with a total of 94% opting to attend PNVs by

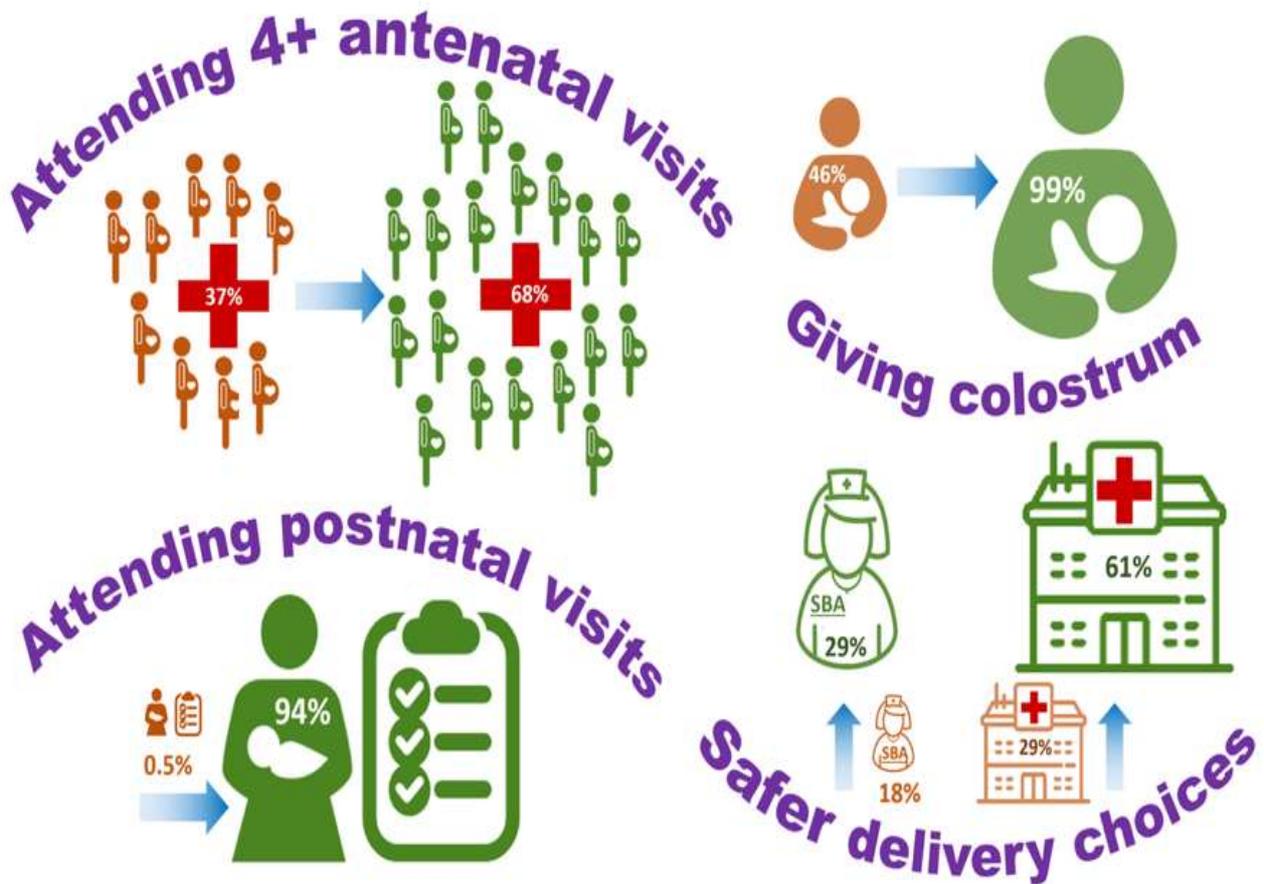
endline, compared to 0.5% at baseline. With most maternal and infant deaths worldwide occurring in the first month after birth, and almost half of these within the first 24 hours, these results are particularly significant for addressing a critical period of survival for both mothers and newborns (WHO, 2015).



**By endline, 94% of participants understood the importance of postnatal visits (Rounds 2-4)**

**Summary:**

Across two years, VP3MI had a significant impact on women's access to information and understanding of how to prepare for a healthy pregnancy and birth. Results from baseline-endline surveys across the four rounds show that knowledge has increased and traditional beliefs have been successfully challenged, supporting over 700 women and their families to make more informed choices during the pregnancy, labour and postnatal period.



# Improved Maternal Outcomes

## 4. Votsira Case Studies

Whilst results from the baseline-endline surveys highlight the achievements of VP3MI in numbers, qualitative insights are also critical for gauging the impact on those at the heart of project delivery. Votsira's Coordinator, Gerard, sat down with two GAs and three course participants to understand their experiences during the final round.

**GAs: Myriam** (*fokontany* Ambinanikely) & **Mirella** (*fokontany* Esokaka)



*Votsira aimed to deliver reproductive and sexual health information through focus groups, individual household visits and attendance at antenatal sessions. Do you feel that participants have been receptive to the education course and willing to improve their health behaviours and practices?*

**Myriam:** Yes. As an example, before the project started, many mothers gave water, tea and herbs to their baby. There was a general consensus that breastfeeding alone was insufficient for newborns. After I delivered the breastfeeding topic, this changed. I have seen many participants switch to practising exclusive breastfeeding as they now know that breastmilk contains everything their baby needs.

**Mirella:** I have seen similar behaviour changes in my *fokontany*. Another example is an increase in the number of mothers who have chosen to vaccinate their newborns following the HPBPC.

*Have there been any topics that participants have been particularly interested in?*

**Mirella:** The two most popular topics have been breastfeeding and HIV/STIs. There have been significant improvements in knowledge of colostrum. I have also had many participants tell me that this is the first time that they learnt STIs can be transmitted from mother to child.



*What do you feel has been the biggest success of Project Votsira?*

**Myriam:** I think the biggest success is the behaviour change amongst course participants. They have moved away from traditional practices that can be detrimental to maternal and child health such as giving birth with a traditional midwife. They have also transmitted their new knowledge to friends and family.

**Beneficiaries:** **Bernardine** (focus group attendee, pregnant mother), **Sofie** (focus group attendee, elder) & **Hanitra** (recipient of household visits, pregnant mother)

*In what ways do you feel focus groups have been useful for you?*



**Bernardine:** Focus group sessions have helped me prepare for the birth of my child as I have gained new knowledge through the different topics, which we have discussed. This has included the importance of antenatal visits, vaccinations and giving birth in hospital. I now feel at an advantage because I can also share what I have learnt with my friends and family.

**Sofie:** I chose to attend focus groups so that I can provide advice to my daughter who is pregnant. The sessions have been useful as I gained knowledge about both maternal and child health. This included the signs of complication during pregnancy and birth, postnatal care and vaccinations.

*In what ways do you feel you have benefitted from one-to-one assistance from the GA?*

**Hanitra:** Household visits have reinforced the information that I have received at focus group sessions. I have also been able to talk about my concerns and clarify my understanding of the topics discussed. I now know that I should attend my first antenatal visit within three months of pregnancy followed by STI testing in the hospital.

*“I would like to thank Project Votsira.  
We have changed our behaviour through you.” (Participant 2)*

## 5. Learning

Ongoing monitoring and evaluation – including baseline-endline surveys, GA feedback sessions and SEED staff meetings – have been crucial for reviewing both the achievements and challenges of VP3MI. *Table 2* provides a snapshot of key project learning, which has informed the next module of Votsira.

**Table 2: Key project learning**

<b>Achievements and Challenges (VP3MI)</b>	<b>Learning for VP3MII (Child Health) (2017 – 2019)</b>
Two GAs replaced for low motivation and poor facilitation of focus groups	Investigate feasibility of GA performance appraisals to reinforce motivation; continue GA review sessions to address emerging issues and provide top-up training
Participants successfully engaged with GAs during household visits	Significant increase in the number of household visits to be delivered (2,376 visits over 2 years)
MEL indicators were weighted towards knowledge uptake	Improve capturing of behaviour change to better assess whether participants are putting course knowledge into practice
Baseline-endline surveys were self-reported	Reduce potential for participant bias through triangulation including investigating feasibility of using health facility data and/or household observations
No assessment of participants' long-term knowledge retention (i.e. endline surveys conducted immediately after each course round)	Improve follow-up of participants; dissemination of information, education and communication (IEC) materials to increase chances of knowledge retention

## 6. Conclusion

Research in earlier Votsira phases highlighted how a lack of reliable and accurate health information hampers women's chances of achieving a healthy pregnancy and birth. The third phase of Votsira sought to address this gap utilising a community-based approach to improve knowledge of a range of issues pertinent to safeguarding the health of both mothers and children.

Through a series of focus groups, household visits and antenatal sessions, VP3MI has equipped over 700 women and families with the tools to make healthier choices for themselves and their newborn. The final round successfully built on the progress made in previous rounds, providing much needed access to essential knowledge on sexual, reproductive, maternal and child health.

Each round showed encouraging and often significant changes in women's knowledge, attitudes and practices across the pregnancy, delivery and postnatal periods. Consistent improvements were displayed in breastfeeding, birth location choices and postnatal visits, providing evidence that beneficiaries were successfully implementing newly-acquired knowledge into practice. For example, whilst 54% of women said they would dump colostrum at baseline, only 1% would continue this harmful practice at endline. There was also a huge shift in participants' understanding of postnatal care, with less than 1% recognising their value at baseline to over 90% attending or planning to attend by the end of the module.

Healthy pregnancies help ensure that children born into difficult conditions are better equipped to deal with the social and environmental challenges they subsequently face. Children in Fort Dauphin face a perilous first few years of life. For every 1,000 children born in Madagascar, around 50 will die before reaching their fifth birthday – a figure in stark contrast to the UK's under-five mortality rate of 4 per 1,000 live births (World Bank, 2015).

VP3MI has shown the willingness of mothers to adapt their behaviour in order to support the healthy development of their child. Building on this success, Module II (July 2017 – June 2019) will implement a Child Health Course (CHC) across 15 communities in Fort Dauphin. Three common childhood illnesses (CCIs) – acute respiratory infections, diarrhoeal disease and malaria – are not only responsible for the majority of under-five deaths but also weaken the capacity of affected children, making them more vulnerable to future infections and reducing their quality of life. Following a similar model to VP3MI, Module II will use focus groups and household visits to impart crucial knowledge around the causes, symptoms and management of CCIs, alongside issues of hygiene and nutrition. Directly targeting caregivers of 4,800 under-fives, the next module aims to empower families to make healthier and safer choices for their children, significantly reducing the incidence and impact of CCIs in Fort Dauphin.

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