MCSP Mozambique Program Brief
Community Health

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Goal

In Mozambique, USAID's flagship Maternal and Child Survival Program (MCSP) contributed to preventing maternal, newborn, and child deaths through its integrated, family-centered approach in two of Mozambique's 11 provinces, Nampula and Sofala. MCSP promotes the institutionalization of community health as a central component of the country's health system in alignment with the Ministry of Health (MOH)'s National Health Promotion Strategy 2015-2019/20.

Raimundo Pires, a community health worker, conducts a health education session and cooking demonstration in Muecate district, Nampula. Photo: Fernando Fidelis/MCSP.

Approaches

MCSP Mozambique strengthened the capacity of and linkages among community health platforms and health services by engaging community members to promote improved family health practices and increase demand for and access to quality health services. To strengthen community health, MCSP worked at the national level to provide inputs for the National Strategy for *Agentes Polivalentes Elementares*/elementary polyvalent agents (APEs, or community health workers [CHWs]), which aims to strengthen the Community Health Committee as an essential platform for coordination of community health cadres. MCSP also provided technical inputs to MOH technical working groups (TWGs) to develop community level tools for measuring achievement of disbursement linked indicator (DLI) quality targets included in the Government of Mozambique's Investment Case, supported by the Global Financing Facility (GFF). At the subnational level, MCSP engaged with different types of community health cadres: APEs, traditional birth attendants (TBAs), traditional healers, activists, and volunteers. APEs are MOH-recognized and trained CHWs that receive a subsidy and are linked to facility-based supervisors. TBAs and traditional healers are trusted in communities and provide health education sessions, identify potential danger signs, and refer people to health facilities for care. Activists and volunteers typically have received training in a vertical program (e.g., family planning [FP], nutrition) to raise awareness of key issues and refer community members to CHWs (APEs) or health facilities. MCSP took a strategic approach with these different types of community health cadres to support them in working together to ensure that community members are educated and effectively linked to health services.

Strengthened Community Health Workers and Groups

- **Strengthened CHCs and community health cadres to promote community health:** In collaboration with other projects, MCSP supported *Comités de Saúde*/Community Health Committees (CHCs),[1] community-based groups chosen or elected by the community to manage community health issues. MCSP supported CHCs to develop activities that encouraged people to adopt healthy

[1] CHCs represent the community, make decisions on health issues, promote community-to-facility linkages, conduct community mobilization activities based on Community Action Cycle action plan implementation, and set up community funds for CHC activities.

lifestyles, use mobile health (outreach) services, and follow the antenatal care (ANC) and reproductive, maternal, newborn, and child health (RMNCH) recommendations provided by health facilities (HFs). In the past, CHCs were made up of only four or five CHWs, activists and volunteers, so MCSP sensitized communities about the importance of revising this structure to ensure that CHCs had 15-20 active members, including traditional and formal leaders, key stakeholders, CHWs, activists, volunteers, and TBAs. MCSP trained community health cadres in the Community Action Cycle,[2] which focuses on developing group roles, responsibilities, norms, and leadership skills; mobilizing and managing resources; action planning; and coordinating with HF staff.

- **Reinforced Co-Management and Humanization Committees (CMHCs):**[3] MCSP supported CMHCs, which bring together community and facility representatives to improve patient care. MCSP mentored CHMC members in organizational skills, enabling them to restructure to align with nationally mandated roles and responsibilities. MCSP also trained and mentored CHMCs in implementing the partnership defined quality (PDQ) approach[4] supported by the MOH, which facilitated the development of joint facility-community action plans to address quality of care issues at the facility level. As part of the PDQ process, communities used a Health Service Quality Scorecard to identify issues in quality of care and provide feedback to facilities for joint discussion and planning. This MCSP-supported joint problem-solving enhanced community and health provider trust.

Increased Demand for and Access to Services

- **Stimulated demand creation and health promotion:** All types of MCSP-supported community health cadres provided an integrated package of community health interventions to address RMNCH; nutrition; malaria; and water, sanitation, and hygiene (WASH). These interventions included outreach and education sessions that took place during cooking demonstrations, live radio shows, theater, community dialogues, mobile brigades, health fairs, and household visits. Integrating health services promoted care-seeking behaviors and increased demand.

- **Expanded access to FP:** MCSP supported the MOH to introduce and scale-up community distribution of FP methods, including contraceptive pills and injectables, and oriented CHWs in their use. The Program provided supportive supervision to 266 CHWs to improve the quality of their FP counseling. MCSP also expanded community-based distribution of FP services by supporting CHWs and activists (trained through other programs) in planning and arranging logistics for community visits and mobile brigades. In addition, MCSP trained CHWs and TBAs to refer women to HFs for FP services.

- **Improved community nutrition interventions:** MCSP supported community-based interventions to improve nutrition in children under five through two complementary intervention approaches. Under the intensive approach, implemented in 11 districts prioritized due to their high rates of malnutrition, MCSP staff provided regular on-the-job trainings and supportive supervision visits to community health cadres delivering dedicated nutrition services, and district staff provided intensive, weekly support to community-based activists and nutrition volunteers promoting awareness of key nutrition messages. Under the integrated approach conducted in the remaining districts, MCSP conducted regular on-the-job trainings and supportive supervision visits to community health cadres delivering nutrition services as part of the integrated RMNCH package, but these were less frequent than under the intensive approach.

- **Provided safe birth interventions**: MCSP supported community health cadres to conduct routine education sessions and home visits with pregnant women and their families to promote facility-based delivery. At the same time, the Program built the capacity of 646 TBAs in MCSP-supported communities to implement key interventions for safe birth in the event that a woman was not able to reach the facility, including the administration of misoprostol for prevention of postpartum hemorrhage and of chlorhexidine for newborn cord care.

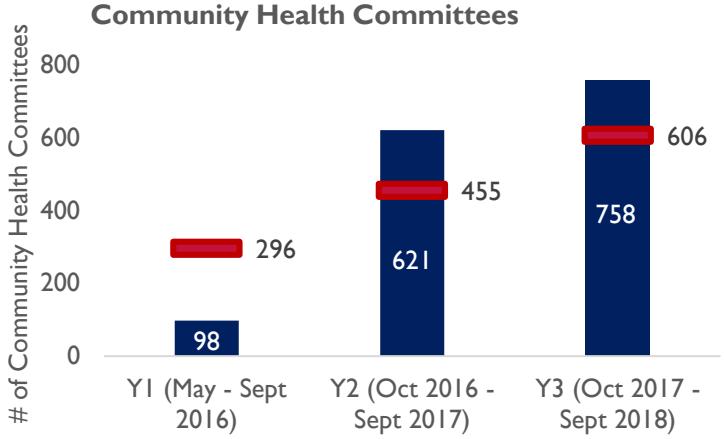
[2] The Community Action Cycle (CAC) is an inclusionary approach to planning and taking action to improve the health of communities that promotes community leadership through the participation of the most affected by and interested in the process, CAC phases are 1) preparation for community mobilization 2) exploration of issues affecting access to and demand for health services, 3) organization and definition of priority actions, and 4) implementation and joint evaluation of the action plan.

[3] CMHCs are composed of community members and health facility staff who work together to improve the quality of facility- and community-based health service delivery and ensure more respectful patient care.

[4] PDQ is an approach that promotes the active and participatory involvement of all community representatives (affected by and interested in the process) in the definition and development of interventions based on indicators that lead to improved quality of services in HF catchment areas.

- **Expanded access to water and sanitation:** MCSP helped CHCs build WASH demonstration centers with local materials in central locations to provide household members with the skills needed to construct convenient and effective WASH products, such as tippy taps, landfill sites, drying stands, and latrines. The demonstration centers coordinated with local businesses and other social marketing projects to promote products (e.g., Certeza to treat water). MCSP also supported CHCs, CMHCs, community health cadres, community support groups, community leaders, and other community-based organizations to implement the Clean Household Approach, which promotes nutrition-sensitive WASH behaviors to be practiced by all family members, aimed at reducing childhood gastrointestinal illnesses that are associated with undernutrition.

Figure 1. Through intensive training and mentoring activities, MCSP revitalized 758 Community Health Committees



- **Reinforced integrated community case management (iCCM):** MCSP supported improved supervision of CHWs, who bring timely and effective treatment of malaria, pneumonia, and diarrhea to communities and especially to children under five who have limited access to facility-based health services.

- **Advanced male engagement**: MCSP trained CHC members to integrate gender into health promotion activities by engaging men through group education sessions as well as one-on-one couples counseling sessions. CHC members stressed the importance of male involvement, counseled men on the recognition of danger signs in pregnancy, and involved them in birth plan development.

Strengthened Community Structures

- **Linked social networks for better health:** MCSP worked with other community groups, such as mothers and fathers clubs, village community banks (VICOBAs), farmers associations, religious leader groups, and youth groups, to identify the health needs of their members and organize community dialogues. These actions allowed for the dissemination of good WASH practices, increased social support for healthy behaviors, enabled identification of social norms that negatively impact health, and increased male involvement in issues that affect the health of women and children.

- **Improved emergency transportation systems and community referral systems:** MCSP helped CHCs conduct a survey of the existing community transportation options (including vehicles and animal-pulled carts). Community leaders requested that the owners of these means of transportation be available to offer emergency services to vulnerable community members, including pregnant women. Contact information for emergency transportation options is now available to community members through the CHCs. MCSP also built the capacity of CHCs to develop VICOBAs, which generate funds to support fuel purchases and motorcycle ambulance maintenance.

Key Results

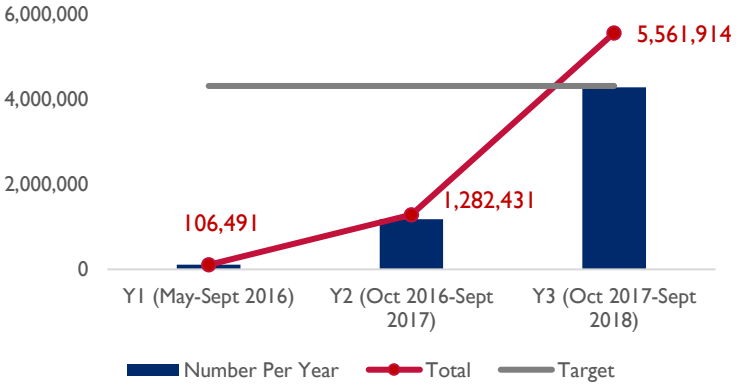
- **CHCs and community health cadres became more responsive to community health needs:** MCSP strengthened 758 CHCs (representing approximately 45% of the total number of communities served by program-supported health facilities) to increase community participation in influencing health outcomes and to advance the sound application of national health CHC guidelines (see Figure 1).[5] All 758 CHCs assessed and prioritized their communities' RMNCH issues, created community action plans, implemented strategies, and monitored outcomes. CHC action plans now respond to the main challenges identified to reducing maternal and child deaths, including actions to increase

[5] *Termos de Referencia para o Estabelecimento e Funcionamento dos Comites de Saude*, May 2012

male involvement in RMNCH, ensure timely referral to HFs for care, and promote exclusive breastfeeding in the first six months of life and adequate complementary feeding in children under five. CHCs and community health cadres now meet regularly to review health data and set new priorities.

- **CMHCs improved service quality**: MCSP strengthened 82 CMHCs over the life of project (representing 100% of the target). As a result, CMHCs are now able to investigate, plan, and act together to improve service quality at HFs, facility-to-community linkages, provider-client relations, and referral networks. CMHCs developed 49 action plans and began to address gaps in care including poor patient-client dialogue, long wait times, lack of privacy, non-family-friendly maternities, poor sanitation at HFs, and drug shortages. Improvements included tighter controls on the delivery and receipt of medications to reduce the quantity of medications sold outside of the health system, greater acceptance of referrals from community health cadres to HFs to reduce home births, and acceptance of male attendance at ANC consultations to increase adherence to ANC guidance.
- **Demand for services grew:** While revitalizing the CHCs, MCSP trained 11,370 CHWs on topics including RMNCH, malaria, WASH, nutrition, and gender. Community health cadres, in turn, reached 5,561,914 individuals with health promotion and education messages on these health priorities (see Figure 2), which drove an increase in demand for services. For example, the proportion of pregnant women who attended four or more ANC visits increased from 39% of at baseline in 2014 to 53% in Year 3 of the project (October 2017-September 2018).
- **More families used FP services:** From October 2016 to September 2018, the 266 Program-supported CHWs provided FP methods to 156,539 new FP users and 48,906 continuing FP users through community visits and mobile brigades. In addition, MCSP-supported CHWs and TBAs referred 186,266 women for FP services in facilities.
- **Improved the nutritional status of children under five:** Over the period of October 2016 to September 2018, nutrition activists, volunteers, and CHWs conducted 60,728 education sessions to promote adequate nutrition behaviors, reaching 910,914 individuals. MCSP also conducted 12,090 culinary demonstration sessions to show how to prepare more nutritious, locally available food. MCSP-supported CHWs screened 188,715 children under five for moderate acute malnutrition and severe acute malnutrition, with 100% of these cases referred to the HFs, ensuring follow-up by skilled staff. As a result, the percentage of children with acute malnutrition who recuperated increased from 59% in Year 2 (October 2016 - September 2017) to 72% in Year 3 (October 2017- September 2018).

Figure 2. MCSP-trained CHWs reached 5,561,914 individuals with health promotion and education



- **Safe birth interventions were provided in MCSP-supported communities:** In MCSP-supported areas, the percentage of women provided with misoprostol in advance of delivery through ANC or by a TBA for prevention of postpartum hemorrhage increased from 50% in Year 2 to 71% in Year 3.
- **WASH education sessions improved health outcomes:** MCSP established 1,313 WASH demonstration centers, where MCSP-trained CHWs conducted 62,560 education sessions reaching 938,407 individuals. As a result, communities installed 122,074 latrines, 79,037 drying stands, 25,934 tippy taps, 84,212 landfill sites, 97,442 pantries, 17,544 fences, and 52,312 racks for storing utensils. Using the DHS 2011 average rural family size of 4.3 individuals, these results represent improved access to basic sanitation services for nearly 525,000 people. Local governments recognized the WASH demonstration centers at the community level for their role in helping to reduce diarrhea and cholera rates.

- **iCCM reduced the need for referrals:** The 266 CHWs in MCSP-supported areas provided malaria treatment to 93% of children under five who had a positive rapid diagnostic test, oral rehydration salts/zinc to 94% of children under five with diarrhea, and antibiotics to 89% of children under five with pneumonia.
- **Male participation and engagement in family health was strengthened:** MCSP helped transform traditional gender norms that act as barriers to RMNCH by facilitating 41,437 couple and community dialogues and holding 26,693 education sessions through theater, home visits, and radio. Male engagement in RMNCH care improved; for example, male participation in ANC visits increased from 55% in 2014 to 75% in April-June 2018.

Nampula CHC celebrating a motorcycle purchased through VICOBA funds. Photo: Meque Fernandes, MCSP Community Development Officer.

- **Emergency transportation systems and community referral systems saved lives**: All 758 CHCs developed emergency transportation and referral systems. 10,909 community members were transferred to HFs for a medical emergency, including 2,331 pregnant women, 2,881 children under five, and 5,697 adults. In addition, MCSP supported 380 CHCs to use VICOBAs to strengthen their financial sustainability. VICOBAs helped operationalize the MOH's motorcycle ambulance strategy by providing a supplementary source of funds for fuel and maintenance, thereby improving access to emergency transportation for children and pregnant women.

Recommendations

- Community health platforms, such as CHCs, and social accountability processes, such as community scorecards and the PDQ approach, should be adopted as part of a strategic mechanism to ensure community engagement and accountability. Such a mechanism will require ongoing mentoring and integration into provincial- and district-level health systems to enhance community-to-facility linkages.
- Government and partners should incorporate data collected by the CHCs, TBAs, and CHWs into the *Sistema de Informação de Saúde para Monitoria e Avaliação*/District Health Information System 2 (DHIS-2/SIS-MA) to ensure that decisions are based on the most comprehensive data available.
- Provincial and district health directorates should continue to assess all available means of emergency transportation and ensure linkages with the CHCs and CMHCs to strengthen the referral system.
- The Provincial Health Directorate and Women, Social, and District Health Services should ensure increased information exchange between HFs and community health cadres to improve tracking of cases that are lost to follow-up and to encourage patients to return to treatment.
- The MOH and partners should ensure that future support to CHCs consistently includes the development and strengthening of community income generation approaches such as VICOBAs, which promote self-sustainability for CHCs and community health initiatives.
- District health directorates should consider requesting in-kind donations of local materials from civil society groups and other local and private sector entities to build WASH demonstration centers, including improved latrines, that are resilient to weather and natural disasters.

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