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Maternal and Child Survival Program

MCSP Community Health Contributions Series: Mozambique

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Background

Mateus Afonso Kalomba, a volunteer CHW, travels around his community on a bicycle in Bairro, near Maputo, Mozambique. The volunteer CHWs have undergone training in family planning, nutrition, and primary health care, and carry out regular visits in the community on bicycles. Photo by Kate Holt, MCSP.

The Maternal and Child Survival Program (MCSP) is a global, $560 million, 5-year cooperative agreement funded by the US Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. To support community health structures in countries, MCSP advocated for institutionalizing community health as part of national health systems, strengthening the capacity of community health workers (CHWs), and supporting community platforms in partnership with country governments and civil society organizations. This brief is one of an eight-part series developed by MCSP to review and understand the processes of community engagement in MCSP-supported countries and identify how the community health approaches that the project implemented contributed to changes in health service uptake and behavioral outcomes.

MCSP in Mozambique was implemented from October 2015 to March 2019 and supported central-level Ministry of Health (MOH) health system strengthening efforts. Specifically, the project worked closely with the Government of the Republic of Mozambique to update national reproductive, maternal, newborn, child, and adolescent health (RMNCAH); nutrition; malaria; and water, sanitation, and hygiene (WASH) strategies, policies, guidelines, training modules, performance standards, job aids, and supervision checklists. With technically sound, up-to-date guidelines and materials, the MOH was able to put forward unified guidance for national implementation of RMNCAH, nutrition, and malaria programs. At the subnational level, MCSP worked with the Nampula and Sofala provincial and district health directorates to strengthen service delivery.

Community Health Focused on RMNCAH, Malaria, and Nutrition

MCSP contributed to preventing maternal, newborn, and child deaths by advancing community health as a central component of the country's health system in alignment with the MOH National Health Promotion Strategy 2015–2019/20. The community-based services were designed to increase access to and demand for the utilization of health services by households and communities. Globally and in Mozambique, MCSP applied a multipronged strategy to enhance community engagement around health and nutrition, integrating

community service delivery with community capacity strengthening, and employing community social and behavior change approaches. This strategy was used to engage community members in practicing an assortment of reproductive, maternal, newborn, and child health (RMNCH) behaviors and increase demand for and access to high-quality health services.

MCSP focused its efforts on increasing community participation in and ownership of health outcomes. The project trained and mentored preexisting and new community health committees (CHCs). Capacity strengthening focused on expanding committee membership to include those most affected by critical health issues; training on group roles, responsibilities and norms, leadership skills, resource mobilization, and management; and creating functional linkages with health facility staff. Using these skills, the CHCs explored and prioritized their community RMNCH challenges, created community action plans, implemented strategies, and monitored outcomes.

Additionally, MCSP built the capacity of co-management and humanization committees (CMHCs) by helping them restructure to align with nationally mandated roles and responsibilities, and by improving their organizational skills through mentorship. CMHC members include health facility staff and community representatives who play a critical role in improving the quality of facility- and community-based health service delivery. Through a Partnership Defined Quality (PDQ)[1] approach supported by the MOH, communities and health providers worked together to improve health quality through ongoing analysis, dialogue, planning, collective action, and monitoring. MCSP developed and integrated a Community Health Service Quality Scorecard into the PDQ process to enhance regular monitoring and analysis of health services by communities and to strengthen social accountability mechanisms. The project also worked to build capacity of mothers' support groups, WASH demonstration centers, and community-based child nutritional support groups. Stronger community-based groups led to greater community participation and ownership over health outcomes, and to more responsive partners for government health services and outreach. An outline of the various activities the project undertook to enhance community engagement are outlined in Table 1.

Achievements

By the end of the project, MCSP increased coverage and improved the quality of and demand for RMNCAH, nutrition, WASH, and malaria interventions at the community level.

Strengthened Community Platforms and Structures

- CHCs used the Community Action Cycle (CAC)[2] to strengthen skills to explore, plan, act together, and monitor achievements using data for decision-making. **The number of communities with a functional CHC[3] increased from 98 in year 1 of project implementation to 758 in year 3, surpassing the target of 606 functional CHCs.** The CHCs and CHWs now meet regularly to review health data and set new priorities.
- Strong partnerships with provincial and district health counterparts provide the foundation for ongoing mentoring of managers and supervisors on community engagement approaches. Starting in the third year, **MCSP gradually transitioned supervision of community-based interventions conducted by CHCs to the Women, Social, and District Health Services (SDSMAS).**
- CMHCs improved community-to-facility linkages, provider-client relations, and stronger referral networks. Community scorecards increased citizen participation in health service quality improvement. **Improvements included tighter controls on the delivery and receipt of drug stocks, which likely reduced the quantity of drugs sold outside of the health system and greater acceptance of CHW referrals to health facilities, contributing to a reduction in home births.**

[1] Partnership Defined Quality (PDQ) is a methodology to improve the quality and accessibility of services with community involvement in defining, implementing, and monitoring the quality improvement process. PDQ links quality assessment and improvement with community mobilization.

[2] The CAC reinforces the capacity of communities to resolve their own health-related challenges, particularly around uptake of quality health services and healthy behaviors at the household and community levels.

[3] A functional CHC is defined as one that conducts data review meetings, holds community dialogue days, and performs outreach activities within the community.

Table 1. Three pillars of the MCSP's community health approaches

Service Delivery	Community Capacity Strengthening	Social and Behavior Change
• Implemented social accountability approaches by applying an integrated (PDQ) and Community Health Service Quality scorecards process to increase citizen participation in identifying quality of care issues and developing solutions in partnership with health facility staff. • Supported coordination meetings with district, health facility, and community representatives to define strategies and operational procedures to improve the effectiveness of the referral network. • Supported the SDSMAS to sustain supportive supervision of community interventions. • Addressed nutrition through screening, referral, and treatment of acute malnutrition, vitamin A supplementation, home fortification with micronutrient powders, and community-based activities, including nutrition education sessions and cooking demonstrations for caregivers. • Reinforced integrated community case management (iCCM) by supporting the MOH's polyvalent agent (*agentes polivalentes elementares, APE, a multipurpose community agent)* program in Nampula and Sofala by conducting refresher trainings and regular supervisions and mentoring to strengthen APEs' capacity to provide high-quality iCCM services.	• Revitalized and strengthened CHCs and CMHCs. • Trained CHCs how to use the CAC. • Assisted CHCs to conduct a survey of the existing community transportation options and develop village community banks to generate funds to support fuel purchases and motorcycle ambulance maintenance. • Strengthened community cadres' capacity to identify danger signs in pregnant women and children under 5, refer cases from communities to the referral health facilities, and follow clinical criteria (iCCM) in certain cases. Also provided training on how to conduct nutrition assessments, malnutrition treatment, community-based distribution of family planning methods, how to administer misoprostol for prevention of postpartum hemorrhage, chlorhexidine for cord care, and ophthalmic tetracycline for prevention of gonococcal conjunctivitis in newborns. • Provided supportive supervision to APEs to improve counseling quality and expanded community-based distribution of family planning services through community visits and mobile brigades. • Built monitoring and evaluation capacity of CHW cadres and their supervisors. • Improved emergency transportation systems and community referral systems, and built the capacity of CHCs to develop village community banks to generate funds to support fuel purchases and motorcycle ambulance maintenance.	• Supported CHWs to provide an integrated package of community health activities, including cooking demonstrations, live radio shows, theater, community dialogues, mobile brigades, health fairs, and household visits. These activities addressed social normative barriers, including gender inequality and unequal power dynamics. • Supported CHCs, CMHCs, CHWs, APEs, community support groups, community leaders, and other community-based organizations to promote "Clean Households"—households where all family members practice improved WASH behaviors. • Trained CHC members to encourage male involvement in issues that affect the health of their wives and children.

- Newly trained and mentored health workers and community nutrition activists reached over 3.4 million children under 5 with evidence-based nutrition interventions, **resulting in an increase in the percentage of children with acute malnutrition who recovered, from 59% in September 2017 to 72% in September 2018.**
- A new approach for improving RMNCH referrals and counterreferrals in Nampula Province decreased for the period between effective referral (leaving peripheral health facility) and arrival at the referral health facility. **The MOH announced it would replicate the referral and counterreferral system in the other provinces in Mozambique.**
- The use of data by community groups is essential in targeted community action plans. MCSP developed and revised data collection forms, reporting tools, and databases, followed by specific trainings in its use for CHWs. **The incorporation of data collected by the community cadres into the District Health Information System 2 by government and partners helped support community decisions and actions based on timely and comprehensive data.**

Increased Demand and Access to Services

- MCSP mapped community emergency transportation options in 758 communities and mentored CHCs to develop 380 village community banks that raised funds to maintain and fuel motorcycle ambulances. MCSP also trained and mentored \11,370 community health cadres to identify danger signs in pregnant women and newborns, and to make referrals. **Over the life of project, 13,216 community members in MCSP-supported communities arrived at health facilities using the community emergency transportation system.**

A member of the health committee puts their weekly contribution in the community box in Perera, near Nampula, Mozambique. The money put in the box is used for community emergencies. The health committee is responsible for all aspects of the community's health. Photo by Kate Holt, MCSP.

- MCSP helped transform traditional gender norms that act as barriers to individuals practicing RMNCH behaviors 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 antenatal care visits increased from 55% in 2014 to 75% in April–June 2018.** The percentage of pregnant women who attended four or more antenatal care visits at 86 MCSP-supported facilities increased from 39% at baseline in 2014 in Nampula and Sofala, respectively, to 53% at endline in Nampula and 65% in Sofala.

- Over the life of project, the MOH's APEs **treated 117,509 (92%) children diagnosed with malaria, 41,443 (93%) children diagnosed with diarrhea, and 33,949 (90%) children diagnosed with pneumonia**. MCSP conducted two rounds of annual mini-surveys to evaluate caregivers' perception of quality of services received from APEs for sick children. Results indicated that, on average, **APEs met 73% of the criteria for iCCM services, an acceptable level of quality of services.**

Conclusion

MCSP's promising results in Mozambique would not have been possible without the leadership and commitment of the Government of the Republic of Mozambique and the MOH. Both structures worked to improve access to high-quality RMNCAH and nutrition care. Furthermore, MCSP found that strong citizen participation in identifying issues affecting quality of care and identifying solutions resulted in improved quality of health services.

Going forward, the MOH and implementing partners should support the strengthening of community health platforms, such as CHCs, and social accountability processes, such as community scorecards and the PDQ approach, as part of a strategic mechanism to ensure community engagement and accountability. Additionally, to increase CHW cadres and their supervisors' confidence in tracking and reporting community mobilization outputs, guidance should be provided on community mobilization indicators and monitoring systems as part of routine training. Lastly, data use for decision-making at the community level will be another important area of focus going forward. A "quick win" for sustainability and institutionalization is to empower communities to analyze their own data and use this information to inform collective action for improved health outcomes.

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