



MOTHERS MATTER: Healthy Mothers, Healthy Societies Program Update – May 2011



Executive Summary

Maternal mortality is a global tragedy. Every day nearly 1,000 expectant mothers die; 98 percent of them in poor countries. When a mother dies her family breaks apart. Her children are less likely to go to school, get immunized against diseases and eat well. The good news: Preventing most maternal deaths can be done. The world has the resources, technology and knowledge. Now is the time to fully use them. Support to CARE's MOTHERS MATTER program has helped us reach a critical turning point in this long-term effort. This report highlights how CARE has invested donor funds effectively to support maternal health programming, research and innovation. A summary of key results include:

- **Scaling up effective maternal health programming:** Both national and regional scale-up models were successfully developed, and CARE's existing maternal health programs in countries like Bangladesh, Democratic Republic of the Congo (DRC) and Peru are now in the scale-up phase to build the capacity of health care providers; strengthen health care systems; empower communities to address barriers to health; and strengthen the evidence base to support advocacy efforts. CARE is now well-positioned to implement national and regional programming to reach significantly more excluded women with quality maternal health care services.
- **Setting the stage for innovative maternal health and cross-sector programming:** Strategies for comprehensive maternal health programming have been initiated in Malawi and Mali and the integration of maternal health initiatives into CARE's village savings and loan association (VSLA)

activities has yielded successful results in Rwanda. Research for integrating maternal health and VSLA programs was conducted in Burundi, Niger and Tanzania. Now that the proper analysis and planning has been completed, CARE looks to initiate new programming in targeted countries.

- **Testing innovative technologies:** Clinical protocols that run on mobile phones were successfully developed and field-tested in India and Rwanda to improve communication linkages between villages, health centers and hospitals. A mobile phone program is also underway in Pakistan. This unique and innovative use of technology can be applied on a broader scale to reduce the delays for women in receiving proper emergency obstetric care when they have a complication during labor.

Program Progress and Highlights

1. Scaling up effective maternal health programming

Bangladesh: Bangladesh has the second lowest rate of delivery at health facilities in the world. Discrepancies between rich and poor in utilizing maternal health services are 52 percent compared to 17 percent. CARE's *Community Support System (CmSS)* program has strengthened health systems and trained community health volunteers to educate women about pregnancy danger signs and use of health care facilities. Communities created a social fund to pay emergency transport costs for women in need of emergency obstetrical care. Recent findings show that antenatal care access in CmSS-supported areas increased from 30 percent to 71 percent in four years; 7 percent received community financial support for transport costs; and disparities in maternal health care based on family wealth in CmSS areas has been eliminated. CARE has been asked to expand the program nationally.



The minister of health in Bangladesh attends a CARE workshop to finalize CmSS

DRC: *Uzazi Bora* is CARE's reproductive health project in Kasongo district. The maternal mortality rate there is more than double the national average and child mortality is the highest in the country. CARE worked with Kasongo's District Health Office and international partners to train health workers from 22 facilities and district hospital doctors and nurses. We collaborated with radio journalists, musicians, dancers and theater troops to deliver health messages to communities and also worked with 360 community health educators, who went door-to-door to build awareness. The *Uzazi Bora* approach in the DRC yielded a 77 percent increase in women using family planning counseling in just eight months, compared to a 34 percent increase in control areas. Women giving birth at health centers increased from 40 percent to 78 percent. CARE is now positioned to scale up activities in Kasongo and in other districts.

Peru: Based on our successful *Foundations to Enhance Management of Maternal Emergencies (FEMME)* project, which reduced maternal deaths in the Ayacucho region by 50 percent, CARE has expanded the program to the Cajamarca, Huancavelica and Puno regions. Our initial focus is on health worker training and strengthening citizen engagement and surveillance systems to monitor the quality of health care. CARE and the Peruvian Ministry of Health also recently launched two national processes: trainers are now building regional-level capacities and a two-year process for implementing national guidelines at hospitals and community health facilities has started. CARE will continue the "scale-up" of

regional evidence-based models in the broader national context and conduct advocacy work to continue momentum for policies and implementation of cost-effective programs.

2. Setting the stage for innovative maternal health and cross-sector programming

Malawi: CARE is the sole international nongovernmental organization working with the World Health Organization, United Nations Population Fund and the Centers for Disease Control and Prevention to build an Implementation Science Alliance for Maternal Health to demonstrate “how” to implement for greatest impact. The first project is in Malawi, where we are developing an implementation roadmap based on demonstrated value of the project for a rapid expansion to other low-income countries. The initial “proof of concept” project includes the integration of services and a demonstration of how to overcome implementation challenges. The success of this alliance, which brings together CARE’s implementation strength in the field with the science and innovation emerging in the global community, will serve as the basis for seeking expanded funding.

Mali: CARE initiated a project to document the impact of social change interventions on maternal health behaviors in northern Mali. The CARE project team is developing an intervention and control research design in two districts. The design will provide proven maternal and newborn health interventions in both districts, while adding a package for social change in the intervention district. Our hypothesis is that the addition of the social change package will significantly improve maternal health behaviors relative to the control district. Project results will contribute to the further development of strategies for social change to improve women’s reproductive health in Mali. Documentation will also be used to reinforce CARE’s integrated approach to global maternal health programming.

Rwanda: Rwanda is the most densely populated African country. A slowdown of the fast-growing population, on track to double in 20 years, would reduce the risk of maternal death and improve living standards. CARE has increased awareness and access to family planning services in Gatsibo district by opening family planning posts in four communities; educating religious leaders on modern family planning methods; and tapping into CARE’s existing 187 VSLAs, training approximately 4,000 women and men to increase community knowledge and voluntary use of family planning services. VSLA members also support health workers to organize local theater events and debates to challenge social norms and promote responsibility sharing between men and women. Between July and December 2010, we found a 46.5 percent increase in new clients registered at family planning facilities. CARE is working with the Ministry of Health to develop a national strategy based on the success of this pilot project.

Burundi, Niger and Tanzania: CARE conducted a study in three countries where VSLA groups exist to assess barriers to health faced by women and inform the design and implementation of VSLAs to include maternal and reproductive health activities. The study suggested an innovative model for CARE to pilot, aimed at reaching more women and girls of reproductive age by training VSLA members to conduct local outreach (e.g., one member reaching 10-15 households in a given village), in coordination with community health workers, to improve maternal health behaviors. VSLA members might also work with couples to resolve social, cultural and economic barriers that prevent women from realizing their maternal health rights and accessing health services. The scale-up potential is at the forefront of our program design considerations to reach a large proportion of women and girls of reproductive age.

3. Testing innovative technologies

India: Bihar state ranks last among all other states in India for antenatal care, second to last for attended deliveries and third from last for institutional deliveries. CARE launched a Family Health Initiative to increase the quality and use of services in eight districts and will use lessons learned to scale up activities across the entire state. As part of that initiative, CARE worked with D-Tree International to develop and

field-test a set of clinical protocols/algorithms running on a mobile phone that takes the health worker step-by-step through the process of delivery of care, providing a solid framework for planning, service delivery and evaluation of the care provided. The trial was conducted in Begusarai district, where we trained an initial 30 community health workers and 10 nurse-midwives. The mobile platform has the potential to serve as the primary point of frontline integration for messages from distinct and state government programs.



Front line health workers in India were trained to use clinical protocols on mobile phones.

Rwanda: CARE worked with Rwanda’s Ministry of Health (MOH) to train public health workers in the northeast Gatsibo district to use mobile phone applications to expand community health programs and support data collection around maternal and infant life cycles, reporting, training and supervision. Forty representatives from 17 health centers and district hospitals received a training-of-trainers course on the RapidSMS system to send and receive short messages to and from the MOH and health centers for urgent support. They also learned to use mUbusima, a system for submitting data from villages on pregnant women, postpartum women and children, until the age of 9 months. Trainers, in turn, trained 1,845 community health workers, who provide coverage to 90,043 women of reproductive age and their families in Gatsibo district. Because community health workers are now able to communicate immediately to health care providers, mothers and their children will now be able to receive appropriate care on time. CARE now has the opportunity to help the MOH apply RapidSMS and mUbusima on a larger scale in Rwanda.

Pakistan: Some 30,000 women die each year during pregnancy and childbirth in Pakistan. Most deaths can be prevented through the proper diagnosis and management of complications. CARE has launched an initial three-year program in Sindh and South Punjab provinces to expand access to quality health services and information, build an awareness campaign to engage rural communities, train health workers and pilot the use of mobile phone technology to enhance women’s access to critical health care services. Following initial test results, a national campaign will be launched to encourage expectant mothers and fathers to register through a mobile short message service or integrated voice response service to receive updates about the stages of their pregnancy, obtain information on diet and nutrition, symptoms or risk factors and problems that generally occur during and after pregnancies. CARE also plans to disseminate health messages through local radio programs, fostering community support to improve safe parenthood and early childhood care. Lessons learned upon completion of the pilot project will be used towards reducing maternal deaths in other similar country contexts where a woman’s mobility without assistance and support of a male family member hinders her access to health care.

Conclusion

No mother should die from something that is preventable, yet maternal mortality rates continue at an unacceptably high level. Donor support to the MOTHERS MATTER program has helped CARE build momentum to reach a critical turning point for improved maternal health. Health workers have been trained. Technology has been field-tested. Communities have been organized. Scale-up of effective programming has begun. Ministries of Health, UN organizations, academia and local and international NGOs have partnered with CARE to leverage our collective knowledge and resources. CARE appreciates the generous investment and commitment of our donors towards ensuring not a single needless maternal death takes place anywhere.