MCSP Madagascar Program Brief

Tanora Mitsinjo Taranaka: Lessons Learned from an Integrated Approach to Increase Use of Health Services by First-Time Young Parents in Madagascar

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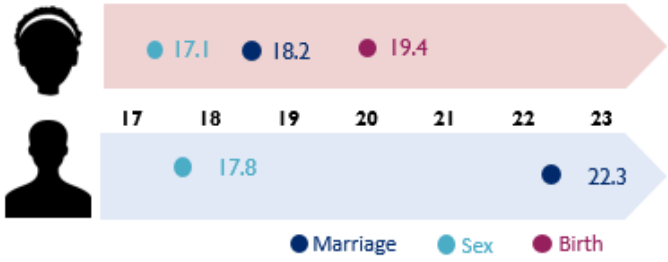
Background

Madagascar has a large youth population, with 32% of the total population aged 10–24.[1] Childbearing begins early: 38.9% of women have already become mothers or are pregnant by age 19.[1] Key reproductive life course milestones happen in rapid succession for young women (Figure 1), with sexual debut, marriage, and first birth happening between the ages of 17 and 19 on average.[2] The maternal mortality ratio has remained unchanged over the last decade, at 478 deaths per 100,000 live births.[3]

Figure 1. Median Age at Key Reproductive Life Course Milestones for Malagasy Men and Women



Institut National de la Statistique (INSTAT), Programme National de lutte contre le Paludisme (PNLP), Institut Pasteur de Madagascar (IPM) et ICF International. 2016. Enquête sur les Indicateurs du Paludisme 2016. Calverton, MD, USA : INSTAT, PNLP, IPM et ICF Macro.

Health consequences of early pregnancy and childbirth in mother and child are well documented in low- and middle-income countries. Early pregnancies increase the risk of maternal mortality; young women under age 20 are twice as likely to die in childbirth as women over 20, and women under age 15 are five times as likely to die in childbirth. Children of adolescent mothers have a 34% higher risk of death in the newborn period and a 26% higher risk of death by age 5.[4]

There is a clear need for interventions to connect young pregnant women to health services, ensuring uptake of maternal and newborn health (MNH) and antenatal care (ANC) services, and healthy timing of a subsequent pregnancy. Yet globally, few programs have considered how to reach first-time young parents (FTYPs) with an integrated approach that meets the broad range of their health and development needs.

[1] Institut National de la Statistique (INSTAT), Programme National de lutte contre le Paludisme (PNLP), Institut Pasteur de Madagascar (IPM) et ICF International. 2016. *Enquête sur les Indicateurs du Paludisme 2016*. Calverton, MD, USA : INSTAT, PNLP, IPM et ICF International.
[2] Institut National de la Statistique (INSTAT), ICF Macro. 2010. *Enquête Démographique et de Santé de Madagascar 2008–2009*. Antananarivo, Madagascar: INSTAT and ICF Macro.
[3] INSTAT. 2013. *Enquête Nationale de Suivi des Objectifs Millénaires de Développement 2012–2013*. Antananarivo, Madagascar: INSTAT.
[4] World Health Organization (WHO). 2011. *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*. Geneva: WHO.

The United States Agency for International Development (USAID)-supported Maternal and Child Survival Program (MCSP) supported the Ministry of Public Health in Madagascar to reduce maternal and newborn mortality over the course of its implementation period (2014–2019). The program interventions, which covered the 16 USAID priority regions, aligned with the Roadmap for the Campaign to Accelerate the Reduction of Maternal and Neonatal Mortality, especially Strategy Three: "Providing essential integrated and quality services around pregnancy and childbirth focusing on adolescent and youth health."

Intervention Design

The first step involved formative research conducted by MCSP in 2016 to identify factors at individual, family, and community levels, and within health care that influence access to and use of health care by FTYPs (adolescents and youth aged 15-24 who had one or two children or were pregnant with their first). The full report of the formative research can be accessed here.

Formative research findings showed that community health workers (CHWs) are trusted sources of information for FTYPs and their family members. Many FTYPs are not aware of the availability and benefits of services in health centers. Even when FTYPs value services for the benefit of women's and children's health, they face supply-side barriers to service use, such as poor quality of reproductive, maternal, newborn, and child health (RMNCH) care, including stock-outs, long wait times, and unwelcoming health providers. Further, FTYPs face family pressure to continue traditions of seeking care from traditional birth attendants and traditional healers.

Figure 1. TMT Poster, Invitation Card, and National Strategic Plan for Adolescent Sexual and Reproductive Health

With these considerations and World Health Organization guidelines in mind, MCSP designed an approach and tools for implementation that involved multisectoral adolescent sexual and reproductive health (ASRH) stakeholders from national, regional, and local levels. This integrated approach, called TMT—which stands for *Tanora Mitsinjo Taranaka,* meaning "young people looking after their legacy"—was launched in two districts of Menabe (Miandrivazo and Morondava) in April 2017 under the leadership of the Ministry of Health. TMT aimed to create enabling environments and strengthen youth assets to allow FTYPs to realize their health choices and access care that is responsive to their needs. To maximize sustainability and scalability, TMT was designed to build on an existing platform—the partnership between health workers and CHWs. As the first intervention to target FTYPs in Madagascar, TMT was implemented on a small scale as a proof of concept to test materials, messages, and approaches before refining and scaling the model. The TMT proof of concept included the following:

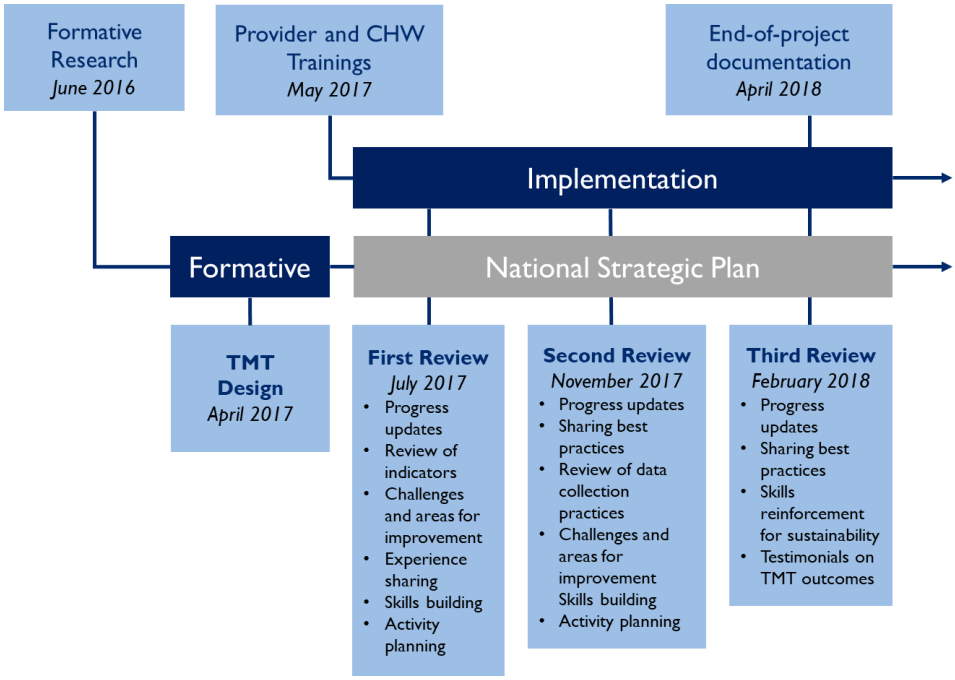
- MCSP trained 75 CHWs and 20 community actors from the Ministries of Youth, Education, Communication, and Population to engage FTYPs through meetings, home visits, and casual encounters. CHWs connected FTYPs to health centers through "invitation cards". They also held community discussions with individuals identified via the formative research as influencing FTYPs' use of health care, including community leaders and parents, particularly mothers and mothers-in-law.

- MCSP trained and supported 32 health providers to provide adolescent-responsive health care in 11 health facilities. Training focused on addressing provider bias toward young, particularly unmarried parents and FP clients to ensure welcoming, nonjudgmental care for FTYPs. As part of its broader RMNCH support, MCSP equipped facilities with technical materials, such as blood pressure cuffs and newborn resuscitation packs.

- Materials, including TMT invitation cards, TMT posters, and TMT booklets (Figure 2), target FTYPs across key reproductive life moments and center on advantages of visiting the health facility.
- To foster a supportive political environment, MCSP contributed financially and technically to the design of the National ASRH Strategic Plan, launched in February 2018, to emphasize a focus on age- and life stage-tailored approaches. MCSP also contributed to advocacy for the revision of a reproductive health law to take into account youth needs.

Figure 3 shows the detailed timeline for TMT development, implementation, learning, and documentation.

Figure 3. TMT Timeline



Methods

The preliminary results and lessons of the proof of concept were derived from the following sources:

Quarterly Learning and Review Meetings

Following the initial trainings and TMT launch, MCSP hosted three quarterly learning and reflection meetings with trained CHWs and health providers to explore implementation challenges, learning, and promising practices for engaging FTYPs. These participatory meetings helped identify additional training needs and areas for midcourse correction, and encouraged CHWs and health providers to collectively identify promising approaches.

Qualitative Documentation

In April and May 2018, MCSP conducted an exercise to document the qualitative results and lessons learned from the TMT proof of concept. This study received a nonhuman subjects research designation from the Johns Hopkins Bloomberg School of Public Health Institutional Review Board, the Save the Children Ethics Review Committee, and the Ethics Committee of Madagascar's Ministry of Public Health. Methods included:

Method	Target People	Topics
Focus group discussions	22 young mothers (over age 18) identified by the TMT-trained CHWs	• Interactions with TMT-trained CHWs and with health workers before, during, and following pregnancy • Client satisfaction • Use of TMT tools • Discussion with peers

Method	Target People	Topics
	46 active and inactive CHWs, determined by number of distributed invitation cards	• Appropriateness of training and follow-up • Activities undertaken to involve FTYPs' and influencers' challenges and approaches to mitigating • Motivators to engage FTYPs • Use of TMT tools
	11 regional officers in different ministries involved in TMT design and implementation	• Local context and challenges • Recommendations for modifications and for scale-up
In-depth interviews	12 young fathers (over age 18) who have or whose wives have used health care	• Use of and satisfaction with health care • Engagement of young fathers • Discussion with peers • Use of TMT tools
	11 health providers	• Feedback on tools • Changes to practices resulting from TMT • Recommendations for modifications and for scale-up
	5 national representatives from ministries in charge of TMT design, training, and follow-up	• Context and challenges • Comprehension of and reactions to TMT • Recommendations for modifications and for scale-up

Reviews of Service Data

MCSP collected age-disaggregated service data from ANC, delivery, and FP registers in the 11 supported health facilities between May 2016 (the 12 months before the start of intervention) and April 2018 (two months following the end of MCSP's support).

Health Facility Assessments

In April 2017 and August 2018, MCSP conducted quantitative baseline and endline assessments of supported health facilities. These assessments explored health facilities' capacity to provide quality, adolescent-responsive ANC, MNH, and postpartum FP services before and after the intervention.

Findings

CHWs and Other Community Activities

CHWs reported that the TMT training equipped them with skills and confidence to engage FTYPs, and helped build trust and earn respect in the community.

> *"My experience is that TMT has freed me from my shyness. It has become a reflex for me to approach any girl with a baby on her arm. I give her advice that seems relevant to her."*
> - CHW, Miandrivazo

The TMT invitation cards were widely used and positively received by CHWs, health workers, and young beneficiaries and their influencers.

Photo by Karen Kasmauski, MCSP.

Through learning meetings and endline documentation, MCSP learned that FTYPs were impressed by the provision of the simple but attractive card to formally invite them to visit the health facility. Further, CHWs appreciated being able to monitor the outcomes of their discussions with FTYPs by seeing how many cards were returned to the health facility, and health providers found the approach useful in monitoring the activities of CHWs. The monitoring data confirmed

that these cards were effective in encouraging service use; 72% of the cards distributed were returned to the facility for services.

> *"I find that what is written on the invitation card—'Young people, take charge of your health'—is a kind of instruction, an order that must be executed because health is the first wealth. We must assume our responsibility for the health of our family."* - Young father, Miandrivazo

Community highlights:
More than two-thirds of invitation cards (72% of 1,430) distributed by CHWs to FTYPs resulted in visits to the health facility. Further, the numbers of community-based distribution of FP to clients ages 10–24 increased from an average of 35 clients to 76 clients per CHW.

Notably, although not part of the TMT model, accompaniment by CHWs to the health facility powerfully motivated FTYPs to use services. CHWs explained that they appreciated this trust and did not raise concerns about the additional demand on their time.

> *"One day, so I was busy working sitting at my desk, there was a knock on the door, and a young mother came in suddenly, smiling. She said to me, 'Come and accompany me to the midwife because today it's my appointment for my [contraceptive] injection!' I was so touched by so much trust and friendship, and I got up, and I accompanied her to the hospital in a rickshaw."* - CHW, Miandrivazo

In addition to their formal responsibilities, some CHWs reported that they used skills and knowledge learned from the TMT training and the booklet in their personal lives.

> *"As we say 'I before you,' I started by educating my family and the children of my sisters and brothers, and I gave them the booklet. As a result, discussion about sex between parents and their children becomes possible."* - CHW, Morondava

Some CHWs did meet with community leaders and held community-level activities. They also noted that some parents of FTYPs remained uncomfortable with discussion of matters related to sexuality, yet they appreciated having CHWs play that role.

> *"At first, I was afraid parents would get angry at me for talking to their children, but no, on the contrary, it's the parents themselves who send their girls to me."* - CHW, Morondava

Health Services Responsive to FTYPs

CHWs, health providers, and ministry stakeholders were motivated to support TMT and saw linkages to RMNCH goals. The emphasis on the relation between young parents' use of health services and national/regional RMNCH goals encouraged health workers to adjust their behavior to make health services more welcoming to FTYPs and implement activities with FTYPs at the community level. Importantly, health workers noted that because they saw the clear connection between increasing FTYPs' use of health services and meeting RMNCH goals, they did not feel that the focus on FTYPs placed an additional burden on their workload but rather helped them to prioritize appropriately.

> *"TMT has helped me a lot in achieving our goals … even ANC, vaccines, and consultations are all increased. The link between TMT and the ASRH National Strategic Plan (NSP) exists and is undeniable because they aim for the same objectives, and the TMT activities contribute to the operationalization of the NSP strategic axes."* - Ministry stakeholder, national level


Photo: Karen Kasmauski, MCSP.

Further, providers appreciated that FTYPs came to facilities well informed after having spoken with a CHW.

> *"Young mothers know and dare to ask for what they want. For example, after giving birth, some come to ask, 'Following what we talked about regarding pregnancies too close together, I do not wish to have a pregnancy after 3 or 5 years. What do you suggest I do?' Some come back for hygiene and dietary advice for their babies."* - Health provider, Miandrivazo

"An outcome that surprised me was to see the young couples who come to the service. One couple was still very young, but the boy knew the date of the last menses of his partner. I do not know if this is the effect of the CHW's encouragement, but they are always present every month for ANC. Every time he asks, 'Is the baby moving well?' I made him listen to the baby's heartbeat, and he was very happy. He said, 'He is very vigorous!'" - Health provider, Morondava

Some providers reported noticing an increase in the numbers of male partners accompanying young mothers for ANC or delivery services. The providers who noted this trend were supportive of male partners at the facility and said that TMT helped them to more confidently engage young fathers. Providers explained that their discussions with young fathers focused around young men's responsibilities to their families in acting as supportive partners. Other providers noted that some young fathers came alone to the health facility to inquire about matters related to their family's health, though this remained a relatively rare occurrence.

"If they are present, I must change the way I consult because I speak directly with them. I tell them, 'You fathers, you are the head of the family, so you have to know how to listen and not be egotistical.'" - Health provider, Miandrivazo

"A nice surprise for me was to see a young father accompanying his wife to give birth! This touched me a lot. They were very young, between 15 and 16 years old." - Health provider, Miandrivazo

TMT successfully challenged health providers to offer services that respond to FTYPs' needs.

"All our staff committed to making our center more attractive. Another change made by TMT is that we hold twice weekly information sessions to clients and their companions in order to promote our service every Monday and Friday. This helped us have our lost clients to come back to our facility because of better services." - Health worker, Morondava

Reactions of FTYPs

Reactions of FTYPs indicated that TMT's reliance on CHWs to conduct home visits was well received. FTYPs remarked that CHWs are trusted community members, known for their efforts to engage mothers and children, and that they appreciated having the CHWs' focus expanded to include young parents. Young mothers in particular were often motivated by CHWs to seek services, especially when CHWs are able to accompany them to the health facility, and noted that they were satisfied with the quality of services at the health facility.

Photo by Karen Kasmauski, MCSP.

"It was the CHW who convinced me to come to the hospital. I was only 16 when I was first pregnant, and the risks of complications are high at this age. We have noticed that there are many children who die in our village. I liked the way I was treated at the hospital, and the midwife answered all questions." - Young mother, Miandrivazo

CHWs also reached young fathers. Respondents spoke positively about the information they learned, particularly the importance of facility-based delivery. The focus on the importance of health services for the health of mother and baby resonated with male partners. Responses across participant groups demonstrated that male partners hold significant decision-making power within the couple, and their engagement is critical.

"I think of the health of my child. The most important information for me was to learn that if the delivery is not done in a health center, there are many risks, so I decided to send her to the health facility to do ANC. She was motivated and went there." - Young father, Morondava

However, discussion of information learned or experiences with the health system with others was mixed. Young mothers were more likely to have shared with peers, family members, or their partners. While some young fathers often felt that it was not their place or not appropriate to share with others, others did share their experience with friends.

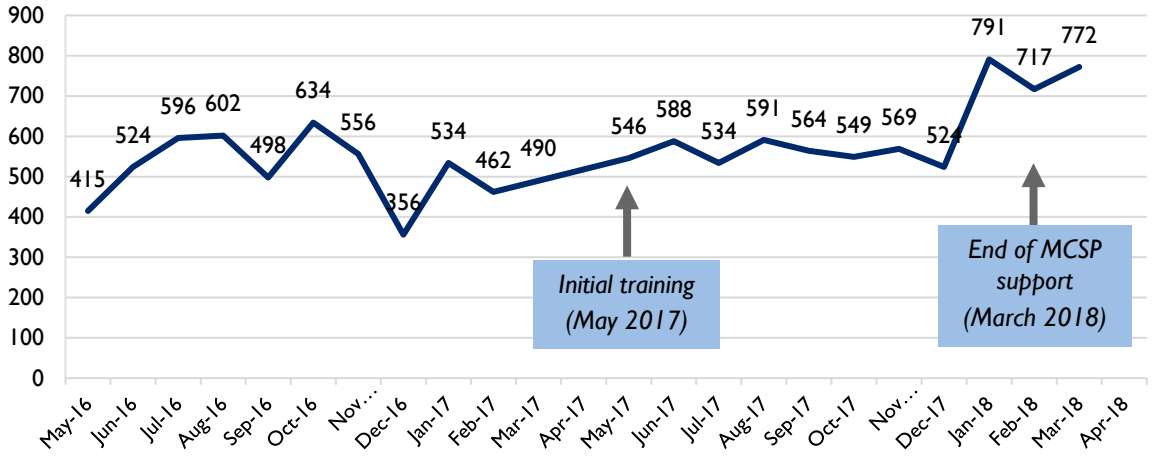
"I spoke with young parents like me and told them about the benefits of going to the health center. What interested me was FP. At work, I talk about my experiences with my colleagues. Some are interested and some even ask questions. They ask,

'Will there be a malformation when we want to have a child again?' I tell them that we should go to a health center for more information." - Young father, Morondava

Impact on Use of Health Services

Health worker and CHW reports of increased use of ANC were confirmed by service data (Figure 4). Monthly ANC visits by adolescents and youth ages 10–24 in the 11 facilities increased from 415 in May 2016 at baseline to 772 in April 2018, after activities had ended. Some providers remarked that use of ANC increased to the point that an unintended consequence was longer wait times. Some reorganized their duties to cope with this increase in client flow by holding separate service times that prioritized FTYPs. However, use of facility-based delivery and FP services by young people did not consistently increase. Respondents cited local insecurity, costs, and other access barriers as prohibitive to using delivery services, and pervasive stock-outs as limiting use of delivery services and FP uptake at health facilities.

Figure 4. Total Number of Monthly Antenatal Care Visits for Adolescents and Youth Ages 10–24 in the 11 Supported Facilities



"The project has had a significant impact on the use of services, especially the increase in the number of ANC visits." - Health provider, Miandrivazo

However, monthly community-based distribution of short-acting FP methods increased from an average of 35 clients ages 10–24 to 76 clients per CHW.

Both health providers and CHWs reported that TMT helped to foster a closer collaboration among health workers, CHWs, and adolescents and youth.

"My collaborations with CHWs and the cohesion between CHWs have improved significantly." - Health provider, Miandrivazo

Challenges

Concern that a focus on FTYPs could incentivize early childbearing: Through learning meetings and the endline documentation, health workers and ministry stakeholders expressed concern about adolescent pregnancy and worried that the focus on those who had already begun childbearing might incentivize adolescent pregnancy. Early in the project's implementation, some stakeholders pushed for a focus on preventing adolescent pregnancy rather than on the needs of FTYPs. Careful messaging in subsequent learning meetings was a helpful midcourse correction to clarify the connection between FTYPs and national and regional RMNCH goals.

Need for continued focus on health systems strengthening: While the TMT proof of concept made progress in building capacity of health system actors to better address the needs of FTYPs, factors within and beyond the health sector require further investment to facilitate FTYPs' access to health services. Notably, service and transport costs are prohibitive, and in many communities, insecurity, often in the form of banditry

on the roads, discourages families from traveling to seek health services. Further, stock-outs of essential commodities and supplies remained problematic and limited the uptake of FP services.

> *"When I talk to young mothers and their families about the importance and benefits of coming to the hospital, they often say, 'We are afraid and ashamed of our poverty, especially since the woman welcomes you badly when you do not have enough money for prescriptions,' or 'We are afraid to go out at night because of insecurity.'"* - Health provider, Morondava

Recommendations

The TMT proof of concept demonstrated that FTYPs, both mothers and fathers, can be effectively engaged through CHWs in Madagascar. TMT tools were well received among users, including beneficiaries, providers, and family members, and health providers were challenged and motivated to offer welcoming services to young parents. Further, the proof of concept showed several programming implications with relevance for global FTYP programs.

Photo by Karen Kasmauski, MCSP.

- **Complement program activities with national advocacy.** Direct program implementation efforts should be complemented by national advocacy to ensure that FTYPs are included in national policies and strategies.
- **Use clear messaging around the focus on FTYPs.** When specifically targeting FTYPs, programs should be clear about the need for comprehensive youth and ASRH programs tailored to the needs of adolescents and youth based on their age and life stage to be clear that efforts do not incentivize early childbearing.
- **Use a broad RMNCH lens that considers the full range of health needs of FTYPs.** A reproductive life course focus was strategic for addressing concerns about family health and fostering connections to the health system early in pregnancy.
- **Ensure facility interactions are positive.** FTYPs appreciated the warm welcome they received at health facilities, an important motivator to return, and invitation cards helped to communicate that FTYPs are expected and welcome to use health services. Invitation cards are a simple, low-cost, powerful tool for encouraging FTYPs to use health services.
- **Balance community norms transformation with health systems strengthening.** While community activities and household visits led by CHWs helped remove some of the taboos associated with discussion of sexuality and encouraged FTYPs to visit health facilities, systems barriers, such as costs, stock-outs, and transportation, limited continued use of services for some FTYPs. A multifaceted approach involving transformation of norms at the community level and strengthening of health systems is important for fully addressing barriers that limit continued use of health services by FTYPs.
- **Explore scalable platforms for engaging community members and leaders in challenging social norms.** While CHWs are an excellent resource for reaching FTYPs and their family members through home visits, their ability to organize communitywide activities is often limited. Consider developing materials for and training religious leaders, whose platform easily reaches mothers/mothers-in-law and community leaders.
- **Consider a CHW accompaniment model.** Accompaniment by CHWs was a powerful motivator for service use for some FTYPs. Future programs could consider incorporating a more formal accompaniment model to task CHWs with visiting health facilities with FTYPs.

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