Community Engagement Series

MPDSR in Focus: Community Engagement Lessons, Challenges and Insights from Zambia and Uganda

Quality, Equity, Dignity
A Network for Improving Quality of Care
for Maternal, Newborn and Child Health

Welcome

Francesca Palestra
Department of Maternal Newborn Child and Adolescent Health
WHO, Geneva

Part 1: Setting the Scene - Introductory Presentations

- Community engagement in MPDSR
- CHAI's project on Community Mortality Surveillance Systems in Zambia and Uganda

Part 2: Panel discussion on lessons learned

Zambia

- Dr Caren Chizuni, Chief Safe Motherhood Officer, HQ, Ministry of Health
- Mr Paul Bwalya, Nursing Officer Maternal & Child Health, Kasama District, Ministry of Health

Uganda

- Dr Richard Mugahi, Assistant Commissioner in charge of Reproductive and Infant Health.
- Dr Daniel Murokora, Technical Advisor and Lead Obstetrician-Gynaecologist, Ministry of Health

Part 3: Q&A Session

Part 1: Introduction

- **Community engagement in MPDSR –** Mary Mbuo, London School of Hygiene and Tropical Medicine

- **CHAI's project on Community Mortality Surveillance Systems in Zambia and Uganda –** Oluwaseun Aladesanmi, CHAI

© UNICEF/UN037871 1/Diarassouba

Introduction:
The role of community engagement in MPDSR

Mary Mbuo

London School of Hygiene and Tropical Medicine

Quality, Equity, Dignity

A Network for Improving Quality of Care for Maternal, Newborn and Child Health

What is Community engagement in MPDSR

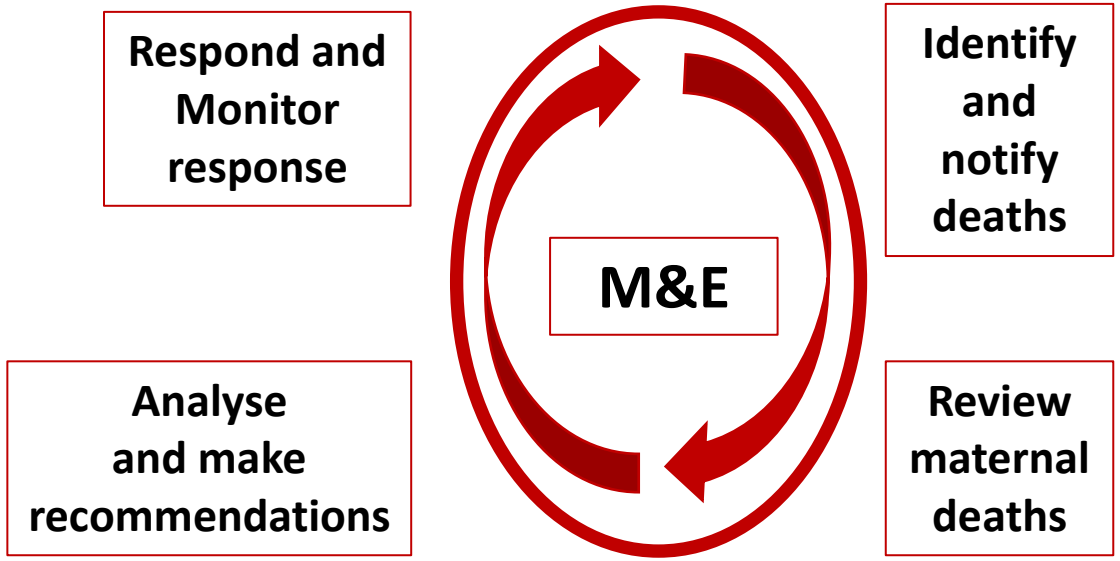
- **Defined** by WHO as *a process of developing relationships that enable stakeholders to work together to address health issues and promote wellbeing to achieve positive heath impact and outcomes'*
  - Involves complex social process with different actors
  - Multiple relationships with social hierarchies

Need to consider

- Capacities of all actors to engage - what they have and what they need for engagement to be meaningful
- Purpose of engagement - what do we want to achieve

What is Community Engagement in MPDSR theorized to do?

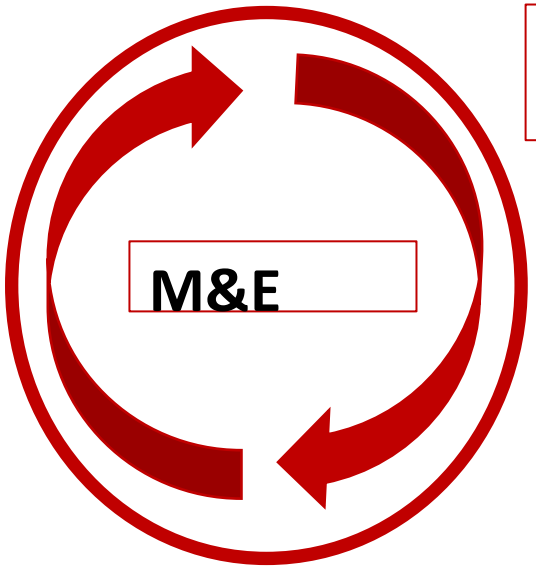
1. Improve data collection on maternal and perinatal deaths through identification and notification of deaths
2. Improve quality of care through death reviews and implementing appropriate actions
3. Improve care seeking behaviour among community members
4. Involve communities in implementing recommendations/actions
5. Increase or establish accountability for MNH through advocacy



Findings from research on Community Engagement in MPDSR

Respond and Monitor response

9 articles



Identify and notify deaths

34 articles

Analyse and make recommendations

18 articles

Review maternal deaths

20 articles

40 articles- LMICs

5 articles- HIC

Conclusions

1. Engagement process requires trust, dialogue, inclusivity, transparency, and accountability among all actors – **Build and maintain relationships**
2. Making **data on deaths visible** to community members and **creating opportunities** to review deaths both in community and health facilities
3. **Building on existing health system** arrangements for reporting such as integrated disease surveillance systems
4. **Training and support** for community informants e.g. supervision and renumeration
5. **Recognize and value community assets** to the process through time, resources, social networks and knowledge
6. **Create enabling environments for engagement** between community members and health professionals
7. **Address blame culture** which remain a critical barrier for engaging communities in review processes

© UNICEF/UNI121487/Esteve

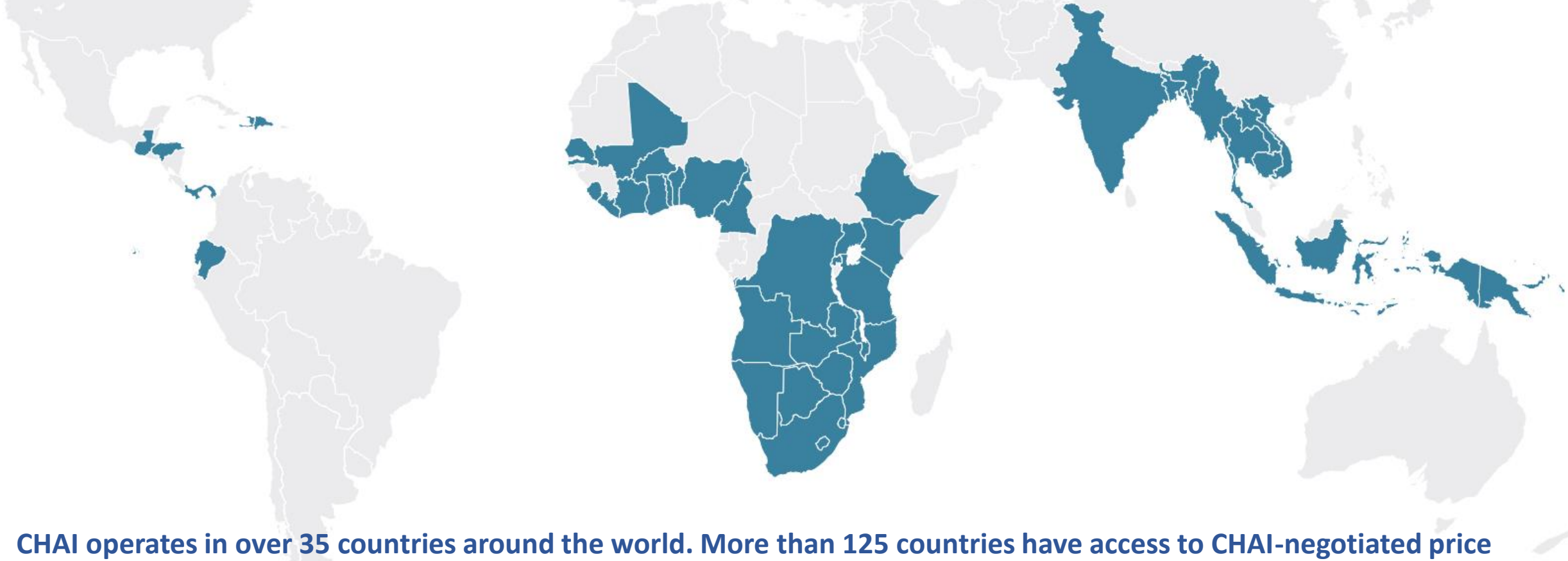
Overview of Community Surveillance of Maternal and Neonatal Mortality and Stillbirths; Country Experiences from Zambia and Uganda

Oluwaseun Aladesanmi
Global Associate Program Director,
Maternal Newborn Health
CHAI

Quality, Equity, Dignity
A Network for Improving Quality of Care
for Maternal, Newborn and Child Health

CLINTON HEALTH ACCESS INITIATIVE

For 20 Years, CHAI's mission has been to save lives and reduce the burden of disease in low- and middle-income countries around the world. We aim to strengthen the government and private sector to create and sustain high-quality health systems in the countries where we work.



CHAI operates in over 35 countries around the world. More than 125 countries have access to CHAI-negotiated price reductions for medicines, diagnostics, vaccines, devices, or other life-saving health products and services.

High-quality, routine data on maternal and neonatal mortality is critical to shaping effective interventions, but many countries lack a system for tracking births and deaths outside of health facilities

- While facility-based reporting systems are well-established in many countries, deaths occurring outside of facilities may not be captured.
- In a pooled analysis of data from 1990 to 2015 across 58 countries in Sub-Saharan Africa, 78% of births took place outside of health facilities.
- Various options exist to capture maternal and neonatal deaths outside the facility are sometimes limited.

Having accurate data on how many, where, and when maternal and neonatal deaths and stillbirths occur is critical to shaping policies and programs to prevent them.

The Uganda and Zambia MOH and CHAI worked together to strengthen systems for recording community-based maternal and neonatal deaths and stillbirths

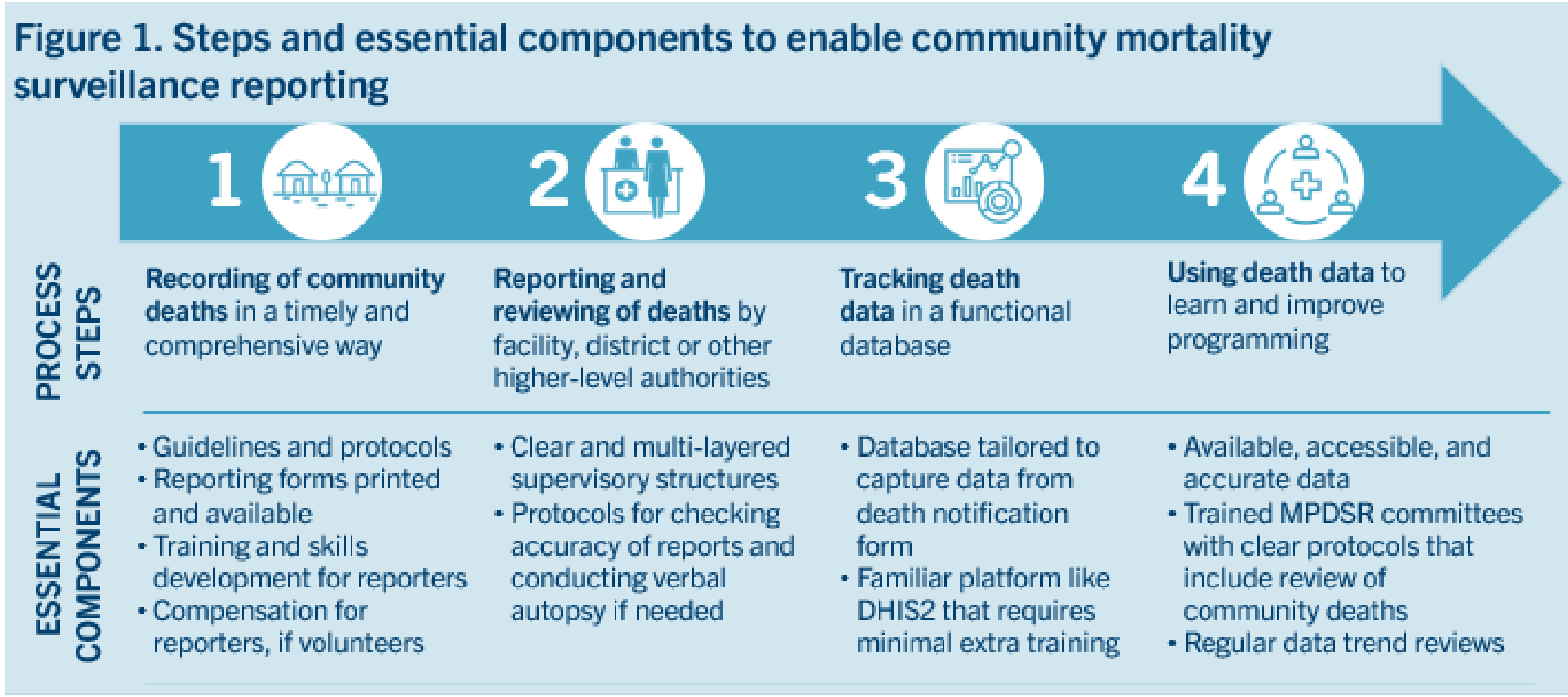
- The system was part of an integrated SRMNH program aimed at reducing maternal and neonatal mortality with a strong focus on community engagement and sustainability.
- Identified complications early to prevent them from becoming life-threatening, intervene as needed to ensure survival, and refer cases quickly to the appropriate health system level for proper treatment

- **MOH and CHAI mobilized existing community-based volunteers to feed maternal and neonatal death reports into facility-based or other government-supported structures.**
- Adapted from a similar model, working with Nigeria FMOH in 2014 where dormant or non-functional community-based health information systems were reactivated, building on the role of traditional leaders.

Two-fold objective - **community tracking and referral of high-risk pregnancies** and **capturing births and deaths** to measure impact.

Four Steps and Essential Components for Community Mortality Surveillance systems

Figure 1. Steps and essential components to enable community mortality surveillance reporting



Ensure **strong government and community engagement and ownership**, and **establish responsibilities, systems, and skills** to ensure that deaths get recorded and reported to facilities. Focus on how to **integrate community deaths into existing systems** that focus on facility-based deaths and review whether those systems are functioning optimally.

The approach in each country was tailored to the context to ensure feasibility and sustainability

High-level summary of the community mortality systems in Zambia and Uganda

System dimension	Zambia	Uganda
Individuals responsible for recording deaths	**Safe Motherhood Action Groups (SMAGs)** (community health volunteers focused on reproductive health	**Village Health Teams (VHTs)** (community health volunteers focused on primary and preventive care)
Individuals responsible for supervision and higher-level reporting	**Community Health Assistants** affiliated with health facilities oversee SMAGs and receive reports, which pass to **District Health Information Officers** for data entry	**Parish Coordinators and Health Assistants** affiliated with health facilities oversee VHTs and receive reports, which pass to the **District Biostatistician** for data entry
Scope of data in community mortality surveillance system	Reports include information on **all births and maternal and neonatal deaths and stillbirths, regardless of where they occur**, as well as **information on ANC and community meeting attendance**	**Death notification registry tracks each maternal and neonatal death and stillbirth that occurs in the community**. Reports also track death data in aggregate form
Frequency and level of data reported	**Monthly reports show the aggregate number** of specified outcomes and data elements per facility catchment area	**Death notifications submitted on a rolling basis** with detailed information about each death; Aggregated data is also submitted quarterly in the HMIS 097 form which captures community-based services

The approach in each country was tailored to the context to ensure feasibility and sustainability

High-level summary of the community mortality systems in Zambia and Uganda

System dimension	Zambia	Uganda
Reporting platform	**DHIS2**	**DHIS2**
Events tracked (2019-2021)	**80,000+ births were tracked, along with 122 maternal and 1581 neonatal deaths/stillbirths** occurring in the community and facilities	**98 maternal and 931 neonatal deaths/stillbirths** in the community were reported
Linkages with Maternal and Perinatal Death Surveillance and Response (MPDSR) systems	**Health facility staff conduct verbal autopsies** to gather more information on community deaths. District-level MPDSR committees review community-based maternal and perinatal deaths that occur in the district.	**Health Assistants from facilities conduct verbal autopsies** to gather more information on community deaths. Facility-level MPDSR committees review community-based maternal and perinatal deaths that occur in that facility's catchment area.
Sustainment and integration into government data systems	Community mortality surveillance was re-prioritized in the **national RMNCAH roadmap in 2022**. The SMAG registers and the aggregate form created by this program were adopted nationally. As of 2021, the **national HMIS includes community mortality** reporting, using data reported by SMAGs.	VHTs report community deaths in the quarterly HMIS 097 form. VHTs are recognized by the government but have been historically equipped and trained by implementing partners. Following this program, **health facility in-charges begun allocation of resources to sustain the VHT workforce using** funds from the World Bank Results Based Financing (RBF), which Government has mainstreamed into the **Public Financial Management System following RBF** closure in 2022/2023 FY.

Project learning: Recommendations for establishing/strengthening community mortality surveillance

Plan for long-term integration into facility-based reporting.

Governments are eager to see community-based mechanisms report deaths in facilities can be activated and operationalized.

Build on existing systems and structures.

To ensure sustainability and efficiency, community mortality surveillance should be built on existing guidelines or policies and through existing structures and stakeholders.

Safe Motherhood Action Group (SMAG) members attending a quarterly meeting near Nsumbu Rural Health Centre in Chilubi District, Zambia

Recommendations for establishing/strengthening community mortality surveillance

Consider trade-offs between aggregate and detailed reporting.

Reporting of aggregate data may be easier to maintain over time but is also more limited in its use and the ability to verify or cross-check data quality. On the other hand, more detailed reporting provides a wealth of information for detailed reviews, but forms may be more burdensome.

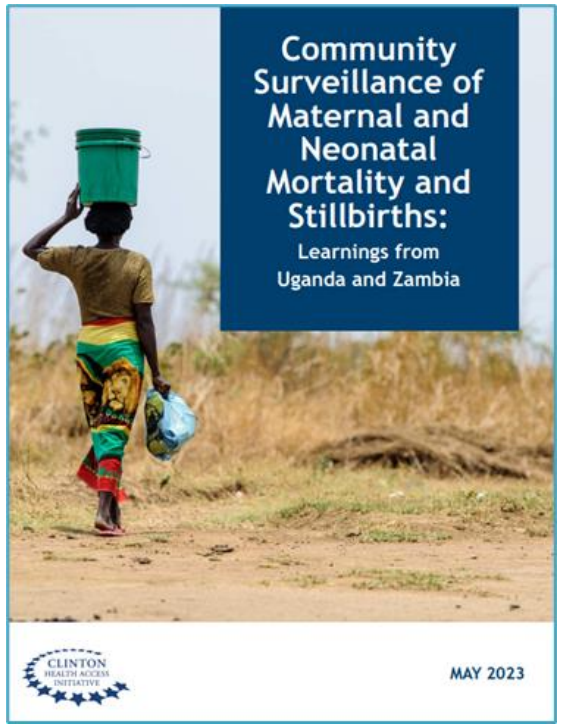
Establish multi-layered supervisory systems.

To cover large geographic areas and populations, large numbers of community volunteers are needed but also require oversight and support.

Data accessibility is critical for enabling use.

Dashboards and scorecards enabling data visualization and access are essential to encouraging use of data to inform programming.

Village Health Team (VHT) member attends a meeting in Malangala, Uganda.



For additional details on the **learnings on Community MPDSR by CHAI** see link to a brief: [Maternal and neonatal mortality and stillbirths' community surveillance: lessons from Uganda and Zambia - Clinton Health Access Initiative]


PLOS GLOBAL PUBLIC HEALTH

RESEARCH ARTICLE

Reducing maternal and neonatal mortality through integrated and sustainability-focused programming in Zambia

Aniset Kamanga[1‡], Lupenshyo Ngosa[2‡], Oluwaseun Aladesanmi[3], Morrison Zulu[1], Elizabeth McCarthy[2], Kennedy Choba[2], James Nyirenda[4], Caren Chizuni[2], Angel Mwiche[4], Andrew Storey[2], Hilda Shakwelele[1], Margaret L. Prust[2*]

1 Clinton Health Access Initiative, Inc., Lusaka, Zambia, 2 Clinton Health Access Initiative, Inc., Boston, MA, United States of America, 3 Zambia Ministry of Health, Lusaka, Northern Province, Zambia, 4 Central Office, Zambia Ministry of Health, Lusaka, Zambia

‡ AK and LN contributed equally to this work (Co-first authors).
* mprust@clintonhealthaccess.org

Abstract

OPEN ACCESS

Reducing maternal and neonatal mortality is a critical health priority within Zambia and globally. Although evidence-based clinical interventions can prevent a majority of these deaths, scalable and sustainable delivery of interventions across low-resource settings remains uneven, particularly across rural and marginalized communities. The Zambian Ministry of Health and the Clinton Health Access Initiative implemented an integrated sexual, reproductive, maternal, and newborn health (SRMNH) program in Northern Province aimed at dramatically reducing mortality over four years. Interventions were implemented between 2018 and 2021 across 141 government-owned health facilities covering all 12 districts of Northern Province, the poorest performing province nationwide and home to over 1.4 million people, around six pillars of an integrated health system. Data on institutional delivery and antenatal and postnatal care were collected through the national Health Management Information System (HMIS). A community-based system for capturing birth outcomes was established using existing government tools and community volunteers since HMIS did not include community-based mortality. Baseline and endline population-based mortality rates were compared for program-supported areas. From the earliest period of population-based mortality reporting in 2019 to program end in 2021, there were statistically significant decreases of 41%, 45%, and 43% in maternal, neonatal, and perinatal mortality rates respectively. Between 2017 to 2021, institutional maternal, neonatal, and perinatal mortality rates across entirety of Northern Province reduced by 12%, 40%, and 41%, respectively. Service readiness and coverage for SRMNH services improved dramatically, supporting increased numbers of patients. Significant mortality reductions were achieved over a relatively short period, reinforced through an emphasis on sustainability and strengthening existing government systems. These results were attained through a consciously cost-efficient approach backed by substantially lower levels of external investment relative to prior programs, allowing many of the interventions to be successfully adopted by government within public sector budgets.

PLOS Global Public Health | https://doi.org/10.1371/journal.pgph.0001162 December 14, 2022 1 / 18

For more on **program results from Zambia**. Kamanga A, Ngosa L, Aladesanmi O, Zulu M, McCarthy E, Choba K, et al. (2022) [Reducing maternal and neonatal mortality through integrated and sustainability-focused programming in Zambia | PLOS Global Public Health]

Acknowledgments - This work represents the product of the efforts of many more individuals at CHAI and the Ministries of Health in Zambia and Uganda.

For CHAI: Aniset Kamanga, CHAI Zambia **Micheal Lyazi**, CHAI Uganda
Andrew Storey, CHAI Global MNH **Margaret Prust**, CHAI Analytics and Implementation Research Team

We gratefully acknowledge the financial support for this project from the ELMA Foundation

Part 2:
Panel Discussion

Quality, Equity, Dignity
A Network for Improving Quality of Care
for Maternal, Newborn and Child Health

Part 2: *MPDSR in Focus: Community Engagement Lessons, Challenges and Insights from Zambia and Uganda*

Zambia

- Dr Caren Chizuni, Chief Safe Motherhood Officer, HQ, Ministry of Health
- Mr Paul Bwalya, Nursing Officer Maternal & Child Health, Kasama District, Ministry of Health

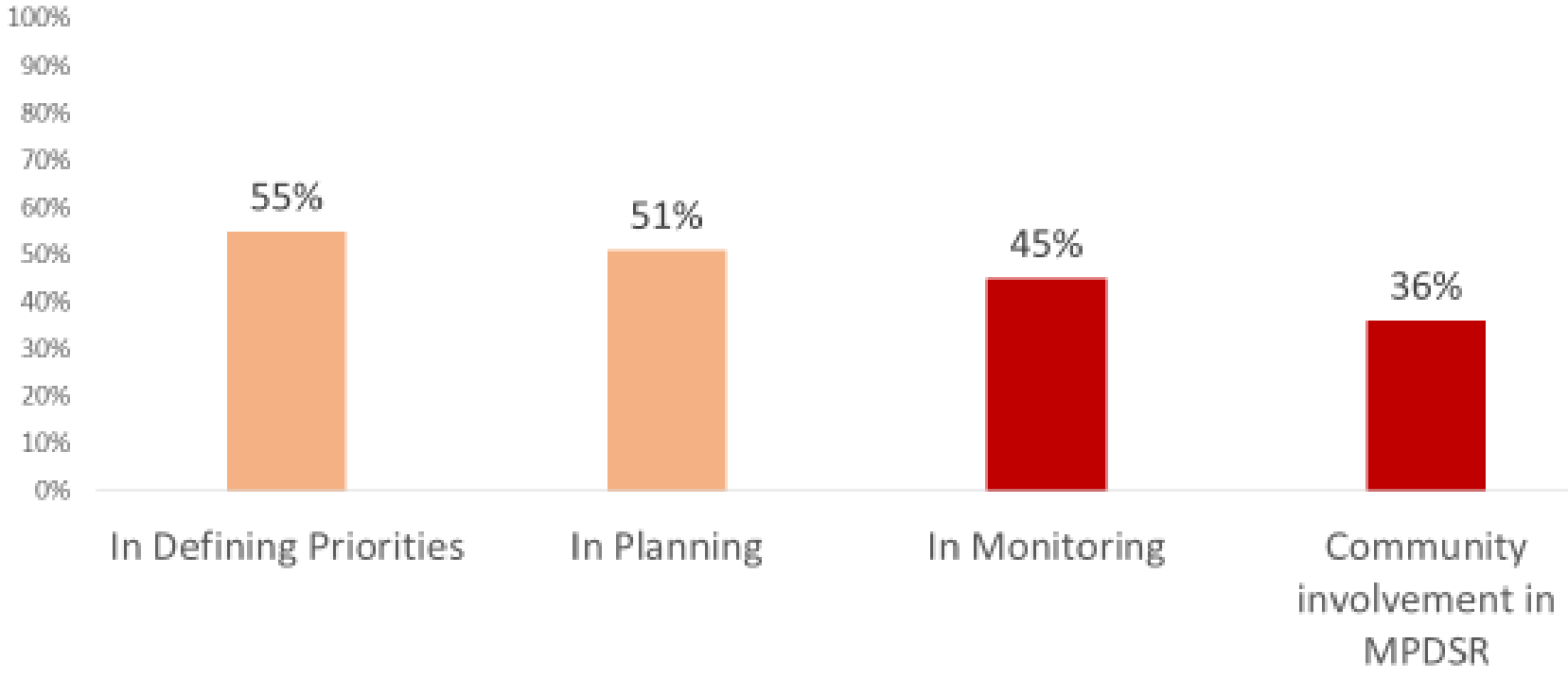
Uganda

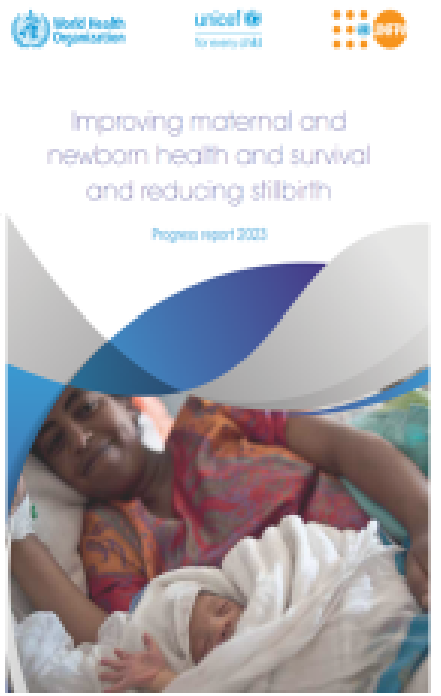
- Dr Richard Mugahi, Assistant Commissioner, Reproductive and Infant Health, Ministry of Health
- Dr Daniel Murokora, Technical Advisor and Lead Obstetrician-Gynaecologist, Ministry of Health

Facilitated by Olive Cocoman

Learning Lead, Quality of Care Network, WHO Secretariat, Geneva.

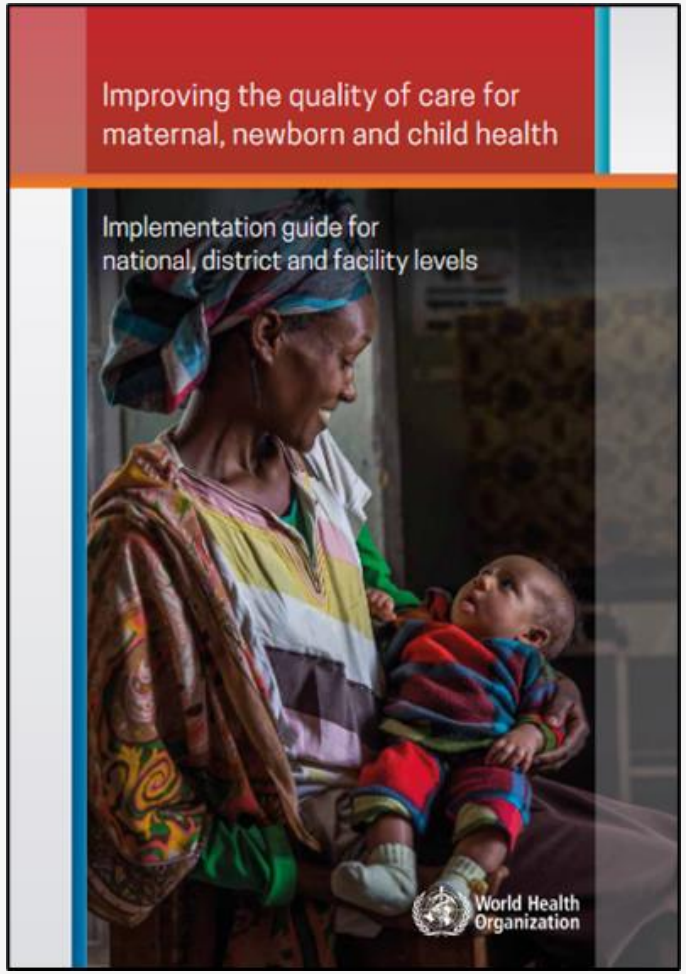
Progress for Community Engagement by 2023

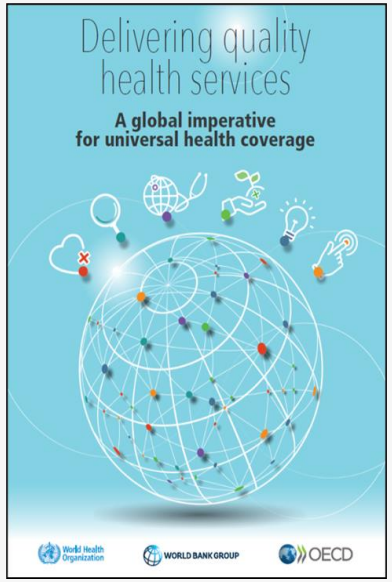


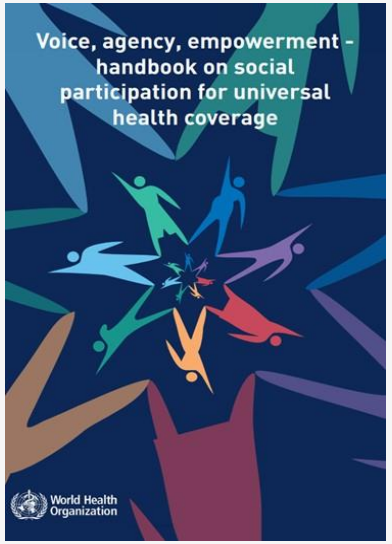


% of 106 Countries with MNH Plan Factoring in Community Participation

Source: MNH Progress Report 2023. WHO, UNICEF and UNFPA May 2023







WHO Recommendations

WHO implementation guidance on improving the quality of MNCH posits community engagement is a core system that is critical to achieving quality MNCH as both a means and an end;

1. to ensure accountability for quality care

2. to help identify gaps, prioritize concerns, monitor performance and provide solutions to improving quality of care

(World Health Organization and Bank, 2018, WHO, 2016, WHO, 2020, WHO, 2021, WHO, 2022).

Part 2: Questions & Answers

Please type your questions in the CHATBOX

Quality, Equity, Dignity
A Network for Improving Quality of Care
for Maternal, Newborn and Child Health

STAY ENGAGED

- Visit website: https://www.qualityofcarenetwork.org/about